

Access to Health Care Services by refugees in Southern Africa: A Review of Literature

by

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ABSTRACT

This study was conducted in order to understand the dynamics of each country in Southern Africa by documenting barriers facing refugees in accessing health care services and aiming to make policy recommendations based on findings. A desktop search was conducted through which papers using both qualitative and quantitative methods were gathered for analysis. A total of sixty-four (n=64) papers were generated, out of which only twenty-two (n=22) were considered for analysis. NVIVO software was used for analysis as it allowed the coding and grouping of findings under themes. The emerging themes included: Availability, Affordability, and Acceptability. These results suggest that access to formal health care services remains a challenge for refugees in Southern Africa. If identified barriers are not addressed, they will continue to affect the health of both citizens and refugees negatively.

Key words:

Refugees, health care services, health-seeking behaviour, Southern Africa, refugees' rights and policies

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1. Introduction

The number of refugees in the world continues to grow at a rapid pace, with a total of 45.2 million worldwide, most of whom are war-related (UNHCR 2013). Southern Africa alone hosts 449,000 forced migrants, amongst whom 145,000 are refugees (162,670 in June 2013), 245,000 asylum-seekers, and some 55,000 internally displaced persons (UNHCR, 2013). Most of the refugees in the Southern Africa region originate from Rwanda, Burundi, DRC, Pakistan, Bangladesh and Somalia (Williams & Peberday, 2007; UNHCR, 2013). Coming from war zones and having witnessed different types of crimes; many refugees suffer mental health related problems and are in need of counselling and psycho-social services. Little evidence exists as to whether such services are provided to refugees in the Southern Africa region. This study therefore seeks to understand the challenges faced by refugees in accessing health care services (HCS) in the region.

For the purpose of this paper, 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). To this end, a lot has been done to address the inequality in access to HCS, but unfortunately, the gap widens continuously. Moreover, only a few studies have been conducted with focus on barriers facing refugees in accessing health care services. Many authors have studied entire groups of migrants, comprising refugees, asylum seekers, documented and undocumented migrants and others. These strata of migrants are challenged differently, and the most vulnerable group are refugees (MacLachlan et al., 2008; Landau, 2007).

Objective: To understand the dynamics of each specific country in the region by documenting the barriers facing refugees in accessing formal HCS and to make policy recommendations based on the findings.

2. Literature review

A refugee's claim to health care services is secured by international human rights law and protocols.¹ Unfortunately, reports suggest that this is not always observed in Southern African countries. This paper investigates these findings through a review of the health status of refugees and the current status of the provision of health care services in Southern Africa.

Health status of refugees and legal framework

Health system scholars have argued that access is an instrumental or intermediate goal of health systems (Schneider et al., 2006; Gulliford et al., 2002). Access to HCS is thus only important if it leads to improved population health promotion, satisfaction, disease prevention and patient satisfaction. Otherwise, utilization of health care is more relevant.

There are also studies that identify themselves within the histo-critical perspective (Davey, 2012; Ferris, 2011). They offer opportunities to view refugees from the lens of suffered violence from native countries, and abuses suffered in host countries. Cohon (1981) reviewed refugee symptomatology and treatment methods and indicates that the intensity of stress resulting from forced migration manifests in symptoms such as delusions of persecution, disturbing dreams, poor sleep, states of confusion, somatic complaints, feelings of insecurity, isolation, resentment, guilt, inadequacy, bereavement, tension, fatigue, restlessness, and detachment. These symptoms suggest mental health problems that impact on the physical health of refugees (Ibid). Some scholars suggest that health professionals should not only concentrate on the past but also on the present and the future well-being of refugees (Kohli & Mather, 2003; Richman, 1998b). Others (Dohrenwend, 1961; Gillian, 2003; Murthy, 2006; Marsella, et al., 1996; Wessells & Monteiro, 2004) argue that second language stress adds a burden apart from traumas of war and mental disorders of refugeeship.

¹ See these agreements and protocols in the Universal Declaration of Human Rights (UN, 1948); the OAU Convention Governing the Specific Aspects of Refugee Problems in Africa (OAU, 1969); the Protocol Relating to the Status of Refugees (UN, 1967); the Convention Relating to the Status of Refugees (UN, 1951).

Thus, non-nationality has a bearing on the social and support service system, such as HCS for refugees.

