

Refugees and other potentially vulnerable groups

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Introduction

Assisting potentially marginalised groups

Refugees, asylum seekers and migrants

Sex workers

Prisoners

Drug users

Lesbian, Gay, Bisexual and Transgender people

Conclusion



Introduction

South Africa's 1996 Constitution was hailed as one of the most progressive constitutions in the world. It provides access to a number of political and socio-economic rights such as housing, health care, education, water, and electricity. However, ensuring the realisation of these rights has proven to be one of the greatest challenges facing South Africa.

As service providers, we are in a unique position to contribute to the future of the country by ensuring the successful realisation of these rights in our respective fields. In some cases, particular population groups may face greater barriers to realising their rights and by being aware of such barriers we can tackle them as they arise.

This chapter specifically addresses some of the barriers facing refugees, asylum seekers and migrants, sex workers, drug users, prisoners and gay men in accessing various forms of health care. Some of these groups have previously been stereotyped as being 'high risk groups' for HIV transmission and infection. It is such prejudice, along with other issues, that we need to tackle in order to ensure equitable access to health care in compliance with existing South African law. Another group of people who are being stigmatised and marginalised are those with multi drug-resistant or extensively drug-resistant TB.

Many health care workers may initially feel uncomfortable assisting some of the categories of people described in this chapter. These are categories of people who may experience prejudice on a number of fronts and it would not be uncommon for some health care workers to share such prejudices. These may face severe challenges to their human rights regarding access to health care as well as other issues. This chapter aims to help health care workers negotiate

some of the difficulties of working with such challenges. In the case of those in prison, it is also important to note that they will be entirely dependent on prison officials to provide access to health care and hence can be additionally vulnerable for this reason.

The palliative care approach sees each person as unique with their own needs and their own stories. Palliative care encourages an empathetic, non-judgmental approach to patient and family members. Palliative care practitioners assist patients to become active members of the care team and to make informed decisions about their health care as best fits their own context and need.

Assisting potentially marginalised groups

Accessing health care can prove a major challenge for potentially marginalised groups. In some cases, these challenges will relate to accessing services once a person arrives at a health care institution. For those in prison, being able to access a health care institution in the first place can be a major challenge. This section will explore how health care workers' attitudes can affect how potentially marginalised groups may access services at health care institutions.

When a patient such as a drug user, sex worker or refugee arrives at a health care institution seeking assistance, some health care workers may be too quick to identify with what they **think** are the real needs of the patient, based on their beliefs about the patient. This may prevent the health care worker from actually hearing what it is that the patient is requesting. For example, a health care worker may believe

Terms you will read in this chapter:

Asylum Seeker: someone who has fled from political oppression in their own country and is seeking protection in another country

Disempowering: to have power or influence taken away from you

Incarceration: putting somebody in prison or a place of confinement

Marginalised groups: groups which are kept away/excluded from the centre of influence, power or acceptance

Migrants: people who move from one place to another, often for employment or economic improvement

Post-exposure prophylaxis (PEP): a short, intense course of antiretroviral treatment to prevent potential infection following exposure to a risk of HIV infection e.g. after a sexual assault, needle-stick injury

Xenophobia: an intense fear or dislike of foreign people, their customs and culture

that a sex worker should leave sex work, because **the health care worker thinks it is best for the sex worker**. In this way, the health care worker would be disempowering the sex worker by making decisions for him or her and risks alienating him or her from accessing further treatment. The process of administering health care should be seen as a partnership between the patient and the health care worker, where both are able to provide input on the course of treatment to be followed. If intervention into a patient's situation is appropriate, the health care worker should contact an organisation that has experience and expertise in dealing with some of these issues and they can provide advice or assistance where necessary.

In this way, no health care worker is dealing with such difficult issues in isolation. If a health care worker is presented with a patient and does not know the best advice to offer, such partnerships can be valuable in then being able to provide a higher quality of service to the patient.

A list of service providers is available in the Resources Section at the end of this book.

At the same time, given the stresses health care workers face on a daily basis, having such a supportive network can reduce the feeling for a health care worker that it is solely up to him or her to 'solve' a patient's problems. By working in such partnerships, such stresses can be alleviated and health care workers can avoid 'burning out'.

The next section of this chapter will focus on working with people who may be more vulnerable and in need of additional assistance to access quality health care.

