

REALISING THE RIGHT OF ACCESS TO MATERNAL HEALTH CARE SERVICES FOR REFUGEE WOMEN IN SOUTH AFRICA

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Prepared by: Tatenda Sandra Mushanguri

Supervisor : Adv. Victoria Balogun (LLB, LLM)

University of KwaZulu-Natal

College of Law and Management Studies

School of Law

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Pietermaritzburg Campus

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DECLARATION

I, Tatenda Sandra Mushanguri, hereby declare that this thesis is original and has never been presented in any other institution. I also declare that any secondary information used has been duly acknowledged in this thesis.

Student: Tatenda Sandra Mushanguri

Signature: _____

Date: _____

Supervisor: Adv VA Balogun

Signature: _____

Date: _____

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ABSTRACT

South Africa hosts a large population of refugees from Africa and beyond. These refugees come to the country with their different needs. Some of the needs are gender-specific and require the realisation of specific human rights for them to be met. Refugee women require maternal health care services. South Africa has a number of policies and legislation aimed at protecting the rights of refugees, women, as well as the right to health. Furthermore, South Africa is a signatory of various human rights instruments relating to (amongst other things), refugee women and health care. Regardless of the international instruments, legislation and policies in place, there still exists a gap between policy and practice which makes it difficult for refugee women to access maternal health care services. Through the use of various literature, this thesis provides a discussion on the components of health care and defines what access to maternal health care is. It exposes the barriers faced by refugee women in South Africa's public health care system. The thesis provides an analysis of the numerous human rights instruments relating to refugees, health and women. It scrutinises South African domestic policies and legislation relating to maternal health care services. Landmark cases on the access to maternal health care services and other socio-economic rights are discussed in the thesis. In the final chapter, recommendations are made on how the maternal health care services for refugee women may be fully realised.

Key words: South Africa, right of access, maternal health care services, refugee women.

ACRONYMS

ACHPR	African Charter on Human and People's Rights 1981
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-retroviral treatment
AU	African Union
CEDAW	Convention on the Elimination of All Forms Discrimination Against Women 1979
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child 1989
CTOP	Choice on Termination of Pregnancy Act 92 of 1996
DHA	Department of Home Affairs
DOH	Department of Health
DRC	Democratic Republic of Congo
EU	European Union
HIV	Human Immune Virus
HRLN	Human Rights Law Network
IAWG	Intreagency Working Group
ICCPR	International Covenant on Civil and Political Rights 1966
ICESCR	International Covenant on Economic, Social and Cultural Rights 1966
ICPD	International Conference on Population and Development
IDPs	Internally Displaced Persons
IOM	International Organisation of Migration

MDGs	Millennium Development Goals
MISP	Minimum Initial Service Package for Reproductive Health in Crisis Situations
MNCWH	Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition in South Africa 2012-2016
NCCEMD	National Commission for Confidential Enquiries into Maternal Deaths
NHA	National Health Act 61 of 2003
NHP	National Health Policy
NMM	Ngaka Modiri Molema
NPRC	National Patients' Rights Charter
PAIA	Promotion of Access to Information Act 2 of 2000
PEPUDA	Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000
PHC	Primary Health Care
PRECCA	Preventive and Combatting of Corruptive Activities Act 12 of 2004
RRO	Refugee Reception Office
RSD	Refugee Status Determination
RSDO	Refugee Status Determination Officer
SADC	Southern African Development Community
SRHRC	Sexual and Reproductive Health and Rights Continental Policy Framework
STDs	Sexually Transmitted Diseases
UDHR	Universal Declaration of Human Rights 1948
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
USA	United States of America
WHO	World Health Organisation
WRC	Women's Refugee Commission

CHAPTER ONE

INTRODUCTION

1.1 Background

South Africa is one of the largest economies in Africa and has been ranked by the World Bank as an “upper-middle income country”.¹ The country has a Constitution² which is regarded as the best in the world,³ admired and respected around the globe,⁴ as it upholds the fundamental values of equality, freedom and human dignity.⁵ This Constitution promotes and protects, amongst other rights, the right to health care services, including reproductive health care.^{6 7} Maternal health care services, which include (but are not limited to) the use of skilled birth attendants, contraception, family planning, nutrition and education fall within the scope of reproductive health, and they are aimed at improving the mother’s health at the preconception, prenatal, delivery and postnatal phases.⁸ These are major pull factors, as they attract people to come to South Africa. This explains why South Africa has become a primary destination for a number of refugees and asylum seekers who migrate from neighbouring countries and beyond.⁹

South Africa has acceded to the 1951 Convention Relating to the Status of Refugees (Refugee Convention) and its 1967 Protocol,¹⁰ and to the 1969 Organisation of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa (OAU

¹ Southafrica.info ‘South Africa: economy overview.’ (28 February 2013). Available at www.southafrica.info (Accessed on 7 May 2014).

² The Constitution of the Republic of South Africa, 1996.

³ Media Club South Africa. ‘Eighteen years of the world’s best Constitution’. (11 December 2014). Available at www.mediaclubsouthafrica.com (Accessed on 17 March 2015).

⁴ *Ibid.* ‘South Africa’s Constitution’.

⁵ Section 1 (a).

⁶ Section 27 (1) (a).

⁷ Reproductive health is a state of complete physical, mental and social well-being, and not merely absence of disease or infirmity. Reproductive health deals with the reproductive processes, functions and systems at all stages of life. (United Nations Population Information Network (POPIN) UN Population Division, Department of Economic and Social Affairs, with the support from the UN Population Fund (UNFPA): Guidelines on Reproductive Health), available at www.un.org/popin/unfpa/taskforce/guide/iatfreph.gdl.html. (Accessed on 16 March 2015).

⁸ M Kimani, ‘Investing in the health of Africa’s mothers.’ *Africa Renewal* Vol 21 no 4 214 maternal health (2008) 8.

⁹ Consortium for Refugees and Migrants in South Africa (CoRMSA) ‘Protecting refugees and asylum seekers in South Africa, Johannesburg’. CoRMSA 2008, available at www.lhr.org.za/files/cormsa08-final.pdf. (Accessed on 16 March 2015).

¹⁰ 1967 Protocol Relating to the Status of Refugees.

Convention). They provide standards and principles which should be adhered to in the reception and treatment of refugees in the various member states' territories. In cognisance of these instruments, the country has promulgated the Refugees Act 130 of 1998 (the Act), which outlines the rights and duties of refugees in South Africa in Chapter Five. In terms of section 27 (g) of the Act, refugees should get the same services as indigenes when it comes to medical treatment. In simple terms, there should be no differentiation whatsoever in terms of how refugees, citizens and permanent residents should be treated in medical facilities. However, in practice, it is not so, as refugees are faced with various challenges which make it hard for them to access health care services, in particular maternal health care services. Despite many existing challenges, xenophobia¹¹ seems to be the most pronounced and influential of them all. Researchers have noted that South Africa is a highly xenophobic society; with media reports from 2008 and 2015 indicating that xenophobic violence is deadly for migrants.¹² This clearly indicates the gap that exists between policy and practice. The challenge then is how the gap between policy and practice may be reconciled in light of the law in a xenophobic environment.

1.2 Distinguishing between an asylum-seeker and a refugee

The International Organisation of Migration (IOM) defines an asylum-seeker as a person who seeks safety from persecution, or serious harm in a country other than his or her own and awaits a decision on an application for refugee status under the relevant international and national instruments.¹³ Conversely, a refugee is:

a person who, due to a founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear is unwilling to avail himself of the protection of that country; or who, not having a nationality or being outside the country

¹¹ Xenophobia is a hatred or fear of foreigners. (W Branford & D Thompson, *South African Pocket Oxford Dictionary of Current English*. 1994).

¹² L Landau, 'Xenophobia in South Africa and problems related to it.' (2005), 3 Johannesburg: University of the Witwatersrand. (Forced Migration Working Paper Series). See also S Jost *et al*, in 'The effects of xenophobia on the integration of migrants in South Africa: An NGO perspective.' (Aug-Sep 2012), available at www.iom.int. (Accessed on 17 March 2015). See also K Ruble, 'We Are Not Safe at All': Immigrants in South Africa Live in Fear Following Deadly Xenophobic Attacks'. (29 April 2015) Available at <https://news.vice.com/article/we-are-not-safe-at-all-immigrants-in-south-africa-live-in-fear-following-deadly-xenophobic-attacks>. (Accessed on 15 January 2016). See also A Ramkissoo *et al* Sexual and Reproductive Health and Rights. Available at http://www.healthlink.org.za/uploads/files/sahr10_3.pdf pg 42. (Accessed on 15 January 2016).

¹³ IOM, glossary on migration, International Migration Law Series No.25, 2011.

of his former habitual residence as a result of such event unable or, owing to such fear, is unwilling to return to it.¹⁴

The OAU Convention of 1969 broadens the definition of refugee to:

Everyone, who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole country of origin or nationality is compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality.¹⁵

The same definition is adopted in section 3 (b) of the Refugees Act 130 of 1998. The Act in section 3 (c) also defines a refugee as anyone who is a dependent of any of the categories of refugees mentioned above. It is quite clear that asylum-seekers and refugees differ in that the former are persons who have applied for recognition as refugees, and are still awaiting the determination of their statuses, and the latter being those who would have already received such recognition from the host state. For the purposes of this study the term “refugee” shall also apply to asylum seekers as they, like refugees, enjoy the same rights as South African citizens in terms of the section 22 permit.¹⁶

1.3 Refugee rights as recognised human rights

Refugee rights are guaranteed by refugee law which emanates from treaty law, customary international law, regional instruments and municipal legislation. Refugees enjoy the basic human rights enjoyed by all people, but other specific human rights apply to refugees due to their circumstances.¹⁷ Balogun and Durojaye state that human rights are useful, as they empower disadvantaged and marginalised groups in society, such as women.¹⁸ One could add that refugee women are even more disadvantaged, as opposed to other women, as they

¹⁴ Article 1A (2) 1951 Refugee Convention. See also section 3(a) of the Refugees Act 130 of 1998.

¹⁵ Article 1(2).

¹⁶ A temporary, renewable permit described in section 22 of the Refugees Act 130 of 1998, which is issued to asylum seekers while they await their decision on their asylum application and allows the bearer to reside, study and work in South Africa. Available at www.blacksash.org.za/index.php/your-rights/refugees-and-asylum-seekers/item/refugees-and-asylum-seekers (Accessed on 23 March 2015).

¹⁷ Volunteer Refugee Tutoring & Community Support. Available at www.refugeetutoring.org/what-are-the-refugees-rights-under-international-law. (Accessed on 3 April 2015).

¹⁸ ‘The African Commission on Human and Peoples’ Rights and the promotion and protection of sexual and reproductive rights’. (2011) Vol 11 No2 *African Human Rights Law Journal* (AHRLJ) pp 368-395.

are often forgotten on the international agenda,¹⁹ whereas about 25% of refugees globally are women of a reproductive age, as noted by Jamison *et al.*²⁰

Scholars are of the opinion that refugee law is a response to the *absence* of human rights and is one of the most powerful means to *restore* human rights.²¹ It could be argued that refugee law is neither a response to an “absence of human rights” nor a “means to restore rights”. It is rather a response to the failure of a country to recognise the human rights of its people, resulting in them seeking asylum in other countries. Human rights cannot be regarded as “absent” at any point in time, as they are inalienable, that is, they cannot be parted with. Article 1 of the Universal Declaration of Human Rights (UDHR) stipulates that all human beings are born free and are equal in dignity and rights.²² A person cannot lose their human rights any more than they can cease being a human being.²³ According to the United Nations High Commissioner for Refugees (UNHCR), people become refugees as a result of violations or threats to their basic human rights.²⁴ In line with this view of the UNHCR, Amnesty International (an international human rights body) defines a refugee as a person who has fled their own country because they have suffered human rights abuses or because of who they are and what they believe in. Their own government cannot and will not protect them and so they are forced to seek international protection.²⁵ When people seek asylum in other countries it does not mean that their rights have ceased to exist, but merely that those rights have ceased to be recognised. Factors such as abuse and threats to basic human rights are what lead to the cessation of their recognition. This implies that, upon their arrival in a country of asylum, refugees ought to receive preferential treatment over other categories of migrants, as they would have been forced to leave their home countries due to undesirable circumstances threatening their lives. For that reason, refugee law cannot

¹⁹ G Camus-Jacques “Forgotten majority” in G Loescher & L Monetam (Eds) *Refugees and International Relations* (1989) 148.

²⁰ DJ Jamieson *et al.*, ‘An evaluation of poor pregnancy outcomes among Burundian refugees in Tanzania’ *Journal of the American Medical Association* (2000) 283 (3): 397-402. Available at <http://jama.jamanetwork.com/article.aspx?articleid=192302> (Accessed on 3 April 2015).

²¹ JC Hathaway, JE Dagan & SA Dagan *Human Rights and Refugee Law*. Edward Elgar Publishing (2014) 1.

²² UNFPA ‘Human Rights Principles’ (2005). Available at www.unfpa.org/resources/human-rights-principles (Accessed on 30 March 2015).

²³ N Flowers (ed) *Human rights here and now. Celebrating the Universal Declaration of Human Rights*. Available at www1.umn.edu/humanrts/edumat/hreduseries/hereandnow/Part-1/whatare.htm (Accessed on 30 March, 2015).

²⁴ Available at www.unhcr.org/pages/4ab388876.html. (Accessed on 30 March, 2015).

²⁵ ‘People on the Move’. Available at www.amnesty.org/en/what-we-do/people-on-the-move/ (Accessed on 30 March 2015).

be said to be aimed at restoring basic human rights to refugees. In actual fact, its purpose is to revive the basic human rights of refugees. Hence refugee rights are basic human rights.

