LIVED EXPERIENCES OF ACCESSING HEALTHCARE SERVICES BY REFUGEES IN SOUTH AFRICA

by

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SUPERVISOR: PROF RMM MMUSI-PHETOE

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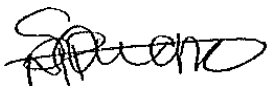
DECLARATION

I declare that **LIVED EXPERIENCES OF ACCESSING HEALTHCARE SERVICES BY REFUGEES IN SOUTH AFRICA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other education institution.



14 January 2018

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SIGNATURE **DATE**

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LIVED EXPERIENCES OF ACCESSING HEALTHCARE SERVICES BY REFUGEES IN SOUTH AFRICA

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ABSTRACT

The purpose of the study is to investigate lived experiences of refugees when accessing healthcare services in Pretoria, South Africa.

A qualitative phenomenological research approach was followed which assisted in exploring and describing the day-to-day lives of refugees living in Pretoria regarding their health outcomes. Face-to-face interviews were conducted on purposively selected participants, representing refugees from different African countries ranging from age 27 to 58 years. Collected data were transcribed, coded, and relevant themes were extracted and analysed by employing Colaizzi's seven-step analysis framework.

Main findings demonstrated that the public healthcare services accessed by refugees, compared to private healthcare services, can be described as mostly dysfunctional. Also, healthcare providers from public healthcare services are often hostile towards refugees of African descent. Failure to speak a local language, unofficial documentation as viewed by a healthcare provider on duty, being a foreigner, and failure to pay undue consultation fees led to refugees being denied access to healthcare or receiving negative treatment in the public healthcare sector.

Recommendations for programmes to promote human rights and refugee awareness in healthcare facilities could subsequently contribute to alleviating complications around access to healthcare services, which would denote improved health outcomes for the refugees.

Key terms

Access; healthcare services; health-seeking behaviour; lived experiences; refugees.

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- Last but not least, my gratitude goes to all the refugees who participated in this study. Without you, this dissertation would not have been possible.

Dedication

I dedicate this study to my daughter, Hitekani Ngobeni, for her to grow and be an advanced scientific researcher outshining her parents.

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LIST OF ABREVIATIONS

CoRMSA	Consortium for Refugees and Migrants in South Africa
DoH	Department of Health
DHA	Department of Home Affairs
DRC	Democratic Republic of Congo
FF	Future Families
FGM	Female genital mutilation
NDP	National Development Plan
NPO	Not-for-profit organisation
SADPMA	South African Department of Planning, Monitoring and Evaluation
SADC	Southern African Development Community
UDHR	Universal Declaration of Human Rights
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

CHAPTER 1

INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION

This study focuses on lived experiences of selected refugees living in Pretoria, South Africa in accessing healthcare services. It illustrates existing legislations in addressing health issues of the country and whether these legislations are implemented with regard to public healthcare services for refugees. The study reflects the reality of healthcare services towards refugees as opposed to what is written on paper. Findings show that there is a contradiction between existing legislation and the practice of healthcare services.

Chapter 1 provides an overview of the study, including background information about the research problem, the aim of the study, significance of the study, definitions of key concepts, research design and method, and conclusion.

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

The number of displaced people in the world (including asylum seekers, internally displaced populations and refugees) has reached 65.3 million by 2015 (United Nations High Commissioner for Refugees (UNHCR) 2015). In sub-Saharan Africa only, there were about 24.2 million people displaced in 2017 (UHNCR 2018:01). From the estimated number, 6.3 million were reportedly refugees while 14.5 million were internally displaced persons (IDPs) due to conflicts regularly taking place in countries such as Central African Republic, the Democratic Republic of the Congo (DRC), Nigeria, Somalia, and South Sudan (UHNCR 2018:01). UNHCR (2013) cited in Zihindula, Meyer-Weitz and Akintola (2015:9) reports that Southern Africa hosted about 145,000 refugees from Rwanda, Burundi, DRC, Pakistan, Bangladesh and Somalia. The reasons for fleeing one's country could be varied; however, they are mostly war related (United Nations High Commissioner for Refugees 2015; Zihindula et al 2015:9). When one considers the statistics provided and the fact that many refugees come from war zones and where they witnessed horrific crimes, and they suffered severe

hardships during travelling such as sleeping with no shelter, lack of food, dehydration, etc., it stands to reason that refugees are more likely to suffer health problems such as stress, depression, heart disease, asthma, etc. Refugees may seek healthcare services as soon as they arrive in the host country, which includes South Africa (Langlois, Haines, Tomson & Ghaffar 2016:320).

In South Africa, refugees experience different challenges when accessing healthcare services, and these challenges could have an impact on their health for various reasons (Majola 2017). A literature review study conducted in Southern African countries on access to healthcare services by refugees found that the language barrier has been identified as one of the principal factors that lead to discrimination towards refugees when accessing healthcare centres in South Africa (Zihindula et al 2015:25). They are mostly discriminated against by healthcare providers as there are no interpreters to assist with consultation, which sometimes leads to their being denied healthcare services (Hunter-Adams & Rother 2017:4).

In South Africa, refugees have the same rights as South African citizens with regard to accessing socio-economic services, except the right to vote (Khan & Schreier 2014:221). These socio-economic services include access to free public healthcare services for all. This comes from Section 27(g) of the Refugees Act, which states that a refugee is "entitled to the same basic healthcare services and primary education which the inhabitants of the Republic receive from time to time" (South African Department of Home Affairs 1998). It is also supported by Section 27 of the South African Constitution that states, “everyone has the right to have access to healthcare services, including reproductive healthcare” (Department of Justice and Constitutional Development 1996:10). It further states, "no one may be refused emergency medical treatment" (Department of Justice and Constitutional Development 1996:10).

Despite all the laws and policies that support and condone refugee rights to accessing free healthcare services, there is a gap between practice and the law. Healthcare providers sometimes deny refugees access to healthcare services because they are xenophobic, or it may be that they are not aware of the rights of refugees or ‘refugee status’ document used by refugees in South Africa (Khan & Schreier 2014:229). Public healthcare services in South Africa are free to any citizen residing in South Africa.

However, there are refugees who are forced to pay fee if they want assistance in a hospital (CoRMSA 2011:34).

1.3 RESEARCH PROBLEM

Refugees and other displaced populations continue to face challenges, deprivation of needs and suffering in their host countries, including South Africa. These challenges include failure to meet the healthcare needs of refugees and providing access to public health services, mainly due to a lack of appropriate documentation, language and communication barriers, and healthcare workers being unfamiliar with women's health problems (CoRMSA 2011:105).

Often, neither the healthcare providers nor the refugees are aware of the legislative rights that they (the refugees) are entitled to, such as those enshrined in Section 27 of the Refugees Act (Act No. 130 of 1998) (South African Department of Home Affairs. 1998) and the South African Constitution (Act No. 108 of 1996) (South African Department of Justice and Constitutional Development 1996). According to Section 27(1) of the Refugees Act (Act No. 130 of 1998), everyone including the refugees has the right to have access to healthcare services, including reproductive healthcare (Department of Justice and Constitutional Development 1996:10). The state has an obligation to protect and ensure realisation of such rights by taking reasonable legislative and other measures within its available resources. Chapter 2 of the South African Constitution (Act No. 108 of 1996) holds that a refugee is entitled to the same basic health services which the inhabitants of the Republic receive from time to time (Department of Justice and Constitutional Development 1996).

On the other hand, the South African government has claimed that the influx of refugees into the country presents an immense burden to the South African health system (Khan & Schreier 2014:230). The strain placed on health systems threatens the ability to meet the health needs of both refugees and South African citizens (Mayosi & Benatar 2014:1344). In light of the limited published studies on the increasing challenges faced by the refugees in accessing health services, as well as those faced by the South African government to meet the healthcare needs of the refugees, this study seeks to explore the experiences of the refugees in accessing healthcare services in South Africa.

1.4 AIM OF THE STUDY

1.4.1 Research aim/purpose

The purpose of the study is to investigate the lived experiences of accessing healthcare services by refugees in South Africa.

1.4.2 Research objectives

- To explore and describe the lived experiences of accessing healthcare services by refugees in South Africa.
- To recommend for the development of information material that informs refugees of their right to healthcare services by using existing legislation such as the Refugees Act and the Constitution.

1.4.3 Research questions/hypotheses

- What are the refugees' lived experiences of accessing healthcare services in South Africa?
- What should be done to make sure that the existing legislation on refugee rights to healthcare services is universal to both refugees and healthcare professionals in South Africa?

1.5 SIGNIFICANCE OF THE STUDY

The research findings of the study may contribute to policy improvement in the healthcare profession and awareness of refugees' rights with regard to provision of healthcare in South Africa. Hopefully, it will lead to a reduction in any form of discrimination encountered by refugees from healthcare providers.

1.6 DEFINITIONS OF TERMS

1.6.1 Access

In healthcare systems, access is an "instrumental or intermediate goal of health systems" (Schneider et al 2006; Gulliford et al 2002 cited in Zihindula et al 2015:10). Access to healthcare services is thus "only important if it leads to improved population health promotion, satisfaction, disease prevention and patient satisfaction" (Zihindula et al 2015:10).

1.6.2 Experiences

Experiences "involve gaining knowledge by being personally involved in an event, situation or circumstance" (Grove, Burns & Gray 2014:17).

1.6.3 Healthcare services

Healthcare services (HCS) is defined as "services provided to people or communities by agents of health services or professions for the purpose of promoting, maintaining, monitoring, or restoring health" (*Farlex Partner Medical Dictionary* 2012 cited in Zihindula et al 2015:9).

1.6.4 Refugees

The term 'refugee' applies to "every person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either a part or the whole of his or her country of origin or nationality, is compelled to leave his or her place of habitual residence in order to seek refuge in another place outside his country or origin or nationality" (Khan & Schreier 2014:75).

1.7 RESEARCH DESIGN AND METHOD

1.7.1 Approach

The qualitative research approach was used in this study as it deals with human lived experiences and natural settings to explore them and give them meaning. The approach was used to investigate the real-life situation of refugees when accessing healthcare services through in-depth face-to-face interviews. The focus was on the lived experiences of accessing healthcare services by refugees in Pretoria, Gauteng.

1.7.2 Research design

The study is also a descriptive phenomenological research as it describes barriers that refugees encountered in accessing healthcare, and also explains reasons why most refugees suffer from these hardships in the healthcare sectors of South Africa. The chosen study design assisted the researcher to explore and describe the lived experiences of refugees in accessing healthcare services.

1.7.3 Setting and population of the study

The study identified participants among the refugee population group who were formally recognised by the South African government as refugees. This meant obtaining a "Formal Recognition of Refugee Status" (Section 24 of the Refugees Act) issued by the South African Department of Home Affairs (1998). Refugees who participated in the study were identified through the FF organisation. FF is a not-for-profit organisation (NPO) that provides socio-economic assistance (food vouchers, agent accommodation, money for rent, business start-up, etc.) to vulnerable populations, mainly refugees, in South Africa. FF assisted in identifying refugees for the study, as they have assisted thousands of refugees in the country who approached the organisation for help. It was easier to approach refugees through FF since it has a database with lists of refugees from different countries.

Data collection took place at the FF compound. The FF database was used to identify and select potential participants for the study. The FF facilities were also used as a venue to host briefing meetings (to introduce the study to potential participants) and

interviews, which were privately held with participants in one of the offices. Short one-on-one interviews that lasted between seven (7) and fifteen (15) minutes per interview were undertaken over a period of seven (7) different days, with an average of two (2) to three (3) participants per day.

1.7.4 Sample and sampling method

The non-probability purposive sampling method was used in the process of selecting participants. To purposefully select participants means that individuals who are selected will best help understand the research problem and the research question (Creswell 2014:294). Selected refugees were in possession of a Section 24 document of the Refugees Act, and resided in Pretoria. All refugees were originally from other African countries such as Somalia, Ethiopia, DRC, Burundi, Eritrea, etc. They were able to communicate in English; however, an interpreter was used for only two (2) participants who believed they would not be able to express their experiences properly, since they could only speak Basic English. This study interviewed eighteen (18) refugees and the sample size was determined on the basis of theoretical saturation; that is, the point in data collection where new data no longer bring additional insights to the research questions (Creswell 2014:239). During data collection, the researcher discovered that the interviewed participants experienced similar outcomes in accessing healthcare services.

1.8 SCOPE OF THE STUDY

The study was based in Pretoria, Gauteng, and only refugees residing in Pretoria were interviewed. Refugees who were unable understand basic English were not included in this study. Only refugees who held formal recognition documentation from the Department of Home Affairs were recruited to share their lived experiences in accessing healthcare services in South Africa.

1.9 STRUCTURE OF THE DISSERTATION

This research study consists of five chapters:

Chapter 1 provides background information of the study, which serves to build an understanding of the research problem, aims and objectives of the study.

Chapter 2 focuses on literature with regard to refugees' lived experiences in accessing healthcare services in South Africa. The literature illustrates the views of various scholars on access to healthcare services by refugees, daily experiences, and explored findings of previous researchers on access to healthcare by refugees.

Chapter 3 explains the methodology used to conduct the study and all procedures followed for data collection, ethical considerations and data analyses.

Chapter 4 presents demographics of participants and study findings. The study findings are described, interpreted and compared with other researchers and verbatim quotes are used as examples of the presented findings.

The final chapter, Chapter 5, comprises a summary of the study findings, limitations of the study, recommendations, and the conclusion of the study.

1.10 CONCLUSION

This chapter has provided an overview of the research study, including the problem statement, research objectives, research questions of the study and definitions of key words. Chapter 2 provides a literature review of the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter provides a literature review that examines the various experiences of refugees in accessing healthcare services in South Africa. Refugees encounter both negative and positive experiences when accessing healthcare services. However, the literature shows that refugees mostly encounter negative experiences in the South African public healthcare services. There are various reasons that led to refugees experiencing negative practices in accessing healthcare services in South Africa. These reasons are discussed in detail in this chapter. The literature firstly discusses international and national legislations available in South Africa that supports refugee rights of free access to healthcare services. This study will show how language, documentation, access to healthcare procedures, xenophobia, healthcare providers, etc. shape the health of refugees in South Africa. It should also be mentioned that refugee men and refugee women sometimes encounter different experiences due to different healthcare needs.

2.2 GENERAL BACKGROUND OF LIVED EXPERIENCES OF REFUGEES

There is no doubt that the various experiences of refugees in accessing healthcare differ from country to country and from location to location (such as rural or urban areas). A country of destination may determine the refugees' experiences and their health outcomes (Lionis, Petelos, Mechili, Sifaki-Pistolla, Chatzea, Angelaki, Rurik, Pavlic, Dowrick, Dückers & Ajdukovic 2018:4). In South Africa, refugees face different challenges when accessing healthcare services, and these challenges have an impact on their health for various reasons (Zihindula et al 2015:11). These experiences will also differ, based on where the health facility is located, the attitude of the healthcare provider, the awareness of the healthcare provider towards refugee documentation, the type of language spoken in the host country, the availability of resources, etc. For example, in South Africa it has generally become common practice that healthcare facilities that are based in urban areas (Gauteng) demand that an ID/passport document

be presented before allowing any patient to consult a healthcare provider. On the on other hand, healthcare facilities based in rural areas do not require any kind of identity documentation before providing healthcare services.

Social inequalities also shape the health outcomes and experiences of refugees. Walls, Vearey, Modisenyane, Chetty-Makkan, Charalambous, Smith and Hanefeld (2016:14) argue that some refugees in the country of destination face health challenges mostly associated with bad living and working conditions, overcrowded living spaces, poor food security, limited livelihood opportunities and (fear of) violence. The authors further argue that these challenges are exacerbated by social exclusion and socio-economic hardships resulting from barriers to accessing social services, including healthcare. Consequently, refugees are often more likely to seek healthcare services in their host countries, which includes South Africa (Mangrio & Sjögren-Forss 2017:4; Zihindula et al 2015:12). Refugees in South Africa encounter different experiences depending on the attitude of the staff on duty or healthcare facilities that do not have sufficient staff and equipment, which often result in some healthcare providers feeling that resources should be used for South African citizens only (Koneshe 2016:81).

2.3 LEGISLATION ON PUBLIC HEALTHCARE

2.3.1 International legislation

2.3.1.1 The Constitution of the World Health Organization (WHO) of 1948

Intergovernmental organisations fight for free access to healthcare for every person living in any country in the world without discrimination on the basis of their citizenship. Free access to healthcare should be irrespective of the citizenship of an individual and should be provided to those who need it. Refugees' rights to access healthcare services in host countries are supported by the Constitution of the World Health Organization (WHO) of 1948. The Constitution of the WHO declares that “every human being has a right to access health” (World Health Organization 1948). The Constitution of the WHO does not view access to healthcare as only a need for a person's wellbeing, but as a right, and that such right should not be determined by race, political belief, religion, or economic or social condition. This means that every individual should be able to freely access public healthcare services.

2.3.1.2 Universal Declaration of Human Rights (UDHR) of 1948

The Universal Declaration of Human Rights (UDHR) promotes healthcare as a right. It is supported by Article 25 of the Universal Declaration of Human Rights of 1948. It states that "… everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control". However, not every country implements the Universal Declaration of Human Rights in its health rights. It could be that the Universal Declaration is not well established in some countries or simply not compatible with domestic legislation on health in some countries (United Nations Office of the High Commissioner for Human Rights 1948). In the case of South Africa, the Universal Declaration shares the same vision with local legislation such the Constitution, the Refugee Law, and the National Health Act in supporting free access to healthcare service for every individual.

2.3.2 Domestic legislation

2.3.2.1 Constitution of South Africa

The Constitution of South Africa is the cornerstone of all legislations used for all decisions made by the South African government. Section 27(1), Chapter 2 of the Constitution of South Africa (Act No. 108 of 1996) states that "everyone has the right to have access to healthcare services, including reproductive healthcare" and Section 27(2) states that "the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights", while Section 27(3) states that "no one may be refused emergency medical treatment" (Department of Justice and Constitutional Development 1996). Even though the Constitution does not directly state the rights of refugees to access healthcare, the Constitution includes everyone living in the country. Refugees therefore have the same right to access healthcare services as the citizens of South Africa. This means that even if the country struggles to provide enough resources to provide healthcare to its own citizens, no refugee may be discriminated against. The available resources for

healthcare should be equally distributed to every person who may be in need of medical treatment.

2.3.2.2 Refugees Act of South Africa (Act No. 130 of 1998)

Refugees who are formally recognised and granted Section 24 Refugee Status are entitled to all social and economic rights enjoyed by South African citizens, except for the right to vote (Fatima & Schreier 2014:221). Section 27(g), Chapter 5 of the Refugees Act also clearly states that "A refugee is entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time" (South African Department of Home Affairs 1998). Again, this supports refugees' rights to free access to public healthcare service provided by the government of South Africa to its citizens. However, what refugees in South Africa actually experience is totally different from the legislation that has been put in place.

2.3.2.3 National Health Act (Act No. 61 of 2003)

The National Health Act was developed to address issues of inequality in public healthcare services. It follows in the footsteps of the Bill of Rights stated in the South African Constitution. The National Health Act reiterates what the Constitution of South Africa states in Section 27(3), namely that "No one may be refused emergency medical treatment"; and in terms of Section 28(1)(c) that "every child has the right to basic healthcare services" (South African Department of Health 2004). Chapter 2 of the National Health Act, Section 20(1) further states that “healthcare personnel may not be unfairly discriminated against on account of their health status” (South African Department of Health 2004). The National Health Act further states that any person who is vulnerable (lactating women, children, people with disabilities, etc.) and any person who does not have medical aid has a right to free primary healthcare services. Refugees are mostly found in vulnerable populations with low earning income that qualify for free primary healthcare services, as it is more likely that they are not paying for any kind of medical aid.

2.3.2.4 National Development Plan (NDP) Vision 2030

Chapter 10, Goal 8: Universal Healthcare coverage, of the National Development Plan vision 2030 states that (a) “Everyone must have access to an equal standard of care, regardless of their income”, and (b) “A common fund should enable equitable access to healthcare, regardless of what people can afford or how frequently they need to use a service” (South African Department of Planning, Monitoring and Evaluation 2012:334). The NPD clearly states that every person living in South Africa has the right to access healthcare services regardless of any circumstances. However, this does not apply to many refugees living in the country.

2.4 HEALTHCARE ACCESS BY REFUGEES IN SOUTH AFRICA

2.4.1 Cost of healthcare services in South Africa

Walls et al (2016:14) argue that the Southern African Development Community (SADC), especially South Africa, receives the greatest number of migrants in Africa. South Africa is home to vast number of people suffering from highly communicable diseases and other diseases (such as HIV) and is struggling with its public healthcare systems. There are policies put in place stating that the public healthcare service in South Africa is free to any citizen residing in South Africa. However, accessing free healthcare has become a political issue. Free access to healthcare is sometimes determined by a person's citizenship. Some refugees are forced to pay a fee or upfront fee before they are offered assistance in a hospital (Wicks 2017). This forces some refugees to opt for self-medication due to fear of being discriminated against or being denied healthcare services, or to avoid being questioned about their citizenship by healthcare providers (Tshabalala & Van der Heever 2015:284). Self-medication may also pose a problem for their health-seeking behaviour, as medication can be costly. On the other hand, those who are asked to pay fees in public hospitals may be unable to pay (Tshabalala & Van der Heever 2015:284). The circumstances around being asked to pay a fee before consulting a healthcare provider compromise health outcomes because refugees are more likely to be employed in low-paying jobs and they might avoid consulting any healthcare professional when they fall ill.

2.4.2 Access to healthcare services and procedures

Generally, in South Africa, when one falls ill, one should consult a clinic or local healthcare centre first before being referred to a hospital. It is a general procedure that is expected to be followed by each individual to avoid unnecessary overcrowding in hospitals. However, refugees are most likely not aware of the procedures, which sometimes lead to their being denied assistance when taken to a hospital at the first occurrence of an illness. Refugees who are not aware of this procedure risk being sent back to visit a local clinic or health centre before being referred to hospital. Some refugees who reside in urban areas live near hospitals. However, it if often the case that they are not close to a local clinic, which poses the challenge of leaving the hospital that is nearby, and trying to find a clinic when they fall ill.