There is yet again a literature thread that can best be described as falling within the "conservative approach". In this approach, the main advocates argue on the basis of traditional understanding of 'citizenship'. They posit that refugees are denied health care services in order to save resources for nationals (Rosenkranz, 2013; Schwartz et al., 2001). This strand is somehow opposed to the aspect of human rights that ought to be accorded to refugees. Landau (2005) notes for example, that "South African citizens and politicians regularly rely on nativist discourses that make one's rights to the city contingent on one's national origins (P12)". Scientifically, this approach has been criticized for taking too narrow an approach, as health problems such as infectious diseases suffered by refugees may easily increase the incidences of diseases in the host population (Bruns & Spiegel, 2003). Conceivably, many but not all health practitioners associate forced migration with health-care seeking, and still some officials regard the refugees as 'asylum shoppers'.

The provision of the laws for refugees in the Southern African countries is yet another challenge for their access and utilization of the health care services. Rutinwa (2002) points out that the currently failed laws and refugee policies are rooted back in the pre-1990s. Rutinwa categorizes the refugee policies/laws in three generations, namely the treatment of matters relating to refugees as an integral part of immigration policy and law without a need for a separate refugee-specific law. The second generation consisted of the refugee control laws that operated alongside immigration laws to regulate selected aspects of refugee protection, and the third generation was characterized by comprehensive refugee legislation governing all aspects of refugee protection in accordance with the relevant international legal instruments (Rutinwa, 2002; Hathaway, 2001; Oucho & Ama, 2009). All these types of refugees' laws did not provide for refugees specifically, but treated them as part of the immigrants at large. Consequently, refugees were then treated as aliens or a prohibited population group. To date, not much has changed from the way in which refugees were treated back in the 1990s. Faris (1999) warned that:

"The problem of the refugee is totally unrelated to immigration law and to the law relating to ordinary aliens. To classify the refugee as an ordinary alien evades the problem. Immigration law is intended to cope with the admission of individuals and not a mass influx of people" (1999, P18).

The author continues to argue that applying ordinary migration laws to refugees resulted in labelling all potential refugees as illegal immigrants (Faris, 1999). The above view of refugees as illegal immigrants has negative implications for accessing health care services in countries where these policies have not been revised. Moreover, the general assembly resolutions hosted by the leaders of the countries in the Southern Africa region in 1992 and 1996 respectively, focused on other issues of forced migrants, including their resettlement, safe return into their countries of origin, safety, etc., but nowhere could any mention be found that related to health care access as a priority.

Current status of provision of health care services in Southern Africa

The WHO reported in 2012 that the Southern Africa region was facing serious health challenges, including losing clinicians to continents with a stable economy and high pay, social and economic weakening, deficient rules, deteriorating health systems and the lack of human resources and supply of medications (WHO, 2012). According to the WHO (2012), Lesotho, Malawi, Mozambique, Zambia, Zimbabwe and Swaziland were the most affected countries by the above-mentioned health challenges. Findings in this paper suggest that all the above countries host refugees who are in need of health care services (UNHCR, 2013). This is an alarming situation, whereby the health sectors of the countries in the region are already over-burdened, yet expected to cater for both the local community and the refugees. This may result in refugees finding it hard to access the services which some of the locals are unable to access accordingly. However, it cannot be assumed that because states lack the capacity to meet the needs of their entire population, they have no responsibility for ensuring an acceptable level of health and health care for refugee communities (Belvedere et al., 2001; Hevens and Brand, 1997; Hathaway, 2001).

In addition to these challenges, there is an anti-foreign attitude in Southern Africa (which has seen an influx of refugees for decades) that has resulted in a structural exclusion – the impact of which has not been analysed in HCS. All these situations mask the harsh reality of worsening health care facilities for refugees; yet access barriers to HCS continue to persist (Crisp & Kiragu, 2010; Crush & Tawodzera, 2014). The refugee experiences demonstrate the complexity of unmet health and medical needs, and highlight the need for access to health services aimed at supporting this population group in a way that is sensitive to their specific health needs.