Refugees, asylum seekers and migrants

The Law

In South Africa, refugee status and the rights this provides are governed by the 1998 Refugees Act. Although this is a very progressive piece of legislation, there are still many challenges in implementing all the measures it provides for. The Department of Home Affairs (DHA) determines who qualifies for refugee status and issues and renews the documents that refugees are provided with. It is well documented that the DHA has experienced many challenges in issuing documents to South African citizens and those applying for refugee status face even more extensive delays.

In terms of the Refugees Act, to be granted refugee status is to be given the right to remain in the country and to have the protection of the South African government. Refugee status also provides for most of the rights granted to South African citizens such as the right to work, study, access health care and have freedom of movement in accordance with the Bill of Rights. The key right refugees are not granted is the right to vote and refugees are not entitled to receive a social grant until they have received permanent residence status.

The Refugees Act provides refugee status for someone who can demonstrate 'a well founded fear of persecution' in his or her own country and could not rely on the protection of his/her own government. This persecution is usually due to factors such as race, ethnicity, nationality, religion, political opinion or membership of a particular social group such as homosexuals (or in some cases, women). A person can also be granted refugee status if there is war or a similar generalised threat affecting the whole or the specific part of the country where they were based. A person with refugee status will be issued with a Section 24 permit and can apply for a refugee ID.

A person who has applied for refugee status, but has not yet had his or her application finalised, is called an 'asylum seeker'. Although the law states that the process of applying for refugee status should be a rapid one, in practice it takes a long time. Many people wait for a number of years before being told whether their applications have been approved or rejected. In the meantime, asylum seekers are allowed to work and study as well as access health care. Asylum seekers will be issued with a 'Section 22 permit'.

Whilst both refugee and asylum seekers' documents have expiry dates, the recent expiration of such a document should not be reason to deny a refugee or asylum seeker access to the services to which they are legally entitled. Refugees and asylum seekers are required to renew their documents at the Refugee Reception Offices run by the DHA. However, the challenges faced by DHA mean that no one is guaranteed access to a Refugee Reception Office on any given day and therefore it is likely that documents may expire before the bearer is given the chance to renew them. Because of these challenges, many foreign nationals in South Africa remain without documents, or are in possession of expired documentation. Because a person does not have valid documents to be in South Africa does not mean that he or she is not deserving of refugee status. Many are forced to become self-reliant, but service providers can assist them by helping to ensure their access to the services they provide.

Health Care

The Law

Basic Health Care

The South African Constitution guarantees ‘access to health care for all’ and everyone within the country is assured access to life-saving health care. In the context of HIV, this guarantee should extend to HIV services, including antiretroviral therapy (ART).

According to Section 27 (g) of the 1998 Refugees Act, a refugee is ‘entitled to the same basic health services and basic primary education that the inhabitants of the Republic receive from time to time.’¹ For asylum seekers the situation was less clear until the National Department of Health (NDOH) issued a directive in 2007. Importantly, this directive clarifies that refugees and asylum seekers – with or without a permit – shall be exempt from paying for ART services, irrespective of the site or level of institution in which these services are rendered. The recent HIV & AIDS and STI Strategic Plan for South Africa, 2007–2011² specifically includes refugees and the National Department of Health (NDOH) has also clarified that patients do not need to be in possession of a South African identity book in order to access ART.³ Without support from all public health practitioners, the intentions of the recent Directive, and supporting guidelines, may not be met.

According to the directive from the NDOH, undocumented migrants should have the same access to basic health care as refugees and asylum seekers given the state’s decision not to discriminate on the basis of documentation. This is a welcome move that allows all people in South Africa to be included in prevention and treatment services.

Children who have arrived in South Africa without their parents are known as ‘unaccompanied minors’ and face additional risks without the care of a guardian. In terms of the law, unaccompanied minors may apply for refugee status as an adult may. In the same way then, the provisions for refugees and asylum seekers also apply to unaccompanied children. It is therefore evident that South African legislation and subsequent policies and directives have become more inclusive and that it is safe to conclude that no person who finds him/herself in the jurisdiction of the Republic is excluded from access to healthcare.