2.4.3 Language barrier

A literature review study conducted in Southern African countries on access to healthcare services by refugees, has found that the language barrier has been identified as one of most prominent factors leading to discrimination against refugees when accessing healthcare centres in South Africa (Zihindula et al 2015:25). Refugees are mostly discriminated against by healthcare providers because there are no interpreters to assist with consultation in the healthcare facilities, which sometimes leads to their being denied healthcare services (Campbell, Klei, Hodges, Fisman & Kitto 2014:172). Tshabalala and Van der Heever (2015:281) argue that South African healthcare providers are not willing to assist non-South Africans if they are unable to express themselves in a language convenient for the healthcare providers. They further argue that some of the healthcare providers are also not willing to speak English, even though documents are written in English. Healthcare providers feel they are not obliged to speak English with refugees, and those who visit healthcare facilities should have at least learnt one South African language (Koneshe 2016:81). Another challenge faced by refugees is that no interpreters are available to assist them in communicating with healthcare providers in South African public healthcare facilities (Koneshe 2016:81).

2.4.4 Documentation matters

One (1) of the reasons that refugees are denied access to healthcare is the lack of legal documentation in South Africa (Zihindula et al 2015:25). Refugees are sometimes denied access to healthcare services because some health providers are not familiar with the Recognition of Refugee Status document, which is an A4 paper issued to all refugees by the Department of Home Affairs (Zihindula & Meyer-Weitz 2017). Some healthcare facilities in South Africa, mostly in Gauteng, require an ID or passport and proof of residence before allowing a patient to consult with healthcare providers (Alfaro-Velcamp 2017:60). This often results in the healthcare practitioner sending the refugee away to obtain an ID or passport before being assisted. The challenge may be that most refugees lack proof of residence as they do not own property in South Africa (Alfaro-Velcamp 2017:62).

An example is drawn from a woman who came from the Democratic Republic of Congo and who gave birth at the Johannesburg Park Station after being turned away by three (3) hospitals whilst in labour, because she only held an asylum seeker permit (Waters 2017). An asylum seeker permit is granted in terms of Section 22 of the Refugees Act, to persons awaiting a determination hearing in order to be granted a Section 24 Refugee Status document, which is a formal recognition of their refugee status (Fatima & Schreier 2014:34).

2.4.5 Dress code

Some refugees are not assisted in healthcare centres owing to the way in which they dress. They experience discrimination by healthcare professionals because of their religious attire which represents Islam (Pollock, Newbold, Lafrenière, & Edge 2012:68). This kind of experience by the refugees has a negative impact on their health outcomes, as it is more likely that a refugee may be neglected while in need of emergency treatment or medical care.

Many South African citizens display a strong anti-foreign attitude, which has a negative impact on refugees trying to access healthcare services, because this attitude of non-acceptability is also displayed by healthcare providers (Zihindula et al 2015:27). The reluctance from/refusal by healthcare providers to render healthcare services has been

associated with discrimination and xenophobia (Lawyers for Human Rights 2016). This has a negative impact among refugees, and may create a psychological fear of exclusion or attack. In the long run, some refugees avoid accessing public healthcare services in South Africa even if they are in need thereof (Zihindula et al 2015:27).

2.4.6 Female genital mutilation (FGM)

Some circumcised women who go to government hospitals or clinics for childbirth face the challenge of being neglected by healthcare providers, because most of the South African healthcare providers are not familiar with FGM (CoRMSA 2011). Sometimes doctors do not cut their genitals in order to ease the way for child delivery or stitch them after delivery (Pollock, et al 2012:68)). This may endanger the lives of both mother and baby. What is of extreme significance in this regard is that the South African public healthcare services do not cater for population diversity. This is a situation similar to that of the refugees based in Canada. Research findings from the study conducted by Pollock, et al (2012:68) show that in Canada, healthcare providers judge refugees on the basis of their cultural background. Consequently, Canadian doctors appeared "scared" when caring for refugees who had undergone female genital mutilation. This results in the healthcare professional having to consider unnecessary caesarean sections, as they would not know how to attend to an FGM woman during labour.

2.4.7 Xenophobic attitude

Refugees residing in South Africa often suffer under xenophobic attacks perpetrated by the citizens of South Africa. According to Amnesty International (2015) and Landau (2011) cited in Zihindula and Meyer-Weitz (2017:459), xenophobia is triggered as a result of the negative stereotypical views around refugees, because some South Africans perceive refugees as a threat in the job market. South Africa faces economic and social challenges such as a high unemployment rate, etc. and some citizens ascribe these challenges to migrants and refugees (Hunter-Adams & Rother 2017:6). Zihindula and Meyer-Weitz 2017:459) note that xenophobic attacks continue to be on the rise and many refugees continuously suffer loss of property or injury, and some are even killed. Victims who survived xenophobic attacks are more likely to seek emergency healthcare services from healthcare facilities in South Africa. However, refugees also suffer under medical xenophobia when seeking healthcare services (Hunter-Adams &

Rother 2017:2; Zihindula & Meyer-Weitz 2017:460). According to Crush and Tawodzera (2014:655), medical xenophobia refers to "the negative attitudes and practices of healthcare professionals and employees towards migrants and refugees based purely on their identity as non-South African". Crush and Tawodzera (2014:655) further argue that medical xenophobia is widely common in the South African public health system, even though the country's Constitution and Bill of Rights, international human rights obligations, and the professional codes of ethics governing the treatment of patients are against any form of xenophobia or discrimination.

2.4.8 Reproductive health

Reproductive health plays a pivotal role in a population's wellbeing, irrespective of age, gender, race or citizenship. However, refugees' experiences in accessing reproductive healthcare vary among gender. Accessing reproductive healthcare has become essential for a population's wellbeing, especially among women. According to Dopfer, Vakilzadeh, Happle, Kleinert, Müller, Ernst, Schmidt, Behrens, Merkesdal, Wetzke and Jablonka (2018:2), in most cases, women on the move are at risk of falling ill or contracting HIV or other illnesses, and they have no access to appropriate antenatal care, vaccinations or medical services. This puts them in extremely fragile circumstances and results in poor health outcomes. In South Africa, there are many refugee women in need of maternal health services. Literature shows that receiving antenatal care during pregnancy reduces the chances of maternal care (Konesh 2016:81). However, refugee women are more likely to be denied maternal health services due to the lack of documentation, language barriers, the bad attitude of health providers towards foreigners, etc. (CoRMSA 2011:105). Those who are not denied services are more likely to suffer from neglect, or being mistreated at the hand of healthcare providers in public healthcare centres. A case similar to this is drawn from that of the Somali women who are sometimes discriminated against during labour because the healthcare providers felt that the refugees were visiting public healthcare facilities more frequently than the South African citizens were. This subjected women refugees to an increased risk of maternal mortality (Konesh 2016:81). Women refugees, according to Konesh (2016:81) and Dopfer et al (2018:2) have been deprived of appropriate maternal healthcare, including reproductive healthcare services such as antenatal care, postnatal care, contraceptives, etc.

2.4.9 Attitude of healthcare providers

South African healthcare providers are supposedly obliged to assist any individual who visits healthcare facilities regardless of background or citizenship status. In South Africa, non-South Africans mostly encounter negative attitudes from healthcare providers when visiting healthcare facilities. Even though there are refugees who would still receive services without suffering discrimination at the point of provision, negative attitudes shown by healthcare providers outweigh the positive attitude. Some healthcare providers may discriminate against refugees or deny them access simply because they dislike non-South Africans. This attitude is common among healthcare providers when it comes to their fellow Africans. Tshabalala and Van der Heever (2015:282) find that the negative attitudes experienced by non-South Africans include delays on or denial of service provision. Women refugees have suffered discrimination or humiliation from healthcare providers who have passed nasty remarks about their non-citizenship (Tshabalala & Van der Heever 2015:282). These researchers further established that different types of treatment were given to foreigners when compared to the treatment given to the citizens of South Africa, especially in healthcare facilities where resources are limited. It can be concluded that bad attitudes towards foreigners can have a negative impact on their health outcomes.

2.5 CONCLUSION

This chapter discussed existing literature on access to healthcare by refugees and their experiences. Key findings of the literature review are as follows:

- In South Africa, there are a number of written legislations, international and national, that promote the right of access to healthcare by everyone living in the country, irrespective of nationality. However, these directives are rarely practised in healthcare facilities, especially the public healthcare facilities.
- As far as the cost of healthcare services is concerned, the literature shows that refugees are frequently charged undue consultation fees in public hospitals.
- It is most likely that refugees will be denied access to healthcare facilities or that such access will be delayed, because they often dress differently than South African nationals do.

- Literature shows that some refugees have undergone female genital mutilation and because local healthcare workers are unfamiliar with the practice of female genital mutilation, they are often afraid to assist refugees.
- Female refugees are the most affected among the refugee population when it comes to accessing healthcare. Being frequently in need of medical provisions when in labour or in postnatal care puts them at risk.
- Healthcare providers in host countries find it hard to serve non-nationals, as they believe that the country's local resources are meant for national citizens. This more than often leads to medical xenophobia.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

In this chapter, the research design and methodology are discussed. A description of the research setting, research design, method and ethical considerations is provided in detail. The section on the research method gives a thorough description of sampling and the data collection method.

3.2 RESEARCH SETTING

Polit and Beck (2012:49) define research settings as the specific places where information is gathered. The study took place at Pretoria, Gauteng in South Africa at Future Families (FF) compound in a private office. Data collection with participants took place during working hours between eight (08) a.m. to three (03) p.m. weekdays. All interviewed participant's shared important information which contributed to the findings and analysis of the research study. Participant felt safe to be interviewed at a place they were familiar with which enabled them to freely express themselves during interviews.

3.3 RESEARCH DESIGN

According to Athanasou, Di Fabio, Elias, Ferreira, Gitchel, Jansen, Malindi, McMahon, Mpofu, Nieuwenhuis, Perry, Panulla, Pretorius, Seabi, Sklar, Theron and Watson (2012:81), a research design aims to provide results that are credible. Grove et al (2014:20) add that the research design is a method of understanding the unique, dynamic, holistic nature of human beings, and is concerned with understanding the meaning of social interactions by those involved. The study was based on the real-life experiences of refugees and conducted through in-depth face-to-face interviews.

The focus of the study was on the lived experiences of accessing healthcare services by refugees in Pretoria, Gauteng. A qualitative descriptive phenomenological research design was used in this study. Because the study focused on what refugees would

normally experience in the healthcare facilities of South Africa, the qualitative descriptive phenomenological research design was considered a suitable method as compared to other research designs as such Case Study Model, Ethnographic Model and Narrative Model. The researcher had carefully read different types of research methods when undertaking a qualitative study but chose the qualitative descriptive phenomenological research design because of the type of data to be collected. The chosen research design helped in gathering the important information required to answer the research question.

3.3.1 Qualitative approach

The researcher used the qualitative approach. According to Du Plooy-Cilliers, Davis and Bezuidenhout (2014:174), qualitative researchers are interested in the profundity of human experience, which encompasses all the personal and subjective distinctiveness that are characteristic of individual experiences and meanings associated with a particular phenomenon. Brink, Van der Walt and Van Rensburg (2012:121) argue that the main aim of qualitative research is to understand rather than to explain and predict phenomena. Marton (1986) cited in Çekmez, Yildiz and Bütüner (2012:78) state that qualitative research is an observation and experience based on an approach of which the intention is to describe differences among different people on their understanding, or perception of a phenomenon. The researcher was driven by a need to understand the real-life situation of refugees from a qualitative approach.

3.3.2 Descriptive phenomenology

In this study, a descriptive phenomenological research design was used. Descriptive phenomenology entails the description of an experience as it is lived by the participants. According to Creswell (2014:245) and Polit and Beck (2012:495), phenomenological studies describe ordinary conscious human experiences of everyday life. The chosen design was suitable in assisting the researcher to explore and describe the lived experiences of the refugees in accessing healthcare.

3.4 RESEARCH METHOD

Polit and Beck (2012:741) define research methods as techniques used to structure a study and to collect and analyse information in a systematic fashion. This section details the sampling method and the data collection approach and method.

3.4.1 Sampling

Sampling involves selecting a group of people, events, behaviours, or other elements with which to conduct a study (Burns & Grove 2011:243). It can be either random or non-random. In this study, the researcher used non-random purposive sampling. Creswell (2012:206) states that in qualitative research, the aim is not to generalise a population but to develop an in-depth exploration of the phenomenon of interest. This sampling technique was chosen because it assisted the researcher to be able to locate and approach refugees who are legally recognised by the South African government through the help of FF as this was one of the main inclusion criteria. This was after realisation that it is not easy to simply identify if a person is a refugee in communities and if a known refugee, is in possession of Section 24 of the Refugee Act of South Africa. The non-random purposive sampling has helped the researcher to be able to identify the targeted population which participated in the study.

3.4.1.1 Population

"Population" of the study is defined as "all elements (individuals, objects, or substances) that meet certain criteria for inclusion in a given universe" (Grove et al 2014:46). The researcher identified participants among the refugee population group who are formally recognised by the South African government as refugees. This means obtaining a Formal Recognition of Refugee Status document (as referred to in Section 24 of the Refugees Act) issued by the South African Department of Home Affairs (1998), and individuals who qualify for this status should be originally from other African countries. All refugees selected to take part in the study were based in Pretoria, Gauteng.

About FF (Gatekeeper): Refugees who took part in the study were identified through FF. The FF is a Not-for-Profit Organisation (NPO) that provides socio-economic assistance (food vouchers, agent accommodation, money for rent, business start-up, etc.) to

vulnerable refugees in South Africa. The FF was selected as a gatekeeper for recruiting refugees. The FF NPO also provides training programmes for small businesses to asylum seekers (refugees awaiting formal recognition of their refugee status from the Department of Home Affairs) and refugees. It is an international organisation and has offices worldwide, including South Africa. One of its offices is based in Pretoria CBD, South Africa and its Pretoria Office has assisted thousands of refugees in the country who approached it for help. The FF is an organisation that is trusted by refugee and asylum seekers.

The researcher realised that it was not going to be easy to approach refugees individually as they are a vulnerable population and would not trust a stranger. It was for this reason that the researcher saw it safe to approach them through the FF. The researcher also chose to use the database of the FF to obtain the contact details of the refugees because FF assists refugees from different African countries.

The Pretoria office of the FF assisted refugees who were residing in Pretoria; hence, the researcher chose the FF office in Pretoria. It was easier for the researcher, with the assistance of FF staff, to identify refugees representing different countries to participate in this study. All refugees who participated in the study were associated with the organisation either in the form of attending training for their well-being or by receiving socio-economic assistance.

3.4.1.2 Eligibility criteria

Polit and Beck (2012:726) define eligibility criteria as the criteria that define who is in the population; that is, the criteria that specify population characteristics. To be included in this study, the participant had to hold a Section 24 document of Refugee Act and had to reside in Pretoria. Further, the participants should have come from other African countries. In the actual sample, all the participants were expected to be able to converse in English in order to participate in the study.

3.4.1.3 Sample size

A sample is a subset of the population elements, which are the most basic units about which data are collected (Polit & Beck 2012:275). When conducting research, it is

almost always impossible to study the entire population that one is interested in, as this may be time consuming and expensive. As a result, researchers use samples as a way to gather data. As stated earlier, the aim in qualitative research is not to generalise findings to a particular population but rather to learn more about a phenomenon; sample size is thus not considered as the most critical in qualitative research but rather valued for the richness of the information.

The refugees in this study were considered to be rich in information related to the objectives of the study. Hence, this characteristic influenced the saturation limit. Sample size was therefore not predetermined, but sampling was done until data saturation was reached. Saturation was achieved with 18 (eighteen) participants, in which 11 were females and 7 were males. Age ranged from 27 to 58 years, and the period they have lived in South Africa ranged from 2 years to 20 years. Participants were all from other African countries such as Somalia, Eritrea, DRC, and Burundi.

3.4.1.4 Sampling technique

According to Creswell (2012:206, 208), purposeful sampling is used to intentionally select individuals or sites to learn or understand a central phenomenon. The authors also state that homogenous purposeful sampling entails purposefully choosing the participants basing on membership in a subgroup that has defining characteristics. The researcher used non-probability purposive sampling to select the study participants. The participants were selected on the basis of holding a Section 24 document in terms of the Refugees Act and residing in Pretoria. Further, to be included in this study, the participants were those who migrated from other African countries such as Somalia, Ethiopia, DRC, Burundi, Eritrea, etc. It was expected that the participants would be able to converse in English. To access the research population for sampling purposes, the researcher used the FF database and the intake days of FF to recruit refugees who already have file application for refugee status with the organisation.

3.4.2 Data collection

Data collection is understood as “the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions, or hypothesis of a study” (Grove et al 2012:45). Data collection is also described as the gathering of

information to address a research problem (Polit & Beck 2012:725). It is one of the crucial aspects of any research study (Du Plooy-Cilliers et al 2014:147). Athanasou et al (2014:88) state that the research question guides the data collection method. The data collection process for this study is described in the subsections that follow.

3.4.2.1 Data collection approach and method

“Semi-structured interviews consist of several key questions that not only help to define areas to be explored, but also allow the interviewer or interviewee to diverge in order to pursue an idea or response in more detail” (Gill, Stewart, Treasure & Chadwick 2008:291). The researcher developed and used an interview guide comprising mostly of open-ended questions with a few closed-ended questions on biographical information (see Annexure D). The questions in the interview guide simply directed the conversation to capture the refugees' narrations on their experiences of accessing healthcare services. The semi-structured individual interviews method was a suitable method as it allowed the researcher to have a two-way communication with a participant and was able to follow up on points made. Considering that refugees are generally a vulnerable population group, the two-way communication had brought comfort on them and at times participants were able to discuss sensitive issues affecting health in South Africa. This method also allowed participants to ask the researcher questions and they were provided with answers and clarifications about the certain matter that they may have made. The interviews with the refugees were conducted face-to-face.

3.4.2.2 Development and testing of the data collection instrument

Polit and Beck (2012:730) define a data collection instrument as a device used to gather data. In this study, an interview guide was used for the face-to-face interviews. This interview guide referred to was developed by the researcher.

To test the feasibility of the data collection instrument, the researcher started by interviewing one participant to see if the questions were clear and understandable to the participant, and the participant answered all questions with good understanding. The researcher found that the research instruments used were feasible and participants were able to answer all prepared semi-structured questions with understanding. The researcher did not need to make any alterations to the research instruments and the

researcher resumed with the prepared questions. The average interview time on actual data collection was seven (7) to fifteen minutes.

3.4.2.3 Characteristics of the data collection instrument

Open-ended/semi-structured questions were developed (see Annexure D) as a tool guide for data collection. The purpose of the questions in the interview guide were to give direction to conversations about lived experiences of accessing healthcare services by refugees in South Africa.

The interview guide comprised two (2) sections, namely Section A and Section B. The purpose of Section A was to assist in understanding the demographics of the study participants. Section B consisted of questions about lived experiences in accessing healthcare services by refugees. Although interviews were driven by the researcher, the researcher managed to draw out the participant's meaning and depth of coverage rather than leading the participant through a range of organised questions. The researcher had therefore used prompts and probes to explore the initial responses further. The interview guide was also developed in English, and the researcher is fluent in English. A voice recorder and a notebook were also used as other forms of data collection instruments. The researcher then transcribed the recorded interviews in a Microsoft Word document where themes were extracted to make sense of the data.

3.4.2.4 Data collection process

Data collection only commenced after permission was sought from and granted FF. The researcher divided the data collection process into two (2) phases. The first phase was the recruitment of the research participants and the second phase entailed the actual collection of data, as explained below.

Recruitment of research participants: The researcher used different methods in recruiting participants for collecting data. Firstly, the researcher accessed the FF database with the help of FF staff members who worked as auxiliary workers, and purposefully selected physical files of refugees who are formally recognised (holding a Section 24 document from Home Affairs). Then the physical files were browsed through one by one to check if the file of the refugee meets the criteria, e.g. resides in Pretoria,

comes from another African country, etc. The researcher wrote down the contact details of each refugee selected from the database, and then contacted each refugee telephonically. The researcher briefly introduced herself, explained how she had obtained the contact number, and proceeded to expand on the reasons for calling and the purpose of the study. The researcher asked the refugees if they could come to FF to hear more about the study and if they would like to participate. Some refugees agreed to go to FF at a scheduled date and time that would be suitable for them. While at the FF compound, the researcher provided them with information sheets while giving a brief introduction of the study, the purpose of the study, and an explanation as to why they were invited to participate in the study. All invited potential participants were allowed to ask the researcher any questions for clarification. The researcher provided potential participants with honest and clear answers as to what they needed to know about the study. Some agreed to be interviewed on the first debriefing meeting while some chose to schedule a different day to be interviewed. The researcher was flexible with regard to the dates and times indicated by the participants.

Secondly, the researcher targeted intake days of the FF to recruit refugees who already have a file opened at the FF. Intake days are specifically allocated days on which refugees come to the office of the FF to follow up on their cases, to get food parcels, attend health programmes, etc. Therefore, the researcher targeted intake days to approach refugees while they were waiting at reception for their appointments. The researcher, with the help of the FF Auxiliary Social Worker, firstly introduced herself and explained why she was at the FF, and then asked which person was holding a Section 24 document among the group waiting at reception. Those who were in possession of a Section 24 document raised their hands, and the researcher then introduced the study by handing each of these persons an information sheet. The researcher then asked the refugees if they had any questions and whether they were willing to participate. Some agreed to take part on the same day while others preferred to schedule another day that would be more suitable for them.

Before commencing with one-on-one interviews, the researcher ensured that all participants understood the following:

Informed consent form (see Annexure F): The informed consent form was produced for participants to sign before they engage in research. It acknowledges that participants'

rights will be protected during data collection (Creswell 2014:134). The researcher made sure that the consent form included the following information as further stated in Creswell 2014:134): (1) Identification of the researcher; (2) Identification of the purpose of the study; (3) Identification of the benefits for participating; (4) Identification of the level and type of participant involvement; (5) Notation of risks to the participant; (6) Guarantee of confidentiality to the participant; (7) Assurance that the participant can withdraw at any time; and (8) Provision of names of persons to contact if questions arise.

The researcher also explained the purpose of the consent form to each individual in a private office provided by the FF. This ensured that participants understand that participation is voluntary and that they have the option of stopping the interview at any time they wish, and that the audio recording was only for reporting purposes. The researcher refrained from using any words that may have caused undue pressure on participants. It was reiterated that the study was for Degree completion purpose at UNISA and only recommendation would be made for possible policy improvement from the information they would have shared. The researcher also made sure that on the consent form, participants had an option of consenting to or refusing the audio recording, and of remaining anonymous. These options were selected on the form by ticking the appropriate boxes. These decisions were made by the participants autonomously, then followed by the signature of participants and the researcher together with dates of the interview. From these decisions of participants, the researcher knew whether to audio record the interview or not. Audio recording was used to collect information during interviews that were permitted audio recording and notes were also taken during interviews. For those who did not permit audio recording, only notes were taken down by the researcher and the researcher made sure that all important information relevant for the study was written down.