3. Theoretical and conceptual framework

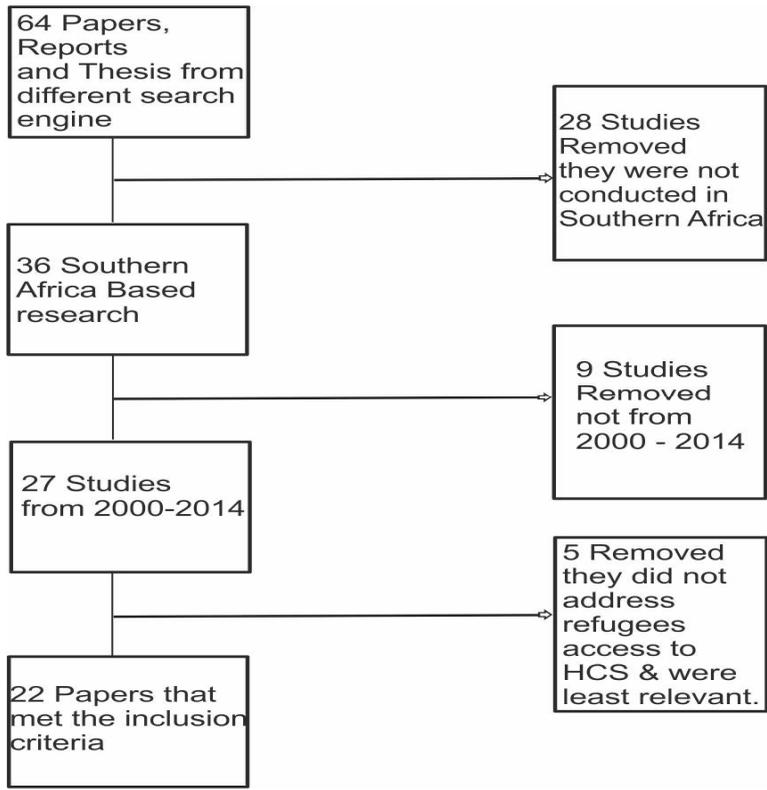
This paper adopts a conceptual framework and uses the theoretical grounds regarding access to health care services as a specifically desirable value as the basis for both the theory and argument presented herein. Penchansky and Thomas (1981) describe access using five dimensions of care, which describe the degree-of-fit between patients and the health system – availability, acceptability, accessibility, affordability and accommodation. The Researching Equity in Access to Healthcare (REACH) study, adopted an 'A' conceptual framework for access (availability, acceptability and affordability), which views access as a dynamic process of interaction between health system (supply-side) and individual (demand-side) issues (Donebedian, 1973). A decentralized integrated health care system has been found to improve uptake of treatment, adherence and retention in care, and increases utilization of health care services (Wallrauch et al., 2010; Legido-Quigley et al., 2010; Coetzee et al., 2004). Some patients may have to overcome more hurdles than others in order to access health care and for continued utilization to be sustained. Patients' expressed demands and expectations, which constituted acceptability, affordability and availability of services; have to be met by the health system for continued uptake of treatment and retention in care. The health system should be able to satisfy the patients' demands although it may or may not be able to immediately alter the availability/physical hurdles that patients (and refugees in this specific context) face. The challenges faced at each level of care may vary for different types of refugees with different health care needs. Although most of the refugees are already utilizing care, understanding the barriers they face in the process and the determinants of hurdles in utilization is

important in shedding more light on the proximate challenges possibly faced by those in need who do not access or utilize care. In addition, this should assist in pointing to areas in which policymakers need to improve to increase accessibility to HCS by refugees (Andersen, 1995; Coetzee et al., 2004; Donebedian, 1973).

4. Methodology

The study was a desktop research. It included key words like 'Integrating health care services for Southern African refugees', 'Refugees' access to health care in Southern Africa', 'Refugees' health-seeking behaviour', 'Refugee policies in Southern Africa', 'Refugees' right to health care', and 'Health policy and social protection'. The search engine consisted of Jstor, EBSCOHost, Google Scholar, governmental organizations, NGOs and the Department of Health websites. All papers meeting the eligibility criteria were then read in order to identify other reports and potential literature relevant to the topic. In total, 64 papers, theses and reports were identified for this study. Only 22 met the criteria for selection after the process depicted in the figure hereunder.

Figure 1: Flow chart showing sample selection



Of the total 22 papers analysed, 3 used mixed methods (qualitative and quantitative) and 15 used the qualitative method. Most of the qualitative literature was evidence-based reporting on the views of key informants on the subject and based on focus group discussions. The last 4 papers used quantitative methodology with an average sample of 250–6000 participants. In total, 16 manuscripts were categorized as contributing strong evidence to the literature on access to health care services in Southern African countries. The study included the review carried out in 14 Southern African countries of which three were excluded due to the lack of availability of data and lack of relevant information on the topic.