Gender issues

In addition to the significant losses experienced by refugees (loss of country, home, possessions) women are vulnerable to sexual exploitation and loss of dignity as described in this very moving account by Alice (not her real name) in a national newspaper in 2008:

Story

‘It’s either you have sex with me or you get deported.’ Living a life like this is far away from the hopes I had growing up in Zimbabwe, dreaming of becoming a doctor. My dreams were shattered when my father passed away before I even finished school. Partly out of desperation, I fell in love with an old businessman in our village. I thought I loved him. He promised to take care of my mother and me, and to pay for my school fees. He took advantage of me, impregnated me and dumped me. I dropped out of school. Since I had no qualifications, my only choice was to find a job as a maid so that I could fend for my old mother and my unborn child. Under all this pressure, I gave birth to an immature baby at six months. I had to stay in hospital until he was old enough to get out. My stepsister down here in South Africa felt sorry for me and asked me to come and look for something here, since there are few opportunities in Zimbabwe. I entered the country illegally, and stayed at home, afraid of being deported. I respected my sister’s husband. He looked like a good, caring husband and father, until all hell broke loose. It started one day when I was coming out of the bathroom. I got inside the house to realise he was back from work earlier than usual. I had only a towel around me. As I took my clothes so that I could go and dress in the bathroom, he moved faster towards the door and locked it from the inside. He became aggressive – I could not take his hands off me. He pushed me on the bed. He touched me everywhere, kissed me and forced me to have sex. This happened for almost three weeks and I suffered in silence. One day I related the whole story of her abusive husband to my sister. Instead of comforting me, she became angry and even accused me of seducing her husband. She told me I was loose and that is why I had a child at home out of wedlock. She threw me out of the house and this is how I ended up on the streets. I am asking for help. I would like to enrol and train so that I get a certificate, I want to be able to stand on my own feet, spread my wings and fly higher.

This story is part of the I Stories series produced by Gender Links Opinion and Commentary Service for the 16 Days of Activism on Gender Violence.

Ingrid Palmary at the Forced Migration Studies Programme at Wits University comments:

Alice's story echoes the experiences of many women who travel far from home to seek opportunities and livelihoods they cannot find in their home country. Both women and men who migrate face a number of challenges, but the nature of these challenges and their impact is very different. Problems often begin for women as soon as they decide to leave their country. The border post is one of the most dangerous places in a woman's journey. Syndicates of smugglers based at the borders are responsible for widespread violence against women.

Moreover, added to the risks of sexually transmitted diseases and unwanted pregnancy, survivors of these attacks often face social stigma and exclusion, rather than support. The stigma attached to victims of sexual violence is what makes it a particularly effective way to harm women. This is one reason why during times of conflict, including the xenophobic attacks of May 2008, rape is such a common and effective weapon used against foreign women.

Once a woman crosses the border, she faces a number of challenges. Overall, women, who bear the primary responsibility for the care of children, find migration with children extremely difficult and more expensive than migrating alone. On arrival in South Africa, they have greater difficulty in finding work given their childcare responsibilities. They may even have greater difficulties finding low-cost accommodation that will accept children. Research also shows women who migrate with their children tend to earn less than those who do not. As with all poor women, they also face difficulty in finding safe and affordable childcare for their children while at work.

Like men, many women arriving in South Africa find themselves unable to get the documents needed to legalise their stay in the country. However, the effects can be much more serious for women than for men, as lack of documentation makes women particularly vulnerable to violence. Undocumented women migrants who suffer from domestic violence, or any other form of gender-based violence so widespread in South Africa, are unlikely to report to the police or make use of other social services. Research by the Forced Migration Studies Programme shows that xenophobia and discrimination from service providers acts as a significant barrier to getting services for women who were in abusive relationships. In addition, abusive men use women's migrant status to justify their abuse, and their inability to go to the police was a reason for their ongoing abuse. In her story, Alice recounts how she was first afraid to tell of being raped by the brother-in-law in her home, and later how she endured abuse because she had no money and nowhere to go. Fear of repercussions means these women are not only unable to seek justice, but also do not get access to psychological and health support, such as post-exposure prophylaxis for HIV.

– Ingrid Palmary is a senior researcher with the Forced Migration Studies Programme at Wits University.

Specialised care

Access to ART

Refugees are often incorrectly stereotyped as ‘disease carriers’, particularly in relation to HIV. In fact refugees often move from countries in conflict with relatively low rates of HIV to more stable countries with higher rates of HIV.

The memo circulated by the NDOH in the first quarter of 2007⁴ provides important clarification that not being in possession of a South African identity booklet should not prevent an individual from accessing ART, providing that all other conditions are met. This has positive implications for both non-citizens and citizens without identity booklets who are in need of ART.