1.4 Maternal health care services as fundamental human rights

Human rights are fundamental and they are guaranteed to every person by virtue of them being a human being. Similarly, maternal health care services are essential to every woman by virtue of her being in her reproductive phase. Human rights and maternal health care services are intertwined, in that human rights can enhance accountability for preventable maternal mortality.²⁶ If health care workers are aware of the rights of their patients, they will be equally aware of their duty to exercise diligence in the performance of their duties towards them. Maternal health care services are peculiar to women, in that naturally they are the ones who bear children and should be able to access them, to curb maternal mortality, which is one of the objects of the Millennium Development Goals (MDGs).²⁷ When it comes to child-bearing, special attention should be given to the wellbeing of women. According to Cook *et al*, ‘A woman is not a womb, but has a womb.’²⁸ This could mean that a woman is not only good for childbearing, but that her womb (which enables her to reproduce) should be taken care of through effective maternal services. Quality sexual and reproductive health care services should be made available to women as a way of protecting their autonomy, dignity and right to life.²⁹ The right of access to maternal health care services emanates from the fact that maternal health cannot be separated from human rights. There would be no need to make provision for maternal health care services in health care institutions if such were not considered as essential, due to a woman’s biological role.

²⁶ Report of the office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights. Geneva: United Nations High Commissioner for Human Rights; 2010, available at <http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.H.RC.14.39.pdf>. (Accessed on 17 March 2015).

²⁷ Millennium Development Goal number 5 (MDG5) aimed at reducing maternal mortality by three-quarters and achieving universal access to universal reproductive health by 2015.

²⁸ RJ Cook, BM Dickens & MF Fathalla *Reproductive health and human rights*. Oxford University Press (2003).

²⁹ MI Plata ‘Reproductive Rights as Human Rights’ in R Cook (ed) *Human Rights of Women: National and International Perspectives* (1994).

1.5 Hypothesis, aims, objectives and research questions

This thesis is based on the preliminary assumption that the government of South Africa has failed to make maternal health care services accessible to refugees within its territory. Laws protecting the rights of refugees have been promulgated, but their interpretation is very different from the reality faced by refugee women in accessing maternal services in public health institutions. This thesis investigates the realisation of maternal services to refugees in South Africa. It considers the barriers in accessing maternal services for refugees in an environment characterised by xenophobic sentiments. The broader aim is to emphasise the importance of making maternal services accessible to refugee women in South Africa in light of Millennium Development Goal number 5 (MDG5) as they are a vulnerable group of people. The objectives of the thesis are as follows:

1. To study the realisation of maternal services to refugee women since the promulgation of the Refugees Act 130 of 1998.
2. To identify the challenges associated with the realisation of maternal services to refugee women residing in South Africa.
3. To identify the gaps in South Africa's maternal health policies.
4. To make recommendations on the realisation of access to maternal services to refugee women in South Africa.

In light of the preceding assumptions, the following questions will be used in this thesis to obtain answers:

1. What are the obligations of the South African government to promote, protect and fulfil the right of access to maternal health care services for refugee women?
2. To what extent do the perceptions of health care workers influence the right of refugees to access maternal health care services?
3. What are the barriers to maternal health care services for refugees in South Africa?
4. What can the government of South Africa do to fully realise the right of access to maternal health care services for refugee women, to address the gap between policy and practice?

1.6 Methodology

This thesis is desk-based and utilises readily available data for analysis. A secondary analysis of qualitative data is being adopted, since access to maternal services involves how human beings are being treated in state-owned health institutions. Information on such treatment is usually ascertainable through sources like books, peer reviewed journal articles, relevant thesis and reliable internet sources. Newspaper articles are being used where authenticity can be ascertained. A secondary analysis of qualitative data is being conducted as it gives a better understanding of the challenges faced by refugees as they access maternal services in government health institutions.

1.7 Rationale

This thesis emphasises the importance of making maternal health care services accessible to refugee women in South Africa as they are inalienable.³⁰ Reproductive health care is a crucial element in giving refugees the basic welfare and dignity that they deserve.³¹ The main motivation for this work is the vulnerability of refugee women who, due to lack of security in their countries of origin, have come to South Africa to seek, amongst other things, maternal services. The thesis is therefore significant as it tries to identify any loopholes within the domestic, regional and international laws which promote access to maternal services within the context of South Africa. To add to that, it identifies various factors which influence failure of refugees' access to maternal services. Furthermore, there are suggestions on the improvements that can be made to the government's health policies within the legal context, in the concluding chapter of this work.

1.8 Scholarly views on maternal health care services

Although scholars in various jurisdictions have written on the subject of maternal health care services, little has been written on access to maternal health care services within the South African context. Furthermore, not much has been written on the subject from a legal perspective and the same is true for South Africa. Several South African scholars have written on other issues affecting refugees, or just their health care in general. Therefore this thesis attempts to close the gap as it is focused on the right of access to maternal health care services for refugee women in South Africa.

³⁰ Article 30 of the Universal Declaration of Human Rights 1948.

³¹ Note 7 above.

Several scholars opine that women should receive appropriate maternal health care. Cook observes that not having obstetric services, prenatal care and similar reproductive health care services leads to high maternal and morbidity rates which are preventable.³² The scholar adds that women's right to life is the right which is mostly violated by avoidable death.³³ Cabal and Stoffregen hold the view that not having maternal health care services violates the right to life.³⁴ Tsawe *et al* believe that maternal health care helps reduce maternal and infant mortality.³⁵ They state that maternal health care is important, as it influences the overall health outcome of the mother and child.³⁶ All these views show the importance of the accessibility of maternal health care services. In various cases in which the courts ruled that women had the right to survive pregnancy to save their lives, the women had already died or experienced great harm due to lack of access to maternal health care services.³⁷ In other cases within South Africa, mothers claimed damages from state health institutions for negligence or delays in the provision of maternal health care services, resulting in birth defects in their children.³⁸ All this is evidence enough that access to maternal health care services prevent and reduce maternal and child mortality and morbidity.

³² R Cook, *Women's Health and Human Rights*, (1994) 10. See also MJ Toole & RJ Waldman, 'Women's and Children's Healthcare Services' in MH Merson, RE Black & AJ Mills, *Global Health* (2012) 589.

³³ *Ibid.* 10 (R Cook).

³⁴ 'Calling a Spade a Spade: Maternal Mortality as a Human Rights Violation.' (2009), 2. Available at <http://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1040&context=hrbrief> (Accessed on 3 May 2015).

³⁵ M Tsawe, A Moto, T Netshivhera *et al*, 'Factors influencing the use of maternal healthcare services and childhood immunization in Swaziland.' *International Journal for Equity in Health* (2015) 14:32, 1.

³⁶ *Ibid.*

³⁷ *CHARM v. State of Bihar and Others C.W.J.C. No. 7650/2011*. Available at <http://www.reproductiverights.org/sites/crr.civicaactions.net/files/documents/CHARM%20factsheet%20FINAL%2010.7.11.pdf> (Accessed on 25 May 2015). See also *Jaitun v Maternity Home, MCD, Jangpura & Ors* W.P. No. 10700/2009 and *Laxmi Mandal vs Deen Dayal Hari Nager Hospital & Ors* W.P. 8853/2008. Available at http://www.who.int/pmnch/media/news/2010/20100604_mm_india/en/ (Accessed on 25 May 2015).

³⁸ *Sonny and Another v Premier of the Province of KwaZulu-Natal and Another* 2010 (1) SA 427 (KZP). See also *H v Fetal Assessment Centre* 2015 (2) SA 193 (CC). See also S Regchand, 'Six moms sue MECs for negligence' (18 November 2015); an article on the current cases in the Pietermaritzburg High Court in which six mothers are claiming damages from public health care institutions for delays and negligence during labour resulting in birth defects in their children. Available at <http://www.iol.co.za/news/crime-courts/six-moms-sue-mecs-for-negligence-1.1947376#.VIAv3fkUHK8> (Accessed on 21 November 2015). See also, I Oellermann, 'Six mothers sue health' (18 November 2015). Available at <http://www.news24.com/SouthAfrica/News/six-mothers-sue-health-20151117> (Accessed on 21 November 2015).

A study was carried out on the right to reproductive health care for internally displaced women in Nakuru, Kenya.³⁹ The study was aimed at finding out if the women staying in a camp for internally displaced persons (IDPs) faced any challenges in accessing quality, affordable maternal health care. The finding was that most of them could not afford medical care and the health care facilities were geographically inaccessible. Health care facilities were not available at all in camps. Most of the problems were caused partially by the government's failure to adopt and implement policies to care for the maternal health care needs of internally displaced women. The present study is highly relevant but was based on the maternal rights of IDPs and not on people who have migrated across borders in search of refuge.

In Tanzania, a study was carried out among Burundian refugees in a camp, to assess how the risk factors associated with poor pregnancy contributed to child mortality amongst Burundian refugee women.⁴⁰ The study revealed that factors such as disparities, previous high socio-economic standing, malaria during pregnancy, first or second time pregnancy and the discontinued use of contraceptives in the country of asylum were the leading causes of maternal mortality.⁴¹ Whilst this study revealed the causes of pregnancy-related deaths amongst Burundian refugees, it did not outline what the role of Tanzania is in the provision of maternal health care services as a host state to Burundian refugees. It mainly focused on the causes of maternal deaths amongst the refugee women and no other causes which are linked to Tanzania's obligations under international refugee law. It is important to note that refugees in South Africa do not reside in camps, but integrate into communities as there are no refugee camps. This implies that health service provision to refugees in South Africa is different as compared to other countries where there are refugee camps, as shall be highlighted later on.

Dass *et al.* state that the health care needs of refugees in South Africa are not being fully met and that there is 'a gap between the practice and the law and the policy.'⁴² These authors point out that this gap is highly influenced by discrimination and dislike of

³⁹ JA Nyagol, 'Realising the right to reproductive health: An analysis of maternal health care challenges in internally displaced persons (IDP) camps in Nakuru County, Kenya.' (2012), 18-19. Available at http://www.searcwl.ac.zw/index.php?option=com_docman&task=doc_download&gid=156&Itemid=89 (Accessed on 13 May 2015.).

⁴⁰ See note 20 above (DJ Jamieson *et al.*).

⁴¹ *Ibid.*

⁴² F Khan & T Schreier (Eds) *Refugee Law in South Africa*. JUTA, 2014.

foreigners. They identified the gap and the factors that contribute towards it in the context of health care in general, but did not focus on one particular aspect of health care nor of refugee women as a vulnerable group of people. Cook stresses that the threat to survival of a woman must not be judged on an individual basis, but also on her membership of a particular group, susceptible to a high risk of mortality and morbidity.⁴³ One could agree with this view, in that when providing reproductive health care services to women, states should not look at the women as one single group, but should identify the different categories or sub-groups within the group, such as refugee women, as they are often forgotten during policy-making.⁴⁴ The scholar adds that these collective rights of women place an obligation on the state to provide appropriate health care services, education and counselling, so as to minimise risks.⁴⁵ This concept of collective rights for a particular group brings to mind the importance of refugee law, as it upholds refugee rights. It is thus important for states like South Africa hosting refugees to create and implement suitable policies for refugee women, as they are a particular group of women vulnerable to maternal mortality and morbidity.

Scholars reason that in South Africa, legal instruments and policies are no longer the main impediments to universal access to health care services, but other factors such as disease, extreme disparities in income or general poverty.⁴⁶ In other words, failure to access health care needs in South Africa cannot be blamed on the current laws and policies. Ngwena, like Dass, agrees that there is a gap between policy, law and practice, but is of the opinion that the gap is caused by other factors too and not merely loopholes within the law and policies. While this argument is true, it fails to acknowledge that perhaps there are some loopholes within those policies and legal instrument which still impede the realisation of health care in South Africa. In Chapter Two, there is a discussion on the ambiguities and contradictions within some health care policies, which present a barrier to access to health care. Fathalla *et al.* maintain that the information and the means to achieve sexual and reproductive health for everyone are there.⁴⁷ They question the political and financial will

⁴³ See note 32 above (R Cook) 24.

⁴⁴ See note 19 above (G Camus-Jacquies) 148.

⁴⁵ See note 32 above (R Cook) 24.

⁴⁶ C Ngwena, 'The recognition of access to health care as a human right in South Africa: Is it enough?' *Health and Human Rights* Vol.5, No.1, 26-44 JSTOR (2000).

⁴⁷ MF Fathalla, SW Sinding, A Rosenfield & MMF Fathalla, 'Sexual and reproductive health for all: a call for action'. *The Lancet*, 2009. Vol 368 Issue 9552 December 9, (2006), Pages 2095-2100. Available at <http://www.sciencedirect.com/science/article/pii/S014067360669483X> (Accessed on 5 November 2014).

through which the means and the information may be utilised.⁴⁸ In other words, the ideas and the ways of achieving sexual and reproductive health care for all are there. The only things that are lacking are the resources and the motivation from political leaders who can help in the implementation of policy. One could agree with this, as there are various health care policies in place, but which are not being implemented in practice. This is especially true regarding refugee women's access to maternal health care services.

In a study carried out by Onouha, it was noted that one of the major barriers to refugees and asylum seekers accessing health care services was the assumption that all migrants are illegal and constitute financial strain on the government coffers.⁴⁹ Subsequently, refugees face unfair discrimination in state hospitals as they are made to wait in queues for several hours, only to be pushed to the back of the queue by health workers when it is their turn to receive treatment.⁵⁰ Such treatment from health care workers shows that foreigners and refugees are not welcomed in public health care institutions. This makes refugees reluctant to go to the public health care institutions even though maternal health care is offered without payment.

1.9 Conclusion

In a nutshell, refugees are protected by international, regional and domestic refugee law since they do not have the protection of their countries of origin. Maternal health care services are fundamental human rights and should be accessible to every woman regardless of her prevailing circumstances. However, refugees in South Africa face difficulties in accessing maternal health care services. Therefore, Chapter Two will examine the barriers to access to maternal health care services for refugee women in South Africa. It will also define the scope of access to maternal health care services through an analysis of the work of different scholars.