Table 1

Author(s)	Titles of papers	Methodologies	Summary of Findings	Publishers
Nkosi, NG 2004	Influences of Xenophobia on accessing health care for refugees and asylum seekers in Johannesburg-South Africa	A mixed of qualitative and quantitative study of 60 refugees, 6 HCWs and 15 South Africans in the control group in South Africa	The author concludes that xenophobic tendencies of HCWs are linked to language barriers, socio-economic and legal status of asylum seekers. The latter suffer due to the lengthy asylum determination procedures, which affect their health status, and the high hospital fees that asylum seekers are expected to pay. Inadequate access to health care services was also linked to lack of information on how the HC system works	University of the Witwatersrand: PhD Thesis Published Online
Campbell, Eugene K 2003	Attitudes of Botswana citizens towards immigrants: signs of Xenophobia?	A quantitative study with a sample size of 781 participants (347 males & 434 females) in Botswana	Negative attitude toward refugees. All refugees are being viewed by citizens as illegal migrants, and the latter propose that the country replaces the border fencing by electric fence to avoid migration flow in Botswana. The xenophobic signs towards immigrants hinder them from accessing social and health services	Blackwell Publishing- [International Migration Vol. 41 (4) 2003]
Carasso, BS et al. 2012	'Health Worker Perspectives on User Fee Removal in Zambia'	A mixture of the qualitative and quantitative study method of 20 facilities and data from the National Health Management Information System in Zambia	Increased take-up of services by the poor and the minority after fee removal at some facilities. A recommendation is made to increase the number of staff while advocating for user fee removal at remaining site and be concerned about the burden that increased demand is likely to place on the already over-stretched health care workers	Human Resources for Health

Author(s)	Titles of papers	Methodologies	Summary of Findings	Publishers
Munyewende et al. 2013	Exploring perceptions of HIV risk and health services access among Zimbabwean migrant women in Johannesburg: A gap in health policy in South Africa	A qualitative study from a 2005 exploratory study and analysis of the DOH strategic plan and 15 interviews with Zimbabwean women living in Johannesburg RSA	The study refers to migrants as economic refugees and asylum seekers including documented and undocumented migrants. They identify access barriers including the migrants' perceptions of relatively low HIV risk, severe constrained financial circumstances, uncertain legal status and experience of unresponsive health workers. They recommend that migrant health rights be placed on South Africa's policy agenda	Journal of Public Health Policy
Apalata et al. 2007	Refugees' perceptions of their health status & quality of health care services in Durban, South Africa: A community-based survey	A mixture of the qualitative (sample size 52) and quantitative study (sample size 250) method, conducted in Durban South Africa	13 themes were generated, grouped as strong, medium and weak. They included discrimination and xenophobic attitudes towards refugees, language barriers increased vulnerability of refugee children, problems with refugee permits and promotion of self-medication among refugees. Lack of systems, structure and appropriate organizations in helping refugees were noted, including illness brought by refugee newcomers	Health System Trust
Mujawamaria Console, 2013	Living with Xenophobia: understanding the lived experiences of Burundian and Rwandese refugees in South Africa	A qualitative descriptive approach study of 10 Rwandan and Burundian refugees living in Durban South Africa	Findings revealed that the refugees are re-traumatized in South Africa due to the experiences of xenophobia which was documented as a main barrier to their access to socio-economic services, including: health care services, proper residential areas, conducting economic activities and failure to integrate in the community	Masters of Social Work Dissertation available on UKZN online library

Author(s)	Titles of papers	Methodologies	Summary of Findings	Publishers
Idemudia, ES, Williams JK and Wyatt GE 2013	Migration challenges among Zimbabwean refugees before, during and post arrival in South Africa	A qualitative study of 20 Zimbabwean refugees (10 male & 10 female) who participated in the FGDs conducted in Limpopo South Africa	A summarized finding suggests that the already stressed and traumatized refugees are faced with a second wave of challenges of documentation, unemployment and other socio-economic challenges which contribute to an aggravated health situation; yet their access to health care is reported to be negative	Journal of Injury and Violence and Research
Adongo Jonathan 2007	Access to social services for non-citizens and the portability of social benefits within the Southern African Development Community	A qualitative report on Social Services for Non-citizens in SADC region. submitted to the World Bank	Refugees access health care services from a clinic based in their camp while undocumented non-citizens are not eligible for state-provided health care and when needed, they must pay for it	World Bank
SPII and OSISA, 2012	Access to Socio-Economic Rights for Non-Nationals in the Southern African Development Community	A qualitative study that consisted of desktop scoping, interviews with UNHCR representatives and focus group discussions with refugees, and asylum seekers in each country within SADC	Access to social protection, right to health care and education for refugees and asylum seekers in SADC is pretty perilous. Refugees and asylum seekers face discrimination, lack of drugs and equipment, reception of inferior services with high pay in some countries (Zambia). They opt for private HCS and their access to HIV/AIDS services	Open Society Initiative for Southern Africa