Confidentiality binding form (see Annexure G): After signing the informed consent form, the researcher handed participants the confidentiality binding form. The contents of this form was also explained to ensure that the participant understood the confidentiality implications. All interviews were conducted in a private room/office at the FF Pretoria Office in Sunnyside, so that participants would feel comfortable and at ease when expressing their lived experiences of accessing healthcare services.

Collection of data: This part of data collection was characterised by obtaining consent from the study participants prior to data collection. The researcher firstly provided each participant who agreed to take part in the study with a consent form to read, understand and to sign before commencing with the interview.

FF facilities were used as a venue to host briefing meetings to introduce the study and conduct interviews with participants. Several briefing meetings took place during data collection, because the researcher recruited participants in the study on a weekly basis.

The method employed in this study was the face-to-face semi-structured one-on-one interview. Interviews were conducted with each of the selected participants who agreed to take part in the study. A private room was used for the interview sessions. Short one-on-one interviews were conducted which lasted between seven (7) and fifteen (15) minutes per interview. The length of the interview depended on how much information each refugee had to share with the researcher. The number of interviews conducted per day depended on the number of participants who agreed to take part in the study after the briefing meeting. On average, the researcher managed to interview two (2) and sometimes three (3) participants per day. The time scheduled for the interviews also depended on the availability of the participant. Data collection took place from August 2017 to October 2017.

3.4.3 Data analysis

Qualitative data analysis is the organisation and interpretation of narrative data for the purpose of discovering important underlying themes, categories and patterns of relationships (Polit & Beck 2012:739).

The data was gathered from the refugees through face-to-face interviews using an audio recorder (where permission had been granted to use such recorder) to ensure verbatim accuracy. The researcher also jotted down notes on the interview guide. In a different study, Shosha (2012:33) employed Colaizzi's seven-step analysis framework and cited Sanders (2003), Speziale and Carpenter (2007) as stating that the process of data analysis described by Colaizzi consists of seven steps in the following order:

- Reading and re-reading each transcript to obtain a general sense about the whole content.
- Extracting significant statements from the transcripts that relate to the phenomenon under study.
- Formulating meanings from the significant statements.
- Sorting the formulated meanings into categories, clusters of themes and themes.
- Integrating themes into an exhaustive description of the participants' statements.
- Describing the structure of the phenomenon.
- Validating the findings with the research participants.

The researcher followed the seven (7) steps described above for data analysis. Since the researcher collected data by means of audio recording the interviews from seventeen (17) participants, who permitted the audio recording, and taking notes (in a notebook) from the interviews, the researcher transcribed all audio recorded information into a Microsoft Word document. Notes taken were also transferred from the notebook to Microsoft Word, especially notes from interviews that did not have an audio recording.

Following Collaizzi's steps of data analysis as described by Shosha (2012:33), all transcribed and noted information was read by the researcher to understand the data and to extract the themes that were found relevant to the study. Themes were organised and categorised based on familiarity or meanings, i.e. themes with similar meanings were clustered together. All themes were analysed to present findings, and document reviews from other researchers were also undertaken to compare and contrast in order to build arguments and discussions from both the findings of the study and previous findings from other researchers. Quotes and extracts from the interview transcripts were used to support or emphasise some argumentative statements.

On the prepared semi-structured questions, some questions required participants to answer “Yes” or “No”. In this regard, data was captured on Microsoft Excel 2010 to present the statistical number of refugees who responded with a “Yes” or “No” to those questions in order to provide statistical analysis built from the questions. The statistical numbers are presented in Chapter 4.

3.5 ETHICAL CONSIDERATIONS

According to Polit and Beck (2012:152), the Belmont Report articulates three broad principles on which standards of ethical conduct in research are based. These are the principles of beneficence, respect for human dignity, and justice. These broad principles are also stipulated in the Department of Health National guidelines in Ethics in Health Research (Department of Health 2015:14).

3.5.1 The principle of beneficence

In order to uphold the principle of beneficence, the researcher has to ensure the well-being of the participants by protecting the participants from physical, psychological, emotional, spiritual, economic, social or legal discomfort and harm (Brink et al 2012:36). The Department of Health National guidelines in Ethics in Health Research states that the ethical obligation a researcher must always carry through is to “maximise benefit ad minimise harm and that the risks of harm posed by the researcher must be reasonable in light of anticipated benefits” (Department of Health 2015:14) In this research, the researcher took care in structuring the questions and observing the interviewees for any signs of distress during data collection. Participants were allowed to verbalise their complaints and they were reminded that the interview could be discontinued if it was causing them intolerable uneasiness. None of the participants showed any signs of discomfort.

3.5.2 The principle of respect for persons

Respect for persons as an ethical principle is based on three convictions. These are: individuals are autonomous and have the right to self-determination; individuals with diminished autonomy require additional protection; and in some rural African communities and religious groups, individuals might not be regarded as autonomous (Brink et al 2012:35). According the Department of Health National guidelines in Ethics in Health Research, “the principle of respect requires that persons capable of deliberation about their choices must be treated with respect and permitted to exercise self-determination”. It further states that “respect for persons recognises that dignity, well-being, and safety interests of all participants are the primary concern in research that involve human participants” (Department of Health 2015:14) The researcher in this

study respected the individual's decision regarding whether to participate in this study or not and the decision to withdraw after the study has commenced if the individual so wished. The participants were also informed and knew that they could refuse to give information and that they had the right to ask questions relating to the study. The researcher did not use coercion or deception to obtain consent from the study participants. All the participants went through the interviews comfortably after giving their consent.

3.5.3 The principle of justice

The principle of justice includes the right to fair treatment and the right to privacy. The right to fair treatment entails selecting the participants based on the study requirements and not on participant vulnerability. The Department of Health National guidelines in Ethics in Health Research states "there should be a fair balance of risks and benefits amongst all role-players involved in research, including participants, participating communities and the broader South African society". The right to privacy is maintained by ensuring that the research is not more intrusive than it needs to be and that data is kept in absolute confidence (Polit & Beck 2012:155, 156). Burns and Grove (2011:114) define privacy as "the freedom people have to determine the time, extent, and general circumstances under which their private information will be shared with or withheld from others". The participants were selected based on the fact that they are refugees and are recognised as legal refugees by virtue of the fact that they hold a Section 24 document (confirmation of refugee status) from Home Affairs. The reason for such a selection was solely that these people were capable of providing valuable information that would answer the research question. That is, selection was not based on availability, manipulability or friendship with the researcher to ensure that the selection was fair.

To safeguard privacy, the researcher conducted the interviews in a private room to ensure participants are comfortable with sharing their experiences and that there is confidentiality. Pseudonyms were used instead of real names. The individual interviews were once off, meaning that there was no need for follow-up interviews with the same interviewee; hence, there was no need to capture the real names of participants. The professional interpreter that was used for two interviews also understood the issues of confidentially and respect for participants' privacy.

In terms of biographical data, the interview guide consisted only of country of origin, gender, age, and period lived in South Africa. Only the researcher will have access to the completed interview guides and the voice recorder, which will be kept under lock and key. The researcher shared the processed data only with relevant staff at the University of South Africa since this study is done for academic purposes. Being an employee of the FF, the interpreter also adhered to the prescriptions of confidentiality and signed a confidentiality form as a staff member of FF. A Confidentiality Binding Form was further signed by both the researcher and the participant (see Annexure G).

In order to ensure that all the principles discussed above are maintained, an Informed Consent Form was obtained from each participant (see Annexure F). According to Burns and Grove (2011:122, 123), informed consent implies that the researcher has imparted information to the subjects and that the prospective participants have comprehended that information. The authors go on to state that informed consent includes four elements, namely disclosure of essential study information to the study participant, comprehension of this information by the participant, competence of the participant to give consent, and voluntary consent of the participant to take part in the study.

Each participant was given an informed consent form to sign only when they agreed to participate in the study. The researcher was careful not to make participants feel obliged to participate in the study when they agreed to be introduced to the study or when they agreed to read the information sheet provided (avoidance of coercion).

Consent forms for this study consisted of an option for each participant to consent to being audio recorded and to be anonymously quoted. Those who did not want to be audio recorded or anonymously quoted had the option of leaving the appropriate box/es blank. A voice recorder was also used to record the interviews with those who consented to a voice recording. For those who did not consent to a voice recording, the researcher only took notes in a notebook and also noted down non-verbal responses. All participants indicated that they understood the information in the consent form prior to giving their consent. The researcher signed the consent form and both the participant and the researcher stated the date on which the interview was conducted.

Information sheet: The researcher made sure that participants are formally approached through FF and that the study was properly introduced by providing information sheet to everyone approached. The purpose of the study was also verbally explained to all potential participants. The researcher made sure that all participants understood the purpose of the study and they all understood participation was voluntarily and should they choose to participate, they also had the option to quit at any time they wanted to.

Throughout the data collection period, the researcher was flexible in terms of date and time to meet for interviews with the refugees who agreed to participate in the study. The researcher did not put any refugee who participated in the study or who agreed for study briefing under pressure or coercion to participate. Even though the proposal of the study was found to be a minimal risk study and was granted ethical clearance from UNISA, the researcher understood the vulnerability of refugees and was aware that some questions may trigger emotions that may affect them psychologically. The researcher, therefore, was prepared to have short breaks during interviews for individuals who became overwhelmed by emotions when sharing their lived experiences in accessing healthcare services. There researcher also had a list of institutions that provide counselling and their contact details for referrals to refugees who may need counselling.

3.5.4 Ethical clearance

Obtaining permission from Future Family (FF) (Gatekeeper): After obtaining ethical clearance from the Health Studies Research Ethics Committee on the 03 May 2017 (see Annexure A), the researcher formally submitted the letter for permission to the Programme Manager of FF in Pretoria (see Annexure B) in order to approach the refugees to participate in the study. The letter was submitted together with the research proposal, proof of registration from UNISA, ethics clearance letter from UNISA, research instruments, information sheet, informed consent form and confidentiality binding form to make sure that FF understands the purpose of the study and how the researcher was planning to work with them as gatekeeper and with the participants. The Programme Manager organised a brief meeting with the researcher so that there could be a common understanding about the study and how confidentiality would be maintained, and consensus that no one would be coerced into being interviewed during the study. The researcher was also allowed to set a date to commence with the study and the

Programme Manager allocated days and a private office where the researcher should be at the site without inconveniencing the daily activities of FF staff when they assist with locating files. The researcher was therefore granted a site permission letter by the FF on 12 July 2017 and was requested to sign the site permission letter to ensure that the researcher maintains the agreement on confidentiality of FF and participants. The researcher adhered to all requirements from FF to protect the reputation of the organisation, the participants, and of the researcher during data collection. Considering that the FF is a service provider to the targeted participants, the FF was not involved in recruiting participants to avoid undue pressure on participants. Participants gave autonomous consent to participate in the study without any involvement of the FF.

3.6 INTERNAL AND EXTERNAL VALIDITY OF THE STUDY

3.6.1 Trustworthiness, credibility, dependability and confirmability, and transferability

Gitchel, Jansen, Malindi, McMahon, Mpofu, Nieuwenhuis, Perry, Panulla, Pretorius, Seabi, Sklar, Theron and Watson (2012:140) cite Perakyla as defining trustworthiness as the way in which data is collected, sorted and classified. Lincoln and Guba (1985) cited in du Plooy-Cilliers et al (2014:258) note that trustworthiness embraces credibility, dependability and confirmability. According to Holloway (2005:290), credibility is used to assess the extent to which the research findings convincingly describe the phenomenon being researched. Du Plooy-Cilliers et al (2014:258) explain credibility as precisely how the researcher interpreted the data that was collected. In the study, credibility of the findings was ensured through using purposive sampling, and the participants selected as primary informants had first-hand knowledge of the phenomena.

Dependability, on the other hand, is like reliability and replicability in qualitative research. It is the ability of the researcher to depict the entire research process in a way that others can understand and follow to reproduce the same research in similar or different settings. Athanasou et al (2012:140) cite Goetz and LeCompte (1984) as stating that dependability (or consistency) is the stability or consistency of the research process and methodology over time. Lincoln and Guba (1985); Shenton (2004); Collis and Hussey (2003:278-279) cited in Plooy-Cilliers et al (2014:259) state that dependability is the “quality of the process of integration that takes place between the

data collection method, data analysis and the theory generated from the data". In this study, dependability was assured through addressing research questions that are wholly consistent with the specified research purpose. Audio-recorded interview transcripts, notebooks, and functional audio-recording devices were used to address distortion and inadequacy in portraying phenomena as expressed by participants. To confirm credibility, developed coded themes were assured if they all derive from the audio transcripts and notes taken during interviews by rereading the data. Themes which seemed diverged from the transcripts and notes were phased out and some themes were paraphrased. The researcher was careful not to fabricate or falsify any information shared by the participants. All collected raw data (audio recordings, transcripts, and notes) are protected in a safe place to remain as evidence that the information provided as findings of the study are true and dependent on them.

According to Brink et al (2012:127), confirmability ensures that the findings, conclusions and recommendations are congruent with the data collected. The authors further state that the researcher's interpretation and the actual evidence should be in harmony. After comprehensibly describing the data gathering and data analysis steps, the researcher reported the conclusions in detail and links these conclusions to the data analysis.

Polit and Beck (2012:745) and Plooy-Cilliers et al (2014:258) note that transferability is the extent to which qualitative findings can be transferred to other settings or groups. In this study, the findings were described in order to produce descriptions and meaning of the phenomenon. The researcher compared the findings of the study with what other researchers have established in the work. Conclusions and recommendations were drawn from both the findings of the researcher and literature reviews of the phenomenon of the study.

3.7 CONCLUSION

This chapter on the research methodology described in detail how the study was conducted. Issues discussed in the chapter include the study setting, the study design and the research method. Data collection was done through face-to-face interviews. Audio recording was done with the permission of the participants. Prior to each interview, a thorough explanation of what the study was all about was provided, and a signed informed consent form was obtained from every research participant. The

searcher followed all protocol regarding the safeguarding of participants' privacy during data collection to avoid vulnerability of participants and to ensure confidentiality of the study during the interview. The qualitative data was analysed through transcribing data, extracting significant statements and summarising these into themes and subthemes. An additional description of ethical considerations sealed-off this chapter.

The following chapter presents findings of lived experiences of refugees in accessing healthcare services in Pretoria.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter presents the findings of the lived experiences of refugees when visiting healthcare facilities in South Africa. These are presented in two main sections. The first section presents the sample demographics and the second section presents the research findings.

The purpose of the study was to investigate the lived experiences of refugees when accessing healthcare services in South Africa, with the following objectives:

- To explore and describe the lived experiences of refugees when accessing healthcare services in South Africa and specifically in Pretoria.
- To recommend for development of information material that inform policy on the refugees' rights to healthcare, using the existing legislation such as the Refugees Act and the Constitution.

Based on the objectives above, the study explored daily experiences of refugees with accessing the healthcare facilities and based on the recounts of the participants, provides recommendations on how services could be improved for refugees living in South Africa. This chapter provides an analysis of the collected qualitative data, supported by quotes from the study participants.

Data collection and study population

Data was collected in the months of August and September 2017 through face-to-face interviews. An interview guide was developed by the researcher and the interviews were conducted in English. Of the eighteen participants, sixteen participants were comfortable expressing themselves in English even though English is not their home language, while two participants (2) were not comfortable enough to express

themselves in English; hence, an interpreter was used for these two (2) interviews. A recording device (an audio recorder) was used to capture information during all the interviews with the consent of each participant. Prior to each interview, each participant was informed that his or her participation is entirely voluntary, and that they are able to withdraw from the study at any time. Confidentiality and anonymity of the participants were maintained throughout the data collection and analysis process. Ethical approval for the study was obtained from the University of South Africa. The collected data was transcribed verbatim, after which is was coded. Analyses of the data are presented in this chapter.

4.2 DATA MANAGEMENT

The audio-recorded data was transcribed verbatim. The researcher made sure that all interview guides and collected data were kept in a locked cupboard throughout the data collection and analysis process. The researcher also checked the collected data for completeness, accuracy and clarity. Appropriate measures were taken in time to ensure completeness before the analysis was done. The data will safely be kept for a period of five years according to the UNISA research data management policy. Thereafter, the data can be discarded with the approval of a UNISA official if no query is laid against the study that demands prolonged retention of data.

4.3 RESEARCH RESULTS

4.3.1 Demographic profile of participants

A total of eighteen (18) interviews were conducted with men and women from different countries. The participants were each asked about their country of origin. Figure 4.1 below indicates that the majority of the refugees (eight participants) in the study originated from the Democratic Republic of Congo (DRC). Five (5) participants came from Somalia, three (3) came from Eritrea, and two (2) came from Burundi.

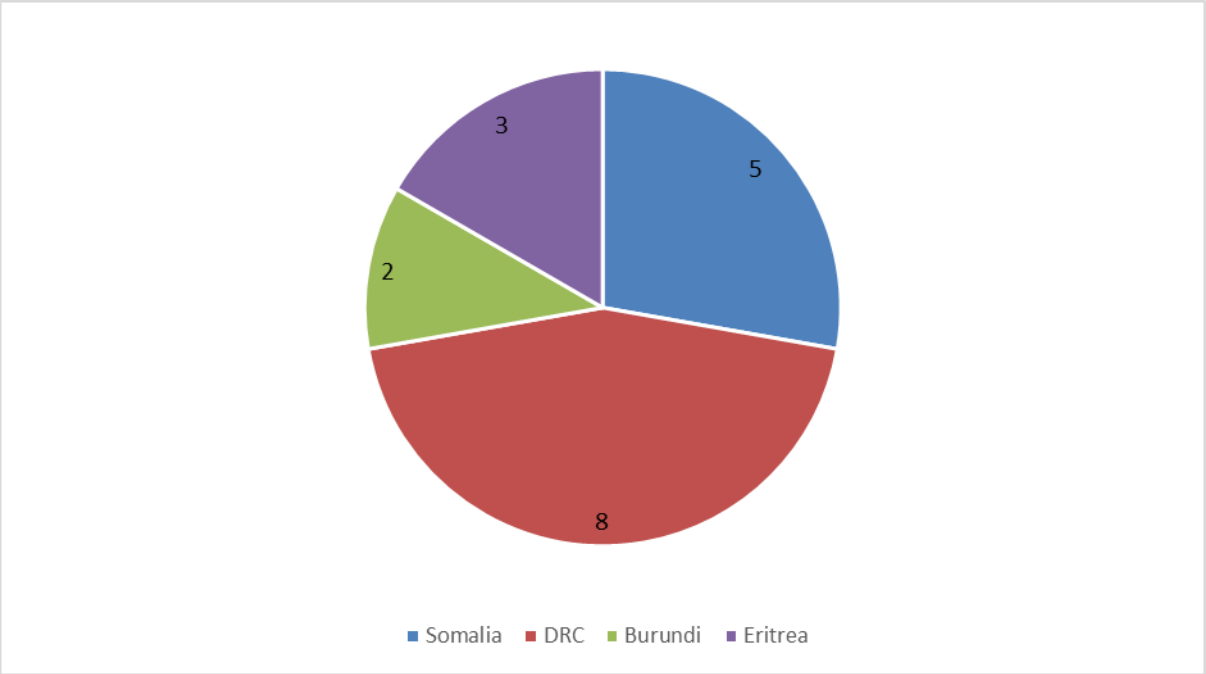

Figure 4.1 Number of participants per country

The participants (refugees) were asked about their biographic information on gender, home language, age, and the period they have been residing in South Africa. Table 4.1 depicts the biographical profile of refugees who participated in the study.

Table 4.1 below, arranged alphabetically by country of origin, shows that of the eighteen (18) (n=18) participants, seven (7) participants were male and eleven were female. There was no participant who spoke English as a first language in their country of origin. Most of the participants learnt to speak English while in South Africa. The participants who were originally from DRC spoke Swahili, Tshiluba, or French as first language; those from Somalia spoke Somali as first language, while those from Eritrea spoke Tigrinya as their first language. Participants from Burundi spoke Swahili or Kirundi as first language. The age of the participants ranged from twenty-seven (27) years to fifty-eight (58) years old. All participants have been living in South Africa for more than two (2) years, and some for more than fifteen (15) years.

Table 4.1 Demographic profile of participants (interviewed refugees)

Number	Country of origin	Gender	Home language	Age	Period living in South Africa
1	Burundi	Female	Swahili	44	17 years
2	Burundi	Female	Kirundi	32	17 years
3	DRC	Male	Bende	36	5 years
4	DRC	Female	Swahili	40	16 years
5	DRC	Female	Swahili	32	5 years
6	DRC	Female	Tshiluba	37	3 years
7	DRC	Male	Swahili	31	3 years
8	DRC	Female	Swahili	38	9 years
9	DRC	Male	Swahili	38	14 years
10	DRC	Male	Swahili	43	17 years
11	Eritrea	Male	Tigrinya	58	20 years
12	Eritrea	Male	Tigrinya	43	13 years
13	Eritrea	Female	Tigrinya	37	5 years
14	Somalia	Female	Somali	34	17 years
15	Somalia	Female	Somali	30	11 years
16	Somalia	Male	Somali	36	2 years
17	Somalia	Female	Somali	27	7 years
18	Somalia	Female	Somali	50	5 years

4.3.2 Themes and subthemes

In analysing the data, an iterative process was followed of reflecting, recording and tracking the thoughts to help make sense of the data. Defined by Bazeley (2013:15), the analytical process involves “seeing and interpreting what has been said, written, or done; reflecting on evolving categories; deciding what is important to follow up”. After the data collection phase, which also involved note taking, raw data was transcribed verbatim. Auerbach and Silverstein (2003:32) define coding as a “procedure for organising the text or transcript and discovering patterns within that organisational structure”. The researcher understood data analysis to mean transforming data into findings by bringing order, structure and meaning to the mass of collected data (Bazeley 2013:15). Consequently, patterns of expressions with similar or divergent themes were identified whereby overarching themes that seemed vital to the study objectives were highlighted and merged together. According to Bazeley (2013:191), “description of 'thematic' codes and categories identified in the data provides a useful starting point in

developing a report of findings from a study". It is further argued that "effective analysis requires using data to build a comprehensive, contextualised, and integrated understanding or theoretical model of what has been found, with an argument drawn from across the data that establishes the conclusion" (Bazeley (2013:191).