⁴⁸ Ibid.

⁴⁹ 'Chapter Five: Major Problems of Refugees in South Africa', (2006) Available at http://wiredspace.wits.ac.za/bitstream/handle/10539/1536/05Enwere_Chapter5.pdf? (Accessed on 5 November 2014).

⁵⁰ P Naicker & R Nair 'To be a refugee in South Africa'. *Track Two*, Vol 9 No 3, (2000).

CHAPTER TWO

BARRIERS TO ACCESS TO MATERNAL HEALTH CARE SERVICES FOR REFUGEE WOMEN

2.1 Introduction

Understanding women's right to health is pivotal. If a woman becomes ill or incapacitated, the entire family structure is likely to collapse.⁵¹ This cannot be rebutted concerning refugee women, whose family structures would have already been affected by forced migration.⁵² Refugee women have been referred to as the 'forgotten majority'⁵³ as, among other challenges they face, they have also been forgotten on the international agenda.⁵⁴ This chapter is an analysis of the literature on the realisation of access to maternal health services in South Africa. In this chapter, the meaning of the term "right of access" in relation to maternal health care services will be derived from the views of leading authorities on the subject. Barriers to the right of access to maternal health services will be identified. The chapter also includes an analysis of journal articles on the general health care system of South Africa. Several articles on the reproductive rights of refugees will be reviewed in a bid to establish the gap between law, policy and practice, in terms of refugee rights to access maternal services in South Africa.

2.2 The right of access to health care

Enshrined in the 1996 Constitution⁵⁵ is the right of access to health care, water and social security.⁵⁶ This right is guaranteed to "everyone".⁵⁷ In the case of *Khosa*,⁵⁸ the applicants alleged that the exclusion of non-citizens from getting social grant entitlements was unconstitutional, based on the equality clause (section 9) and section 27(1) (a) of the 1996 Constitution, which guarantees the right to health care, food, water and social security. The Constitutional Court held that the word "everyone" referred to citizens and those with

⁵¹ See note 19 above (G Camus-Jacquies) 148.

⁵² United Nations *Compendium of Recommendations on International Migration and Development: The United Nations Development agenda and the Global Commission on International Migration Compared* (2006) pp24. Available at www.un.org/esa/population/publications/UN_GCIM/UN_GCIM_ITTMIG.pdf (Accessed on 4 May 2015).

⁵³ Note 19 above (G Camus-Jacquies) 148.

⁵⁴ M Hajdukowski-Ahmed *Not Born A Refugee Woman: Contesting Identities, Rethinking Practices* (2013).

⁵⁵ The Constitution of the Republic of South Africa, 1996.

⁵⁶ *Ibid.* Section 27.

⁵⁷ *Ibid.* Section 27(1).

⁵⁸ *Khosa and Others v Minister of Social Development and Others* 2004 (6) SA 505 (CC).

permanent residence, thus excluding temporary residents such as refugees.⁵⁹ Refugees cannot receive health care services, as they are temporary residents who cannot be classified as “everyone,” as construed by the Constitutional Court. This somehow infringes on the right to dignity that refugees have in that they are not distinguished from other types of temporary residents or migrants who are often said to be straining the few available state resources.⁶⁰ Furthermore, refugees ought to be treated with dignity by virtue of being human.⁶¹ Refugee status might be temporary, but for the purposes of meeting international obligations towards refugees, section 27(g) of the Refugees Act 130 of 1998 (the Act) provides that refugees should receive the same treatment as citizens when it comes to medical issues.

Importantly, after mentioning the right of everyone to have access to health care services, the 1996 Constitution specially mentions the right to reproductive health care.⁶² One then wonders whether reproductive health care services are not part of the health care services in general. Why is there no special mention of other health care services? It is worthy of note that in the Constitution of the Republic of South Africa Act 200 of 1993 (the Interim Constitution) there was no provision for reproductive health rights *per se*. The right to health was mentioned in section 29, which provided for the right to an environment which is not detrimental to one’s health or well-being. The special mention of reproductive health services in the 1996 Constitution could be explained by the *Travaux Préparatoires* which provided guidelines on how the South African legislators were to include socio-economic rights in the 1996 Constitution, to align it with the provisions of the International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966).⁶³ Furthermore, the inclusion of reproductive rights in the 1996 Constitution is explained by the *Certification Case*⁶⁴ which served the purpose of determining if the provisions of the proposed new (1996) Constitution were in line with the principles of the Interim Constitution.⁶⁵

⁵⁹ Ibid. Para 59.

⁶⁰ See note 49 above (‘Chapter Five’).

⁶¹ See the case *Minister of Home Affairs and Others v Watchenuka and Another* 2004 (4) SA 326 (SCA), 2004 (2) BCLR 120 in para 25 where the Court mentioned that all people are entitled to their dignity guaranteed in section 10 of the Constitution, regardless of their nationality or their reason for being in South Africa.

⁶² Section 27(1) (a) Constitution, 1996.

⁶³ K McLean, *Constitutional Deference, Courts and Socio-economic Rights in South Africa*. (2009),15

⁶⁴ *Certification of the Constitution of the Republic of South Africa*, 1996 (CCT 23/96) [1996] ZACC 26; 1996 (4) SA 744 (CC); 1996 (10) BCLR 1253 (CC).

⁶⁵ Ibid. Par 1.

It is also worth noting that the Constitution was first adopted by the Constitutional Assembly in May 1996 and only signed into law in December of the same year. This was two years after the International Conference on Population and Development (ICPD), where the Millennium Development Goals (MDGs) 4 and 5⁶⁶ were adopted. Scholars opine that though sexual and reproductive health is not one of the MDGs, realising the right of access to sexual and reproductive health services will certainly help in meeting the MDGs.⁶⁷ Therefore the special mention of reproductive health care in the Constitution could have been made in cognisance of MDGs 4 and 5. Upholding people's rights to sexual and reproductive health would meet the MDGs in many ways.⁶⁸ Thus reproductive health, particularly maternal health, is crucial to the existence of the human race and should be given special attention.

It could be reasoned that most rights find their origin in maternal health rights. In *S v Makwanyane*,⁶⁹ *orbita dicta* was made that the rights to life and dignity are the most important human rights and the source of all the other personal rights outlined in Chapter Three.⁷⁰ It could be justified to refer to maternal health rights as the “mother of all rights,” in that without being born, one cannot enjoy all the other human rights. In a landmark judgment passed in the Delhi High Court in India it was held that a woman has a constitutional right to survive pregnancy.⁷¹ This right was derived from the right to life prescribed in the Indian constitution.⁷² This judgement indicates that the failure of a state to provide maternal health care services to its female citizens grossly violates their human

⁶⁶ MDG 4 Aimed at reducing child mortality by 2015; MDG 5 Aimed at improving maternal health by 2015. Available at www.undp.org/content/undp/en/home/mdgoverview.html (Accessed on 6 May 2015).

⁶⁷ See note 12 above (*A Ramkissoo et al*) 34.

⁶⁸ H Benn, ‘Sexual and reproductive health rights.’ A position paper (2004). Available at http://www2.ohchr.org/english/issues/development/docs/rights_reproductive_health.pdf (Accessed on 5 May 2015).

⁶⁹ *S v Makwanyane and Another* (CCT3/94) [1995] ZACC3.

⁷⁰ Chapter 3- Fundamental Rights in the Interim Constitution. Available at <http://www.gov.za/documents/constitution/constitution-republic-south-africa-act-200-1993> (Accessed on 5 May 2015).

⁷¹ See note 37 above (*CHARM v Bihar*). See also K McBroom, ‘Why we need legal accountability for maternal health’ (2015). Available at <https://copasah.wordpress.com/page/2/?app-download=ios> (Accessed on 25 May 2015). See also CJ Pieterse, ‘Reproductive justice, public policy, and abortion on the basis of fetal impairment: lessons from the international human rights law and the potential impact of the Convention on the Rights of Persons with Disabilities. (Issues of Reproductive Rights: Life, Liberty, and the Pursuit of Policy).’ *Journal of Law and Health*, Volume 28 (2015).

⁷² Article 21 Indian Constitution, ‘No person shall be deprived of his life or personal liberty except according to procedure established by law.’ Available at http://india.gov.in/sites/upload_files/npi/files/coi_part_full.pdf (Accessed on 25 May, 2015).

rights. With regard to abortion, pro-life⁷³ supporters argue that life starts at conception, even though only as a cell.⁷⁴ The unborn baby has a distinct, unchanging and unrepeatable genetic code, unique in all of history, from the moment of conception until death and nothing is added except nutrition and oxygen.⁷⁵ However, the South African legal system follows a pro-choice approach which states that life only starts at birth.⁷⁶ In South Africa, life only starts at conception where the *nasciturus* fiction is applicable.⁷⁷ A government's systematic failure to protect maternal health can violate a number of women's fundamental human rights, such as the right to life, health, equality, information, education and freedom from discrimination.⁷⁸ Failure on the part of the government to protect maternal health rights not only violates a woman's right to life, but also that of the unborn child.

State health policies should comply with international law. South Africa is a signatory to various international and regional instruments which are aimed at the realisation of health care.⁷⁹ Its health policies are also influenced by soft law relating to health care.⁸⁰ These international law provisions will be discussed in detail in Chapter Three. Ensuring the realisation of maternal health rights influences the right to life as this could decrease infant

⁷³ Advocating full legal protection of embryos and fetuses (especially opposing the legalization of induced abortions). Available at www.thefreedictionary.com/pro-life. (Accessed on 4 May 2015).

⁷⁴ '10 Reasons Why Abortion is Evil & Not a "Pro-Choice".' Available at www.tfpstudentaction.org/politically-incorrect/abortion/10-reasons-why-abortion-is-evil.html. (Accessed on 4 May 2015).

⁷⁵ JC Willke & BH Willke *Why Can't We Love Them Both?* Available at http://www.abortiofacts.com/online_books/love_them_both/why_cant_we_love_them_both_10.asp. (Accessed on 3 May 2015).

⁷⁶ Section 2 of the Choice on Termination of Pregnancy Act 92 of 1996 (CTOP Act) provides for the situations in which a woman may terminate her pregnancy. See also *Christian Lawyers Association v Minister of Health* 1998 (11) BCLR 1434 (T) SA 1113 (T) where the plaintiff challenged the provisions of the CTOP Act on the basis that they violated the right to life guaranteed in section 11 of the Constitution. The Court held that the word 'everyone' in section 11 of the Constitution did not include the unborn, as they do not have legal personality and according such a right to the unborn would infringe on various rights of the mother.

⁷⁷ *Nasciturus* fiction is as a fiction that the foetus is regarded as having been born at the time of conception whenever it is to the foetus' advantage, provided that the child is subsequently born alive. Available at <http://wikistudent.ws/wiki/images/4/4e/PVL101Q-UNIT3.pdf> (Accessed on 15 January 2016).

⁷⁸ See note 34 above (L Cabal & M Stoffregen), See also article 4 (1) of the African Women's Protocol which stipulates that every woman shall be entitled to respect for her life.

⁷⁹ See article 12 of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW). Available at <http://www.ohchr.org/Documents/ProfessionalInterest/cedaw.pdf> (Accessed on 3 May 2015). See also article 12 of International Covenant on Economic, Social and Cultural Rights (ICESCR). Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/ICESCR.aspx> (Accessed on 3 May 2015). See also article 14 of Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. Available at http://www.achpr.org/files/instruments/womenprotocol/achpr_instr_proto_women_eng.pdf (Accessed on 3 May 2015).

⁸⁰ For example, article 25 of Universal Declaration of Human Rights (UDHR) (1948). Available at http://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf (Accessed on 2 May 2015). See also World Health Organisation (WHO) Constitution (1946). Available at http://www.who.int/governance/eb/who_constitution_en.pdf (Accessed on 3 May 2015).

mortality at birth. Although the 1996 Constitution emphasises the realisation of reproductive health care rights, some barriers still exist which make it difficult or impossible for refugees to access maternal health care and services. These barriers affect health workers⁸¹ as well as refugees. However, before a discussion of these barriers to health care, it is important to define what access to maternal health services entails in relation to the various factors discussed below.

2.3 The scope of maternal health care services

Maternal health services include services such as contraception, use of skilled birth attendants and access to abortion. It is worth noting that maternal health care services are categorised under sexual and reproductive health. Sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system, and allows people to have a satisfying safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so.⁸² All these are health care services; thus the factors which determine access to health care services also apply to maternal health services. It is worth mentioning that that these services are exclusive to women (female persons of any age)⁸³ in their reproductive age. There are five main factors which determine access to health care. All of these factors are different, though they are all interlinked. These are availability, acceptability, affordability, effectiveness and access to information. They will be discussed separately below.

2.3.1 Availability

For people to be able to enjoy the right of access to health care services, the state has a duty to protect, promote and fulfil that right. This can be done through the building of health care facilities in several parts of the country. This would make health care facilities physically accessible to everyone within the population. Such health care facilities should cater for people with disabilities too; with health services as close as possible to their own communities, including in rural areas.⁸⁴ Facilities ought to be easily accessed by the disabled and the facilities should be user-friendly. The aspect of availability has to do with the government's provision of functioning public health and health care facilities, goods

⁸¹ Any person who is included in the provision of health services to a user but does not include a health care provider. (Section 1 of the National Health Act 61 of 2003).

⁸² UNFPA, 'Sexual and Reproductive Health.' Available at <http://www.unfpa.org/sexual-reproductive-health> (Accessed on 16 January 2016).

⁸³ Section 1 of the CTOP Act. (Definition of 'woman').