The recent (September 2007) Directive goes further and indicates that refugees and asylum seekers – with or without a permit – shall be exempt from paying for ART services, irrespective of the site of level of institution where these services are rendered.⁵

HIV is a public health issue and ensuring the free provision of ART to all individuals within South Africa who are in need of treatment, will have a public health benefit, particularly from an infectious disease control perspective. Whilst the numbers of non-citizens within South Africa are small, they are significant. It is important to ensure that individuals are able to access treatment early, as the burden upon the health system will be greater for untreated, sick individuals, as well as increasing the burden within society as communities will have to care for the sick and dying.⁶

Fees

Health care

The NDOH directive BI 4/29 REFUG/ASYL 8 2007 announced that refugees and asylum seekers ‘with or without a permit that do access public health care shall be assessed according to the current means test.’⁷ Refugees and asylum seekers therefore fall into the same categories as South Africans in terms of paying fees according to their income. This means that those without income will pay minimal fees whilst only those with a high level of income will be classified as ‘Private Patients’ and pay the maximum fees.

Because the NDOH directive does not discriminate against asylum seekers who have not yet been issued with documentation, the same means test applied to South Africans will determine the fees they pay. In terms of the 1998 Refugees Act, refugees and asylum seekers

should not be classified as ‘foreigners’ and asked to pay the R1 800 deposit required of other non-nationals. Because the NDOH does not discriminate between asylum seekers with or without documentation, if a person is unable to provide identification documents they must then be charged in terms of the same means test structure as South African citizens.

In practice

In practice foreign nationals experience a number of barriers to accessing the health care to which they are entitled under South African law. For example, public hearings held by the South African Human Rights Commission in June 2007 on the issue of access to health care, revealed that refugees are denied access to services due to inconsistent application of the relevant policies and laws.⁸ Some hospitals have indicated to service providers that whilst they recognise the requirements of the NDOH directive to provide health care to those without documents, they do not intend to comply with the directive given the limited budget with which their institution is provided.

In addition, a number of research reports have found that barriers to general health care for refugees and asylum seekers came in the form of:

- **Lack of documentation** issued by the Department of Home Affairs due to the large queues and limited services being provided by the Refugee Reception offices.
- Unaccompanied minors facing further obstacles due to the additional challenges they face in accessing documentation from the DHA.
- Undocumented nationals facing additional obstacles due to their constant vulnerability to arrest and deportation whatever their circumstances. They may be unwilling to present themselves at hospitals or clinics for fear of being reported to police and deported.
- **Xenophobia** from health care staff. Frontline staff (clerks and nurses) were described as being the most likely to refuse services to refugees and asylum seekers. Treatment was more likely to be provided once contact had been made with a doctor. In addition, it was suggested that xenophobia was heightened towards refugees with disabilities.⁹
- Confusion by health care service providers over the rights of different categories of foreign nationals. Many service providers are unaware of the legal status of refugee documents and asylum seeker permits and are fearful of getting into trouble for assisting someone with such documents.
- Confusion over the fees to be paid by the different categories of foreign nationals. Until the NDOH directive, it was generally unclear as to how asylum seekers were to be charged.¹⁰
- Poverty, as some refugees and asylum seekers were not employed and thus perceived financial barriers to

accessing health care. Uncertainty about fee structures by health care staff contributed to this as some foreign nationals were charged higher fees than they should have been in terms of the law.

- Language issues as translators were often not available to assist foreign nationals in explaining their illness to health care service providers.¹¹

Barriers to accessing ART

- It is often the internal policy of health care institutions that creates the barrier to ART for non-citizens, where institutions **WRONGLY** demand an ID booklet, individuals – citizens or otherwise – without an ID booklet are refused treatment, and referred out of the public sector and into the NGO sector. This not only increases the burden on a resource limited (and externally funded) NGO sector, but prevents the public health system from fulfilling their obligations to provide healthcare to all.¹²
- A previous lack of clarification from the NDOH regarding the rights of asylum seekers to access ARTs. The new

policy directive issued by NDOH will go a long way towards tackling this issue but there will still be challenges in ensuring there is widespread awareness of this new measure.