Author(s)	Titles of papers	Methodologies	Summary of Findings	Publishers
Katy, L and Jeff, C 2011	In harm's way: the irregular movement of migrants to Southern Africa from the Horn and Great Lakes regions. New issues in refugee research	A qualitative and critical review of literature on issues surrounding migration from other African Countries to Southern Africa region	While the study did not specifically address issues around refugees and access to health care, it documented the challenges and risks faced by refugees when not provided with health and psychosocial services in receiving countries. The authors pointed to the problem of discrimination and failure to integrate. These may hinder access to health care services	Research paper no. 200. United Nations High Commissioner for Refugees, Geneva, Switzerland.
Vearey, J & Nunez, L 2011	Towards Improving forced migrants access to health and psychosocial rights in urban South Africa	A qualitative report of a migration issue brief summarizing the state of the art research and intended to inform discussions and debates surrounding human mobility in Southern Africa	The policy brief reveals that forced migrants/refugees in South Africa are assured a range of rights including the protection of their health and psychosocial wellbeing, but these are not always upheld. The refugees therefore are forced to become self-sufficient and to cover all their costs including that of health care services	CSVR in collaboration with ACMS and the University of Witwatersrand
UNHCR 2013	Health Care Services for Refugees in Tongogara Refugees Camp	A qualitative report of the situation of camp-based refugees in Zimbabwe	The report concluded that refugees in Zimbabwe receive basic free health care services at a camp-based clinic and that serious cases are referred to the main public hospital in town	UNHCR- Annual Report
Landau, LB and Jacobsen, K 2007	'Refugees in the New Johannesburg	A mixed method of Qualitative and quantitative study of 737 respondents in Johannesburg South Africa	A concluding summary suggests that migrants in Johannesburg are harassed by police and immigration officers. The authors recommend that access to preventive health care by migrants and refugees need to be improved	Forced Migration Review

Author(s)	Titles of papers	Methodologies	Summary of Findings	Publishers
Makhema, M 2009	Social Protection for Refugees and Asylum Seekers in the Southern African Development Community (SADC)	Qualitative study of refugees in SADC region	The study focused on case studies of Botswana and South Africa, and concluded that social protection of refugees is lacking due to barriers in accessing basic human needs	World bank
Palmary, L 2004	Refugees, Safety and Xenophobia in South African Cities: The role of local government	A qualitative study conducting interviews with key informant from the city of Cape Town, a review of refugee-related service provision policies and FGD with 40 refugees and asylum seekers	Refugees reported barriers to conduct informal trading, eviction from houses and difficulties in accessing government subsidised and private housing and barriers to local government work. They blamed xenophobic practices as drivers of these barriers, which also prevent refugees from accessing health care services	Centre for the Study of Violence and Reconciliation (CSVR)
Wachira Mukundi George 2014	Migrants' Right to Health in Southern Africa	A qualitative study of Migrants' right to health in Southern Africa region	The study concludes that some countries in the SADC region limits the right to health care to their citizens, while a few others include the migrants	SIDA- International Organization for Migration
Muyembe, M 2007	'Access to Social Services for Non-citizens and the Portability of Social Benefits within the Southern African Development Community (SADC):' Zambia Country Report	A qualitative descriptive report of access to social services by refugees in Zambia	Health care services for refugees are covered by the UNHCR. However, a fee is charged for citizens to access it except children <5 years, pregnant women and older people. This translates that refugees whom the UNHCR does not cover, will have to pay a fee for the same service if they do not fall under the specific age group	Zambian Ministry of Labour and Social Security