⁸⁴ Article 25 (c) of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) 2006.

and services and programmes in sufficient quantity.⁸⁵ Health care facilities should be within the reach of the marginalised and vulnerable people.⁸⁶ Vulnerable people would include refugees, as they face various challenges in trying to access health care services in foreign countries. The underlying determinants of health, which include safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, should be provided.⁸⁷ Health care facilities for refugees ought to be built, to accommodate their needs. They could be built in refugee camps and they should be able to offer basic health care services, particularly, maternal health services like ante-natal care and family planning. Trained medical and professional personnel receiving domestically competitive salaries must be available, as well as essential drugs as defined by the World Health Organisation (WHO) Action Programme on Essential Drugs.⁸⁸ It goes without saying that there should be sufficient and appropriate equipment.

With regard to medical and professional personnel (health workers), their training must be sufficient to allow them to work with vulnerable groups such as refugees, without stereotyping or excluding them. In other words, they must be multilingual and able to work with medical interpreters. They should be sensitive, as refugees experience much trauma during migration and thus need special care and attention. The use of medical interpreters is important, especially where there is a language barrier between the patient and the service provider. It is necessary to have medical interpreters who are able to understand sign language to cater for the patients who are deaf and dumb. Being able to communicate with the refugee women will make the services acceptable and effective. The reproductive health care needs of refugees are urgent and acute, as they are susceptible to abuse during the chaos of displacement, resulting in trauma.⁸⁹

Such urgent needs place South Africa under an obligation to achieve a progressive realisation of the rights in section 27(1) of the 1996 Constitution; through reasonable

⁸⁵ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4. Available at: <http://www.refworld.org/docid/4538838d0.html> (Accessed 8 May 2015). Par 12 (a).

⁸⁶ *Ibid.* Para 12 (b).

⁸⁷ *Ibid.* Para 12 (a).

⁸⁸ *Ibid.* Para 12 (a).

⁸⁹ See note 7 above (UNFPA). See also C Kaplan, 'Migration, Vulnerability and Xenophobia: Central African Refugee and Asylum Seekers' Access to Health Services in Durban, South Africa'. (2011). Available at http://digitalcollections.sit.edu/cgi/viewcontent.cgi?article=2125&context=isp_collection (Accessed on 16 March 2015) 39.

legislative and other measures.⁹⁰ All this should be done within the available resources of the state.⁹¹ This section does not imply that the state should immediately realise the stipulated rights but that, with the available resources, the state should take steps towards providing them. In other words, policies and programmes should be in place to ensure that by a certain time, people would be able to fully enjoy their rights. Progressive realisation entails taking all reasonable steps to ensure that rights are protected, promoted and fulfilled, as well as achieving universal access to health care over time.⁹² An example is that of the case of *Soobramoney*,⁹³ which recognised that the right of access to health care services does not impose a duty on the state to provide everything to everyone at once.⁹⁴ The state therefore did not have to provide dialysis treatment to people whose medical condition was the same as Mr Soobramoney's. Availability of health care services should thus be within available state resources.

2.3.2 Acceptability

While it is important for health care facilities to be available, they must also be acceptable. Acceptability entails conformity to patient preferences regarding accessibility, the patient-practitioner relationship, the amenities and the effects and cost of care.⁹⁵ Acceptability has many components, which include whether the goals, processes and potential outcomes of a programme or service are both welcome and valued by a particular group.⁹⁶ This factor relates to cultural and social factors determining the possibility for people to accept the aspects of the service, plus the judged appropriateness for the persons seeking the care.⁹⁷ Health care facilities should be efficient, so that the outcome of their utilisation is proportional to the resources used. Acceptability means that the facilities, goods and services offered should be considerate of medical ethics and people's cultures.⁹⁸ In

⁹⁰ Section 27 (2) of the 1996 Constitution.

⁹¹ Ibid.

⁹² F Hassan, M Heywood & J Berger 'The Constitution and public health policy' in the book *Health and Democracy*. Siber Ink (2007).

⁹³ *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC).

⁹⁴ Ibid.

⁹⁵ A Donabedian, 'The seven pillars of quality.' *Archives of Pathology & Laboratory Medicine* 1990,114 (11) 1115-1118. Available at <http://europepmc.org/abstract/med/224519> (Accessed on 17 June 2015).

⁹⁶ R Hayes & S Barraclough 'The problems of accessibility and acceptability in integrated health care for men: some Australian reflections' *Commonwealth Health Partnerships* (2012) 112-114. Available at www.commonwealthhealth.org/wp-content/uploads/2012/05/112-114.pdf (Accessed on 11 May 2015).

⁹⁷ J Levesque, MF Harris & G Russell 'Patient-centered access to health care: conceptualizing access to the interface of health systems and populations.' *International Journal for Equity in Health* (2013) 12:18. Available at <http://www.equityhealthj.com/content/12/1/18> (Accessed on 11 May 2015).

⁹⁸ Note 85 above (CESCR) Para 12 (c).

addition, the facilities must be gender-sensitive and sensitive to life-cycle requirements.⁹⁹ In short, there must be no discrimination in health care facilities, as required by the 1996 Constitution.¹⁰⁰

From the above discussion of the acceptability factor, it appears that scholars agree that the cultures, values and religious views of the health care users should be taken into consideration. It is also clear that the quality of services should be acceptable too. Acceptability within South Africa's health care facilities is a necessity, as refugees make use of their services regularly. Refugees have different cultural practices and different religious beliefs, which should be respected. For example, when a Somali woman requires a Caesarean section (C-section) due to a prolonged or obstructed labour, she needs approval from her father-in-law or the father of the unborn child to undergo that procedure.¹⁰¹ In terms of their culture, if they do not get this approval, the procedure cannot be performed leading to death in most cases.¹⁰² Such a woman, though in pain, might refuse to be attended to by health workers as a way of adhering to her culture. It would be appropriate for health workers not to perceive such refusal as an act of stubbornness. Instead, the health workers should explain to the Somali woman by all means possible that continued delays whilst awaiting permission to undergo a C-section might eventually lead to death. Religions such as Hinduism, Buddhism, Judaism and Islam strongly uphold modesty, such that casual physical contact between unmarried men and women is forbidden, making it hard for other people to access health care facilities where the health care workers are of the opposite sex.¹⁰³ Whatever the case might be, the beliefs of refugees should not be undermined or misconstrued. Health workers ought to be patient enough to understand them. Reproductive health care services should respect the various religious and ethical values and backgrounds of refugees, while conforming to universally recognised international human rights

⁹⁹ Ibid.

¹⁰⁰ Section 9 (3): The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

¹⁰¹ NS Deyo, "Cultural Traditions and the Reproductive Health of Somali Refugees and Immigrants". (2012). *Master's Theses*. Paper 29, 5.

¹⁰² Ibid.

¹⁰³ Note 96 above (R Hayes & S Barraclough).

standards.¹⁰⁴ When reproductive health care services take into account the cultures, religions and backgrounds of refugees, they become more acceptable.

In the South African context, how feasible is it for reproductive health care services to accommodate the cultural and religious backgrounds of the different ethnic groups, including refugee women? What distinguishes one ethnic group from the next are ethical values, religions and backgrounds. The existence of various ethnic groups is evidence that the indigenes of South Africa have different ethical values, beliefs and religions. It is quite difficult to determine acceptability using a subjective approach, as it will be biased. What could be seen as adequate and appropriate health care services by one person may be seen as the total opposite by the other person. How does one measure adequacy? How can appropriateness be determined? The factor of acceptability is challenging, as different groups may judge appropriateness and quality differently.¹⁰⁵ As long as the acceptability factor is determined from a subjective point of view, the gap between policy, law and practice in relation to access to maternal health services will continue to exist or even widen. It would be sensible for South African policy-makers and legislators to adopt the objective approach in a bid to improve the right of access to maternal services for refugees. This would help satisfy the acceptability factor as it is close to impossible to accommodate the needs of each and every individual. While using the objective approach, the state should provide a more conducive platform which takes into consideration the needs of vulnerable groups or individuals.

2.3.3 Affordability

Health care facilities should not only be available and acceptable, they should also be affordable. The cost of the services should be such that any member of the society, regardless of their status or income, should be able to pay for them. Access to primary health care should not be limited by a person's ability to pay.¹⁰⁶ Health facilities, goods and services must be affordable to all.¹⁰⁷ The underlying determinants of health should be

¹⁰⁴ J Ehman, 'Religious Diversity: Practical Points for Health Care Providers.' (2012). Available at http://www.ups.edu/pastoral/resed/diversity_points.html (Accessed on 8 May 2015). See also Reproductive Health. Available at www.unhcr.org/pages/4ae95d226.html (Accessed on 8 May 2015).

¹⁰⁵ MF Harris, E Harris & M Roland, 'Access to primary health care: three challenges to equity'. *Australian Journal of Primary Health* (2004), Vol 10, 21-29.

¹⁰⁶ K Denhill, L King & T Swanepol (eds), *Aspects of primary health care, community health care in Southern Africa*. (1998).

¹⁰⁷ Note 85 above (CESCR) Para 12 (b).

affordable to ensure equity even for the socially disadvantaged groups.¹⁰⁸ This means that the services and the underlying determinants of health, such as water and sanitation, should be economically accessible. They should be of low cost, such that people may stay healthy. Incorporating the principles of equality in health care policies promotes affordability. These principles further influence all the other factors which determine access to health care (availability, acceptability, effectiveness and access to information). In access to health care, equity aims at reducing the disproportionate burden of the health expenses faced by the poorer households, as opposed to the richer ones.¹⁰⁹

South African the policy-makers have tried to make health care services affordable to pregnant women and children under the age of six, through the remission of service fees for Primary Health Care (PHC) services offered in the public health sector.¹¹⁰ This major transformation was introduced in 1994, to increase access to the poor, improve the quality and to make the system more cost-effective.¹¹¹ The remission of fees in access to maternal health services is quite pivotal, as it is a way for South Africa to achieve MDGs 4 and 5. In this way, vulnerable groups (such as refugees) within South Africa can also have access to maternal services. It is not only the remission of fees that contributes to the affordability factor. All the factors in relation to access to health care services are intertwined. Therefore the affordability factor is also dependent on the proximity of health care facilities. They should be physically and geographically accessible as required by Article 14.2 (a) of General Comment No.2 of Article 14 of the Women's Protocol. Even if the primary health care services are for free, the health care users might still incur transport expenses to reach the facilities. Thus, public health care facilities must be close to, or be within the residential areas of the users.

2.3.4 Access to information

For people to be able to fully utilise the health care facilities they must have access to information. Everyone has the right to freedom of expression; this right includes freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of their

¹⁰⁸ Ibid.

¹⁰⁹ Ibid.

¹¹⁰ A National Health Plan for South Africa (1994). Available at <http://www.anc.org.za/show.php?id=257> (Accessed on 12 May 2015).

¹¹¹ Free health services for the poor. Available at www.southafrica.info/about/social/govthealth.htm#VVHKefntmko (Accessed on 12 May 2015).

choice.¹¹² The phrase, ‘...receive and impart information and ideas of all kinds...’ implies that access to information includes the right to seek, receive and impart information and ideas concerning health issues.¹¹³ This means that individuals should not be denied any information with regards to access to health care facilities or about matters relating to their health. The information must not be confusing and must be precise. Health care users should not be denied information about the location of health care facilities, costs involved, performance of medical procedures and any other health care information they might require.

The 1996 Constitution recognises the right of access to information.¹¹⁴ South Africa’s Department of Health has a National Patients’ Rights Charter (NPRC),¹¹⁵ which serves as a common standard for realising the right of access to health care services. It helps the health care users acquire knowledge of their rights with regard to health care access. On the other hand, the state must take reasonable measures to make sure that its inhabitants are well informed about existing health care policies, new ones and any proposed reforms. People should have knowledge about how new health care policies are going to affect them. Access to health care information is an essential factor in meeting the MDGs.¹¹⁶ Lack of access to health care information and knowledge impedes the delivery of quality health care and contributes to a number of avoidable deaths worldwide.¹¹⁷ It is clear that access to health care information enables people to make free and informed decisions with regard to, amongst other things, the available health care facilities, their functions and the available treatment. When dealing with specific groups such as refugees, access and quality of information is critical. This will include the use or availability of interpreters and literature translation, where necessary.

¹¹² Article 19.2 of the International Covenant on Civil and Political Rights (ICCPR) 1966.

¹¹³ See note 85 above (CESCR) Para 12 (b).

¹¹⁴ Section 32.

¹¹⁵ Available at

http://www.hpcs.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_3_patients_rights_charter.pdf (Accessed on 13 May 2015).

¹¹⁶ N Pakenham-Walsh, ‘Healthcare Information For All by 2015’ (2008). Available at http://www.ehealth-connection.org/wiki/images/d/d8/HIFA2015_Presentation.pdf (Accessed on 13 May 2015).

¹¹⁷ P Chatterjee, ‘Healthcare information and the rural primary care doctor’. *The South African Medical Journal (SAMJ)*. Vol 102, No 3 (2012). Available at www.samj.org.za/index.php/samj/article/view/5672/3915 (Accessed on 13 May 2015).

2.3.5 Effectiveness

To measure the effectiveness of a thing, one must check whether its intended objectives have been achieved or not. In health care, effectiveness refers to the degree to which attainable health improvements are realised.¹¹⁸ Thus, the effectiveness of health care policies and laws relating to access to health care services must be weighed against their purpose. The purposes of each policy or legislation must be met so as to prove effectiveness. A typical example is that of South Africa's PHC policy.¹¹⁹ Some of its main objectives are to make health care services accessible to the poor, improve quality and make the system cost-effective.¹²⁰ If this policy fails to meet these objectives, it means that it is not effective. Therefore health care facilities should meet the objectives of their establishment, so as to be regarded as effective. Effectiveness of health care facilities will also influence their acceptability to the users, as the facilities will be able to satisfy the users by meeting the intended objectives.