- A fear of approaching the police regarding post-exposure prophylaxis (PEP). A number of foreign nationals have reported negative experiences in dealing with the various South African police services. Many foreign nationals also appear unaware that they can present themselves at a public hospital for this service (PEP) and health care providers are obliged to keep clinical information confidential.
- The challenges of providing information to non-national populations in an accessible and appropriate way. Refugee and migrant populations live in many different areas and it is difficult to communicate with all. Many non-nationals are therefore not aware of initiatives such as the prevention of mother to child transmission of HIV (PMTCT).
- Stigma in non-national communities around HIV. Such stigma challenges common support structures such as ‘treatment buddies’ or support groups. Instead it was been found that foreign nationals often prefer to be

CASE STUDY: ACCESS TO ANTIRETROVIRAL THERAPY

Jean* arrived in South Africa in 1998. He left the Democratic Republic of Congo (DRC) in order to escape violence and conflict. He travelled to Johannesburg where he applied for, and received refugee status. Although he did have refugee papers, these were stolen in 2001. He has applied for a replacement but is still waiting and currently has no documentation. Jean has been working informally since his arrival, he currently mends shoes. He lives in the inner-city and shares a flat with other people he met there who came from the DRC. Jean had a South African girlfriend for several years, but she has now left Johannesburg; he does not know where she is.

In 2006, Jean started to become unwell, and developed a bad cough. When he was too sick to work, he went to the local government clinic. He was diagnosed with TB and started on treatment. He was advised to test for HIV, which he did at the clinic. He found out that he was HIV positive and was referred to the closest ART rollout site. There, they tested his CD4 count and found that it was 194. The counsellor explained that he must finish his TB treatment before he could commence ART. However, once Jean had completed his TB medication, he was then told that he could not receive ART because he did not have a green South African identity booklet. He explained that his refugee booklet had been stolen but the counsellor said that he needed a green South African identity booklet. At this point, although feeling better, Jean was still very weak; he was still unable to work and his friends were no longer able to support him.

The counsellor at the ART site referred Jean across the city to an NGO site that provides ART. They did not ask him for any documentation. They checked his CD4 count and found it was 120. He received adherence counselling and then started ART. Jean has been receiving ART at this site since 2006 and is currently well. Jean has to travel far to the NGO site to receive his medication and to have his CD4 count monitored and the taxi fare is expensive. He is eligible to receive ART at his local government ART rollout site (that is in walking distance) but unfortunately, the right to access ART is not being upheld.

– Jean is a refugee and has the right to access ART. The September 2007 Directive confirms that refugees and asylum seekers – *with or without a permit* – are entitled to free ART.

* *Not his real name*

part of such support structures located outside of the communities where they live.

In South African hospices, palliative care is provided regardless of citizenship and is free of charge so that refugees can access palliative care if they are in an area that has a service. In addition, a number of South African hospices are ARV treatment sites (funded by the US government through Catholic Relief Services which promotes access to ART for refugees). Tapologo Hospice in Rustenburg North West Province is one of these sites that provide a comprehensive treatment and palliative care service, including care for orphans and vulnerable children.

Addressing the challenges as Health Care Practitioners

- Know the rights of refugees, asylum seekers and migrants and inform your colleagues of these.
- Challenge prejudice against foreign nationals where you see it. Remember that the law is on your side and it is the duty of each and every health care practitioner to provide fair health care access in terms of the law.
- Maintain communication with civil society service providers who can offer advice and assistance if specific challenges emerge. Key organisations such as Lawyers for Human Rights (Johannesburg, Pretoria and Durban), Wits Law Clinic (Gauteng), UCT Law Clinic (Cape Town) and the Legal Resources Centre (Cape Town, Grahamstown, Durban and Johannesburg) can provide clarity on any legal concerns regarding non-national access to health care.
- Where the policy of the health care institution where you work prevents refugees, asylum seekers or migrants from accessing health care, you can challenge this policy or else refer to the legal service providers listed in the Resources Section at the end of this book for advice on the issue. If necessary, this could then be an issue that they then address with the institution.
- Create a relationship between your organisation and an organisation offering translation services. Local migrant and refugee service providers may be able to assist you in this regard.

Other potentially vulnerable groups

Although there is likely to be less confusion around the rights of South African citizens to health care access, there are potential barriers that affect a number of categories of citizens. These barriers relate largely to issues of stigma and prejudice. By being aware of these issues, we as service providers can tackle such challenges to ensure the services we provide are accessible to all.