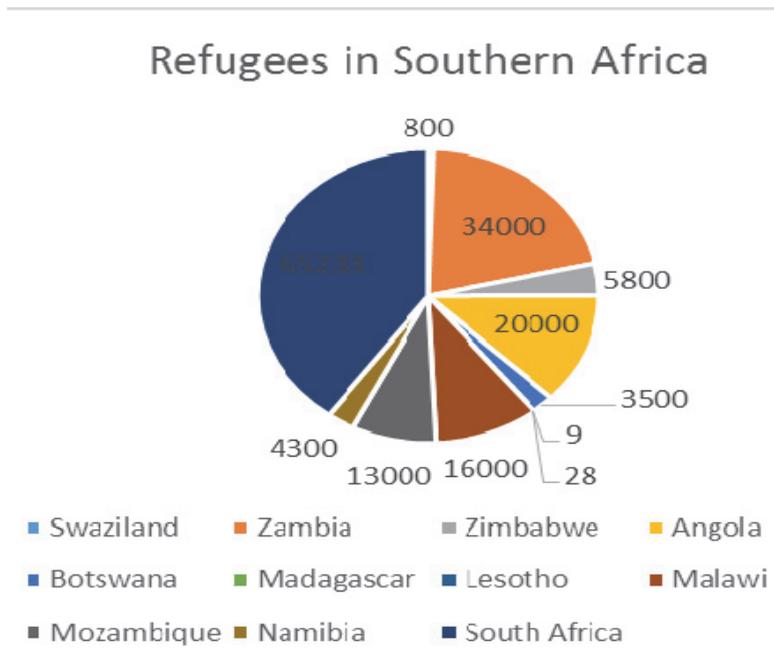
Author(s)	Titles of papers	Methodologies	Summary of Findings	Publishers
Oucho and Ama, 2009	'Immigrants' and Refugees' Unmet Reproductive Health Demands in Botswana: Perceptions of public health care providers'	A quantitative study that targeted 4667 participants and a sample study was later determined to 851 allocated to 23 districts in Botswana	ARVs and PMTCT programmes are not accessible for refugees. The latter are charged a fee for other health care services. The study recommends that the Botswana government improve the availability of reproductive health services to immigrants and refugees	Journal of South African Family Practice
Steinberg, J 2005	'A mixed reception; Mozambican and Congolese Refugees in South Africa: Monograph No 117,	A qualitative report of the situation of DRC and Mozambique refugees in South Africa	The lack of documentation acts as a barrier to refugees in accessing both health care services and other social grants provided by the government to those who have already qualified for permanent residency	Institute for Security Studies ISS monograph series
CoRMSA 2011	Protecting Refugees, Asylum Seekers and Migrants in South Africa during 2010	A qualitative report of the general situation and experiences of refugees services in South Africa.	The report at page 125 reveals that refugees do not have access to formal health care services in South Africa. It further documents that although undocumented migrants face the greatest challenges in accessing public health care services, those with documentation also experience problems in accessing basic health care, including antiretroviral treatment (ART)	Consortium for Refugees and Migrants in South Africa (CoRMSA)
Vearey, J et al. 2010	Urban Health in Johannesburg: The Importance of Place in Understanding Intra-urban Inequalities in a Context of Migration and HIV	A quantitative study using cross-sectional survey on 1533 individuals comprising of migrants and non-migrants in Johannesburg South Africa	The results show that migrants, including refugees, face challenges in accessing health care services and other social services due to discrimination and policies against migrants	Health and Place,

Author(s)	Titles of papers	Methodologies	Summary of Findings	Publishers
Collinson, MA 2010	Striving against adversity: the dynamics of migration, health and poverty in rural South Africa	A quantitative study using the 2005 surveillance data from 70527 people living in the Agincourt sub district of the Bushbuckridge district of Mpumalanga province of South Africa	The study examined the link between migration and health with specific focus on HIV. The author recommends that health policies have to consider forced migrants and that health services need to adapt to a reality of high levels of migration	Global Health Action

Some of the papers in the table above address issues of refugees while others refer to migration in general. Despite their titles, the papers addressed refugee issues as one stratum of migrants and their challenges in accessing health care services. Hence, some papers do not reflect refugees in their titles, but refer to them as 'forced migrants', 'asylum seekers' and 'undocumented migrants' throughout the content.

Against this backdrop, only countries hosting refugees were included in this study, namely Angola, Botswana, Lesotho, Madagascar, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The distribution of refugees within these countries is graphically portrayed in Figure 2 below.

Figure 2: Refugees in Southern Africa



Source: *UNHCR Refugee Count at June 2013*. <http://www.unhcr.org/statistics.html>

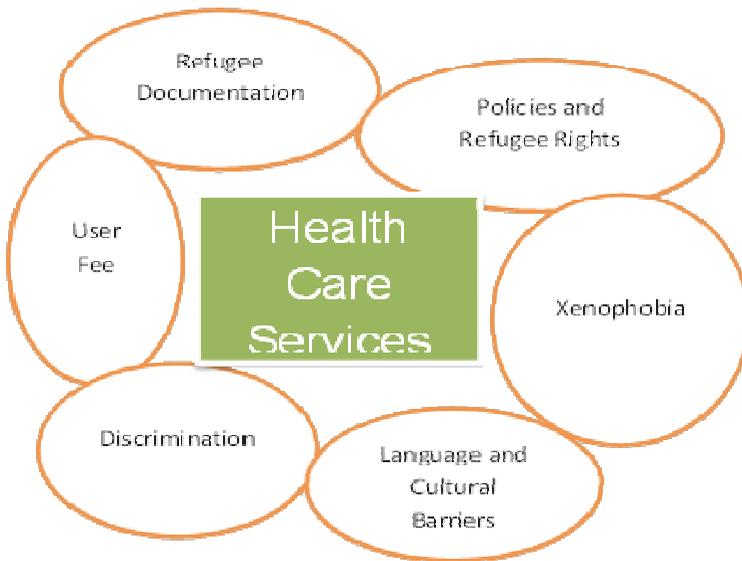
Figure 2 shows South Africa as having the highest number of refugees, while Madagascar hosts the smallest number in the region. The reasons for such disproportion are explained in the data analysis section. Furthermore, only the 11 countries above were selected for inclusion in the study because they are the only ones hosting refugees in the region.