2.4 Reproductive health rights in refugee situations

Usually, when crises erupt in a country, those who flee to other countries to seek asylum prioritise the preservation of their lives. Other priorities include shelter, food, water and sanitation, as these are the basic necessities for human survival. Some scholars add reproductive health services as another priority to this list, as they believe that these services are increasingly being recognised as a priority.¹²¹ They believe that a minimum package of these services must be available from the commencement of crises.¹²² Other scholars have argued that, though reproductive health services (save for obstetric care) are not necessary for immediate survival, reproductive health is essential for long-term survival and thus humanitarians should address these in their early responses.¹²³ Though refugees require food, water and shelter, reproductive health care is a crucial element which gives refugees basic human welfare and dignity which they are entitled to.¹²⁴ However, other scholars maintain that not all humanitarian organisations regard reproductive health care as

¹¹⁸ See note 95 above (A Donabedian).

¹¹⁹ See note 110 above (A National Health Plan for South Africa).

¹²⁰ See note 111 above (Free health services for the poor).

¹²¹ J Austin, S Guy, L Lee-Jones, T McGinn & J Schlecht, 'Reproductive Health: A Right for Refugees and Internally Displaced Persons.' *Reproductive Health Matters (RHM)*. 2008; 16(31):10-21.

¹²² *Ibid.*

¹²³ LA Bartlett, S Purdin & T McGinn, 'Forced migrants _turning rights into reproductive health.' *The Lancet*. (2004) Vol 363:76-77.

¹²⁴ United Nations High Commissioner for Refugees (UNHCR), *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual* (Geneva: UNHCR, 1999).

a priority during an emergency, as there is not enough research upon which policy and realistic decisions may be based.¹²⁵ Though there is insufficient research to make realistic decisions and policies with regards to this issue, the matter should not be unheeded, as paying attention to it will help to meet MDGs 4 and 5, as well as control refugee populations.

The above arguments show that reproductive health care needs (in particular maternal health needs) should be addressed as soon as crises start, so as to meet MDGs 4 and 5, control refugee populations, and to plan accordingly. Nevertheless, this is highly difficult to achieve as refugees hardly obtain these services until they reach the country of asylum. To most refugees women, the crises do not end when they flee their countries of origin, but rather continue even in transit. Violence against refugee women is mostly committed by military troops, police, fellow refugees, border guards and others and it occurs between social disruption and flight.¹²⁶ This gives a better understanding of the several rape cases of refugees in the border towns of South Africa such as Musina.¹²⁷ Refugee women are highly susceptible to rape, unwanted pregnancies, unsafe delivery, sexually transmitted diseases (STDs), as well as HIV and AIDS.¹²⁸ As a result, they require more than an average reproductive health package.¹²⁹ Thus, reproductive health services form part of the Sphere health standard, which is used as an international benchmark of governing minimum standards of services in humanitarian situations.¹³⁰

Regardless of various conflicting views on prioritising reproductive health services for refugees, much has been and is being done globally. The Interagency Working Group (IAWG) came up with the Minimum Initial Service Package for Reproductive Health in Crisis Situations (MISP). The MISP provides guidelines to health personnel in

¹²⁵ CA Palmer, L Lush & AB Zwi, 'The emerging international policy agenda for reproductive health services in conflict settings.' *Social Science and Medicine*. (1999) 49 (12): 1689-1703.

¹²⁶ A Lehmann, 'Safe Abortion: A Right for Refugees?' *Reproductive Health Matters (RHM)* 2002; 10 (19):151-155.

¹²⁷ Amnesty International, 'Zimbabwean Refugees face further hardship in South Africa.' (2009). Available at www.amnesty.org.au/refugees/comments/21261/ (Accessed on 28 May 2015). See also Sokari, "INFO: Rape of Zimbabwean refugees at South African borders." Available at <http://kalamu.posthaven.com/info-rape-of-zimbabwean-refugees-at-south-afr> (Accessed on 28 May 2015).

¹²⁸ F Girard & W Waldman, 'Ensuring the Reproductive Rights of Refugees and Internally Displaced Persons: Legal and Policy Issues.' *International Family Planning Perspectives (IFPP)*.2000, Vol 26, Number 4. Available at www.guttmacher.org/pubs/journals/2616700.html (Accessed on 27 May 2015).

¹²⁹ B Rojnik, L Andolsek-Jeras, D Obersnel-Kveder, 'Women in difficult circumstances: war victims and refugees.' *International Journal of Gynaecology & Obstetrics*. 48 (1995) 311-315.

¹³⁰ Women's Refugee Commission, 'Reproductive health at a glance'. Available at <https://womensrefugeecommission.org/programs/reproductive-health> (Accessed on 6 June 2015).

humanitarian crises on the steps they should take in addressing reproductive health-related issues in the early stages of crises.¹³¹ This policy is implemented through the work of the Women's Refugee Commission (WRC). The WRC also encourages governments and the United Nations (UN) to change or come up with policies which make it possible for those affected by crises to access reproductive health.¹³² The WRC advocates for governments and humanitarian agencies to deal with the violence faced by displaced women and girls when they collect firewood to use as a fuel for cooking or for business purposes.¹³³

Despite positive developments in reproductive health services, access for refugee women remains uneven.¹³⁴ As discussed above, the availability of reproductive health care services for refugees has improved drastically over the years and yet access to maternal health services remains a challenge to refugee women in South Africa. This is due to the common barriers refugees face in accessing maternal services. Some of the barriers discussed below are, however, peculiar to the South African health system.

2.5 Barriers in access to maternal health services

2.5.1 Language

Language is very important as it is essential for communication. It is more vital when it comes to health matters where, among other issues, a patient must effectively communicate with a health worker to be understood, so as to get effective treatment. Language can interfere with the scheduling of appointments, hinder the compilation of an accurate medical history, or block understanding of a health provider's instructions.¹³⁵ It can also impede diagnosis. South Africa is a multi-lingual country, with eleven official languages which are recognised by the Constitution.¹³⁶ A study conducted in the Cape Town area revealed that in accessing health care, the doctor's inability to speak the patient's language

¹³¹ Ibid.

¹³² Ibid.

¹³³ Women's Refugee Commission, 'Fuel and Firewood Initiative.' Available at <https://womensrefugeecommission.org/fuel-and-firewood-rss/1454-beyond-firewood> (Accessed on 6 June 2015).

¹³⁴ L. Schreck, 'Turning point: A Special Report on the Refugee Reproductive Health Field'. *International Family Planning Perspectives (IFPP)* Vol 26, Number 4, 2000. Available at www.guttmacher.org/pubs/journals/2616200.html (Accessed on 6 June 2015).

¹³⁵ MS Lee & CR Pope. *Patients who don't speak English: Improving language minorities' health care with professional interpreters.* (2001).

¹³⁶ Section 6(1).

was the second biggest obstacle after income.¹³⁷ This was a study conducted in a place where the most spoken languages are Afrikaans, English and isiXhosa. This shows that the linguistic diversity of South Africa is a challenge in itself in that even the indigenes themselves sometimes do not know the languages of the other ethnic groups. The finding of this study clearly shows that in general language is a barrier to many South Africans in terms of accessing health care services.

In such situations it is quite clear that professional medical interpreters would be useful. Under the National Health Act 61 of 2003 (NHA) a health care provider is required to provide full knowledge to the user in a language that the user understands and in a manner that takes into account the user's level of literacy.¹³⁸ However, language barrier is not as problematic to the indigenes compared with refugees, as they can try to communicate with health workers in other indigenous languages despite grammatical errors.¹³⁹ One could disagree with this argument as the Constitution's recognition of eleven official languages probably creates complacency amongst the indigenes. An indigene might possibly think that there is no need to learn the other languages, since his language is already recognised as an official language. This in turn will create communication problems when needing assistance from a health care worker, who speaks a language which is different from that of the user. Nonetheless, South Africa generally has no professional interpreting posts within the health care system for both signed and spoken languages.¹⁴⁰ The reason for the non-existence of these posts could be that it could be difficult to have professional interpreters for each of the languages. The problem becomes more challenging when having to deal with refugees who use languages such as French, Shona, Arabic, Somali, Ibo, Amharic and Portuguese, which are not recognised as official languages in South Africa. How many interpreters will there be and for how many languages? A survey revealed that desperately ill patients have to rely on nurses or relations as *ad-hoc* interpreters, as hospitals in South Africa are notorious for failing to address the language needs of patients.¹⁴¹ These people are unqualified and lack technical terminology, resulting in increased medical errors, less

¹³⁷ ME Levin, 'Language as a barrier to care for Xhosa-speaking patients at a South African paediatric teaching hospital.' *South African Medical Journal (SAMJ)*. Vol 96 no 10 (2006), 1076-1079.

¹³⁸ Section 6(2).

¹³⁹ NG Nkosi, 'Influences of xenophobia on accessing health care for refugees and asylum seekers in Johannesburg.' Available at <http://wiredspace.wits.ac.za/bitstream/handle/10539/14863/Nkosi,%20Gugu.%20Nomcebo..pdf?sequence=1> (Accessed on 13 May 2015).

¹⁴⁰ South Africa Language Practitioner's Council Bill [B14-2013].

¹⁴¹ What about liaison interpreting? Available at www.witslanguageschool.com (Accessed on 6 March 2015).

effective patient-clinical provider communication and poorer follow-up and adherence to clinical instructions, including possible conflict with patient privacy rights.¹⁴²

In view of all these challenges, it can be concluded that the language barrier greatly hinders access to health care services for refugees. If being a multilingual country makes access to health care services a challenge to South Africans, it may be asked how health workers cope with refugees, as most of them are from entirely different linguistic backgrounds. In a survey conducted in Durban, it was found that in South Africa the lack of translators for refugees contributes to inappropriate treatment and at times, HIV tests are even conducted without the refugees' consent.¹⁴³ Most refugees attributed the high maternal and neonatal death rates to the language barrier faced by refugee women in health care facilities.¹⁴⁴ The lack of good care during birth and the post-partum period were also seen as contributing factors towards maternal and neonatal death within the refugee communities of Durban.¹⁴⁵ These high maternal and neonatal deaths are clearly setbacks in the achievement of MDGs 4 and 5.

While language is generally important for communication, not being able to speak it can actually lead to discrimination. Refugee women in Durban face discrimination when receiving counselling and antenatal education, as these are offered in Zulu.¹⁴⁶ A similar survey conducted in the Netherlands, found that refugee women faced discrimination in antenatal class as they could not speak Dutch.¹⁴⁷ It has been observed that South African doctors consult across both a cultural and language barrier; thus ways need to be found to bridge the communication barrier, so that patients may get effective treatment.¹⁴⁸ Health care users such as refugees may find it hard to make any queries with regard to their health condition. On the other hand, health workers (though willing to help), once they realise that they cannot understand the patient's language might find it difficult to proceed for not wanting to make a wrong diagnosis. It has been observed that most South African doctors

¹⁴² M Regenstein 'Language Barriers in Health Care,' (2008). Available at <http://www.rwjf.org/en/library/research/2008/09/language-barriers-in-health-care.html> (Accessed on 6 March 2015).

¹⁴³ T Apalata & ET Kibiribiri *et al.* 'Refugees' Perceptions of their Health Status & Quality of Health Care Services in Durban, South Africa: A Community-Based Survey' (November 2007).

¹⁴⁴ *Ibid.*

¹⁴⁵ *Ibid.*

¹⁴⁶ *Ibid.*

¹⁴⁷ N Ascoly, I Van Halsema & L Keyzers, 'Refugee Women, Pregnancy and Reproductive Health Care in Netherlands.' (2001) *Journal of Refugee Studies*, Vol 14, issue 4, 371-393.

¹⁴⁸ I Couper & C Pfaff 'How do doctors learn the spoken language of their patient?' *South African Medical Journal (SAMJ)*. Vol 99 no 7 (2009), 300-301.

do not wish to specialise in obstetrics or gynaecology, as they are considered ‘high risk’ for claims of malpractice.¹⁴⁹ A wrong diagnosis might be deemed as medical negligence,¹⁵⁰ leading to delictual and criminal charges, therefore jeopardising their careers.

This paints a vivid picture of how language presents a great barrier in access to health care services. In public health institutions the maternal health care services might be considered to be available and affordable, but the language barrier makes the services unacceptable especially to refugee women. Consequently, refugee women will not be able to access information, thus violating their rights in the NPRC. The effectiveness of the health care facilities will be reduced, as the facilities would have failed to provide services to expectant mothers as per their mandate. From a legal perspective, this is a reflection of South Africa’s failure to adhere to its obligation to treat refugees in the same way as its citizens, as required under s27 (1) (g) of the Refugees Act. There should thus be provision for the creation of official medical interpreter positions in the health care system. Where competent medical interpreters are available, communication between doctors and patients will be more effective, leading to fewer errors. This in turn will enable refugee women and other foreign nationals to challenge service providers in a court of law when they are not satisfied with the service received.

2.5.2 Medical xenophobia

Xenophobia is a term used to denote a dislike of foreigners and is defined as a negative attitude towards foreigners, a dislike, a fear, or hatred towards them as foreigners.¹⁵¹ In South Africa, xenophobia is exacerbated by the majority of the economically impoverished indigenes, who perceive the presence of refugees as a threat to jobs, food, education and other amenities provided by the government.¹⁵² Such dislike towards foreigners serves as a barrier in accessing basic services such as health care, as they will be afraid of being victimised, since refugees are regarded as cumbersome to state resources. The 2015

¹⁴⁹ See note 38 above (S Regchand).

¹⁵⁰ Any negligence by an act or omission of a medical practitioner in performing his or her duty. Medical negligence happens when the medical practitioner fails to provide the care which is expected in each case thus resulting in injury or death of a patient. Available at <http://definitions.uslegal.com/m/medical-negligence> (Accessed on 5 May 2015). See note 38 above (*H V Fetal Assessment Centre*) a case in which the defendant was sued by a mother on behalf of her child for failing to diagnose that the child would be born with Down’s syndrome. See also, note 38 above (*Sonny v Premier of the province of KwaZulu-Natal & Another*).