Sex workers¹³

Sex workers face a number of potential barriers to health care. Due to their employment choice, sex workers are among the most marginalised and stigmatised in our society. This is a crucial issue that requires a lot of self awareness from health care workers. It requires that a health care worker does not judge the patient based on his or her own values. Many sex workers say their work is their way to achieve financial security and independence. In terms of prejudice, many service providers do not treat and approach sex workers in the same way they deal with other clients. A number of sex workers have spoken of feeling judged and being lectured to by service providers who have effectively ignored the reasons why the sex worker came for a service. It is vital that you support such people by ensuring they have access to health care services. Service providers need to be approachable and friendly to all people from all walks of life. Despite sex work being seen as a criminal activity, the Constitution protects the rights of all within South Africa and therefore the right of all to seek medical care.

Suggestions for service providers

- Treat people humanely regardless of what work they do and try to reserve your comments and opinions as these may hurt the patient and cause him or her to become more reluctant to seek out health care assistance in the future.
- Regardless of the work that people do, resist the urge to tell others either about their health status unless they have given you permission to do so. Treat them with the respect and confidentiality that you would give to any other patient.
- Avoid talking to sex workers in a manner that may be interpreted as 'preaching' with regards to their choice of employment. In the same way you would not tell a teacher or a nurse to change their job do not tell sex workers to change their jobs, unless they have asked you for advice or to tell them of other work opportunities. Whilst you may feel that you are trying to help, in fact the patient is likely to feel judged, humiliated and not heard.
- Challenge prejudice where you see it. In the same way that not everyone in South Africa is HIV positive or taking drugs, not all sex workers are HIV positive and take drugs.
- Listen to what the patient is asking as he or she may be asking about other things that are not related to the work that he or she does.
- Organisations should consider undergoing stigma training workshops for working with marginalised people.
- Sex workers may approach health care workers for

multiple needs. In such cases, health care workers can play a key role by contacting, or referring patients to, organisations that are better equipped to provide for specialised needs. You might not be able to assist with all needs, but you can refer people to others who can assist. For this reason it is useful to be familiar with the various services provided by other organisations and to network with them.

- The majority of people know what they need, but might not know how to ask for it or how to get what they want and need. Bear in mind that some may have experienced gross human rights violations and repeated abuse without adequate support and as a result they can end up overwhelmed and unable to articulate what the problem is. Try to be patient and give the patient time and space to think through what they need, even if at times these needs are contradictory. All of us from time to time want conflicting things.
- Try to find staff members who speak the main languages of the patient as the patient can then be more articulate. This is not to say that one should assume that the person does not speak English but rather that people can be given the option to either speak in English or their mother tongue.

Prisoners

The Law

International norms and standards provide that prisoners must have access to the same quality and range of health care services as the general public receives from the National Health Service.¹⁴ In this way, incarceration should not impact on a person's ability to access health care. Section 12 of the Correctional Services Act and the accompanying Regulations provide specific requirements regarding health care for prisoners.

Section 35(2)(e) of the Bill of Rights provides for the rights of prisoners to have 'adequate medical treatment' whilst Section 35(2)(f) provides for a detainee to be visited by his or her chosen medical practitioner. If the state is unable to provide a particular treatment, it needs to demonstrate that it cannot afford this treatment or that such treatment would place an unwarranted burden on the state.¹⁵ Furthermore, Section 11 of the Bill of Rights provides for the right to life. The high numbers of natural and unnatural deaths in prisons illustrate that this right is violated to a significant degree.¹⁶

Health care for prisoners in South Africa is regulated by the Department of Correctional Services (DCS) rather than the NDOH. This can pose challenges in ensuring a consistent standard of health care is available to all South Africans across the country. In June 2006, the Durban High

Court ordered the DCS to provide ART to prisoners in Westville Prison in accordance with public sector policy.¹⁷ Prior to this ART was being denied to prisoners. Whilst the state has been criticised for the slow speed at which it has sought to rectify this, the DCS has managed to increase the number of sites where ART is available.

Medical Parole

Section 79 of the Correctional Services Act provides for a prisoner to be placed under correctional supervision or on parole if they are diagnosed by a medical practitioner as being in the final phases of a terminal illness. This is to allow for a prisoner to die a 'consolatory and dignified death.'¹⁸ Medical parole has long been a contentious issue and the Correctional Services Act Amendment Bill being reviewed at the time of writing proposes changes to the current legislation on medical parole.