In this study, the 'family' of themes with subthemes was created at the time of presenting the research findings as described below.

Three (3) themes emerged from participant narratives which were classified as good:

- Refugees' day-to-day experiences in healthcare facilities
- Understanding their rights as a refugee
- Healthcare inequalities

To carefully analyse the data, the researcher followed Colaizzi's seven-step analysis framework as follows: Each transcript was read and re-read, which assisted in building a general sense around the whole content. Transcripts were carefully read to gain a better understanding of each interview and to make sense of the interview before breaking it into parts. This assisted in determining where participants similarly expressed their emotional life experiences with the healthcare systems in South Africa. The emerging relevant themes were recorded, translated and then coded. Significant statements from the transcripts, as related to the objectives of the study, were extracted, and meanings were then formulated from the extracted significant statements. These meanings were then organised into categories, clusters of themes and subthemes. The themes were integrated into an exhaustive description of the participants' statements. Themes and subthemes were interpreted, examined, and described to bring about the phenomena of the research study, whereas references from one theme to another were also made. Furthermore, verbatim quotes were also used to emphasise the findings. To validate the findings, consistency of information from participants was checked.

Findings were also discussed, compared, and contrasted to existing research studies to exemplify the study findings. The interpretation of data revealed that each phenomenon of a participant's life influenced the other. Participants had mutual and similar

encounters with similar outcomes in relation to access to healthcare services in South Africa.

Table 4.2 Summary of themes and subthemes

Themes	Subthemes
1 Refugees' day-to-day experiences in healthcare facilities	1.1 Overall service delivery from healthcare facilities in Pretoria 1.2 Denial of access to healthcare services 1.3 Public healthcare service fee 1.4 Documentation first, healthcare services after 1.5 Language as barrier 1.6 Healthcare services procedure in South Africa 1.7 Interactions between healthcare professionals and refugees 1.8 Inconsistencies of information in healthcare facilities
2 Understanding their rights as a refugee	There were no subthemes established for this theme
3 Healthcare inequalities	3.1 Private healthcare delivery versus public healthcare service delivery 3.2 Overcrowding of healthcare facilities in Gauteng 3.3 Healthcare professionals' attitude towards refugees 3.4 Gender and access to reproductive health

4.3.2.1 Theme 1: Refugees' day-to-day experiences in healthcare facilities

The refugees all agreed that they came to South Africa with the hope of living peacefully and being free from conflicts that were destroying lives in their country of origin. They thought by being accepted in South Africa as refugees and being formally granted refugee status they would begin to experience a better life and freedom. However, some refugees revealed that some of the experiences they face in South Africa are not much different from the challenges they faced in their home countries. They still experience pain in their lives, as elaborated hereunder.

4.3.2.1.1 Subtheme 1.1: Overall service delivery from healthcare facilities in Pretoria

From the eighteen (18) refugees interviewed, sixteen (16) stated that their experiences in accessing healthcare services in South Africa have been both good and bad. Only two (2) refugees stated that they had never encountered any bad or unkind experience when visiting healthcare facilities in South Africa. Examples cited as bad or good when visiting a healthcare facility were shaped by the perceived attitude and demeanour of the healthcare practitioner they would have met on the day of the visit. For example, if a healthcare practitioner was in a bad mood, it was more likely that a healthcare practitioner would insult or discriminate against patients or even deny them access. One participant who described his experience as positive when accessing healthcare services, mentioned that when he had an asthma attack he received the medical care he needed and even to date he is still taking medication monthly without any challenges.

Lack of access to healthcare services means life is at risk and may lead to stress and depression (Fellmeth, Plugge, Fazel, Charunwattana, Nosten, Fitzpatrick, Simpson & McGready 2018). Healthcare services play a vital role in a human's life. It sometimes determines the life or death of a human if sickness is severe; therefore, it is important that healthcare services are always accessible when needed.

Other researchers found that discrimination is one of the key factors associated with anxiety and depression among refugees (Lewis, Cogburn, & Williams 2015:409). A negative experience was related to being denied, or insulted, or discriminated against, or being neglected when visiting a healthcare facility because one is not South African, while others were perceived as receiving preferential treatment. The extract below demonstrates:

> “What I have experienced the most in the healthcare facilities is discrimination by nurses and being made to feel unwelcome. For example, nurses always say, why you foreigners like coming to the hospital; can't you stay in your country, and don't you have hospitals in your country?” (Female from Somalia, 34)

Another participant aired:

> “We always get assisted but the nurses who provide the healthcare services always discriminate against us. I remember when my wife was in labour at Tshwane District Hospital and I visited her at that hospital she was admitted in, the nurses asked me why is she pregnant, why did you make her pregnant and they further made remarks like 'we don't want to see lots of pregnancies from foreigners here'.” (Male from DRC, 36)

The above extracts can also be compared to the study findings by Pollock et al (2012:63) on refugees who settled in Canada and who reported that they suffered discrimination from healthcare providers. The Canadian healthcare practitioners even labelled the refugees as “time consumers” because they do not regard refugees as important citizens (Pollock et al 2012:63). Discrimination can be defined as a “systematic practice, judgment, and action that creates and reinforces oppressive relations or conditions that marginalise, exclude, and/or act against or in favour of something/someone" (Lippert-Rasmussen 2014:24). In the of healthcare context, discriminating acts may include insensitivity, unfriendliness, or ignorant treatment from health providers, to racial slurs, stereotyping, and receipt of inferior care (Lewis et al 2015:410; Pollock et al 2012:63). Similarly, findings from other studies conducted among refugee communities in Malaysia (Chuah, Tan, Yeo & Legido-Quigley 2018), and in Canada (Pollock et al 2012), revealed that refugees often face similar hardships where healthcare services are concerned. Both studies demonstrated that discrimination and dissatisfaction about healthcare services were some of the major findings, which resulted in some refugees citing a feeling of defenceless in the hands of healthcare practitioners and that they are being undermined whenever they try voice the problems that they face in healthcare (Chuah et al 2018:4; (Pollock et al 2012:70). The high levels of morbidity and mortality among refugees when compared to host population in general have also been attributed to this phenomenon (Mangrio & Sjögren-Forss 2017:8).

Sixteen (16) participants mentioned that they had negative experiences when using healthcare services in South Africa, and further indicated that they had difficulty sleeping at night. The experience at the healthcare facilities brought them nightmares and they are always in pain and depressed. Some said that the mistreatment refugees

are subjected to by some healthcare practitioners is not normally acceptable. A refugee from the Democratic Republic of Congo (DRC) shared his encounter with nurses:

> “The way nurses treat us refugees is not normal. Before they could decide whether to give you treatment or chase you out of the premises, they usually ask questions that are not related to the illnesses or purpose of the visit, such as 'why did you come to South Africa? You say you are a refugee and you are not working, so why are you dressed nicely?' This has repeatedly happened to me whenever visiting clinics or hospitals around Pretoria such as Steve Biko Academic Hospital, Tshwane District Hospital, Tshwane Clinic in CBD, etc.” (Male from DRC, 36)

He further viewed that:

> “Unfortunately, we have no say about how we are treated in the clinics and hospitals. If I want to get help, the best thing to do is to keep quiet even if I do not approve of the way I am being treated. The problem is, as a refugee, if I try to stand up for myself and talk back to the healthcare service providers or confront them about the bad treatment I receive, they will simply chase me out of the healthcare facility and I will not get the help that I need.” (Male from DRC, 36)

The extracts above show that some refugees must endure mistreatment from healthcare providers to continue receiving the healthcare they need. Some need to pay undue costs to receive healthcare. News reports by Mathope (2017) and Skosana (2016) revealed that refugees are regularly denied treatment in government clinics and hospitals in South Africa, and if they do happen to be provided with healthcare, the refugees are required to pay a high cost. In some cases, when refugees visit a pharmacy to collect their medication, they are informed that the medicine is out of stock even if it is available (Skosana 2016). The latter statement demonstrates how refugees are sometimes unfairly treated and denied their right to healthcare.

On the other hand, a good experience in the healthcare facilities is encountered when one is accepted to consult with the healthcare practitioner and is provided with the necessary treatment or medication/prescription while following appropriate procedures. The refugee from Somalia aired his views about a good healthcare service:

> "I went to Eersterust Clinic when I suffered mental illness and I was treated nicely. It was not just because they gave me medication, it was the way they treated me. I did not even pay any cent, I access healthcare services for free whenever I need it." (Male from Somalia, 58)

The narrative above illustrates that the refugee was happy with the treatment he received whenever he visited healthcare facilities, though often refugees report negative experiences with healthcare services in host countries, as revealed by studies done elsewhere (Tomita, Kandolo, Susser, & Burns 2016:370; Langlois et al 2016:319). Studies by Tomita et al (2016:370) and Langlois et al (2016:319) have shown that refugees could be happy with the services but still experience some challenges. In this regard, the authors mention language barriers, health providers refusing to consult face to face with patients from refugee communities, lack of trust and culturally appropriate care, inadequate information and awareness about the availability of services, culturally insensitive care, and inadequate provision of interpreters and other related barriers (Tomita et al 2016:371; Langlois et al 2016:320). It is evident that most refugees living in South Africa face hardships when it comes to accessing socio-economic services, especially healthcare.

4.3.2.1.2 Subtheme 1.2: Denial of access to healthcare services

To understand the extent to which healthcare services are accessible to the refugee community, participants were asked if they had ever been denied access to healthcare since arriving in South Africa. The majority (10) of the study participants indicated that they had never been denied access, whereas 8 refugees said they had been denied access to healthcare in public healthcare facilities. However, those who had never been denied access to healthcare services pointed out that they still suffered some form of humiliation at the hand of healthcare practitioners, for example, insults and disrespect. Those who were denied access to healthcare services cited different reasons that led to them to being denied access.

Study findings and literature show that many factors may lead to refugees being denied access to healthcare in South Africa. Refugees can be denied access to healthcare services, especially in the public healthcare sector, simply because they do not speak the local language (Crush & Towadzera 2014:656); they did not have the documents

required by the healthcare provider on duty (Meyer-Weitz, Asante & Lukobeka 2018:02); the nurse felt that the refugee was quick to visit a healthcare facility when felt sick (Odhiambo 2012); the healthcare professional on duty felt there were many foreigners visiting the particular healthcare facility, and so forth (Crush & Towadzera 2014:657; Meyer-Weitz et al 2018:2; Pollock et al 2012:69; Zihindula et al 2015:8). This conforms to the statement that the fate of refugees' gaining access to healthcare is in the hands of the healthcare provider on duty and not on what is ethically correct (Crush & Towadzera 2014:667; Meyer-Weitz et al 2018:9; Odhiambo 2012; Zihindula et al 2015:17).

The findings of this study agree with the literature because many of the participants demonstrated occasions where they were denied access to healthcare. One female refugee reported to have taken her child to Tshwane District Hospital. At the time, the child had a fractured ankle after a minor car accident. They were unfortunately turned back from the hospital as she explained:

> "There was a time I was denied access to health services at Tshwane District Hospital when I had taken my son because his ankle was broken, and it was an emergency. However, a nurse told me I should take the child to the clinic, and they did not consider the injury as an urgent matter. While queuing at the clinic, I was questioned by a nurse wanting to know what I was doing at the clinic with a child who has got a broken leg. I explained I was referred to the clinic from Tshwane District Hospital, and the nurse just sent me back to the hospital. Even though it was late at the time, I had to go back to the hospital to get assistance." (Female from Somalia, 34)

The quote above gives an impression that urgent matters are sometimes taken lightly even when it is a matter of health. This has many implications. For most part, it means increased transport costs for the patients, which might cause distress. Refugees shared that it is also a common practice for healthcare practitioners to send them back and forth between a clinic and a hospital, which this further delays the required treatment. This shows that refugees are denied medical attention with no proper explanation. However, there is no well-known case where healthcare practitioners are held accountable for denying treatment to refugees.

Other challenges expressed were that the nurses sit at the reception and decide who should consult with a healthcare practitioner and who should not. Some stated that because they have experienced denial before, they try to avoid the public healthcare facilities and only go there when there is a public campaign or when there is an emergency and they do not have money at the time to seek private healthcare. Another reason that led to refugees being denied access was inability to pay a consultation fee, as elaborated in the quote below:

> "I was once denied access to healthcare because I failed to pay a consultation fee at Steve Biko Academic Hospital. It was one of my monthly doctor's appointments as I was suffering from gallstones. That day they asked me to pay for a consultation fee even though I was never asked to pay money before. I told them I do not have money today. I begged to be assisted and I will pay the money later or on my next appointment because I already had an appointment with a doctor. However, the receptionist did not allow to me see the doctor. I stayed at the hospital for more than 3 hours begging him to allow me to see the doctor with no success until I decided to leave the hospital." (Female from Somalia, 30)

Those who had never been denied access shared that they are assisted when they visit healthcare facilities; however, healthcare practitioners still give them problems such as openly discriminating against them. An example below demonstrates some of the problems a refugee encounters in healthcare facilities.

> I once took my wife for a follow-up check-up while she was pregnant. While we were there we did not receive a friendly welcome from the nurses. They kept asking us questions like why you foreigners like coming to South Africa? Is it because you get free things here in South Africa?" (Male from DRC, 39)

The quote above shows that refugees are wrongly perceived as coming to South Africa in order to receive free social services. Such discriminatory remarks, from healthcare practitioners, are likely to discourage refugees to access healthcare services at any time. Some participants said they had never been denied access because they have learned to express their needs and articulate their rights and to deal with the bad attitude of healthcare practitioners, especially nurses. One participant explained:

> "I have never been denied any healthcare services because I know how to stand up for myself. I understand that as a refugee, I have the right to access public healthcare services. So, if they try to show attitude I talk to them about my rights as a refugee when it comes to public healthcare services." (Female from DRC, 40)

The discussion above shows how persistent refugees must be in order to be provided with the healthcare services they need. However, this may also put refugees at a disadvantage, as some healthcare practitioners may perceive the refugees as having a bad attitude, and this may lead to denial to access health services (Crush & Tawodzera 2014:660; Meyer-Weitz et al 2018:8). Healthcare practitioners from public healthcare facilities seem to believe that refugees should not make any demands, because the government is doing refugees a favour by allowing them free access to public healthcare services (Odhiambo 2012). To illustrate this, Odhiambo (2012) indicates that if a healthcare practitioner senses that a non-South African is making demands, they easily get annoyed and stop assisting them, all the while telling them that these services belong to South Africans only. This was evident from a story in the *Mail and Guardian* newspaper reported by Odhiambo (2012) about Somali women, where they cited that nurses regarded complaints as disrespect towards them.

The findings are consistent with a study done in South Africa about Zimbabwean migrants living in South Africa (Crush & Tawodzera 2014). The participants reported that nurses viewed talking back as disrespectful, while a study conducted on refugees living in Canada reported that they were also subjected to a culture of discrimination from doctors and were not allowed to articulate their rights to healthcare (Pollock et al 2012:73).

Some refugees cited that they were denied access because they lacked the necessary documentation. One participant said that his wife could not be admitted to a public hospital because she did not have a refugee status document. Even though his wife was in labour, she was turned away because she did not have the appropriate documents. The following extracts confirm that healthcare services are often inaccessible due to a lack of proper documentation:

> "My wife was once denied admission at Steve Biko Academic Hospital because she did not have valid documentation. At the time, she was pregnant and in labour, but they did not accept her at the hospital. This left me no choice but to get a loan and I took her to a private hospital; she then gave birth at a private hospital." (Male from Eritrea, 43)

The participant above further stated that he produced their marriage certificate to the nurses at the hospital as well as his maroon refugee ID book in an effort to convince the nurses to admit his wife, but with no success. He further stated that he took his wife to another public hospital (Tshwane District Hospital) and she was still denied admission due to a lack of documentation. The woman was pregnant and in labour when she was denied access to healthcare services. This frequently took place at public health facilities, which led them to borrow money so they could visit a private hospital.

As previously mentioned, refugees try to avoid such kind of disappointment, and they therefore limit their visits to public healthcare facilities, as illustrated in the quote below:

> "I try to avoid using the public hospital. I only use public hospital when there are campaigns. I only visit if it is announced or campaigned there is a dosage for measles, chicken pox, etc. for the children. Other than that, I do not go to a public hospital or clinic. Sometimes, I only visit hospitals when there is emergency." (Female from Somalia, 34)

The above quote signifies that some refugees do not trust healthcare providers in public healthcare facilities.

4.3.2.1.3 Subtheme 1.3: Public healthcare service fees

Of the eighteen participants interviewed, most of them (14) stated that they are always asked to pay consultation fees at public healthcare facilities if they are foreigners. The issue of free basic healthcare services in public healthcare facilities remains questionable and confusing. As mentioned in Chapter 2, the Constitution of South Africa states that "everyone has the right to have access to healthcare services, including reproductive healthcare. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights, no one may be refused emergency medical treatment" (Department of

Justice and Constitutional Development 1996). This statement includes everyone living in the country, regardless of nationality status. Correspondingly, the National Health Insurance assures that refugees from Southern African Development Community (SADC) countries have the same rights to treatment at public sector hospitals as South African citizens (Johannesburg Migrant Health Forum 2016). Refugees are supposed to pay only what they can afford based on their income (Lawyers for Human Rights 2014). This does not provide any information about refugees coming from non-SADC countries. However, the National Health Act states that anyone in a vulnerable situation has the right to access free basic healthcare (South African Department of Health 2004). Even though refugees fall under the latter, most refugees are asked to pay a service fee when they arrive at public healthcare facilities. According to the South African Constitution and National Health Act, refugees are supposed to have free access to basic healthcare (South African Department of Justice and Constitutional Development 1996; South African Department of Health 2004). The Johannesburg Migrant Health Forum (2016) argues that refugees are excluded from the “Uniform Patient Fee Schedule” for migrants; i.e. they are excluded from paying any healthcare service fee and must receive free healthcare service just like South African nationals. The "Uniform Patient Fee Schedule" for migrants is a Department of Health schedule formulated for non-South Africans to pay for healthcare services as required in public healthcare facilities (Johannesburg Migrant Health Forum 2016).

One participant commented:

> “I was in hospital myself, nurses say foreigners must pay.” (Female from DRC, 32)

If they do not have any money with them, it will be noted on their files that they owe such money, and they might not receive any assistance on their next visit until the debt has been paid off. One (1) female refugee from the DRC, who is 39 years of age, shared that she was made to pay a consultation fee of up to R250 at Steve Biko Academic Hospital because she did not have the ID or passport they requested; however, she did have the Section 24 (refugee status) document. Even though she was referred by the Sunnyside Clinic to go to the hospital, they were expected to pay a consultation fee of R250. She said she did not have the R250, so it was noted on her file as debt.

Other studies show that some refugees are denied access to healthcare in public hospitals, even when they need urgent medical attention, because they failed to pay the healthcare service fee. Lawyers for Human Rights (2014) found that in 2014 there was a case where a 12-year-old Somali girl was denied urgent life-saving heart surgery at Steve Biko Academic Hospital because her parents were unable to pay the R250 000 deposit. Lawyers for Human Rights intervened in the matter. A court order determined that the 12-year-old girl would undergo life-saving heart surgery (Lawyers for Human Rights 2014). There possibly are even more cases of refugees facing similar situations and who receive no assistance, but these cases go unreported to Lawyers for Human Rights.

Some refugees revealed that they are sometimes charged a consultation fee based on how they looked. Specifically, if they look clean and well dressed, they are asked to pay. Some government officials classify this as the "means test assessment". A means test assessment is used to calculate a payment percentage according to annual income, and ensures that all those who can pay do pay, according to the health department's evaluation of affordability based on income (South African Department of Health 2015).

According to the South African Department of Health (2015), there is a uniform patient fee schedule for paying patients attending public hospitals. However, pregnant women, children under the age of six (6) years, the elderly and those receiving government grants are exempted from being charged for healthcare services in the public health sector. However, findings show there are refugees who were not assisted while in labour because they could not pay consultation fees.

A number of studies and reports from organisations advocating for human rights highlighted that the South African public health system, on many occasions, has been implicated with mistreatment of non-South Africans, including refugees (Lawyers for Human Rights 2014; Johannesburg Migrant Health Forum 2016; Mathope 2017; Skosana 2016; Tshabalala & Van der Heever 2015:284). Mistreatment includes charging non-South Africans undue medical/consultation fees in the healthcare facilities. Reasons behind the undue medical costs are underlying xenophobic attitudes of healthcare providers and the attitude that refugees waste resources meant for South Africans (Lawyers for Human Rights 2014; Johannesburg Migrant Health Forum 2016; Tshabalala & Van der Heever 2015:285). The findings of this study echo those of

Lawyers for Human Rights (2014) that refugees are often charged consultation fees simply because they are non-nationals. It is surprising to refugees that government healthcare facilities always ask them to pay a consultation fee even though the refugees are aware of their rights to access free basic healthcare in South Africa.

4.3.2.1.4 Subtheme 1.4: Documentation first, healthcare services after

The public healthcare system has developed a document first, service delivery after practice, which affects refugees in many ways. Nine (9) of the study participants reported that they have once or twice encountered problems with healthcare providers when they produced their refugee status documents/maroon refugee passport at the clinic/hospital. Instead, they are expected to produce an identity document or passport. Requiring an identity document as a procedure to healthcare delivery cannot be labelled as a 'problem'. The problem starts when the refugee's legal status document is classified as not being the correct or acceptable document by healthcare officials (Alfaro-Velcam 2017:61). The stud findings reflect that correct or acceptable documents are only 'correct' when reference is made to the green South African identity book or passport. Participants further shared that if they fail to produce either of the two recognised documents, they face challenges, and healthcare providers are even reluctant to assist them if they are at all lucky to receive medical attention. They are sometimes chased away from the healthcare facility especially if the healthcare worker on duty is unfamiliar with refugee documents. Some participants stated they sometimes feel harassed whenever they go to public healthcare facilities because they are always being asked to come with a proper passport or ID book on their next visit. A female refugee from DRC narrates her encounter below:

> “One day my husband was sick, and I took him to Sunnyside Clinic. They then referred us to visit a hospital because he was very sick and we went to Tshwane District Hospital. While we were there, a nurse asked my husband for his ID or passport. He produced his maroon refugee ID book. The nurse asked 'what is this? And where is your passport?' We explained that it is a refugee ID which we got from the Department of Home Affairs (DHA). The nurse did not believe that it was a legal document produced from the DHA, and she refused to open a file for my husband to see a doctor. Though we were referred to the hospital from Sunnyside Clinic, they refused my husband to consult with a doctor.” (Female from DRC, 38)

This demonstrates that some healthcare workers are ill informed about refugees and the legal documentation they use while living in South Africa.