¹⁵¹ B Harris, ‘Xenophobia: A new pathology for a new South Africa?’ in D Hook & G Eagle (Eds) *Psychopathology and Social Prejudice*. (2002), 169-184.

¹⁵² L Sisulu, ‘Meeting the Challenges of Forced Migration’ in M Zonke (ed) *The Challenges of Forced Migration in Southern Africa*. (2001), 6.

xenophobic attacks strongly disrupted access to health care and endangered the health of foreign nationals as a vulnerable community.¹⁵³ It was reported that some foreign men who were treated for bad injuries sustained during these attacks had not tried to get care, due to fear, despite the severity of their injuries (one had fractured his ribs, whilst another had multiple arm fractures).¹⁵⁴ It could be reasoned that their fear cannot only be attributed to the latest attacks, but also to the medical xenophobia which had been experienced long before the attacks started.

Medical xenophobia is the negative attitudes and practices of health sector professionals and employees towards migrants and refugees on the job.¹⁵⁵ This type of xenophobia is demonstrated in several ways, which include verbal abuse and the ill-treatment of non-South African patients, such that they have to wait in long queues until all the indigene patients have been attended to regardless of who came first.¹⁵⁶ This is the case in most South African public health institutions, as evidenced by the various reports of humanitarians, refugees and other migrants. Several migrants have had to give birth on the floor of labour wards or on the waiting room benches as nurses refused to attend to them.¹⁵⁷ Thousands of asylum seekers, refugees and migrants are routinely restricted or denied access to health care and treatment by South African medical practitioners due to xenophobia or mere ignorance of refugee rights.¹⁵⁸ Refugees and asylum seekers who are

¹⁵³ T Njanji, 'The People's Health Movement of South Africa strongly condemns xenophobia (Afrophobia)', (2015). Available at <http://phm-sa.org/the-peoples-health-movement-of-south-africa-strongly-condemns-xenophobia-afrophobia/> (Accessed on 18 May 2015).

¹⁵⁴ South Africa: MSF Assists People Displaced by Xenophobic Violence. Available at <http://www.doctorswithoutborders.org/article/south-africa-msf-assists-people-displaced-xenophobic-violence> (Accessed on 18 May 2015).

¹⁵⁵ J Crush & G Tawodzera, 'Medical Xenophobia: Zimbabwean Access to Health Services in South Africa.' *Journal of Ethnic and Migration Studies*, 2014. Vol 40, No. 4 655-670. Available at <http://dx.doi.org/10.1080/1369183X.2013.830504> (Accessed on 15 May 2015).

¹⁵⁶ Ibid. See also Human Rights Watch, 'South Africa: Improve Migrants' Access to Health Care'. (2009). The article cites an interview in which a refugee said that xenophobia is still there in South Africa, just that it had shifted to hospitals. Available at <https://www.hrw.org/news/2009/12/07/south-africa-improve-migrants-access-health-care> (Accessed on 17 November 2015). See also C Fritsch, E Johnson & A Juska, 'The plight of Zimbabwean unaccompanied refugee minors in South Africa: a call for comprehensive legislative action.' *Denver Journal of International Law & Policy*. Volume 38 (2010).

¹⁵⁷ Lawyers for Human Rights, 'South Africa health system shuns asylum seekers.' Available at <http://www.lhr.org.za/news/2014/south-africa-health-system-shuns-asylum-seekers> (Accessed on 4 June 2015).

¹⁵⁸ D Dass, K Ramjathan-Keogh & F Khan, "The socio-economic rights of refugees and asylum seekers in South Africa" in F Khan, T Schreier, (Eds) *Refugee Law in South Africa*. (2014), 230, see also SA accused of health care xenophobia. Available at www.thezimbabwean.co/lifestyle/health/27427/sa-accused-of-health-care.html (Accessed on 15 May 2015). See also Human Rights Watch, 'South Africa Improve Migrant's Access to Health Care.' Available at <http://www.hrw.org/news/2009/12/07/south-africa-improve-migrants-access-health-care> (Accessed on 26 May 2015).

mostly African feel that (in public hospitals) they are often prevented from seeing doctors, getting emergency medical care and receiving appropriate treatment.¹⁵⁹

At times the language barrier leads to xenophobic attitudes from the health workers and as a result, refugees are not accorded the same treatment as South African citizens.¹⁶⁰ Sometimes refugee women requiring prenatal care are ignored, even if they bring interpreters. For instance, if the refugee women speak in English, they are ignored and asked to speak in local languages. If they do not know how to speak any of them and make use of interpreters, the interpreters are ignored and the women are asked to speak in English.¹⁶¹ A Congolese woman who was having her first child could not effectively communicate with the Zulu nurses, as they did not allow her husband to interpret for her. It is as if health workers sometimes deliberately create the language barrier in some where a language such as English could have been used.¹⁶² Such an attitude shows that over and above the language barrier, health workers are just not willing to help, even if refugees bring interpreters. This makes it difficult for the refugee women to effectively communicate with the health workers, despite their attempts.

Some refugees have reported that presenting their refugee permits triggers non-acceptance from the health care workers and females are more frequently rejected than males, being discharged without clear diagnosis.¹⁶³ The above scenarios clearly indicate how medical xenophobia can be prompted by issues such as language barriers or even the presentation of identity documentation. As a result of xenophobic attitudes, non-nationals such as refugees might be scared of going to public primary health care facilities for fear of victimisation. Such victimisation can be difficult to prove and many refugees and advocates have expressed concerns that this abuse goes easily undetected due to lack of accountability in South Africa's health care system.¹⁶⁴ Though the facilities are available and affordable, the services rendered there are unacceptable. A reasonable person is bound to ask himself if such unfair treatment is worth it and whether he or she can settle for it. If the answer is no,

¹⁵⁹ See note 96 above (R Hayes & S Barracluogh). See also J Handmaker, L Hunt & J Klaaren, *Advancing Refugee Protection in South Africa*. Volume 2, (2013) 250.

¹⁶⁰ Refugees and HIV. Available at www.unhcr.org/45e58abc2.pdf (Accessed on 15 May 2015).

¹⁶¹ See note 89 above (C Kaplan).

¹⁶² Ibid.

¹⁶³ See note 143 above (T Apalata).

¹⁶⁴ Human Rights Watch. 'No Healing Here: Violence, Discrimination and Barriers to Health for Migrants in South Africa.' (2009). Available at <http://www.hrw.org/sites/default/files/reports/SA.pdf> (Accessed on 26 May 2015).

then that person would avoid going to the facility regardless of his or her need for medical assistance, rendering the facility ineffective.

2.5.3 Remission of service fees

The remission of fees in South Africa's public health system for pregnant women and young children is a privilege. This policy enables the poor and the unemployed to have access health care, as there are fewer worries about affordability.¹⁶⁵ While this remission of service fees can be seen as a privilege, it comes with its own challenges. A survey found that South Africa's public health centres are understaffed and recommended that the working environment be made more attractive.¹⁶⁶ While the government's health care policies have improved availability and affordability, there are challenges of implementation, coupled with challenges of training, distribution and motivation of health care workers.¹⁶⁷ Since the public health facilities are understaffed, the health care workers are burdened with greater workloads, as the great number of the poor and the unemployed resort to public health facilities. The free health care policy for pregnant women has led to an increased demand and declining staff morale, as their workload has increased and the resources not increasing to meet the high demand.¹⁶⁸ It is evident that the policy contributes to a lack of drugs and medical supplies.

In another study, about 85% of the interviewed nurses stated that, as a result of the free health care policy, their workload had substantially increased.¹⁶⁹ The respondents emphasised that certain people were abusing the health care system.¹⁷⁰ Such perceptions mostly lead to hostility towards refugees, as it is already believed that they put a strain on

¹⁶⁵ Simunye Primary Health Care. South Africa: Primary Health Care at Present. Available at <http://www.simunyehealthcare.com/simunye-phc/phc-at-present> (Accessed on 5 May 2015).

¹⁶⁶ E McDuff & P Maillacheruvu "South Africa's Return to Primary Care: The Struggles and Strides of the Primary Health Care System." *The Journal of Global Health*. Available at www.ghjournal.org/south-africas-return-to-primary-care-the-struggles-and-strides-of-the-primary-health-care-system/ (Accessed on 5 May 2015).

¹⁶⁷ M Chopra, E Daviaud, R Pattinson, S Fona & JE Lawn 'Saving the lives of South Africa's mothers, babies and children: can the health system deliver?' *Lancet* 2009, 374 (9692):835. See also K Cullinan, *Health Services in South Africa: A basic introduction* (2006). Available at http://www.health-e.org.za/wp-content/uploads/2013/04/Health_services_briefing_doc.pdf (Accessed on 19 June 2015), in which the scholar holds the view that the absenteeism experienced in South African public hospitals due to burn-out and demoralisation is closely linked to understaffing. See also M Segall, "The Bottle is Half Full": Policy Oriented Overviews of the Main Findings of a Review of Public Health Service Delivery (1999).

¹⁶⁸ Ibid.

¹⁶⁹ L Gilson & L Walker, "We are bitter but we are satisfied': nurses as street-level bureaucrats in South Africa". *Social Science & Medicine*. Vol 59 Issue 6. (September 2004), 1251-1261.

¹⁷⁰ Ibid.

state resources.¹⁷¹ This in itself is a barrier to refugees' access to maternal health services, since they fear being ill-treated by health workers. There however, seems to be a misconception about the issue of the offering of free services in public health care facilities. It should be remembered that South Africa does not provide free medical services in public hospitals, but in primary health centres and clinics. In tertiary institutions (hospitals) a means-based payment system has been adopted, wherein patients are classified according to their income and they pay the hospital fees in proportion to their means.¹⁷² However, in the public health system free services are guaranteed for pregnant women from the time the pregnancy is diagnosed to forty-two days after the pregnancy has terminated or if a complication has developed as a result of the pregnancy, until the patient has been cured or the condition as a result of the complication has stabilised.¹⁷³ This system of payment allows those who receive no or little income to receive treatment for free. The system aims to protect the poor and vulnerable groups of people. Refugees are a vulnerable group of people who, in most cases, have very little or no incomes at all, thus qualifying for free treatment. The challenges they face result in them being unable to find employment in either the formal or informal job market.¹⁷⁴

While the remission of fees has improved the affordability factor in access to health care, it also has its own disadvantages. As mentioned earlier, the remission of service fees has led to increased workload, meaning that the service could be slow as the health facilities are understaffed. Waiting periods are longer and foreigners, who include refugees, are likely to be at the receiving end of poor treatment as they are often pushed to the end of the queues.¹⁷⁵ Therefore the remission of service fees can reduce acceptability and effectiveness in access to health care services, in particular maternal services. This grossly affects the quality of services offered to refugee women when compared to their citizen counterparts.

¹⁷¹ See note 152 above (L Sisulu).

¹⁷² A Teagle, "Refugees: Out of the frying pan into the fire of South Africa's healthcare system." Available at <http://www.dailymaverick.co.za/article/2014-10-16-refugees-out-of-the-frying-pan-and-into-the-fire-of-south-africas-healthcare-system/#.VVscGfntmko> (Accessed on 19 May 2015).

¹⁷³ See note 164 above (Human Rights Watch).

¹⁷⁴ *Somali Association of South Africa and Others v Limpopo Department of Economic Development and Others* 16541/2013. Available at www.lhr.org.za/sites/lhr.org.za/files/somali_judgment_friday_18_10_2013.pdf (Accessed on 25 May 2015).

¹⁷⁵ See note 155 above (J Crush & G Tawodzera).

2.5.4 Culture and religion

Different cultural practices often negatively influence access to maternal health services. Most refugee women are from backgrounds which are culturally different from those of their host populations. After migration refugees continue with their cultural practices. Forced migrants such as refugees are not a homogeneous group thus; their differing characteristics require tailored approaches.¹⁷⁶ While reproductive health care facilities should respect the various religious and ethical values and backgrounds of refugees,¹⁷⁷ it might be quite difficult in South Africa to take into account such values. The country is already culturally diverse, with about thirteen ethnic groups. The cultural and religious backgrounds of refugee women make it hard for them to adjust to South African medical practices, as the practices sometimes clash with their traditions. Similarly, South African health workers might find it hard to understand the cultural practices of refugee women. In different cultures and religions, some medical practices falling within the scope of maternal health are forbidden. Such medical practices include, but are not limited to, abortion, the use of contraceptives and undergoing C-sections, each of which is discussed in detail below.

In countries such as the Democratic Republic of Congo (DRC), where rape is often used as a weapon of war, women might not be able to access abortion services.¹⁷⁸ Most of the victims cannot publicly testify against the perpetrators, due to the shame and stigma associated with rape in their communities.¹⁷⁹ Furthermore, abortion is illegal in the DRC, with the result that, when female refugees come to South Africa, where abortion is legal, they would not consider seeking abortion due to lack of information and the stigma associated with abortion and rape in their country of origin. It is therefore possible that, when such women come to South Africa as asylum seekers, it would be too late to abort the pregnancies. With such a cultural background, it is also very likely that, if a Congolese refugee were to be raped in South Africa, she would not opt for an abortion due to her cultural beliefs. Thus liberal abortion laws in most African countries remain

¹⁷⁶ See note 123 above (LA Bartlette, S Purdin & T McGinn).

¹⁷⁷ See note 104 above (J Ehman).

¹⁷⁸ M Kimani, 'Congolese women confront legacy of rape. War and sexual violence leave survivors in desperate need.' (2007). Available at www.un.org/africarenewal/magazine/january-2007/congolese-women-confront-legacy-rape (Accessed on 21 May 2015). See also, 'Family burnt to death in the DRC.' Available <https://www.realisingrights.wordpress.com/2014/11/27/16-days-family-burnt-to-death-in-drc/> (Accessed on 28 May 2015).