5. Data analysis

NVIVO software was used to analyse the data, which allowed easy generation and classification of themes. Prior to the analysis, an excel spread sheet was used to record specific extracted information that included details on the study population, the methodologies of the studies, the context, country in the region, publishing journal and the year of publication. The rationale across the diverse studies was reviewed and a list of barriers was drawn. The most dominant barriers that emerged are reflected in the figure hereunder.

5.1 Emerging barriers

Figure 3: Interconnected barriers to accessing HCS by refugees



The barriers in Figure 3 were identified in countries where refugees live in the city. These interconnected barriers do not affect Zimbabwe, where refugees are camp-based and receive their treatment in the camp (UNHCR, 2013). However, other countries like Malawi, Mozambique, Namibia and Botswana host refugees in

camps but they do not provide health care services within the camps like Zimbabwe does. These refugees face either discrimination, xenophobia, language and cultural barriers, or the lack of policies that favour them in the host country.

6. Findings and discussions

The findings in this paper are consistent with those of many authors who have conducted studies on refugees living in the Southern African region. As described by the following themes, some countries continue to face problems in accessing HCS due to affordability, accessibility, and availability. There was, however, a lack of data for many countries under each specific theme. Moreover, more than 7 countries in sub-Saharan Africa did not have information related to refugees and health. As shown in Table 1 above, 11 studies (50%) were conducted in South Africa alone, and 6 papers were based on research conducted in all countries of the SADC and Southern African region. The other 5 included Zambia (2), Botswana (2) and Zimbabwe (1). The limited number of studies per country hosting refugees translated into a lack of information about refugees' access to health care services in the rest of the region. This explains the lack of information for some countries under each theme hereunder.

Availability

While data from other countries in the region could not be found through the search, findings from South Africa, Namibia and Malawi reveal a degree of coverage of accessibility greater than the other 9 countries. In Botswana, refugees cannot access health care services due to economic, geographic, cultural, linguistic and administrative barriers. amongst others (SPII & OSISA, 2012 p31). Out of the 22 papers reviewed, 7 (representing 31.8% of the literature) showed that health care services are available in Botswana but that refugees face language barriers and discrimination in health facilities. Hence, health care is only available to the nationals and not to refugees (Campbell, 2003; Makhema, 2007; Oucho & Ama, 2009; Williams and Crush, 2004).

Similarly, in Lesotho, the report suggests that refugees do sometimes face discrimination from health practitioners in public hospitals for being refugees. Many other barriers and challenges, including identification papers, language problems, and cultural problems were identified. Another challenge is the limited institutional capacity and partnerships among stakeholders (MIDSA, 2009). Likewise, in Swaziland, challenges in providing refugees with access to health care include the lack of data on migration for programming targeted interventions (Ibid). In Malawi, two problems that hampered utilization of health care services by refugees included insufficient staffing, and drugs in hospitals (SPII and OSISA, 2012).

In Angola, refugees access HCS in the same way as nationals do. No documentation is required to access health services. Despite the challenges in the health system, indications show that refugees have access to health facilities (Chigavazira et al., 2012). As is the case in Angola, the statutory body of Botswana does not have discriminatory tendencies in its HCS to refugees on the basis of non-nationality. However, the policy in Botswana requires that refugees are first registered and confined to a refugee camp before accessing health care. This is despite the possibility that refugees may have arrived in the country already exhibiting signs and symptoms of an illness. Waiting for the long process of registration and placement in a camp could therefore result in the deterioration of their health. Further research revealed that refugees are not included in the government's programme for free ARV provision and PMTCT care in Botswana (Chigavazira et al., 2012; Makhema, 2007; Oucho & Ama, 2009).

Affordability

Refugees are economically disempowered and consequently, affording health care services can become a challenge. Some countries in the region still charge refugees for utilization of HCS, regardless of their economic conditions. According to Mutembe (2007, p.11), "Under Zambian law, refugees have equal rights with citizens... In the past Zambian citizens had free access to health care, but now fees are charged to both refugees and the citizens". According to Carasso et al. (2012), only a few refugees can afford the fees for HCS. The authors noted that Zambia is experiencing an overburdened health care system due to the removal of user fees for

primary health care services. The situation in Botswana was described as similar to that of Zambia. Oucho and Ama (2009) conducted a quantitative study among refugees and asylum seekers, which revealed that refugees do not have access to reproductive health care services. They identified a specific age group of citizens (18–55 years, excluding pregnant women) who are charged a fee to access specific health care services, and which refugees also have to pay, regardless of their economic disempowerment.