Another issue that came to light about documents, as explained by participants, is the demand of proof of residence by healthcare providers. Refugees mentioned that they live in rented properties where there is a landlord, and they would need to get proof of residence after consulting with the landlord. They further said that obtaining up-to-date proof of residence is a challenge and this affects accessibility to healthcare services as they usually fail to produce proof of residence.

Some refugees were able to access public healthcare centres only after NGOs such as FF, Lawyers for Human Rights and other non-governmental organisations working with the refugee community in South Africa had intervened with the Department of Health. Of the interviewed participants, two (2) shared that they were once chased away from Tshwane Clinic in the Central Business District (CBD) because nurses would not accept their refugee document as legal. They were only accepted for medical healthcare after FF intervened in the matter with a written letter explaining refugees' rights was submitted the Department of Health and the healthcare facility.

The plight of refugees in South Africa has become a widespread issue in traditional media and social media. However, the findings show that there is still a lack of knowledge with regard to refugees and the legal documents they use. Government workers, especially those who work with a diverse population of local and non-locals are supposed to know the different types of legal documentation used by refugees, as issued by the South African government (Lawyers for Human Rights 2017). Healthcare workers are among those government workers who deal with diverse populations daily. It is not clear if there is a written policy at hand mentioning that healthcare facilities in Pretoria must require patients to have legal documentation at hand before they could be assisted. For this reason, refugees suffer the consequences.

4.3.2.1.5 Subtheme 1.5: Language barrier

Most of the refugees who participated in this study could speak English. Accordingly, English is one of the official languages spoken in South Africa. English is also a language of communication in workplaces. Language barriers were found to be one of the factors that led to refugees being denied access to healthcare services in South Africa. Some studies show that language was seen as a barrier in accessing healthcare among refugees as they find it difficult to understand any local language, or simply being in need of a translator when in foreign countries (Lawrence & Kearns 2005:453; Meyer-Weitz et al 2018:4). Language difficulties do not only limit communication within the medical appointment but have an impact on every stage of the healthcare process (Mangrio & Sjögren-Forss 2017:4). A language barrier may lead to misrepresentation of symptoms by refugees, which in turn may result in a wrong diagnosis and prescription or, if it so happens that the diagnosis is correct, refugees are still at risk of misunderstanding the prescription (Langlois et al 2016:321; Mangrio & Sjögren-Forss 2017:4). All of the interviewed refugees cited having difficulties communicating with healthcare workers in the first years of arriving in South Africa, which in turn resulted in delayed healthcare attention or being denied healthcare altogether.

A female refugee relates her story below:

> "When I was new in the country, my son got sick and I went to Tshwane District Clinic for assistance. My English was very bad at the time, which was difficult for me to explain what the problem was. The nurse just chased me away and told me to come back with an interpreter without even examining my son." (Female from DRC, 37)

Another one shared:

> "I once had terrible flu while I was still living in KwaZulu-Natal, and I went to Addington Hospital. I could not speak English at the time so I kept pointing where I was feeling pains. The nurse got angry and ended up ignoring me and attended another patient and left me sitting on the bench for hours. She said she could not assist me unless I brought someone to interpret for me." (Female from DRC 38)

The above extracts demonstrate two sides of the frustration caused between the healthcare worker and the refugee. The initial approach of the healthcare worker towards the refugee shows willingness to provide a medical examination. However, complications began when the refugee failed to communicate in any of the local languages. It seems that the language barrier is more likely to frustrate healthcare workers, who are also put under pressure when they know that there are still other patients to assist (Hunter-Adams & Rother 2017:2; Crush & Tawodzera 2014:664). In the South African healthcare facilities, there are no professional interpreter services available (Hunter-Adams & Rother 2017:3). According to Kotovicz, Getzin and Vo (2018:29), in most cases, refugees depend on family members who speak English to interpret on their behalf. Families carry the responsibility of scheduling and arranging appointments with health professionals and being physically present during consultations (Kotovicz et al 2018:29). Nevertheless, the patient-to-interpreter and interpreter-to-healthcare provider interactive triad raises concerns about accuracy of translation (Hunter-Adams & Rother 2017:2; Kotovicz et al 2018:33). The challenge is that there is sometimes a lack of understanding of certain medical words where the family interpreters struggle to find the direct equivalent translation in their language (Kotovicz et al 2018:33). This in the end impact diagnosis processes.

However, as far as language difficulties are concerned, findings show a different angle of language as barrier to healthcare accessibility among refugees interviewed. As mentioned earlier, participants could speak and understand English, therefore, they are at least able to describe their symptoms whenever visiting healthcare facilities. Some of them have even learnt to speak local languages spoken in Gauteng such as Sesotho, Zulu, Sepedi and other local languages. It was brought to light that healthcare practitioners prefer that refugees speak vernacular languages as spoken by the majority of the population in Pretoria. Some refugees said that nurses would sometimes express disappointment that they could not speak Sesotho or Sepedi, even though they have been living in South Africa for some time now. The participants further reported that nurses would say they would not change the way they operate in the healthcare facilities just because refugees could not learn local languages. One female participant from Somalia said that nurses seemed to get annoyed the moment they communicate in English. She further stated that they would get so annoyed that when it is one's turn to consult with a healthcare practitioner, they would skip the refugee and rather attend to the locals who can speak in vernacular. South African healthcare professionals,

especially nurses in the public health sector, seem to dislike speaking English (Crush & Tawodzera 2014:664). English mostly puts refugees and migrants in trouble with nurses (Crush & Tawodzera 2014:664). The problem in this case is the fact that refugees learnt to speak the English language not a vernacular, whereas nurses in clinics and hospitals prefer to communicate in their vernacular language during medical consultations.

Another challenge experienced by refugees was the language used for instructions in healthcare facilities in Pretoria. They cited that instructions and announcements are mostly provided in Sesotho or Setswana, which makes it difficult to understand what procedure to follow when in the facility. They would get confused about which appropriate queue to join and wait for a consultation with a healthcare practitioner. They reported that whenever they complained that they are unable to understand the instructions, the healthcare practitioner in the facility would shout at them or sometimes even chase them out of the facility. So, to avoid more problems, they would meekly follow other patients, only to find themselves in the wrong queue, and then being forced to join another queue. This means that they now have to go the very end of the "new" queue, which also causes a delay in their receiving assistance from a healthcare provider. These are some of the challenges that a refugee has to face on a daily basis, and the fact that they usually are the minority in the healthcare facility often results in their crisis not being taken into consideration.

It was cited that the mood of healthcare practitioners seem to change whenever they realise that a non-South African has made an effort to learn and speak a local language (Crush & Tawodzera 2014:665). The practitioner suddenly becomes more friendly and provides good service. A female refugee from Burundi shared that:

> “With regard to communicating with nurses, I do not suffer because I tried to learn local languages. So, whenever I go to local clinics or hospitals I speak Setswana or Sesotho and that way they become friendlier. When I sometimes speak English, I realise their mood immediately changes to show their dislike.” (Female from Burundi, 32)

4.3.2.1.6 Subtheme 1.6: Healthcare services procedures in South Africa

Participants were asked if they have any knowledge of healthcare service procedures in South Africa (i.e. visiting a local clinic first before going to a hospital). Thirteen (13) responded that they have knowledge of the South African healthcare procedures. This has contributed to their following the procedure whenever one is ill and in need of medical care. They also cited that only in the case of an emergency (i.e. in the case of accidents, labour, etc.) may one visit the hospital without visiting a clinic first. Only five (5) participants responded that they were not aware of the healthcare services procedure, which is why they were not following it.

They were also asked if they followed the healthcare service procedures when visiting any healthcare facility. Thirteen (13) responded that not only did they have knowledge of healthcare service procedures, they also adhered to these procedures. This is evident since the number of participants who always follow the procedure is equivalent to those who have knowledge of healthcare procedures. Only five (5) responded that they were not aware of the healthcare service referral system; hence, they have not been observing the healthcare service procedures.

4.3.2.1.7 Subtheme 1.7: Interactions between healthcare professionals and refugees

Some refugees complained that nurses do not see it as a right to communicate or interact with them. Some nurses assume refugees do not have the right to know what type of illness they are suffering from, or that they do not need to ask the refugees to describe the symptoms they suffered from prior to falling ill. In general, effective communication between a health practitioner and a patient is important as it may help in diagnosing the type of illness a patient may be suffering from (Azizam & Shamsuddin 2015:57). According to Azizam and Shamsuddin (2015:57) and Bogart, Chetty, Giddy, Sypek, Sticklor Walensky and Bassett (2013:845), effective communication between the healthcare provider and the patient is a vital element in patient care. It is comforting for patients to know what illness they are suffering from, and whether they will be helped and get better, and how to take care of themselves, and which prescriptions to adhere to in order to complete the treatment. Communication between healthcare provider and patient also brings healthcare satisfaction for patients (Azizam & Shamsuddin 2015:50) Jardien-Baboo, Van Rooyen, Ricks & Jordan (2016:398) argue that poor

communication between healthcare provider and patient is seen as one of the leading causes of preventable deaths in hospitals. Some health providers do not properly communicate with patients because they prefer some patients over others (Bogart et al 2013:847).

Iroju, Soriyan, Gambo and Olaleke (2013:263) state that in clinical practices of medicine, a healthcare provider gathers information in order to facilitate accurate diagnosis, counsel appropriately, give therapeutic instructions, and establish caring relationships with patients. This practice is through communication with the patient. Findings of this study revealed that these basic procedures are not always applied to many refugees. A few refugees asserted that healthcare practitioners do things as they please – even when it comes to their bodies or to their children – without any proper communication. For instance, if a nurse were administering an injection, the nurse would inject them without informing the purpose of the injection or the kind of illness that they may be suffering from. If they ask why they are being injected, the health practitioner would immediately take offense at the question, become very rude and threaten to chase them out of the facility. Refugees are often expected to be quiet and never question what the health practitioner may be doing to them. A female refugee said the following:

> “Some of my experiences bring me emotional pain. One day my daughter had measles and I took her to a local clinic. While we were waiting to go to the consultation room, a nurse just came to us and took my daughter with her without saying anything or informing me as a mother where she was taking her and for what reason. The nurse just gave my child an injection for measles without informing me she was taking her for the measles injection. When I asked why she just took my child without saying anything, the nurse just ignored me and called in the next patient.” (Female from Somalia, 34).

Jardien-Baboo et al (2016:398) believe that the reason for poor communication between healthcare provider and patient is that some healthcare providers discourage patients from voicing their concerns and expectations or from requesting more information. Some healthcare providers do not explain a diagnosis sufficiently enough so that the patient also understands the illness and its implications (Bowling, Rowe & Mckee 2013:; Jardien-Baboo et al 2016:400). In many cases, patients are not empowered to reach

consensus with their healthcare providers (Jardien-Baboo et al 2016:401). This is usually the case with refugees living in South Africa. Findings also show that refugees mostly feel disempowered when they are dealing with healthcare providers. Sometimes health practitioners ignore refugees and attend to others without communicating the reason why they are not being attended to in the queue. Even though it is their turn to enter the consultation room, they are ignored, and this forces them to spend the whole day at the healthcare facility, waiting for assistance.

4.3.2.1.8 Subtheme 1.8: Inconsistencies of information by healthcare facilities

The participants believed that the information provided by public healthcare practitioners and healthcare facilities in Pretoria is inconsistent. Participants cited Steve Biko Academic Hospital, Tshwane District Hospital, Sunnyside Clinic, Tshwane Clinic in the CBD and Laudium Clinic as healthcare facilities where the information provided was not consistent. There may be a number of healthcare practitioners working in a particular healthcare facility (hospital or clinic); however, every healthcare practitioner provides different information to patients visiting the facility. The refugee were of the opinion that the information these practitioners were sharing with their patients differed so vastly that one could not be sure they complied to the same provincial policies or legislations. These inconsistencies in the information being provided or procedures to be followed create confusion. As patients, they do not know what is correct and what is incorrect. An example of how these inconsistencies in information affect refugees can be drawn from the quote below:

> "Information differs from one nurse to another within the same hospitals, and also differ from one hospital or clinic to another in the same province. This confuses us refugees. There should be a uniform written law or policies that we can all follow. Information and access to health resources should not be based on an individual attitude." Female from Somalia, 34)

One refugee stated that one day she went to Steve Biko Academic Hospital and she was advised that refugees had to pay an administration fee of R60 (sixty rand) before they could consult with a doctor whereas, before, she was asked to pay an administration fee of only R20 (twenty rand). Given the example above, the interviewed refugees wondered if information provided by healthcare practitioners in the public

clinics and hospitals is governed by any written policy or law. It is questionable why healthcare practitioners in public healthcare facilities provide contradictory information to patients.

4.3.2.2 Theme 2: Understanding the rights as a refugee

When asked if they are aware of their rights as refugees, the majority (11) were aware of their rights as refugees in South Africa, while seven (7) were not aware of their rights. It was clear, however, that refugees are not aware of the type of rights that refugees are entitled to in South Africa. Section 27(g) of the Refugees Act No 30 of 1998 states that “a refugee is entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time” (South African Department of Home Affairs 1998). Even though many of the interviewed refugees reported to know that they have rights in South Africa, they had limited knowledge on the type of rights they are entitled to. The challenge posed by refugees not being aware of their rights in accessing healthcare is that it deprives them of the power to stand up for themselves when they experience poor service in healthcare facilities. Healthcare practitioners tend to make refugees feel that they are not entitled to quality healthcare, and that it is offered to them as a favour.

4.3.2.3 Theme 3: Healthcare inequalities

Healthcare inequalities are defined as "differences in the health achievements of individuals and groups (Braveman 2014:06). Inequalities across groups are mostly driven by socio-economic position, race, and ethnicity, place of residence/geographic location, gender and age" (Braveman 2014:06). There is inequality of access and treatment in healthcare facilities among populations living in South Africa, for both South Africans and non-South Africans (Vearey, Modisenyane & Hunter-Adams 2017:90). These inequalities in treatment are likely caused by misunderstanding of cross-border migrants (Vearey et al 2017:93).

4.3.2.3.1 Subtheme 3.1: Private healthcare service delivery versus public healthcare service delivery

South Africa's healthcare system consists of private healthcare and public healthcare (which is run by government) (Benatar, Sullivan & Brown 2017:5). Participants were asked if they had ever visited any private healthcare facilities to obtain healthcare (such as a private hospital or private doctor). Nine (50%) of the participants had visited a private healthcare facility before, while the other half had never visited a private healthcare facility. The nine participants who had visited a private healthcare facility had also visited a public healthcare facility, and they all agreed that there was a vast difference between services rendered in a private healthcare facility and those rendered in a public healthcare facility. This study reflects unequal qualities between private and public healthcare. Public healthcare provides free care services and is easily accessible but has disadvantages such as long waiting times, poor quality of care compared to private facilities (Mkhwanazi 2012; National Department of Health 2015:9). The advantages of private healthcare advantage are short waiting hours, good quality of care; and health providers are friendly (Coetzee, Klopper, Ellis & Aiken 2013:164). However, private healthcare is not easily accessible because its healthcare services are costly and therefore not affordable to the majority of the population.

The study findings showed that there was minor confusion among refugees with regard to the issue of healthcare accessibility in private and public healthcare facilities. As provided in Chapter 1, access to healthcare is a means of bringing about improved health promotion, satisfaction, disease prevention and patient satisfaction (Zihindula et al 2015:10). With an understanding of the definition of access to healthcare, refugees are rarely satisfied with the healthcare provided, and many of them reported that they are being denied disease preventing or health promoting information in the public healthcare sector. For these reasons, on the one hand, public healthcare is accessible simply because it is normally free or at low cost and supposedly open to anyone. But when it comes to refugees, healthcare provision is viewed as being inaccessible due to the visible fact that they suffer from neglect, are subjected to longer waiting hours and discrimination and are sometimes denied any healthcare at all at the hands of healthcare providers.

On the other hand, private healthcare is generally inaccessible because of high cost, and such care is only open to those who can afford the healthcare service. However, refugees view private healthcare as being easily accessible because they always get the healthcare services they need at any time. Refugees always felt respected with no fear of discrimination, neglect, or denial of illness prevention information and subsequently, they are satisfied when visiting private healthcare facilities. Focusing on the latter, the difficulties of accessing healthcare by refugees in South Africa remain a major problem, since refugees are mostly unemployed or employed in low-paying jobs (Greyling 2016:237). This makes it impossible for refugees to afford private healthcare. This can be applied to Donebedian (1973), cited in (Zihindula et al 2015:13), who refers to the concept of availability, acceptability, and affordability, which views access as a dynamic process of interaction between the healthcare system and the patient. Patients expect their health needs and expectations to be met by the health system for continued uptake of treatment and care (Donebedian 1973 cited in Zihindula et al 2015:13). Refugees are rarely satisfied with the acceptability, affordability and availability of healthcare services.

With an understanding of the concept of availability, acceptability and affordability, findings indicate that, typically, refugees are not accepted in the public healthcare system. In addition, Burger and Christian (2018:01) argue that staff in the public healthcare sector are mostly rude and are likely to incorrectly diagnose refugees, simply because they do not really want to assist non-South Africans. This is also reflected in this research. In the private healthcare sector, however, affordability has become a problem among refugees. Even though refugees cited to always receive a warm welcome with good treatment and no discrimination in the private healthcare sector, the costs of services are high, and they could not sustain constant visits. They also argued that they think the good treatment they receive in private healthcare facilities is attributable to the high cost of private care. They argued that it was not because of affordability that they opted to access healthcare services only in the private hospitals, but they knew they would always receive the assistance they need with care.

When asked about the reasons why the treatment was different in public healthcare facilities as opposed to private healthcare facilities, they could not provide the reasons to support their observations. However, six of the interviewed refugees assumed that money plays a vital role in receiving good treatment in private healthcare facilities

compared to public healthcare facilities where services are generally free. Private healthcare services are expensive, and every individual pays a lot of money to receive treatment; hence, the treatment is fair and equal to all (Burger & Christian 2018:05). It is further argued that the service at private hospitals is quick and saves time (Burger & Christian 2018:05). The extract below of a woman originating from DRC aired:

> "If I need quick medical attention, especially for my children's immunisation, I go to a private hospital. I prefer private healthcare because I get help quickly and especially if I'm working, I do not have to spend the whole day at a clinic or hospital just for immunisation." (Female from DRC, 40)

Another refugee from DRC argued there is a big difference between a public hospital and private hospital because private hospitals always provide good healthcare services. He aired that:

> "If a refugee woman is pregnant and visits a public hospital she does not get a good treatment as compared to private hospital. I will always get good treatment at a private hospital. I think because the difference is because public hospital is normally free and private hospital requires payment." (Male from DRC, 31)

This is supported by the arguments from United Nations Population Fund (2016) and Lawyers for Human Rights (2016) that women and girl refugees endure discrimination and mistreatment that affect their access to healthcare. They are prone to discriminated because of their constant need for healthcare services.

4.3.2.3.2 Subtheme 3.2: Overcrowding of healthcare facilities in Gauteng

From eighteen (18) participants, only two (2) responded to have accessed healthcare services outside of Gauteng. The rest (16 participants) have been accessing healthcare services in Gauteng since they arrived in South Africa. Therefore, most of the participants had no source of comparison to other provinces to measure if treatment toward refugees in Gauteng healthcare facilities is poorer or better compared to other provinces. The two (2) participants who accessed healthcare facilities outside Gauteng reported to have done so during a visiting period, whereas they are officially based in Pretoria. All of them agreed that when they arrived in South Africa, Gauteng was the

only province they chose to live in mainly because of the Refugee Office that is based in Pretoria. Some said they moved to Gauteng because they already had relatives living in Gauteng.

Gauteng is a highly populated province and is home to the highest concentration of migrants, many of whom are refugees. According to the Statistics South Africa (2016) population estimates reported by provinces for 2016, the population of Gauteng was 13.3 million, with Pretoria hosting 3.2 million of the population. According to the Gauteng Department of Health (2017), currently, there are only about 57 public clinics and 31 hospitals (both public and private) available in Pretoria to accommodate this densely populated metropolitan. The healthcare facilities in Gauteng are therefore mostly overcrowded. Public clinics and public hospitals are said to be always overcrowded and healthcare practitioners are overworked, which causes frustration towards patients, particularly non-citizen patients. The *Citizen* newspaper quoted the South African Minister of Health, Dr Aaron Motsoaledi, in June 2017 stating: “quarterly statistics from Adendale, Charlotte Maxeke, and Steve Biko academic hospitals indicate that 47% of those who received healthcare were African refugees” (Mathope 2017). The Minister further indicated, “at Charlotte Maxeke alone during the month of May 2017, 57% of those who received healthcare were foreigners” (Mathope 2017). He further argued that the push factor was the collapse of healthcare systems in other African countries (Mathope 2017). According to the aforementioned statistics, there is always a growing competition for healthcare resources among citizen and non-citizen populations residing in Pretoria. The increase in the number of immigrants at public healthcare facilities can be related to Dinbabo and Nyasulu (2015:29) and Mayosi and Benatar (2014:1344), who argue that over the years, there has been a serious increase in the rate of international migration inflows into South Africa as a result of a variety of push-and-pull factors from other countries. Consequently, this increases competition of resources, and healthcare providers are inevitably forced to come to terms with cultural diversity in the healthcare service premises and providing equal distribution of the healthcare resources.

Furthermore, since there is always competition of resources in the healthcare facilities, healthcare providers tend to put non-citizens on triage. In medical terms, triage is a principle of prioritising the treatment of a patient. The South African triage system prioritises emergency departments' workloads and shortening the waiting time for those

critically ill and in danger (Gordon, Brits & Raubenheimer 2015:18). However, Gordon et al (2015:18) argue that most of the South African public healthcare hospitals rarely follow the triage system. Instead, the triage assessment is affected by snap judgements and the credibility of the patient, familiarity of the patient and their body language (Amoo & Mash 2016). According to Crush and Tawodzera (2014:662), in South Africa, migrants are marginalised and triaged based on race, language, how they look or their country of origin. The snap judgement element is based on their "foreign" appearance, which in the end leads to prolonged waiting times at the healthcare facility (Crush & Tawodzera 2014:662). Crush and Tawodzera (2014:662) further argue that some healthcare facilities in South Africa operate two queues, in which one queue is for locals and the other for non-locals. Preference is firstly given to the locals while ignoring the foreign nationals. This affected all interviewed refugees. Findings reflect that those of Somali, Eritrean and Ethiopian origin are triaged because of their easily identifiable religious attire and ethnicity, while refugees from DRC and Burundi were triaged as soon as they started speaking.