¹⁷⁹ Ibid.

unimplemented and administratively inaccessible; due to the stigma and controversy that surrounds the procedure, as well as its criminalisation.¹⁸⁰ In the case of the abortion law in South Africa, it has been implemented and can be said to be accessible but highly underutilised by the refugee women within the territory.

Contraception and childbearing are issues which have different meanings in various cultures. In many of the cultures and religions of refugees, the role of a married woman is to bear many children for the husband, so as to expand the family. However, this might present a challenge to health workers who, according to their perceptions, coupled with xenophobic attitudes, believe that when refugees have too many children, it increases the population of foreigners within the country. An example is that of a Congolese woman who was verbally abused at Addington Hospital for having seven children.¹⁸¹ She was told to stop having children as she was just increasing the number of foreigners. However, she could not understand why they were telling her to stop having children as her culture permitted her to have many children as a married woman. Such treatment from health workers is humiliating and violates women's rights to make decisions about the number of children to have. Furthermore, refugees have a right to procreate, as prescribed by Community Services for Urban Refugees.¹⁸² In Somali culture, which is highly influenced by the Islamic religion, it is believed that the purpose of marriage is to procreate.¹⁸³ It follows that the use of contraception is highly discouraged among most of the Somali people, as the highly religious believe that Allah is the one who determines the number of children a couple will have.¹⁸⁴ It is therefore not surprising why Somali refugees have many children, even in refugee camps.

Finally, C-sections are discouraged in various Congolese and Somali cultures. Amongst the Congolese, C-sections are only done as a last measure, when the woman has failed to give

¹⁸⁰ CG Ngwena, E Brookman-Amisssa & P Skuter, 'Human rights advances in women's reproductive health in Africa.' *International Journal of Gynaecology & Obstetrics*. Vol 129, Issues 2 (May 2015) 184-187. Available at <http://www.sciencedirect.com/science/article/pii/S0020729215000764> (Accessed on 3 June 2015).

¹⁸¹ See note 89 above (C Kaplan).

¹⁸² UN High Commissioner for Refugees (UNHCR), Community Services for Urban Refugees. Available at <http://www.refworld.org/docid/49997b0119.html> (Accessed on 27 May 2015). See also General Comment No.2 of Article 14.1 (f) of the Women's Protocol.

¹⁸³ See note 101 above (NS Deyo).

¹⁸⁴ A Borkan, 'Rejecting Vulnerability: Somali women's resistance to cesarean section in Columbus, Ohio.' (2010). Available at <http://deepblue.lib.umich.edu/bitstream/handle/2027.42/77628/aborkan.pdf?sequence=1> (Accessed on 22 May 2015).

birth naturally, or in cases of extreme emergency.¹⁸⁵ Similarly, Somali women do not like to give birth by C-section, as the procedure limits the number of children that one can have because it causes scarring of the uterus. Moreover, the Somali practise female genital mutilation (FGM).¹⁸⁶ Thus, in most cases when the women give birth in foreign countries they are not given the choice to do so vaginally or through C-sections. The main reason is that health workers just perform C-sections on them because their vaginas are different, such that they might die if they deliver naturally.¹⁸⁷ However, the percentage of C-sections performed in South Africa annually is very high. The private sector rate is around 70% and about 18% in the public sector.¹⁸⁸ Though the majority of refugee women in South Africa would rely on the public sector for maternal services, the rate of C-sections performed there still exceeds the rate prescribed by the World Health Organisation (WHO), which is at 10-15% C-sections per country.¹⁸⁹ Some refugee women have reported that at times they are coerced to undergo C-sections or the procedures are performed without being informed about them.¹⁹⁰ These clashes between the religion and culture of refugee women and the various medical practices within the South African health care system present a barrier in access to maternal services. Though the services are available and affordable, they are not acceptable due to cultural and religious barriers.

2.5.5 Unfamiliarity with the health care system

Some foreign nationals residing in South Africa do not have adequate information about how the health care system works. Migrants are often ignorant about the services available to them and the scope of their rights to obtain them.¹⁹¹ Such ignorance greatly impedes access to maternal health services, as expectant refugee mothers are sometimes not aware of their rights to health. The lack of access to reproductive health information results in high rates of unsafe sexual practices, unwanted pregnancies and dangerous abortions

¹⁸⁵ See note 143 above (T Apalata).

¹⁸⁶ “Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury in the female genital organs for non-medical reasons.” Media Centre, Female genital mutilation (2014). Available at www.who.int/mediacentre/factsheets/fs241/en/ (Accessed on 28 May 2015).

¹⁸⁷ See note 143 above (T Apalata).

¹⁸⁸ S Fokazi, ‘Experts call for cut in C-section birth rates’ (2011). Available at <http://www.iol.co.za/lifestyle/family/birth/experts-call-for-cut-in-c-section-birth-rates-1.1029667#.VV7ybPntmko> (Accessed on 22 May 2015).

¹⁸⁹ World Health Organization. Appropriate technology for birth. *Lancet* 1985; 2 (8452): 436-7.

¹⁹⁰ See note 143 above (T Apalata).

¹⁹¹ See note 164 above (Human Rights Watch).

amongst refugee populations.¹⁹² In addition, their vulnerability to sexually transmitted infections, including HIV/AIDS is increased.¹⁹³ Challenges such as the language barrier and medical xenophobia also contribute to the unfamiliarity that most foreign nationals have with the health care system, as there is no effective communication with the health workers. Unfamiliarity with the system at times creates negative perceptions of the public health care system, when migrants are told to go to more appropriate health facilities by hospital staff.¹⁹⁴ When this happens they assume that they are being denied treatment.

Health workers also seem to be unfamiliar with how the health care system works. Health care providers have not been informed by the Department of Health (DOH) of South Africa about the policies of access to treatment for asylum seekers, refugees and undocumented migrants.¹⁹⁵ Consequently, these groups of people are not receiving the treatment they should. As prescribed by the Act, refugees must be treated in the same way as the citizens and permanent residents of South Africa when it comes to accessing health care facilities.¹⁹⁶ In the same way asylum seekers are entitled to access health care facilities as they await Refugee Status Determination (RSD). It could be argued that refugees should be given preferential treatment, as opposed to other foreign nationals within the country because of their vulnerability. Such discrimination could be seen as fair and is permissible under the 1996 Constitution.¹⁹⁷ Upon the issuance of refugee status, the Refugee Status Determination Officers (RSDOs) must take reasonable steps to inform refugees about their entitlements in the Republic. Sadly, refugees and asylum seekers face discrimination in accessing health services, as all foreign nationals are perceived to be a burden on state resources.¹⁹⁸

2.5.6 Contradictory health policies

The 1996 Constitution provides for the right to have access to health care for everyone residing in the Republic. In the case of *Soobramoney*,¹⁹⁹ the Constitutional Court interpreted the word ‘everyone’ to mean citizens and permanent residents of South Africa.

¹⁹² SK Krause, M Otieno & C Lee, ‘Reproductive health for refugees.’ *Lancet Supplement* Vol 360 (2002). S15-S16. Available at www.thelancet.com (Accessed on 30 May 2015).

¹⁹³ *Ibid.*

¹⁹⁴ See note 164 above (Human Rights Watch).

¹⁹⁵ *Ibid.*

¹⁹⁶ Section 27 (1) (g).

¹⁹⁷ Section 9 (5), which states that discrimination on one or more of the grounds listed in section 9 (3) of the 1996 Constitution is unfair unless it is established that the discrimination is fair.

¹⁹⁸ See note 152 above (L Sisulu).

¹⁹⁹ See note 93 above.

This appears to imply that non-South Africans who are neither permanent residents nor citizens do not have access to health care services. The National Health Policy (NHP) states that asylum seekers, refugees and undocumented migrants from Southern African Development Community (SADC) countries have the same rights to treatment at public sector hospitals as South African citizens.²⁰⁰ The only requirement is that they pay fees which are proportional to their income. In 2013, the Gauteng Department of Health issued a draft of the Non-South African Citizens Guidelines for Gauteng public hospitals. These guidelines require hospitals to demand full, upfront payment from patients who do not have permits, refugee documents or who are asylum seekers. This clearly shows that, in Gauteng, foreign patients who cannot prove legal residence have to make full payment for treatment. This is contrary to the NHP as the foreign patients' guidelines fail to distinguish between undocumented migrants from the SADC and those from elsewhere. These guidelines fail to take into account the income of the foreign patients, which is required in all public hospitals. Though the guidelines do not directly affect refugees, it has been noted that patients are being incorrectly classified and charged, as some health workers are not familiar with refugee identity documents.²⁰¹

In terms of the Patient Classification Manual, all pregnant women and children under the age of six have free access to health care services. The guidelines do not say anything about foreign nationals' access to these free services. They simply make provision for basic health care for maternity cases. These contradictions and ambiguities present a barrier in that health care workers might not know how to deal with the different categories of non-nationals, thus over-charging or turning away some patients. The guidelines also make it impossible for asylum seekers to access health care services, as it is the duty of the admissions clerk to report or hand over all undocumented persons to the Department of Home Affairs (DHA) for deportation.²⁰² Nevertheless, when it comes to emergency medical treatment, the guidelines provide that both documented and undocumented migrants shall

²⁰⁰ National Department of Health. 2007b. *Revenue Directive: Refugees/Asylum Seekers with or without a Permit*. BI 4/29 REFUG/ASYL 8 2007. Available at http://www.passop.co.za/wp-content/uploads/2012/07/revenue-directive_refugees-and-asylum-seekers-with-or-without-permit.pdf (Accessed on 20 October 2015).

²⁰¹ See note 157 above (Lawyers for Human Rights).

²⁰² See note 170 (A Teagle) above.

have access. This is consistent with the provisions of the NHA²⁰³ and the 1996 Constitution.²⁰⁴

2.6 Conclusion

Reproductive health, particularly the provision of maternal health services, remains an important aspect of human rights, even in refugee situations. On a global scale, much has been done to improve access to maternal health services for refugees. However, much work still needs to be done in practical situations to realise access to maternal services for refugees. In the South African context, various government policies have been implemented to ensure the realisation of this right. Though there has been improvement with regard to access to maternal health services in South Africa, refugee women continue to face various difficulties in accessing them, due to many factors. South Africa is a signatory to various international and regional instruments aimed at refugee protection. These instruments shall be discussed in the next chapter, to establish whether or not there are any loopholes within them which are barriers in the fulfilment of South Africa's obligations towards refugees.

²⁰³ Section 5.

²⁰⁴ Section 27 (3).

CHAPTER THREE

INTERNATIONAL REFUGEE PROTECTION, HEALTH STANDARDS AND SOUTH AFRICA'S OBLIGATIONS

3.1 Introduction

As observed in the preceding chapter, various organisations have done much to protect refugee rights. Globally, efforts are still being made to protect refugees as a vulnerable group of people. The 1951 Convention relating to the Status of Refugees (Refugee Convention) sets the standard for how refugees should be treated in countries of asylum. The 1967 Protocol relating to the Status of Refugees (1967 Protocol) was introduced to remove geographical and temporal limits which were imposed by the Refugee Convention. This makes the Refugee Convention and the 1967 Protocol the only global legal instruments indisputably covering the most important aspects of a refugee's life.²⁰⁵ As a result, these two instruments have greatly influenced the promulgation of continental instruments on refugees such as the 1969 OAU Convention Governing the Specific Aspects of Refugee Problems in Africa (1969 OAU Convention),²⁰⁶ the Declaration on Refugee Protection within Southern Africa 1998 (1998 SADC Declaration) and the Cartagena Declaration on Refugees 1984.²⁰⁷

With regard to access to health care, there are international and continental instruments to which South Africa is a contracting party. Though these instruments were not created for the specific purpose of protecting rights to maternal health care services, they touch on the provision of health care or women's rights, thus maternal health care services would be included. This chapter will therefore be based on an analysis of the various UN, African and Southern African Development Community (SADC) instruments and policies on refugee protection and those aimed at promoting access to health care services. Reference will also be made to soft law and customary international law. The objective of this analysis is to find out if South Africa has any obligations to realise the access to maternal health rights of refugee women.

²⁰⁵ Convention and Protocol Relating to the Status of Refugees. Available at www.unhcr.org/3b66c2aa10.pdf (Accessed on 8 June 2015).

²⁰⁶ Available at www.unhcr.org/45dc1a682.html (Accessed on 1 July 2015).

²⁰⁷ Available at <http://www.unhcr-centraleurope.org/pdf/resources/legal-documents/international-refugee-law/1984-cartagena-declaration-on-refugees.html> (Accessed on 1 July 2015).

3.2 Refugee protection under international law

Refugees enjoy the protection of their rights under international law. This can be evidenced by the United Nations (UN) international human rights instruments aimed at refugee protection. These instruments are effective as they have influenced the promulgation of continental human rights instruments on people's rights, including refugees. Any country which signs and ratifies an instrument undertakes to be bound by the principles of such an instrument and has to incorporate the principles of that instrument into its municipal law. In other words, the municipal law of any contracting state²⁰⁸ to an international instrument must be consistent with international law, in-as-far as the instrument is concerned. International instruments and policies relating to refugees are there to promote, protect and fulfil the right of persons to seek asylum from persecution in other countries, as provided for in the Universal Declaration of Human Rights of 1948 (UDHR).²⁰⁹ While there are a number of instruments aimed at refugee protection, focus shall be on the UN conventions, to which South Africa is a state party, as well as the African conventions on refugee protection. Soft law²¹⁰ on international refugee protection will also be analysed. Though customary international law²¹¹ is not going to be analysed in relation to the realisation of maternal health care services for refugee women, it is still relevant in refugee protection, especially when dealing with the principle of non-refoulement.²¹²

²⁰⁸ A state which has agreed to be bound by the obligations of a treaty.