Influenced by South Africa, the constitution of Mozambique is another milestone that guarantees the right to health care for all citizens, including refugees (Chigavazira et al., 2012, p55). Regardless of the constitution guaranteeing refugees the right to HCS, they still face challenges in accessing said services. The most cited challenge is the fact that the refugees in the country are camp-based, and cannot afford transport to public hospitals situated in the main cities (Ibid). The same applies to refugees in Malawi, where they have to travel a distance from the refugee camp to the health care centre (Chigavazira et al., 2012; Katy & Jeff, 2011; McDonald, 2001; Steinberg, 2005).

Acceptability

Anti-foreign attitudes in South Africa remain very high and impact negatively on the acceptability to utilization of HCS by refugees (SAMP, 2011). Specific to the case of South Africa and Namibia, findings have shown that non-acceptability to HCS is associated with discrimination and xenophobia. These have made it increasingly difficult to access health care services. There are many reasons for this, as the literature has shown, with one of these being the psychological fear of being attacked or excluded. As a result, many refugees resort to avoidance of medical and HCS (Crush et al., 2005; Nkosi, 2004; Oucho and Ama, 2009; Vaerey, 2010).

SAMP conducted a study in 2011 to investigate the South African health system's medical xenophobia. The study found that medical xenophobia existed and manifested itself through different ways, namely (1) the requirement that refugee patients produce identification documentation and proof of residence status before receiving treatment; (2) health professionals refusing to communicate with patients in English or allow the use of translators;

(3) treatment is sometimes accompanied with xenophobic statements, insults and other verbal abuse; (4) non-South African patients are required to wait until all South African patients have received medical attention, even if they have been waiting longer for treatment; and (5) refugees and asylum seekers have such difficulty accessing ARV for HIV in public hospitals that many are forced to rely on NGO treatment programmes (Crush & Tawodzera, 2014; Odhiambo 2012; SAMP 2011). These are signs of denied access to health care services.

The report reveals that in Lesotho and Swaziland, stigma and discrimination towards STIs, HIV and AIDS bring about fear to utilize HCS (MIDSA, 2009). In some instances, Zambia experiences language barriers resulting in refugees' receiving unfriendly service and experiencing feelings of unacceptability (MIDSA, 2009). Acceptability remains a challenge, although refugees may geographically access public hospitals. For example, a refugee, according to the Namibian Constitution, is 'a person who has been granted refugee status in terms of section 13(4)(a) 212.' This means that he/she becomes a refugee upon application. The implication is that sheltering of refugees whose applications have been approved is not as such a burden for Namibia, but the capacity shortages in HCS are (Allotey et al., 2012).

In a qualitative study conducted in Namibia, respondents reported good public health facilities, among which are reproductive health care, hospitals, HIV and AIDS education and prevention for refugees (Chigavazira et al., 2012). However, there are incidences where the country failed to treat refugees fairly and their basic rights were denied. According to Hathaway (2005), this was in order to prevent other refugees from arriving. According to the UNHCR (2013), refugees in Zimbabwe live in a camp where they access and utilize free health care services provided by the organization called Christian Care. On the contrary, Madagascar could not be included in the analysis because it hosts in total only nine refugees (UNHCR, 2013) and during our search, no literature was found documenting refugees and health-care seeking in Madagascar.

7. Conclusion

Access to health care services remains a challenge to refugees in Southern Africa. Ultimately, the importance of access to health care for all form of refugees is acknowledged widely, but limitations in the availability of resources prevent the full realization of this right. The state is therefore required to commit to the delivery of a set of services while also providing the fall-back that it meets its obligation in the context of available resources. Although the approach followed in this paper is not appropriate to generalise the findings for the whole region, it is, however, worthwhile to note that there are interconnections of barriers across countries hosting refugees in Southern Africa. Challenges of availability and affordability of drugs as well as the acceptability of the refugee individual by the health care workers and the community were the dominant barriers identified. Some other barriers specific to each country that were identified included but were not limited to language and cultural barriers, discrimination, policy and its implementation, health care workers xenophobia, and refugee documentation.

All countries in the region have the UN recommendations for refugees, but the adherence remains questionable. This report suggests that in order to address inaccessibility and poor utilization of HCS, planners in Southern Africa should involve local refugee communities in the planning and delivery of services. They should also develop coordinated actions between districts and agencies for some services, while recognizing the resource demands on practices with large numbers of refugees in the region, information and training on refugees' rights and the services available for this group should be provided for health care workers and support staff, such as receptionists and doorkeepers. In order to address the refugee health problems accordingly, all the countries in the region should review the policy and the UN Refugee Act binding the region.

Further research is encouraged in the region, especially in countries where data could not be found about refugees' situation. These countries include Swaziland, Lesotho, Mozambique, Namibia, Angola, Madagascar and Malawi.

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