One refugee testified:

> “The moment the nurses hear you are speak in English, they immediately know you are not South African and just become rude towards you and sometimes they ask you to step aside.” (Female from Burundi, 32)

This shows that healthcare providers assess social differences of patients visiting facilities before they provide healthcare. This approach represents the existence of social groupings that reflect the unequal distribution of resources and life opportunities across segments of society (Van Rensburg 2014:2).

In general, healthcare facilities in South Africa practise a first come, first served system, and refugees are aware of these procedures. In other words, healthcare services are provided to whoever arrived at the healthcare facility the earliest, unless in the case of an emergency. Nevertheless, because of the triage principle applied towards foreign nationals as mentioned above, the first come, first served system does not help refugees. Due to the unwillingness of healthcare workers in providing healthcare before South Africans, some refugees find themselves in a situation where they have to go back and forth to a healthcare facility or decide to visit a different healthcare facility with

a long waiting period. More than half of the participants (11) stated that they had at least been told once or more by health practitioners that this country is not for foreigners and they are wasting South African resources. As a result of this viewpoint, healthcare practitioners decide to provide service to citizens first before assisting non-South African nationals.

4.3.2.3.3 Subtheme 3.3: Healthcare professionals' attitude towards refugees

When asked about their observations on how they were treated in healthcare facilities compared to South African citizens, half of the participants 9 (nine) felt that they were treated differently for being foreigners. However, eight (8) participants responded they did not notice any difference in treatment even though they hold refugee status. One participant was not sure whether the difference in treatment was caused by their refugee status. Those who responded to have noticed a difference in treatment agreed that discrimination is experienced in many ways. For example, one is treated differently by delaying medical assistance or by denying the patient access to healthcare because of his/her refugee status and inability to speak a local language.

Furthermore, one female refugee stated that healthcare providers sometimes treat refugees differently based on their country of origin. She further specified that she had noticed preference being given to refugees coming from the South African Development Community (SADC) countries.

4.3.2.3.4 Subtheme 3.4: Gender and access to reproductive health

Of the seven (7) male participants, four (4) cited that their wives suffered more negligence, discrimination, or denial in healthcare facilities while in labour. Of the 11 (eleven female participants, eight (8) cited that they had experienced most pain in the hands of healthcare workers while in labour. This shows that when it comes to the health needs of refugees, female refugees are particularly vulnerable. According to the United Nations Population Fund (2016), women of childbearing age are always the highest in number in every displaced community and they are the most affected whenever healthcare is inaccessible. Women and girl refugees endure discrimination and mistreatment that affect their access to healthcare (United Nations Population Fund 2016; Lawyers for Human Rights 2016). The research findings have revealed several

occasions where female refugees were denied access to public healthcare facilities while in labour. An example can be drawn from the male participant who claimed that his wife was denied access to a public hospital while in labour and because he understood the emergency of the medical attention needed, he borrowed money to take his wife to a private hospital. Childbearing is an obvious example of the different needs between men and women when it comes to healthcare services. Being in labour is a fragile stage for a woman, and there is the possibility that she could be in need of emergency medical attention regardless of nationality or affordability. However, there seems to be little empathy from some healthcare practitioners for the health needs and outcomes of refugees. The focus tends to be more on their nationality or financial state, while the focus should only be on the wellbeing of all patients who visit the healthcare facility.

This study established that some refugees receive threats from nurses when they are in labour. A male refugee shared the story of what his wife experienced in different healthcare facilities when she was in labour as follows:

> "When my wife was in labour with our first child, she went to Sebokeng Hospital to deliver the baby. However, a nurse refused to help her because she could not speak proper English. When she tried to speak in English, she was mixing it with her home language, and this made the nurse to assume my wife was insulting her. I explained to the nurse that my wife was simply speaking her mother tongue because she could not speak English properly. The nurse continued threatening to harm my wife. We wanted to open a case, but we did not because we were afraid." (DRC male, 38)

Even though his wife was not harmed, this experience frightened the participant and his wife because they were afraid to do anything that could help them bring justice to the nurse who threatened them. O'Mahony and Donnelly (2013:715) and Fellmeth et al (2018) argue that considering the struggles and difficulties that female refugees have to endure, they are more likely to suffer from postpartum depression (PPD).

Based on what the study established, women refugees mostly receive non-dignified care during childbirth. Non-dignified care during childbirth is described as "intentional humiliation, blaming, rough treatment, scolding, shouting, publicly divulging private

patient information, and negative perceptions of care" (Bowser & Hill 2010:09). The study established that healthcare practitioners might believe that non-South Africans give birth at a higher rate compared to South Africans. Healthcare practitioners are often unfriendly when it comes to assisting a foreign woman in labour and they ignore them for hours without examining them when they visit the healthcare facility (Odhiambo 2012). They make hateful conclusive remarks toward female refugees, for example, that they give birth to too many babies. Because of these remarks, nurses are not always interested in assisting female refugees when they are in labour. One participant further explained as follows:

> "Another bad encounter was when my wife was in labour for the second time and we went to Hillbrow Hospital in Johannesburg. They told her to wait in a queue while she was in pain and needed urgent attention. They did not assist until we went to another hospital." (DRC male, 38)

One may conclude that, with all insights of healthcare accessibility from participants, refugees suffer from unjust treatment at the hands of healthcare workers. In this regard, unjust refers to inequalities in healthcare that are deemed to be unfair or stemming from some form of injustice (Asanda, Hurley, Norheim & Johri 2015). This relates to the fact that there are healthcare service inequalities between refugees and the citizens of South Africa, especially in the public health service. This is unjust because health inequalities reflect an unfair distribution across social groups (Asanda et al 2015). Even though the law and policies of South Africa, as stated in Chapter 2, promote equal access and distribution of healthcare services to all living in the country, findings show that some refugees feel excluded. Based on the above evidence and the examples of healthcare inequalities, it can be concluded that refugees' experiences of hardships when accessing healthcare services in the country seem to be associated more with political and attitudinal factors than with socio-economic factors. It also shows that the practices of healthcare providers do not respect the human dignity of refugees. Vearey et al (2017:89) argue that even though migration has an impact on the South African public healthcare system, it is not as bad as it is perceived. They further argue that there is a need for proper understanding of migration and proper use of existing policies and new strategies to reduce health inequity regionally and nationally.

4.4 CONCLUSION

The chapter presented the findings of the study. The chapter revealed that the refugees in South Africa experienced different challenges in accessing healthcare services. The findings on lived experiences of accessing healthcare services in South Africa were classified into good and bad. This study reflected that there were more bad encounters than good; hence, the conclusion is that bad experiences outweigh the good experiences. The themes that emerged from the study are: (1) Refugees' day-to-day experiences in healthcare facilities; (2) Understanding their rights as a refugee; and (3) Healthcare inequalities. The themes assisted in breaking down challenges faced by refugees who access healthcare facilities in South Africa, especially in the public healthcare sector.

From the findings, one can conclude that refugees are not satisfied and their needs for healthcare are not always met as they are not getting the healthcare they are entitled to. Health professionals seem to believe that they are authorised not to provide services to refugees because of the documents they use, their inability to speak a local language and failure to pay the consultation fee. Chapter 5 will provide a summary and discussions of the findings, as well as recommendations that may contribute to improved accessibility and acceptability of refugees when accessing healthcare facilities in the country.

The following chapter, which is the final chapter, summarises the study. The chapter further presents the overall conclusions, recommendations and the limitations of the study.

CHAPTER 5

SUMMARY, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

This last chapter gives a summary of the major findings as well as the recommendations as informed by the study. The limitations of the study and recommendations for future research are also included in this chapter.

The refugees who were interviewed for the study have fallen sick at some point and visited a healthcare facility in South Africa to seek healthcare services. For this reason, the study aimed at investigating the lived experiences of accessing healthcare services by refugees in South Africa.

- To explore and describe the lived experiences of accessing healthcare services by the refugees in South Africa and specifically in Pretoria.
- To recommend for development of information material that inform policy on the refugees' rights to healthcare, using the existing legislation such as the Refugees Act and the Constitution.

What refugees commonly encountered in the healthcare system of South Africa is complex. Different strategic approaches are needed when dealing with such a dysfunctional health system as portrayed by refugees. The discussion of themes and future research possibilities may assist in answering the following questions, as stated in Chapter 1:

- What are the refugees' lived experiences of accessing healthcare services in South Africa?
- What should be done to make sure that the existing legislation on refugee rights to healthcare services is universal to both refugees and healthcare professionals in South Africa?

5.2 RESEARCH DESIGN AND METHOD

The study used a qualitative approach in the form of descriptive phenomenological research design. The chosen methodology allowed the study to describe and explore the experiences of refugees as they live their daily lives in South Africa.

The refugees who participated in the study were approached through FF (a not-for-profit organisation) where audio-recorded one-on-one interviews were conducted with the participants in the study. The interviews were conducted in a private office of FF at their Pretoria offices in Gauteng, where each refugee was able to share his/her experiences of accessing healthcare, narrate such experiences and give examples or incidents encountered where possible.

Non-probability purposive sampling was used as a selection process tool. Refugees selected for the study were those who originated from African countries and who are formally recognised as refugees in South Africa.

Semi-structured questions were used as a tool to guide the interviews. The data was collected by means of audio-recorded interviews and taking notes (in a notebook) from interviews. Data was analysed by employing Colaizzi's seven-step analysis framework as described by Shosha (2012:33).

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

5.3.1 Sample demographics

The demographics of the participants depicted that the majority of the interviewed refugees were from the DRC, followed by refugees from Somalia, Eritrea and Burundi. The majority of the participants in the study were female. The participants who originated from DRC spoke Swahili, Tshiluba or French as first language; those from Somalia spoke Somali as first language; the ones from Eritrea spoke Tigrinya as first language; and lastly, participants from Burundi spoke Swahili or Kirundi as first language. The study also discovered that all refugees interviewed only learnt to speak English while in South Africa for ease of communication. The age of participants ranged from twenty-seven (27) years to fifty-eight (58) years old. All participants have been

living in South Africa for more than two (2) years and some for more than fifteen (15) years.

5.3.2 Themes and subthemes

The research findings comprised three (3) main themes that were developed from the collected and transcribed data. The main themes are as follows:

(a) Refugees' day-to-day experiences in healthcare facilities
(b) Understanding their rights as a refugee
(c) Healthcare inequalities

Some of the main themes comprised subthemes, all of which are summarised and discussed below.

5.3.2.1 Theme 1: Refugees' day-to-day experiences in healthcare facilities

This theme has eight (8) subthemes, namely (1) Overall service delivery from healthcare facilities in Pretoria; (2) Denial of access to healthcare services; (3) Public healthcare service fees; (4) Documentation first, healthcare services after; (5) Language as barrier; (6) Healthcare services procedures in South Africa; (7) Interactions between health professionals and refugees; and (8) Inconsistency of information in healthcare facilities. A brief summary of each subtheme is provided below.

5.3.2.1.1 Subtheme 1.1: Overall service delivery from healthcare facilities in Pretoria

Participants asserted that what they experienced in the healthcare sector of South Africa is far from what they expected when they first arrived in the country. They thought because they are formally recognised refugees of South Africa, they would be able to receive the socio-economic services that they are entitled to. Contrary to their initial beliefs, participants discovered that the hardships they face in the healthcare system are not much different from what they experienced in their own countries.

The impression of the researcher is that healthcare services in South Africa do not cater for diversity, let alone refugees. The study reflects that the refugees have been living

and continue to live in crises when it comes to healthcare services. The majority of refugees interviewed stated that since they arrived in South Africa, overall healthcare services in the country have been bad to them in addressing their health issues. Even though they agreed that healthcare services could be good at times, this observation is surpassed by the bad treatment they receive from healthcare facilities in terms of poor management, negative attitudes from staff, inefficiency and long waiting periods. Findings show that a bad encounter when visiting a healthcare facility was associated with denial of healthcare services, insults or discrimination, or neglect because one is not South African. The study also reflected that refugees living in South Africa encounter similar hardships where healthcare services is concerned, as the findings were consistent with other studies about refugees living in Malaysia (Chuah et al 2018) and Canada (Pollock et al 2012).

5.3.2.1.2 Subtheme 1.2: Denial of access to healthcare services

Many participants had once or more than once been denied access to healthcare services in South Africa; however, this denial of healthcare was observed in public healthcare facilities only. Participants who asserted they had never been denied access to healthcare, did, however, mention that they have been insulted by healthcare providers. Study findings, aligning with other studies, echo several factors as the main cause for refugees being denied healthcare. Refugees were more likely to be denied access to healthcare because they do not speak a local language; they do not carry documents preferred by a healthcare provider on duty; the nurse felt the refugee was too quick to visit a healthcare facility when he/she felt sick; the healthcare professional on duty felt there were many foreigners visiting the particular healthcare facility; and so forth (Crush & Towadzera 2014; Meyer-Weitz et al 2018; Odhiambo 2012; Pollock et al 2012; Zihindula et al 2015:13). Some participants mentioned that the only way to deal with being refused access to healthcare services is being persistent. They further narrated that when they are rejected by a certain public healthcare facility, desperation forces them to visit a different health facility so that they can obtain the service they need.

5.3.2.1.3 Subtheme 1.3: Public healthcare services fees

The majority (14) of the participants revealed that they were always asked to pay a consultation fee whenever they visited any public healthcare facility in Pretoria. This study also reflected that there was confusion on the issue of consultation fees in the public healthcare sector. On the one hand, the Constitution of South Africa, Section 27(1)(a) and (3), states that every person living in the country has the right to access basic healthcare (Department of Justice and Constitutional Development 1996). On the other hand, refugees are classified differently in such a manner that those coming from Southern African Development Community (SADC) countries have the same rights to treatment at public sector hospitals as South African citizens (Johannesburg Migrant Health Forum 2016). At the same time, however, refugees are supposed to pay only what they can afford based on their income but there is no information about refugees coming from non-SADC countries (Lawyers for Human Rights 2014). According to the Johannesburg Migrant Health Forum (2016), refugees are excluded from the "Uniform Patient Fee Schedule" for migrants; i.e. they are excluded from paying any healthcare service fee and must receive free healthcare services just like South African nationals. Even though there are written policies that spared refugees from paying any fees in the public healthcare sector, findings show that refugees are always required to pay consultation fee presumably because they are non-South Africans.

5.3.2.1.4 Subtheme 1.4: Documentation first, healthcare services after

Half of the participants proclaimed to have been negatively affected by the identity document first, healthcare services after system. This system is a general practice among healthcare facilities based in Pretoria. Since participants were in possession of legal refugee documents, they said that their problems started when they were asked to produce a passport or a green South African ID book. This has negatively affected their access to healthcare services because they could only produce the A4 Refugee Status document, or a maroon refugee ID book as provided by the South African Department of Home Affairs. Healthcare workers in the public healthcare sector do not classify refugees' legal documents as 'correct' documents whenever they presented them for consultation. Participants recounted that if they were not able to produce the documents (passport or South African ID book) preferred by healthcare workers, they would be denied access to healthcare services and sometimes they would even be harassed by

the staff. The study shows that healthcare staff lacks basic knowledge regarding refugees and the legal documentation they use. Lawyers for Human Rights (2017) argue that it is the duty of government employees to be familiar with and aware of all legal documents used by refugees in South Africa so as to render services to refugees if required.

5.3.2.1.5 Subtheme 1.5: Language as barrier

All participants were able to speak English, which is one of the official languages in the country. However, language remained a barrier for healthcare services among refugees. Some studies found language as being a barrier to accessing healthcare among refugees because they experience difficulty in understanding any of the local languages (Lawrence & Kearns 2005:453; Meyer-Weitz et al 2018:4). However, this was not the case for these participants, as they could speak at least one local language, even though all participants acknowledged having difficulty communicating with healthcare workers in the first years of arriving in South Africa. This in turn slowed down the whole process of receiving healthcare services, and some instances they were denied healthcare provision. Participants agreed that they made an effort to learn to speak English to avoid the language barrier challenges. However, they still encountered problems in the healthcare sector where language is concerned, because healthcare staff prefer using vernacular languages rather than communicating in English. The vernacular languages spoken in Pretoria are mostly Sesotho or Sepedi, which most refugees are unable to understand, let alone use as a communication tool. This has negatively affected refugees' access to healthcare because they sometimes misunderstand instructions or the medication prescriptions when visiting healthcare facilities.

5.3.2.1.6 Subtheme 1.6: Healthcare service procedures in South Africa

One may assume that the occurrence of refugees being chased away or mistreated in the healthcare sector is caused by failure to follow the general procedures when visiting the healthcare system (i.e. visiting a local clinic first before going to a hospital). However, findings show that the majority of the participants interviewed are well aware of, understood and adhered to the healthcare procedures. Only five of the participants

admitted to having no knowledge of the procedures, and consequently not adhering to the procedures as stipulated by healthcare facilities/staff.

5.3.2.1.7 Subtheme 1.7: Interactions between healthcare professionals and refugees

Participants complained that healthcare providers, especially in the public healthcare sector, did not deem it appropriate to communicate or interact with them. According to Azizam and Shamsuddin (2015:57) and Bogart et al (2013:850), effective communication between the healthcare provider and the patient is a vital element in patient care. In the clinical practice of medicine, a healthcare provider gathers information to facilitate accurate diagnosis, counsel appropriately, give therapeutic instructions, and establish caring relationships with patients (Iroju et al 2013:264. However, the majority of the participants who were interviewed mentioned that these basic procedures are rarely applied. Participants stated that healthcare practitioners do things outside the stipulated procedures and attend to them without communicating accordingly on what they were doing and the reasons for doing so. They further stated that nurses could administer an injection without informing the purpose of the injection or the kind of illness that they may be suffering from and the side-effects (if any) caused by the illness. The participants mentioned that they would be scared to question the healthcare staff on their actions for fear of being victimised and refused access to healthcare services. This observation coincides with the finding of Jardien-Baboo et al (2016:398) that healthcare providers normally discourage patients from voicing their concerns. The study findings have also shown that refugees normally feel too disempowered by healthcare providers to communicate their views, and that they generally felt disgruntled towards healthcare providers.

5.3.2.1.8 Subtheme 1.8: Inconsistencies of information provided by healthcare facilities

The study has established that there is a lot of inconsistency in the information provided by public healthcare practitioners and by healthcare facilities based in Pretoria, Gauteng. Interviewed refugees discovered that different healthcare practitioners working in the same hospital or clinic would frequently provide them with different information. Steve Biko Academic Hospital, Tshwane District Hospital, Sunnyside Clinic, Tshwane Clinic in the CBD and Laudium Clinic were mentioned as some of the public healthcare facilities that provide contradictory information to refugees. These

inconsistencies in information provided or procedures that need to be followed create confusion among refugees and they sadly do not know what is 'correct' and what is 'incorrect'.

5.3.3 Theme 2: Understanding their rights as a refugee

Even though more than half of the participants were aware of their rights as refugees in South Africa, some mentioned that they were not aware of these rights. For them, not being aware of their rights put them in a more vulnerable situation when they happen to be mistreated in the healthcare sector. Some understood that having knowledge about their rights could sometimes put them at an advantage and enable them to stand up for themselves if they were to be denied access to healthcare. Very few participants narrated a situation where they had to stand up for themselves and inform a healthcare provider about their rights of free access to basic healthcare services. The study reflects that refugees' awareness of their rights can give them strength to articulate their rights to healthcare in case they were to be denied access to healthcare services.

5.3.4 Theme 3: Healthcare inequalities

Most of the refugees' suffering in the healthcare system is triggered by the unequal treatment they commonly receive from healthcare providers. The unequal treatment is mainly caused by the fact that refugees are non-South African nationals and the fact that some healthcare providers think they are wasting resources when they provide healthcare services to non-nationals in South Africa, whom they consider undeserving of healthcare services (Vearey et al 2017:95). The subthemes under the theme Healthcare inequality are private healthcare service delivery versus public healthcare service delivery; overcrowding of healthcare facilities in Gauteng; health professionals' attitude towards refugees; and gender and reproductive health.

5.3.4.1 Subtheme 3.1: Private healthcare service delivery versus public healthcare service delivery

Half of the participants only visited public healthcare facilities and had no experience of private healthcare services; therefore, they could not share any comparison insights. The other half had visited both private healthcare and public healthcare facilities, and

they could draw a comparison between the two healthcare sectors in terms of the quality of service, waiting time, and the general treatment of and attitude towards patients. This study has revealed a distinct difference between the quality of service rendered by private and public healthcare facilities. While public healthcare services are free, their services are slow, inefficient, not easily accessible for refugees and of poor quality. Private healthcare services are quick and the services rendered are of high quality, but at the same time these services are also costly, which makes them more or less inaccessible (Coetzee et al 2013:166). Participants asserted that the discrimination, mistreatment or being denied access to healthcare services they experienced, occurred only in public healthcare facilities. They assumed money plays a major role in private healthcare facilities, as they always received good service with a warm welcome. All in all, refugees are not satisfied with the acceptability, affordability and availability of healthcare services in the country because in the public healthcare sector they are treated very badly, while in the private healthcare sector, they are unable to afford costly services.

5.3.4.2 Subtheme 3.2: Overcrowding of healthcare facilities in Gauteng

Of the eighteen participants, sixteen have been accessing healthcare services only in Gauteng since they arrived in South Africa, and they could therefore not make any comparisons with other provinces. Gauteng is a highly populated province and is home to the highest concentration of migrants; consequently its public clinics and public hospitals are always overcrowded. Healthcare practitioners are overworked, which brings frustration towards patients, particularly non-citizen patients. For this reason, there is always competition of resources in public healthcare facilities, and healthcare providers tend to put non-citizens on triage. However, Gordon et al (2015:21) argue that most of the South African public healthcare hospitals rarely follow the triage system. Instead, the triage assessment is affected by snap judgements and the credibility of the patient or their body language (Amoo & Mash 2016). According to Crush and Tawodzera (2014:662), in South Africa, migrants are marginalised and triaged based on race, language, how they look, or their country of origin. The snap judgement element is based on their "foreign" appearance, which in the end leads to a prolonged waiting time at the healthcare premises (Crush & Tawodzera 2014:662). Unfortunately, participants coming from Somalia, Eritrea and Ethiopia reported as having been triaged because of

their easily identifiable religious attire and ethnicity, and those from the DRC and Burundi were triaged as soon as they started speaking.