In practice

The *Judicial Inspectorate of Prisons Annual Report*¹⁹ described health care in most of South Africa's prisons as 'in crisis'. Factors such as a lack of medical staff, overcrowding in prisons, poorly resourced prison hospitals, as well as operational inefficiencies, were some of the items of concern raised. In one prison, an acute shortage of staff was discovered whilst pregnant patients were being kept in the same accommodation space as TB patients and had no access to gynaecological services. In addition only limited screening of newly-admitted prisoners took place and prisoners with infectious diseases were not isolated from the rest of the prison population. The *DCS Annual Report of 2007*²⁰ reveals a high level of vacancies within the Correctional Services system and this is likely to put further pressure on the ability of the system to meet inmates' needs. The DCS recognised the shortage of skilled staff in the form of professional nurses, medical practitioners, psychologists and pharmacists²¹ and the impact this was having on the health care it was able to provide for prisoners. It committed itself to taking steps to rectify this situation. Further major challenges to the health care of inmates are the presence of gangs inside many prisons as well as practices relating to the use of tattooing in prisons. Access to PEP (Post Exposure Prophylaxis) for those who have been sexually assaulted inside prisons can also prove a significant challenge.

Medical Parole in practice

Despite the legal prescriptions, in practice medical parole involves a lengthy and bureaucratic process. In some cases, the condition of prisoners worsens and some die before being released²². In *Stanfield vs Minister of Correction Services and Others*²³ the Court judgment declared that ‘the overriding impression gained from [the state’s] attitude in this regard is that the applicant must lose his dignity before it is recognised and respected’.

It also appears that the Parole Boards have been denying people living with AIDS medical parole due to a fear that those released on medical parole could then access ART and recover to a degree where they could continue to commit crime. A submission by the Civil Society Prison Reform Initiative (CSPRI) to parliament suggested that medical parole be converted to other forms of parole if a person recovered significantly. There is as yet no indication of whether this suggestion has been adopted. As a result, whilst the numbers of people being diagnosed with AIDS in prisons is increasing, the numbers of those released on medical parole is stable or declining.²⁴

Additionally, significant delays occur in the process of applying for medical parole. Such delays occur due to:

- Reluctance by family members to accept a terminally ill family member back home.
- The requirement that a prisoner due for release on such grounds be seen by the district surgeon, specialist, social worker and parole board before being released.
- A potential lack of skills on the Parole Board to assess complex medical conditions, resulting in the rejection of applications due to incorrect consideration of the circumstances.²⁵

Prison pharmacies

A delegation from the Correctional Services Portfolio Committee visited Pollsmoor Prison in Cape Town and discovered, amongst other concerns, that medicines past their expiry days were being dispensed to prisoners. This is unlikely to be an isolated incident and reflects a further challenge to the provision of ‘adequate’ health care in prisons. Investigations by the Jali Commission as well as the Special Investigations Unit found major irregularities regarding grey medicine, repackaging of expired medicine and the selling of medicine destined for the prison population to private companies.

Continuation of care after release

It is vital that preparations are made for prisoners undergoing treatment when they are released from prison. Whilst some prisoners may have been able to have good access to treatment whilst inside the prison, their release may pose challenges for the way in which they now have to access care. For those on a course of ART, it is critical that planning is co-ordinated between the DCS and NDOH, as well as the patient’s support structures, to ensure the patient is able to maintain access to the course of ART. It appears that currently there is limited support to ensure continuity of care after release and this is a major area that needs to be addressed.²⁶ Where the prisoner’s family is unable to care for the prisoner at home, appropriately qualified and experienced doctors assisting Parole Boards need to be aware of palliative care services and make enquiries to establish what services might be available for such prisoners on release.

Drug Users²⁷

Background

Drug addiction has been recognised internationally as a disease that is manageable rather than curable. As a primary and progressive disease, it is the addiction itself that is the key problem rather than its consequences, and it can become worse over time. Key characteristics of the disease can include withdrawal, shame, loss of control, manipulation and lying, and drugs becoming the main focus in the person’s life.

Addicts can be ambivalent about their situation with part of them recognising the destructive impact of drugs on their life but with another part attached and attracted to their drugging for different reasons. Service providers can play a useful role by supporting the addict who wants to stop.