5.3.4.3 Subtheme 3.3: Health professionals' attitude towards refugees

Half of the participants noticed that healthcare professionals treated them differently from South African nationals. The different treatment mostly included discrimination. Among the group of refugees, non-SADC participants reported to have been discriminated against by healthcare practitioners. The consensus is that healthcare practitioners normally prefer refugees from SADC countries.

5.3.4.4 Subtheme 3.4: Gender and access to reproductive health

This study has shown that female refugees are affected the most as far as healthcare services in the country are concerned. It is often the case that female refugees are more in need of healthcare compared to male refugees. Most female participants recounted that their ordeal in a healthcare facility took place while they were pregnant or in labour. They claimed to have been denied access to healthcare services even in their critical and fragile condition, to such an extent that they had to seek help in the private healthcare sector. Furthermore, they reported being called names and being subjected to the xenophobic attitudes of health professionals who often believe foreigners give birth to too many children. This is in alignment with the argument that refugee women and girls endure discrimination and mistreatment that affect their access to healthcare services (United Nations Population Fund 2016; Lawyers for Human Rights 2016). It was further argued by O'Mahony and Donnelly (2013:715) that, considering all these struggles that female refugees have to endure, they are more likely to suffer from postpartum depression (PPD). To alleviate the suffering endured by refugees in public healthcare institutions, a better understanding of refugees by healthcare staff and proper use of existing policies and new strategies may assist in reducing healthcare inequities regionally and nationally (Vearey et al 2017:89).

5.4 CONCLUSION

This chapter provides a summary of the study findings. The study demonstrates that refugees' daily encounters in the public healthcare sector are mostly bad, and they face

many barriers whenever they try to access healthcare services. Only when one has money to pay for private healthcare services, can these encounters be defined as having been good. There are still many factors that need to be dealt with before healthcare provision for refugees would improve. For example, before the existing legislations on healthcare provision are amended, all healthcare facilities and health professionals must first learn how to practise and implement the existing laws. The practice of the law could bring an improvement in the healthcare services provided for refugees. Secondly, if healthcare providers are aware of refugees' rights, it will be easier to accept these refugees and provide them with the healthcare services they so desperately need. This would limit the number of cases where refugees are discriminated against, mistreated, or denied access to healthcare. The frequency of refugees being denied access to healthcare in the public healthcare sector is alarming and needs urgent intervention. Refugees wait and hope to be accepted and treated equally in the healthcare sectors of South Africa. The study findings showed that when it comes to access healthcare services by refugees in different countries, they mostly suffer from similar struggles such as language barrier, discrimination etc. Their health needs are hardly met. However, the findings showed slight difference of hardships faced by refugees based in South Africa, which is discrimination driven by xenophobic attitude of healthcare workers and their dislikes of providing services to patients who speaks English but not vernacular.

5.5 RECOMMENDATIONS

Recommendations that may improve the quality of access to healthcare by refugees in South Africa are categorised below.

Future study: Another study focusing on healthcare professionals and managers in local healthcare facilities, policy developers, and senior government officials at the Department of Health should be conducted to help provide new perspectives on the topic. This will help in coming up with broader issues related to gaps in the healthcare system and service delivery to refugees. It will be good to understand the challenges experienced by healthcare providers when it concerns rendering healthcare services for refugees.

Government: All spheres of government (national, provincial, and local) should consider amending some of the policies, such as the National Health Act or the Refugees Act or the National Development Plan, to specifically address healthcare provision for refugees.

- The amendments should include information addressing human rights issues with regard to healthcare, refugee awareness, medical xenophobia, and how healthcare facilities are expected to operate and be user-friendly towards refugees.
- It is clear that, because of poor healthcare standards and the shortage of healthcare resources, the citizens of the country blame non-South Africans for all poor services provided in the public healthcare system. The government should come up with monetary policies to increase funding of socio-economic services, in order to improve the quality of the healthcare system and to provide affordable healthcare insurance.

Standard operating procedures (SOPs) for public healthcare facilities: Throughout the years, different research indicated that the language barrier has been one of the main causes of illnesses being misdiagnosed, undue death and discrimination among refugees.

- There should be written SOPs for each province stating that all public healthcare facilities must promote human rights and refugee awareness, and avoid medical xenophobia. All health professionals should comply with these procedures. This will promote a user-friendly environment for refugees.
- Providing interpreters to ease communication between refugees and health providers will prevent all the frustrations that occur during consultations. The provision of interpreters can be made compulsory in provinces hosting a high influx of refugees such as Gauteng, KwaZulu-Natal and Western Cape. Healthcare staff must be mandated to use English in cases where the patient does not understand the vernacular but does have a knowledge of English.
- Refugees complained about inconsistencies in the information provided in public hospitals. This means that health professionals must uniformly comply with the SOPs for each province. If there are charges to be paid by migrants, it should be clear what type of migrants are liable for payment without confusing refugees.

The amount should be clearly stated and be uniform in all healthcare facilities, and healthcare providers must be aware that refugees and asylum seekers are excluded from any payment for primary healthcare.

Media usage: The government of South Africa, through the Department of Health and the Department of Home Affairs can use the media as a platform to promote awareness of refugees' rights to healthcare. Refugee awareness and knowledge of their rights must be part of existing health promotion activities.

Department of Home Affairs (DHA): It is the duty of the DHA to inform senior officials at the Department of Health of all types of legal identity documents that are accepted as being legal documents, and these senior officials must inform all staff members of these documents. This will prevent some of the healthcare professionals classifying refugee status documents as "incorrect" documentation. It should also be the duty of health professionals to familiarise themselves with all legal documentation available in the country.

Proof of residence for healthcare: Refugees should not be asked to produce proof of residence in healthcare facilities since most of them do not own property or have bank accounts in South Africa, as they do not qualify to own any property.

Health professionals/workers: Healthcare workers should be provided with immigration and refugee awareness training, so that it would be easier for them to provide unbiased healthcare services to a diverse population.

Professional bodies: The Health and Care Professions Council of South Africa and the South African Nursing Council are professional organisations that should ensure that respect for diversity, refugees and refugees' rights to healthcare become part of a health provider's work ethics.

5.6 CONTRIBUTIONS OF THE STUDY

The one-on-one in-depth interviews with refugees brought a deeper understanding of their day-to-day experiences in the healthcare system. The findings shed light on how public healthcare services react to population diversity in Gauteng. The study provides

important recommendations that would be useful to the Department of Health and the Department of Home Affairs to inform healthcare policy development to afford refugees better access to healthcare facilities.

The researcher is of the view that the study objectives have been met.

5.7 LIMITATIONS OF THE STUDY

Even though the study sample was determined based on saturation of new data, the study sample was not large enough to the extent that the lived experiences of accessing healthcare in Pretoria by refugees could be generalised. Participants for this study were purposefully selected through only one not-for-profit organisation, which assists refugees with securing socio-economic opportunities. There is therefore the risk of creating sample biasness.

The study focused only on refugees living around Pretoria and who have been in South Africa for a minimum of two years; those living in other parts of the country were not able to participate. In addition, some refugees living outside Pretoria CBD, but who were willing to participate, could not do so because they lacked money for transport to travel to the FF offices. Unfortunately, there was no budget for this study or any reimbursements for participants' transport. Furthermore, there were no incentives to compensate participants for the time spent participating in the study.

The FF helps refugees and asylum seekers socio-economically, and asylum seekers face the same problems as refugees do. Asylum seekers are, by law, refugees who are still waiting for formal recognition by the Department of Home Affairs (DHA), and they hold a Section 22 status in accordance with the Refugees Act No 130 of 1998. During fieldwork, it was discovered that most refugees who visited FF were still holding a Sections 22 status in accordance with the Refugees Act. Because the study focused only on refugees who held a Section 24 status under the Refugees Act, asylum seekers could not participate in the study, which would have expanded the sample size.

Although the researcher still believes that the qualitative research and one-on-one interviews with refugees were the right methodology to apply, multi-interviews, including interviews with healthcare providers and healthcare managers, would have established

more information that can be used for better recommendations. Focusing on both the health receiver (refugees) and health provider (nurses/healthcare managers) would have given more credibility and strengthened the data more. This would have greatly addressed the issues of healthcare practitioners' attitude towards refugees, the inability to accept refugees' documentation, the language problem, and their general understanding of the refugee's plight. Consequently, to have included healthcare providers in the study would likely have established the foundation of why refugees are treated the way they are being treated by healthcare providers, and what the solution to these problems could be.

5.8 CONCLUDING REMARKS

The purpose of the study was to establish the lived experience of accessing healthcare services by refugees in Pretoria, South Africa. The study also revealed the legislations that are in place as directives for healthcare service delivery to all citizens living in the country and what is actually being done in practice. Existing legislations in South Africa that promote free access to basic healthcare for refugees and the rights of refugees are not applied in practice and in the functions of the South African healthcare system. There are international legislations (the Constitution of the World Health Organization (WHO) of 1948, and the Universal Declaration of Human Rights and national legislations (the Constitution of South Africa, the Refugees Act of South Africa, the National Health Act, the National Development Plan) that the South African government is bound to comply with to ensure that there is equal provision of healthcare to anyone living in the country.. However, it seems that most healthcare professionals in the public healthcare sector are unaware of these written legislations, as they do not follow the directives of these legislations.

Refugees have indirectly ranked the South African public healthcare sector as a bad service provider towards non-South Africans. The reason for this is that most refugees are denied access to healthcare services, and are mistreated and discriminated against in the public healthcare sector. Factors such as a different language, being foreign, speaking English, or holding a refugee document cause healthcare professionals to deny refugees access to healthcare. Participants mentioned that sometimes when they access healthcare services, services that they are entitled to would be delayed, or they would be misinformed, or be provided with medication not meant for the illness they

may suffer from. Based on the findings, it seems that South African healthcare professionals find it hard to accept foreigners and diversity. These aspects show how most refugees opt to visit private healthcare facilities rather than public healthcare facilities. However, the predicament is that private healthcare services are costly, and refugees can rarely afford these services. This places refugees in a vulnerable situation whenever they need healthcare services.

Government healthcare facilities in Gauteng are inconsistent with the information they provide to non-South Africans. Some facilities inform refugees that they are required to pay for basic healthcare services even though access to basic healthcare is free in South Africa, whereas some follow directives of the law with regard to access to basic healthcare. It is questionable what legislation governs the Gauteng Department of Health, and the Tshwane healthcare centres.

Some refugees are aware of their socio-economic rights in the country while others do not know about these rights. Those who are aware will at least be able to articulate their rights to healthcare services in case they are being denied or mistreated.

The study has shown that there are continuous inequalities in healthcare services being rendered to refugees and those rendered to South African citizens. Refugees are either denied access to healthcare services or such access is deliberately delayed, and they are often mistreated or approached with negative attitudes by healthcare professionals when compared to healthcare services provided to South African citizens. Healthcare professionals judge them even before they provide them with healthcare services. Consequently, if a patient's way of dressing seems foreign or if a patient speaks a non-South African vernacular (i.e. speaking English) in a healthcare facility, the patient is more likely to encounter problems with the healthcare professional. These healthcare disparities chiefly affect female refugees. Most female refugees suffer at the hand of medical xenophobia in healthcare facilities when they seek antenatal or postnatal care, or contraceptives. The belief of healthcare professionals that foreigners give birth to too many children here in South Africa also complements the negative attitude towards the provision of reproductive healthcare to refugees.

LIST OF REFERENCES

Alfaro-Velcamp, T. 2017. Don't send your sick here to be treated, our own people need it more: Immigrants' access to healthcare in South Africa. *International Journal of Migration, Health and Social Care* 13(1):53-68.
From: https://www.emeraldinsight.com/doi/pdfplus/10.1108/IJMHSC-04-2015-0012 (accessed 31 October 2018).

Amoo, A & Mash, AB. 2016. Patients' perceptions of the triage system in a primary healthcare facility, Cape Town, South Africa. *African Journal of Primary Healthcare and Family Medicine* (online), AOSIS. From: http://www.scielo.org.za/pdf/phcfm/v8n1/17.pdf (accessed 31 October 2018).

Auerbach, C & Silverstein, LB. 2003. *Qualitative data. An introduction to coding and analysis*. New York, London: New York University Press.

Athanasou, JA, Di Fabio, A, Elias, MJ, Ferreira, R, Gitchel, WD, Jansen, JD, Malindi, MJ, McMahon, M, Mpofu, E, Nieuwenhuis, J, Perry, JC, Panulla, S, Pretorius, G, Seabi, J, Sklar, RH, Theron, LC & Watson, M. 2012. Complete your thesis or dissertation successfully: Practical guidelines, edited by JG (Kobus) Maree. Cape Town: Juta.

Azizam, NA & Shamsuddin, K. 2015. Healthcare provider-patient communication: A satisfaction study in the outpatient clinic at Hospital Kuala Lumpur. *The Malaysian Journal of Medical Sciences : MJMS* 22(3):56-64.
From: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4681722/ (accessed 03 July 2018).

Bazeley, P. 2013. *Qualitative data analysis: Practical strategies*. 1st edition. London: SAGE.

Benatar, S, Sullivan, T & Brown, A. 2017. Why equity in health and in access to healthcare are elusive: Insights from Canada and South Africa, Global Public Health. *Global Public Health: An International Journal for Research, Policy and Practice*:[1-26]. From: http://www.dsa.uct.ac.za/sites/default/files/image_tool/images/55/paper_of_the_week/Why%20equity%20in%20health%20and%20in%20access%20to%20health%20care%20are%20elusive%20Insights%20from%20Canada%20and%20South%20Africa_Global%20Public%20Health%202017 (accessed 03 July 2018).

Bogart, LM, Chetty, S, Giddy, J, Sypek, A, Sticklor, L., Walensky, RP & Bassett, IV. 2013. Barriers to care among people living with HIV in South Africa: contrasts between patient and healthcare provider perspectives. *AIDS Care* 25(7):843-853.

Bowling, A, Rowe, G & Mckee, M. 2013. Patients' experiences of their healthcare in relation to their expectations and satisfaction: a population survey. *Journal of the Royal Society of Medicine* 106(4):143-149. From: https://doi.org/10.1258/jrsm.2012.120147 (accessed 31 October 2018).

Braveman, P. 2014. What are health disparities and health equity? We need to be clear. *Public Health Reports* 129(1_suppl2):5-8. From: https://journals.sagepub.com/doi/pdf/10.1177/00333549141291S203 (accessed 11 November 2018).

Brink, HL, Van Rensburg, G & Van der Walt, C. 2012. *Fundamentals of Research Methodology for Healthcare Professionals*. 3rd edition. Pretoria: Juta.

Burger, R & Christian, C. 2018. Access to healthcare in post-apartheid South Africa: availability, affordability, acceptability. *Health Economics, Policy and Law* X:[1-13]. From: http://repository.uwc.ac.za/xmlui/bitstream/handle/10566/3918/Burger_Access-to-health_2018.pdf?sequence=1&isAllowed (accessed 02 August 2018).

Burns, A & Grove, SK. 2011. Understanding nursing research: Building evidence based practice. 5th edition. Texas: Elsevier/Saunders

Campbell, RM, Klei, AG, Hodges, BD, Fisman, D & Kitto, S. 2014. A comparison of health access between permanent residents, undocumented immigrants and refugee claimants in Toronto, Canada. *Journal of Immigrant and Minority Health* 16(1):165-176. From: https://link.springer.com/content/pdf/10.1007%2Fs10903-012-9740-1.pdf (accessed 03 July 2018).

Çekmez, E, Yıldız, C & Bütüner, SÖ. 2012. Phenomenographic research method. Balıkesir University Necatibey *Faculty of Education Electronic Journal of Science and Mathematics Education* 6(2):77-102. From: http://nef.balikesir.edu.tr/~dergi/makaleler/yayinda/13/EFMED_FBE180.pdf (accessed 05 January 2017).

Chuah, F, Tan, ST, Yeo, J & Legido-Quigley, H. 2018. The health needs and access barriers among refugees and asylum-seekers in Malaysia: A qualitative study. *International Journal for Equity in Health* 17(1), 120:[1-15] From: doi:10.1186/s12939-018-0833-x (accessed 26 September 2018).

Coetzee, SK, Klopper, HC, Ellis, SM & Aiken, LH. 2013. A tale of two systems — nurses practice environment, well-being, perceived quality of care and patient safety in private and public hospitals in South Africa: A questionnaire survey. *International Journal of Nursing Studies* 50(2):162-173.

Consortium for Refugees and Migrants in South Africa. 2011. *Protecting Refugees, Asylum Seekers and Immigrants in South Africa during 2010*, April 2011. From*:* http://www.cormsa.org.za/wp-content/uploads/2008/06/CoRMSA-Report-2011.pdf (accessed 11 November 2015).

Creswell, JW. 2014. Research design: Qualitative, quantitative, and mixed methods approaches. 4th edition. University of Nebraska-Lincoln: SAGE.

Crush, J & Tawodzera, G. 2014. Medical Xenophobia and Zimbabwean migrant access to public health services in South Africa. *Journal of Ethnic and Migration Studies* 40(4):655-670.

Dinbabo, MF & Nyasulu, T. 2015. Macroeconomic immigration determinants: An analysis of 'pull' factors of international migration to South Africa. *African Human Mobility Review* 1:27-52.
From: http://sihma.org.za/wpcontent/uploads/2015/03/AHMR-Vol-1-No-1-January-April-2015.pdf#page=30 (accessed 19 July 2018).

Dopfer, C, Vakilzadeh, A, Happle, C, Kleinert, E, Müller, F, Ernst, D, Schmidt, R, Behrens, G, Merkesdal, S, Wetzke, M. & Jablonka, A. 2018. Pregnancy related healthcare needs in refugees — a current three center experience in Europe. *International Journal of Environmental Research and Public Health* 15(9):[1-13]. From: https://www.mdpi.com/1660-4601/15/9/1934 (accessed 31 October 2018).

Du Plooy-Cilliers, F, Davis, C & Bezuidenhout, R. (eds). 2014. *Research matters*. Cape Town: Juta.

Fatima, K. & Schreier, T. 2014. Refugee law in South Africa. Pretoria: Juta.

Gauteng Department of Health. 2017. Clinics. From: http://www.gauteng.gov.za/government/departments/health/Documents/List%20of%20Clinics/Clinics.pdf (24 February 2018).

Gordon, SAN, Brits, H & Raubenheimer, JE. 2015. The effectiveness of the implementation of the Cape Triage Score at the emergency department of the National District Hospital, Bloemfontein. *South African Family Practice* 57:1:18-23. From: 10.1080/20786190.2014.977056 (accessed 28 October 2018).

Greyling, T. 2016. The expected well-being of urban refugees and asylum-seekers in Johannesburg. *South African Journal of Economic and Management Sciences* 19(2):232-248.

Grove, SK., Burns, A & Gray, J. 2014. Understanding nursing research: Building an evidence-based practice. 6th edition. Texas: Elsevier.

Grove, SK., Burns, A & Gray, J. 2012. The practice of nursing research: Appraisal, synthesis and generation of evidence. 7th edition. Texas: Elsevier.

Hunter-Adams, J & Rother, HA. 2017. A Qualitative study of language barriers between South African healthcare providers and cross-border migrants. *BMC Health Services Research* 17(1), 97:[1-9]. From: DOI: 10.1186/s12913-017-2042-5 (accessed 31 October 2018).

Iroju, O, Soriyan, A, Gambo, I & Olaleke, J. 2013. Interoperability in healthcare: benefits, challenges and resolutions. *International Journal of Innovation and Applied Studies* 3(1):262-270.
From:
https://www.researchgate.net/profile/Iroju_Olaronke/publication/282322922_Interoperability_in_Healthcare_Benefits_Challenges_and_Resolutions/links/560bada308ae6de32e9a457a.pdf (accessed 31 October 2018).

Jardien-Baboo, S, Van Rooyen, D, Ricks, E & Jordan, P. 2016. Perceptions of patient-centred care at public hospitals in Nelson Mandela Bay. *Health SA Gesondheid* 21:397-405. From https://ac.els-cdn.com/ S1025984816300114/1-s2.0S102598481 6300114-main.pdf?_tid=76dcceb0-1f74-4eba-b6e3-9637ef3a4d11&acdnat=1541409630_c78818c6235e459c35a7743866e6884c (accessed 31 October 2018).

Johannesburg Migrant Health Forum (JHB-MHF). 2016. Migrant health forum submission on the white Paper on National Health Insurance. 07 June. From: https://www.mm3admin.co.za/documents/docmanager/f447b607-3c8f-4eb7-8da4-11bca747079f/00104917.pdf (accessed 15 June 2018).

Koneshe, MGV. 2016. South African midwives caring for immigrant and refugee women. Forced Migration Review (FRM) 53, General Articles.
From: http://www.fmreview.org/community-protection.html (accessed 07 January 2017).

Kotovicz, F, Getzin, A & Vo, T. 2018. Challenges of refugee healthcare: Perspectives of medical interpreters, case managers, and pharmacists. *Journal of Patient-Centered Research and Reviews* 5(1):28-35.
From:
https://digitalrepository.aurorahealthcare.org/cgi/viewcontent.cgi?article=1577&context=jpcrr (accessed 12 October 2018).

Langlois, EV, Haines, A, Tomson, G & Ghaffar, A. 2016. Refugees: towards better access to health-care services. *Lancet*, Vol 387 (10016): 319-321. From: http://doi.org/10.1016/S0140-6736(16)00101-X (accessed 26 September 2018).

Lawrence, J & Kearns, R. 2005. Exploring the 'fit' between people and providers: refugee health needs and healthcare services in Mt Roskill, Auckland, New Zealand. *Health and Social Care in the Community* 13(5):451-161.

Lawyers for Human Rights (LHR). 2014. *South Africa health system shuns asylum seekers, 31 October 2014*. From: http://www.lhr.org.za/news/2014/south-africa-health-system-shuns-asylum-seekers (accessed 05 January 2017).

Lawyers for Human Rights (LHR). 2016. *Thematic report on the rights of migrants, asylum seekers and stateless persons in South Africa. Geneva, March 2016*. From: https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/ZAF/INT_CCPR_CSS_ZAF_23067_E.pdf (accessed 26 September 2018).

Lawyers for Human Rights (LHR). 2017. *Thematic report on the rights of migrants, asylum seekers and stateless persons in South Africa*. Legal Resource Centre. March 2017. From: https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/ZAF/INT_CCPR_CSS_ZAF_23067_E.pdf (accessed 21 July 2018.

Lewis, TT, Cogburn, CD & Williams, DR. 2015. Self-reported experiences of discrimination and health: scientific advances, ongoing controversies, and emerging issues. *Annual Review of Clinical Psychology* 11:407-440.

Lionis, C, Petelos, E, Mechili, EA, Sifaki-Pistolla, D, Chatzea, VE, Angelaki, A, Rurik, I, Pavlic, DR, Dowrick, C, Dückers, M & Ajdukovic, D. 2018. Assessing refugee healthcare needs in Europe and implementing educational interventions in primary care: a focus on methods. *BMC International Health and Human Rights* 18(1), 11:[1-8]. From: https://bmcinthealthhumrights.biomedcentral.com/track/pdf/10.1186/s12914-018-0150-x (accessed 31 October 2018).

Lippert-Rasmussen, K. 2014. *Born free and equal? A philosophical inquiry into the nature of discrimination*. Oxford: Oxford University Press.

Mangrio, E & Sjögren Forss, K. 2017. Refugees' experiences of healthcare in the host country: A scoping review. *Bio Med Central Health Services Research* 17(814):1-16. From: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5721651/pdf/12913_2017_Article_2731.pdf (accessed 26 September 2018).

Majola, B. 2017. Refugees have an equal right to healthcare. *Mail & Guardian*, 23 June. From: https://mg.co.za/article/2017-06-23-00-refugees-have-an-equal-right-to-healthcare (accessed 26 September 2018).

Mathope, G. 2017. SA's healthcare system strained by refugees and migrants-health minister. *The Citizen*, 07 June. From: https://citizen.co.za/news/south-africa/1535473/sas-health-system-strained-by-refugees-and-migrants-health-minister/ (accessed 15 June 2018).

Mayosi, BM & Benatar, SR. 2014. Health and healthcare in South Africa — 20 years after Mandela. *New England Journal of Medicine* 371(14):1344-1353. From: https://www.nejm.org/doi/pdf/10.1056/NEJMsr1405012 (accessed 26 September 2018).

Meyer-Weitz, A, Asante, KO & Lukobeka, BJ. 2018. Healthcare service delivery to refugee children from the Democratic Republic of Congo living in Durban, South Africa: a caregivers' perspective. *BioMed Central (BMC) Medicine* 16(163):[1-12]. From: https://bmcmedicine.biomedcentral.com/track/pdf/10.1186/s12916-018-1153-0 (accessed 29 September 2018).

Mkhwanazi, A. 2012. Patients fed up with bad attitude from nursing staff. *Health E News: South African Health News Service*, 27 June. From: https://www.health-e.org.za/2012/06/27/patients-fed-up-with-bad-attitude-from-nursing-staff/ (accessed 26 September 2018).

Odhiambo, A. 2012. A sick system abuses its refugees. *Mail and Guardian Newspaper*, 16 March 2012.
From: https://mg.co.za/article/2012-03-16-a-sick-system-abuses-its-refugees/ (accessed on 26 September 2018).

O'Mahony, JM & Donnelly, TT. 2013. How does gender influence immigrant and refugee women's postpartum depression help-seeking experiences? *Journal of Psychiatric and Mental Health Nursing* 20:714-725.

Polit, DF & Beck, CT. 2012. *Nursing research: Generating and assessing evidence for nursing practice*. 9th edition. Philadelphia: Lippincott, Williams & Wilkins.

Pollock, G, Newbold, KB, Lafrenière, G & Edge, S. 2012. Discrimination in the doctor's office: Immigrants and refugee experiences. *Critical Social Work* 13(2):60-79.

Shosha, G.A. 2012. Employment of Colaizzi's strategy in descriptive phenomenology: A reflection of a researcher. *European Scientific Journal* 8(27):31-43.

Skosana, I. 2016. Refugees ripped off at state hospitals. Bhekisisa, Centre for Health Journalism. *Mail & Guardian*, 12 May. From: https://bhekisisa.org/article/2016-05-12-sa-is-no-haven-for-sick-refugees (accessed 24 May 2018).

South African Department of Health. 2004. *National Health Act, No. 61 of 2003*. Pretoria: Government Gazette. From: http://www.gov.za/sites/www.gov.za/files/a61-03.pdf (accessed 22 March 2017).

South African Department of Health. 2015. *National Policy on Management of Patient Waiting Time in our Patient Departments*. 14 November 2015.
From:
https://www.idealclinic.org.za/docs/policies/Patient%20Waiting%20time%20Policy%2014%20November%202016%20PDF.pdf (accessed 02 August 2018).

South African Department of Health. 2015. *Ethics in Health Research Principles, Processes and Structures. Pretoria: Government Gazette.* From: https://www.ul.ac.za/research/application/downloads/DoH%202015%20Ethics%20in%20Health%20Research%20Guidelines.pdf (accessed 29 March 2019).

South African Department of Home Affairs. 1998. *Refugees Act of South Africa Act No. 130, 1998*. Pretoria: Government Gazette.
From: http://www.gov.za/sites/www.gov.za/files/a130-98_0.pdf (accessed 22 March 2017).

South African Department of Justice and Constitutional Development. 1996. *Constitution of the Republic of South Africa, Act No. 108 of 1996*. Pretoria: Government Printer.

South African Department of Planning, Monitoring and Evaluation. 2012. *National Development Plan Vision 2030*. Pretoria: Government Printer.

Statistics South Africa. 2016. The 2016 population figures refer to the Community Survey 2016. *Stats SA web*. From: http://www.citypopulation.de/php/southafrica-admin.php?adm1id=7 (accessed on 22 February 2018).

Tomita, A, Kandolo, KM, Susser, E & Burns, JK. 2016. Use of short messaging services to assess depressive symptoms among refugees in South Africa: Implications for social services providing mental healthcare in resource-poor settings. *Journal of Telemedicine and Telecare* 22(6):369-377. From: http://doi.org/10.1177/1357633X15605406 (accessed 26 September 2018).

Tshabalala, MM & Van der Heever, H. 2015. Health seeking behaviours of migrant domestic workers in Centurion, South Africa. *African Journal for Physical, Health Education, Recreation and Dance*, October (Supplement 2:2):275-286.

United Nations High Commissioner for Refugees (UNHCR). 2015. *UNHCR statistics: The world in numbers*. From: http://popstats.unhcr.org/en/overview (accessed 20 August 2016).

United Nations High Commissioner for Refugees (UNHCR). 2018. *Update of UNHCR's operations in Africa.* Executive Committee of the High Commissioner's Programme. From: https://www.unhcr.org/uk/excom/excomrep/5b9f537a4/africa-regional-update.html (accessed 20 March 2019)

United Nations Office of the High Commissioner for Human Rights. 1948. *Universal Declaration of Human Rights. General Assembly*.
From: http://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf
(accessed 07 January 2017).

United Nations Population Fund (UNFPA). 2016. *Refugees' and migrants' reproductive health needs overlooked*. 14 September 2016.
From: https://www.unfpa.org/news/refugees%E2%80%99-and-migrants%E2%80%99-reproductive-health-needs-overlooked (accessed 12 August 2018).

Van Rensburg, HCJ. 2014. South Africa's protracted struggle for equal distribution and equitable access - still not there. *BioMed Central*, *Human Resource Health 12 (*26):[1-12]. From: doi:10.1186/1478-4491-12-26 (accessed 31 October 2018).

Vearey, J, Modisenyane, M & Hunter-Adams, J. 2017. Towards a migration-aware health system in South Africa: a strategic opportunity to address health inequity. *South African Health Review* 20th edition:89-98.
From:
http://www.hst.org.za/publications/South%20African%20Health%20Reviews/9_Towards%20a%20migration%20aware%20health%20system%20in%20South%20Africa_a%20strategic%20opportunity%20to%20address%20health%20inequity.pdf (accessed 19 July 2018).

Walls, HL, Vearey, J, Modisenyane, M, Chetty-Makkan, CM, Charalambous, S, Smith, RD & Hanefeld, J. 2016. Understanding healthcare and population mobility in Southern Africa: The case of South Africa. *South African Medical Journal (SAMJ)* 106(1):14-15.

Waters, J. 2017. Mom gives birth at Park Station after three hospitals turn her away. I*OL News*, 5 June.
From: http://www.iol.co.za/news/south-africa/gauteng/mom-gives-birth-at-park-station-after-three-hospitals-turn-her-away-9552507 (accessed June 2017).

Wicks, J. 2017. 'Free' hospital fee shock. The Times: *TimesLIVE*, 05 July. From: https://www.timeslive.co.za/news/south-africa/2017-07-05-free-hospital-fee-shock/ (accessed 26 February 2018).

World Health Organization (WHO). 1948. The Constitution of the World Health Organization. Vol 1. New York: WHO.

Zihindula, G & Meyer-Weitz, A. 2017. Lived Experiences of Democratic Republic of Congo Refugees facing Medical Xenophobia in Durban, South Africa. *Journal of Asian and African Studies (JAAS)* 52(5):458-470.
From: http://journals.sagepub.com/doi/pdf/10.1177/0021909615595990 (accessed 09 August 2018).

Zihindula, G, Meyer-Weitz, A & Akintola O. 2015. Access to healthcare services by refugees in Southern Africa: A review of literature. *South African Journal of Demography* 16 (1):7-35.
From:
http://www.unisa.ac.za/contents/faculties/ems/docs/2015%20SA%20Journal%20of%20Demography.pdf (accessed 15 July 2016).

ANNEXURES

ANNEXURE A: Ethical clearance: Research Ethics Committee, Department of Health Studies, UNISA

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

3 May 2017

HSHDC/688/2017
NP Sowane
Student: 5708-360-6

Supervisor: Dr MM Mmusi-Phetoe
Qualification: D Litt et Phil
Joint Supervisor: -

Dear NP Sowane

Decision: Ethics Approval

Name: NP Sowane

Proposal: Lived experiences of accessing healthcare services by refugees in Pretoria, South Africa.

Qualification: MPCHS94

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 3 May 2017.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof L Roets
CHAIRPERSON
roetsl@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

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ANNEXURE B: Letter seeking consent from FF Organisation

APPENDIX C: Letter of Permission

D72 Parktown Place
Mayville
Pretoria
0182
Cell No: +27 (0)78 9767 653
Tel No: +27 (0)12 302 2121
Date: 06/06/2017

Future Families South Africa
PO Box 209
Willow Acres
0095

For attention: Jolande Jooste

REQUEST FOR PERMISSION TO CONDUCT RESEARCH ON YOUR PEOPLE OF CONCERN (REFUGEES)

My name is Nkateko Sowane and I am a Master of Public Health Student at University of South Africa (UNISA) in Pretoria. The research I have chosen to conduct for my Master of Public Health full dissertation involves "Lived experiences of accessing healthcare services by refugees in Pretoria, South Africa", in which a qualitative research will be conducted. This project will be conducted under the supervision of Dr R.M Mmusi-Phetoe (UNISA, South Africa).

I am hereby seeking your consent to approach 30 refugees based in Pretoria with your assistance to participate for this project using your database to identify the potential participants and to use your Pretoria offices to host individual interviews.

I have provided you with a copy of my dissertation proposal which includes copies of information sheet for potential participants, research instruments, consent form, confidentiality form, and proof of registration to be used in the research process. I have also included copy of the ethical clearance letter which I received from the UNISA Research Ethics Committee of department of Health Studies.

Upon completion of the study, I will acknowledge your contribution for my Master of Public Health Degree with appreciations. Please do not hesitate to contact me for any further information that might not be clear on cell: 0789867653, email: 57083606@mylife.unisa.ac.za or proudsowane@yahoo.com.

Thank you so much for your time and consideration.

Yours Sincerely,

Nkateko Sowane
Master of Public Health, Department of Health Studies, UNISA

ANNEXURE C: Letter of approval: FF, Pretoria Country Office

NPO 084-926
PBO 930034781

12 July 2017

Dear Prospective Research Student.

RE: Permission to conduct research at Future Families.

We would like to inform you that your application to conduct research with Refugees at our Sunnyside office was successful. You will be able to conduct your research based on the following terms:

Topic: **Lived Experiences Of Accessing Healthcare Services By Refugees In Pretoria, South Africa**

1. All participants participate voluntary and signs an consent form
2. A copy of all signed consent forms to be placed on the clients files.
3. A copy of all findings and recommendations of study to be shared with Future Families after the research is finalised.

Please note that all our client information is confidential and by signing this agreement you agree to keep all information shared by the participating clients confidential and treat them with respect at all times.

Looking forward to the outcome to your research.

Jolande Erasmus
Program Manager
Sunnyside Office
012 320 6838

Research Student

FUTURE FAMILIES
Sunnyside Office
Tel: 012 320 6838
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0095

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Mamelodi & Mamelodi East
Ford Care Centre
Simon Vermooten Rd
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Tel: 012 803 0103/211
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Eersterust & Nellmapius
406 Kawie Avenue
Eersterust
Tel: 012 806 4032
Fax: 012 806 4037

Olievenhoutbosc
5 Concerto Place
Extension 4
Tel: 082 095 0155

Musina
10 Harper Road
Musina
Tel: 082 671 9166

Sunnyside
Kutlwanong Democracy Centre
357 Visagie Street
Tel: 012 320 6838
Fax: 012 320 6859

ANNEXURE D: Data collection instruments

INTERVIEW GUIDE: LIVED EXPERIENCES OF ACCESSING HEALTHCARE SERVICES BY REFUGEES IN PRETORIA, SOUTH AFRICA

A. Demographic information

The demographic information collected is for statistical and data analysis purposes.

1. Gender (please tick)

Male		Female		Other	

2. What is your country of origin?

3. What is your home language?

4. What is your age?

5. For how long have you been living in South Africa?

B. Questions on lived experiences on accessing healthcare services by refugees in South Africa

1. The broad question: What are your experiences on accessing healthcare services in South Africa?
2. The questions below should be indicated as probing questions:
   - 2.1 Have you or anyone in your family ever visited any of South African public healthcare facilities for healthcare assistance (such as clinic, healthcare centre, hospital, etc.?
   - 2.2 If you answered 'Yes' in Question 1, have you ever been denied access at any public healthcare facilities?
     - 2.2.1 If yes, what was the reason for being denied access?
     - 2.2.2 If no, why not?
   - 2.3 In which province have you visited any healthcare facilities?
   - 2.4 Are you aware of your rights in respect of healthcare provision in South Africa?
   - 2.5 Can you comment on your rights to healthcare as a refugee living in South Africa?
   - 2.6 Do you have knowledge of healthcare services procedures in South Africa? (Such as visiting local clinic first before visiting hospitals)
   - 2.7 Did you follow the healthcare procedures services when visiting any healthcare facilities in South Africa?
   - 2.8 Have you ever visited any healthcare facilities to obtain healthcare?
   - 2.9 If yes, what was your reason for visiting a healthcare facility?
   - 2.10 Did you receive any help?
   - 2.11 Do you find healthcare professionals friendly and welcoming when visiting any healthcare facilities in South Africa?
   - 2.12 Did you notice any difference in treatment because of your refugee status?
   - 2.13 Do you have any comment you would like to share?

ANNEXURE E: Information sheet

INTERVIEW GUIDE: **LIVED EXPERIENCES OF ACCESSING HEALTHCARE SERVICES BY REFUGEES IN PRETORIA, SOUTH AFRICA**

Name: Nkateko Sowane
Position: Master of Public Health Research Student
Contact Cell No: 078 986 7653
Email: 57083606@unisa.ac.za or proudsowane@yahoo.com

Introduction

I would like to invite you to participate in this project which is concerned with day-to-day experiences when accessing healthcare services in South Africa. This project seeks to find out your lived experiences in accessing public healthcare services in South Africa and the impact it has in your health outcomes. The research seeks to find out what happens if one experiences challenges such as being denied or discriminated against when accessing healthcare and what other alternatives you take for better health. I am also interested in establishing whether, in the event of your being denied access to healthcare service in a healthcare facility, you need to pay money for other alternatives for your health such as visiting a private healthcare facility or do you simply visit another public healthcare facility, and how does it affect you economically. Generally, in South Africa, if one is sick, one is advised to visit a local clinic or local healthcare centre before being taken to hospital. The researcher will also want to know how much awareness you have towards these procedures of visiting healthcare services. In this study, you may also be asked experiences you have encountered about attitudes you feel you receive from healthcare providers whenever you visit healthcare centres in South Africa. The project is part of my Masters' Research Dissertation in Public Health at the University of South Africa (UNISA). The project could provide useful information for healthcare professionals to advise and make recommendations for better access and awareness programmes on healthcare services to accommodate refugees. The research project will contribute towards improving attitudes of healthcare providers towards refugees.

Expectations if you agree to take part

Those who agree to take part may return the consent form you are provided to me so that I know you are interested.

1. We will then arrange time to meet, which is convenient for you to come to FF for an interview.
2. There will be a single one-on-one interview with myself during which I will ask you questions from a few questionnaires. The interview is expected to be less than half an hour long and is a once-off event.
3. When I have completed the study I will produce a summary of the findings which I will be more than happy to send to you if you are interested.

Time needed for participation

One interview with each participant lasting no more than half an hour.

Confidentiality to participate in the project

If you agree to take part, your name will not be recorded on the questionnaires and the information will not be disclosed to other parties. Your responses to the questions will be used for the purpose of this project only and I will not have access to any of your medical records. You can be assured that if you take part in the project you will remain anonymous. A confidentiality form will be provided to each of you during the interview.

Advantages of taking part

You may find the project interesting and enjoy answering questions stating your experiences when accessing healthcare services. Once the study is finished it could provide information about your challenges, attitudes and awareness, which is useful to healthcare professionals and policy development.

Disadvantages of taking part

You may not feel comfortable talking about your experiences and knowledge of healthcare services in South Africa and sometimes it may bring emotional moments as you narrate your experience. Should you need a small break during the interview to

ease your discomfort, you are allowed to ask for one and you will be given it with no pressure.

Participation on the project

Participation in this project is entirely voluntary. You are not obliged to take part; you have been approached as an asylum seeker/refugee who is a person of concern of the Jesuit Refugee Service with a view that you might be interested in taking part. However, this does not mean you have to. If you do not wish to take part, you do not have to give a reason and you will not be contacted again. If you do agree to participate you are free to withdraw at any time during the project if you change our mind.

What happens now?

If you are interested in taking part in the study, you are asked to complete the consent form and return it to me. If you would not mind to be audio recorded during the interview, also tick number 5 on the consent form. If you would not mind being anonymously quoted, kindly tick number 6. However, if you do not want to be audio recorded or anonymously quoted, kindly ignore the boxes in the appropriate numbers on the consent form. Once I have received the consent form, I will contact you so we can arrange to meet at FF at a time that is convenient for you. If you decide you would rather not participate in this study, you need not to return the response slip to me. Simply ignore this letter and no further contact will be made.

Conclusion

Thank you so much for taking time to read the information sheet and for your consideration.

Researcher: Master of Public Health Student, University of South Africa
Supervisor: Dr RM Mmusi-Phetoe
College of Human Sciences, Department of Health Studies, University of South Africa

ANNEXURE F: Consent form

INTERVIEW GUIDE: LIVED EXPERIENCES OF ACCESSING HEALTHCARE SERVICES BY REFUGEES IN PRETORIA, SOUTH AFRICA

Name: Nkateko Sowane
Position: Masters Research Student
Contact Cell No: 078 986 7653
Email: 57083606@unisa.ac.za

	Please initial box
1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
3. I agree to take part in the above study.	☐

Note for researchers:
Include the following statements if appropriate, or delete from your consent form:

4 I agree to the interview being audio recorded.	☐
5. I agree to the use of anonymised quotes in research findings/write-ups.	☐

_____	_____	_____
Name of Participant	**Date**	**Signature**
_____	_____	_____
Name of Researcher	**Date**	**Signature**

ANNEXURE G: Confidentiality binding form

RESEARCH GUIDE: LIVED EXPERIENCES OF ACCESSING HEALTHCARE SERVICES BY REFUGEES IN PRETORIA, SOUTH AFRICA

As a Masters Research Student, I understand that I will have access to confidential information about study sites and participants. By signing this statement, I am indicating my understanding of my responsibilities to maintain confidentiality and agree to the following:

- I understand that names and any other identifying information about study sites and participants are completely confidential.
- I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research project that could identify the persons who participated in the study.
- I understand that all information about participants obtained or accessed by me in the course of my work is confidential. I agree not to divulge or otherwise make known to unauthorized persons any of this information, unless specifically authorized to do so by approved protocol or by the local principal investigator acting in response to applicable law or court order, or public health or clinical need.
- I understand that I am not to ask questions of study participants for my own personal information but strictly for the purpose of the project.
- I agree to notify my Supervisor immediately should I become aware of an actual breach of confidentiality or a situation which could potentially result in a breach, whether this be on my part or on the part of another person.

_____ _____

Signature **Printed name** **Date**

_____ _____

Signature **Printed name** **Date**

Name: Nkateko Sowane

ANNEXURE H: Letter from the editor

07 December 2018

TO WHOM IT MAY CONCERN

I hereby certify that I have edited Nkateko Sowane Master's dissertation, **LIVED EXPERIENCES OF ACCESSING HEALTH CARE SERVICES BY REFUGEES IN PRETORIA, SOUTH AFRICA** for language and content.

Annelize Allner
Cell/Mobile: 083 375 4480
Email: AnnelizeA@statssa.gov.za

ANNEXURE I: Turnitin originality report

LIVED EXPERIENCES OF ACCESSING HEALTHCARE SERVICES BY REFUGEES IN SOUTH AFRICA

by Nkateko Proud Sowane

Submission date: 09-Jan-2019 02:49PM (UTC+0200)
Submission ID: 1062496508
File name: Nkateko_Sowane_for_exam_04_Jan_2019.doc (1.69M)
Word count: 34030
Character count: 203686

LIVED EXPERIENCES OF ACCESSING HEALTHCARE SERVICES BY REFUGEES IN SOUTH AFRICA

by

NKATEKO PROUD SOWANE

submitted in accordance with the requirements

for the degree of

MASTER OF PUBLIC HEALTH

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF RMM MMUSI-PHETOE

DECEMBER 2018

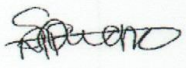
Student number: 57083606

DECLARATION

I declare that **LIVED EXPERIENCES OF ACCESSING HEALTHCARE SERVICES BY REFUGEES IN PRETORIA, SOUTH AFRICA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other education institution.



10 December 2018

.....

SIGNATURE

Nkateko Proud Sowane

.....

DATE

LIVED EXPERIENCES OF ACCESSING HEALTHCARE SERVICES BY REFUGEES IN SOUTH AFRICA

ORIGINALITY REPORT

3%	0%	0%	3%
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