A key palliative care perspective is that the drug user in pain requires higher doses of opioid analgesics because of the effect of drug use on speeding up the metabolism of these analgesics. This can result in discrimination as the requirement for higher doses is seen as expression of addiction and manipulation. Also problems occur with previous drug users who have now stopped using and are afraid to take medication for pain control for fear of slipping back into addiction. So both situations are challenging to the palliative care practitioner as the patient still requires and should receive adequate pain management.

Roles to avoid and to be aware of as Service Providers

- The Rescuer; by attempting to ‘rescue’ an addict to make him or her feel ‘safe’ and ‘loved’ can have the effect of sheltering the addict from experiencing the negative effects of his or her actions and thus slowing down the healing process.
- The Persecutor; by punishing the addict by denying him or her services or privileges you do not stop the addictive behaviour, you give the addict a person to blame for his or her behaviour and thus avoid dealing with the problem.
- The Victim; this is a role that can be played by the addict when he or she wants something. Essentially, the addict avoids taking responsibility for the issue and instead shifts the blame for his or her behaviour onto others.

As a service provider, it is important to avoid the roles of the rescuer or persecutor as these roles can reinforce that of the ‘victim’ and allows the addict to continue his or her behaviour. Instead, service providers could play a supportive rather than rescuing role, and a limiting rather than a persecuting role. In this way they can assist by helping set appropriate boundaries or limits.

Counsellors at the Cape Town Drug Counselling Centre suggest that it is important for service providers NOT to take on cases as individuals, but rather to work as part of a team in dealing with issues of addiction.

Lesbian, Gay, Bisexual and Transgender people²⁸

A study conducted by OUT Well-being in 2004 found that many black gay men and black lesbians had been refused access to health care due to their sexual orientation²⁹. Although the law is clear, prejudice on the part of service providers can inhibit access to key services. Such prejudice can present in a number of ways. It could be overt in the form of direct refusal of services or it could be less obvious in the form of behaviour that makes the patient uncomfortable, such as insensitive questions and comments or looks from the practitioner or other staff.

Many health care practitioners may have private religious beliefs that conflict with a sexual minority patient’s lifestyle. This should not detract from the health care provider’s duty to provide equitable services to all patients without discrimination. If a health care service provider is unable to get past his or her own prejudice and is therefore not able to provide services without making the patient feel uncomfortable, then the service provider should refer the patient to another service provider who can. Although in such circumstances a patient may be referred, this does not

absolve the physician from becoming aware of the basics of their care. In addition, if no other referral services are available, the provider has a duty of care and should work through their prejudice in order to offer an acceptable service.

Practitioners need to distinguish between people’s identities and their behaviour. A person may be gay but that may not impact upon their specific health care needs. If a male patient has sex with men, then it is this behaviour that may be more relevant to preventative measures or treatment being addressed by the health care practitioner.

It is also important that the support staff in a clinic or hospital are given training on sexual minority issues. Such patients are likely to come into contact with receptionists, medical assistants and bookkeepers and it is important that issues of prejudice on the part of these support staff are examined and addressed.

It is possible that many sexual minority patients may be mistrustful of Western medicine. This may be because some patients have had a negative experience with prejudiced physicians. Sexual minority patients may also be suspicious of mental health practitioners. Many people believe in ‘curing’ people with ‘deviant’ sexual behaviour and therefore some sexual minority patients may misinterpret referrals to psychologists or counsellors as being for the same purposes. As a practitioner, you may be far more successful if you are able to assure the patient truthfully that you do not consider his or her behaviour or sexual identity a problem.

Conclusion

This chapter has illustrated that there continue to remain significant barriers in South Africa for the provision of equitable access to health care that does not alienate potentially vulnerable minorities. Many of these challenges relate to attitudinal barriers to accessing health care, and for this reason it is vital that staff in all health care institutions are made aware of the effect their attitudes can have on patients. Measures need to be in place to ensure that the prejudice of a health care practitioner does not result in any person in South Africa being denied their right to access health care. Further challenges involve ensuring that staff are aware of the current legislation with regard to providing health care for foreign nationals with or without documents. Access to health care in prisons remains tenuous, and the reliance of inmates on prison officials for access to health care increases inmates’ vulnerability. By addressing the challenges outlined in this chapter, South Africa will be in a better position to ensure that the standard of health care offered in this country is an achievement of which all can be proud.

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