²⁰⁹ Article 14.

²¹⁰ Soft law refers to the rules that are neither strictly binding in nature nor completely lacking legal significance. In the context of international law, soft law refers to guidelines, policy declarations or codes of conduct which set standards of conduct. They are, however, not directly enforceable. Available at www.definitons.uslegal.com/s/soft-law/ (Accessed on 1 July 2015).

²¹¹ The law that applies to all states, irrespective of whether they are a party to relevant treaties or not. 'Rule of Law in Armed Conflicts Project RULAC' Available at www.geneva-academy.ch/RULAC/international_refugee_law.php (Accessed on 1 July 2015).

²¹² Non-refoulement entails the duties of countries:

- 1) Not to return asylum seekers or refugees to a place where their life or liberty would be at risk;
- 2) Not to prevent asylum seekers or refugees—even if they are being smuggled or trafficked from seeking safety in a country, if there is a chance of them being returned to a country where their life or liberty would be at risk;
- 3) Not to deny access to their territory to people fleeing persecution who have arrived at the border (access to asylum).

UNODC "Protecting refugee victims of trafficking" in *Toolkit to Combat Trafficking in Persons* 363. Available at https://www.unodc.org/documents/human-trafficking/Toolkit-files/08-58296_tool_7-9.pdf (Accessed on 8 July 2015).

3.2.1 *The Refugee Convention*

3.2.1.1 *Purpose*

The Refugee Convention was created in recognition of the United Nation's profound concern for refugees and the endeavor to assure refugees the widest possible exercise of fundamental human rights and freedoms.²¹³ Additionally, the Refugee Convention was created as a consideration of the affirmation made in the Charter of the United Nations (UN Charter) and the UDHR that human beings shall enjoy fundamental rights and freedoms without discrimination.²¹⁴ Article 14 of the UDHR particularly influenced the object of the Refugee Convention, as it declares the right of all persons to seek asylum from persecution in other countries. The leading courts in common law jurisdiction make use of the Refugee Convention preamble to follow a human rights approach in its construction, placing emphasis on the fact that it was written on the premise of international human rights law.²¹⁵ Human rights continue to exist even outside a person's state territory. Refugees are thus entitled to enjoy the exercise of their fundamental human rights, regardless of their circumstances. The failure or loss of state protection is actually that which makes international refugee protection essential.²¹⁶ The object and the purpose of the Refugee Convention is to give a voice and force to rights for refugees, and to responsibilities for their surrogate protection.²¹⁷ One of the most remarkable features of the Refugee Convention is the creation of an international protection system for people requiring it.²¹⁸

3.2.1.2 *Protection of health rights in the Refugee Convention*

The Refugee Convention does not make specific mention of health rights. Even so, the right to health could be included under the right refugees have to public relief and assistance, in

²¹³ See the preamble of the Refugee Convention. Available at <http://www.unhcr.org/4d934f5f9.pdf> (Accessed on 8 July 2015).

²¹⁴ Ibid.

²¹⁵ M Foster, *International Refugee Law and Socio-Economic Rights: Refugee from Deprivation*, (2009) 42.

²¹⁶ UNHCR, *The Refugee Convention, 1951. The Travaux Preparatoires analysed with a commentary by Dr Paul Weis*. Available at <http://www.unhcr.org/4ca34be29.pdf> (Accessed on 8 July 2015).

²¹⁷ "The Refugee Convention at 60: Still fit for its purpose?" *Protection Tools for Protection Needs*. Statement by Erika Feller during the Workshop on Refugees and the Refugee Convention 60 years on: Protection and Identity. Prato, 2 May 2011.

²¹⁸ See note 216 above (UNHCR).

article 23.²¹⁹ With regard to the right to health it is generally accepted that the phrase “public relief and assistance,” mentioned in article 23 of the Refugee Convention, should be interpreted widely as encompassing various areas of public and social welfare systems, including medical and hospital care.²²⁰ Scholars maintain that the meaning of public relief and assistance is dependent, to a certain extent, on the meaning accorded to it in municipal law, and therefore should be construed widely.²²¹ Similarly, a publication by the United Nations High Commissioner for Refugees (UNHCR) highlights that the level of assistance that refugees and, indeed all beneficiaries will receive in terms of public relief and assistance will depend on the situation of each contracting state, since the Refugee Convention provides no definition for it.²²²

One could agree with the views above, in that the scope and extent of public relief and assistance can only be defined in the municipal law of each contracting state. This would allow for the contracting states to create policies which are possible to implement. Policies pertaining to socio-economic rights, such as health care, are usually drafted after a consideration of the available state resources. Therefore, allowing contracting states to determine the scope and extent of public relief and assistance in their municipal law enables them to meet their international obligations pertaining to health care. This probably explains why the drafters of the Refugee Convention did not provide a definition for public relief and assistance. This unforeseen gap could lead to health hazards in refugee camps such as those in the European Union (EU), where there are currently large influxes of refugees. While this could be viewed by some as a loophole, it could actually be viewed as a necessary omission, as a definition would probably have cast the net of state obligation too wide or too narrow. The Refugee Convention thus creates a measure for refugees to receive equal treatment regarding health rights by simply stating that contracting states “...shall accord...to refugees...the same treatment...as is accorded to their nationals.”²²³ Article 3 of the same instrument stipulates that its provisions are to be applied without

²¹⁹ Article 23 of the Refugee Convention stipulates that the Contracting States shall accord to refugees lawfully residing in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals.

²²⁰ UN Ad Hoc Committee on Refugees and Stateless Persons, Ad Hoc Committee on Refugees and Stateless Persons, Second Session: Summary Record of the Thirty-Eighth Meeting Held at the Palais des Nations, Geneva, on Thursday, 17 August 1950, at 3 p.m., 26 September 1950, E/AC.32/SR.38. Available at: <http://www.refworld.org/docid/3ae68c180.html> (Accessed on 16 July 2015).

²²¹ P Weis, *The Refugee Convention, 1951* (1995) 174.

²²² UNHCR, *Chapter V Public Relief and Social Security*. Available at <http://www.unhcr.org/3cf33fbc4.pdf> (Accessed on 15 July 2015).

²²³ See note 219 above.

discrimination as to race, religion or country of origin. This non-discrimination clause serves as a yardstick in determining whether refugees are receiving public relief and assistance or not.

3.2.1.3 *A critique of the Refugee Convention*

One of the main objectives of the Refugee Convention is the restoration of human rights to people seeking asylum in other states. The instrument is thus regarded as the centerpiece of international refugee protection.²²⁴ The strengths of the Refugee Convention and its notable achievements are highly influenced by the principles of non-refoulement, non-discrimination and non-penalisation. These three principles play an important role regarding the protection of refugee rights and especially, the right of access to maternal health care services. The Refugee Convention has its own shortcomings, however, which have an impact on refugee rights and in particular, access to maternal health services.

The principle of non-refoulement is a unique feature of the Refugee Convention. It is arguably the most important provision of the Refugee Convention²²⁵ and forms part of international customary law.²²⁶ It is enshrined in article 33 and, in summation, the principle entails the notion that no refugee should be returned to any country where he or she is likely to face persecution and torture.²²⁷ However, the principle does not apply in cases where the asylum seeker committed a serious non-political crime, a crime against humanity, war crimes or where the person is a threat to the state security of the country of asylum.²²⁸ Non-refoulement only applies to aliens physically present within the territory of the host country and should not be interpreted too broadly, thus the use of the term “refouler” instead of “return”.²²⁹ The UNHCR has criticised this lack of extra-territorial application of non-refoulement as being inconsistent with international refugee law, as well as the purpose and

²²⁴ UN General Assembly Resolution 429 (V) of 14 December 1950. Available at <http://www.unhcr.org/refworld/docid/3b00f08a27.html> (Accessed on 18 July 2015).

²²⁵ M Achiron, ‘A ‘timeless’ treaty under attack’ in *50th Anniversary- The wall behind which refugees can shelter. The 1951 Geneva Convention, Refugees* Vol 2 Number 123 (2001) 3.

²²⁶ Customary international law consists of rules of law derived from the consistent conduct of states acting out of the belief that the law required them to act that way. (R Shabtai, *Practice and Methods of International Law* (1984) 55).

²²⁷ See note 212 above. See also GS Goodwin-Gill & J McAdam, *The Refugee in International Law*. (1996) 117.

²²⁸ Article 33 (2).

²²⁹ See the case of *Sale v Haitian Centers Council*, 509 U.S.155 wherein the US Supreme Court had to decide whether article 33 of the Refugee Convention and 243 (h)(1) of the Immigration and Nationality Act of 1952 (INA) were applicable to refugees on the high seas. Available at <https://www.law.cornell.edu/supct/html/92-344.ZS.html> (Accessed on 18 July 2015).

the spirit of the Refugee Convention and the 1967 Protocol.²³⁰ This particular limitation has an adverse effect on the realisation of maternal rights of pregnant asylum seekers in transit. Though there are hardly any refugees who migrate to South Africa through the high seas, one wonders how treaty monitoring bodies ensure that states are not sending away refugee women on the high seas requiring medical attention such as, emergency obstetric care, in compliance with the UN requirements.²³¹ This remains a grey area in international refugee protection and needs to be addressed. The essence of refugee law is the protection and revival of the rights of refugees and asylum seekers; thus article 33 is the most important provision of the Refugee Convention. This particular principle influences the realisation of maternal health care rights of refugee women. For instance, women from war-torn countries seeking asylum in other countries may be in dire need of reproductive health care, especially maternal health care. In most cases rape is used as a weapon of war by rebel groups and women end up with unwanted and unplanned pregnancies.²³² If, upon arrival in countries of asylum, such women are returned to their war-torn countries, chances are that they will be subjected to rape again and other violence associated with war. It also goes without saying that access to maternal health care services would have been indirectly denied when refoulement occurs. The principle of non-refoulement is thus important, as it is the driving force behind the acquisition of refugee status and the entitlement of the rights that come with it.

Another important aspect of the Refugee Convention is the non-discrimination clause. This is provided for in article 3 of this particular instrument. Article 3 requires that its provisions be applied without discrimination as to race, religion or country of origin. The non-discrimination clause is arguably the basis of the provision of the socio-economic rights granted to refugees in the Refugee Convention. Such rights include, but are not limited to, public relief and assistance,²³³ housing²³⁴ and education.²³⁵ This provision is of great significance with regard to access to maternal health care services, in that the Refugee

²³⁰ UNHCR Note on the Principle of Non-Refoulement. Available at <http://www.refworld.org/docid/438c6d972.html> (Accessed on 18 July 2015).

²³¹ Article 98 (1) of the United Nations Convention on the Law of the Sea (UNCLOS) 1982. Available at http://www.un.org/depts/los/convention_agreements/texts/unclos/unclos_e.pdf (Accessed on 20 July 2015).

²³² 'Rape: Weapon of War.' Available at <http://www.ohchr.org/en/newsevents/pages/rapeweaponwar.aspx> (Accessed on 20 July 2015). See also, C Clifford 'Rape as a Weapon of war and its Long-term Effects on Victims and Society' (2008). Available at <https://www.inter-disciplinary.net/ptb/hhv/vcce/vch7/Clifford%20paper.pdf> (Accessed on 20 July 2015).

²³³ Article 23.

²³⁴ Article 21.

²³⁵ Article 22.

Convention specifies that contracting states are to treat refugees in the same way as their nationals with respect to public relief and assistance. This clause empowers refugees to claim the rights that they are entitled to. It is through this provision that refugees are able to institute legal proceedings against host states in cases of unfair discrimination.

In terms of article 31 of the Refugee Convention, refugees should not be punished for their illegal entry or stay in a country of asylum. This provision recognises that those trying to escape persecution cannot be expected to leave their country or enter another state in a regular manner. They cannot be penalised or arbitrarily detained purely on the basis of having resorted to such means so as to apply for asylum.²³⁶ The non-penalisation principle is highly relevant, in that it makes a distinction between how illegal migrants and refugees should be treated. When people travel to other countries without visas and other travel documents in search of asylum, they should not be treated like criminals. They should neither be penalised nor detained but should be granted the protection that they require. Illegal migrants, conversely, ought to be punished as they evade immigration officers at ports of entry for lack of passports and visas.

The Refugee Convention is not without constraints. There are quite a number of notable shortcomings, but for the purposes of this work, only those which affect the right of access to maternal health services for refugees will be discussed. While the non-refoulement principle might be regarded as the most significant feature of the Refugee Convention, it is the very thing that is manipulated by fraudulent asylum seekers. The non-refoulement principle makes the asylum system prone to abuse. Many people migrate for several reasons which are not necessarily linked to persecution. These include employment, natural disasters, and the quest for a better life. It seems that the inhabitants of developing countries have become aware of life in the developing world and this influences migration.²³⁷ The complexity of modern-day migratory patterns which contain a mixture of economic migrants, refugees and others makes it difficult for governments to do effective, proper asylum determination procedures, because it is difficult to distinguish between genuine asylum seekers and those who are not.²³⁸ When economic migrants find it impossible to migrate legally to another country, they may apply for asylum under the Refugee

²³⁶ E Quinn, *The Refugee Convention Sixty Years On: Relevant or Redundant?* Working Notes, Issue 68 (2011).

²³⁷ J Straw, 'The Convention: Britain's view. The need for debate is now.' See note 225 above (M Achiron) 9.

²³⁸ See note 236 above (E Quinn).

Convention in a bid to gain from the rights that come with refugee status.²³⁹ It has been noted that in most European countries there is a problem of economic migrants who apply for asylum so as to gain access to the Council of Europe member states.²⁴⁰ Scholars suggest that improvements in the economic performance of poorer and less privileged states will help to reduce, or remove, some of the pressures that induce people to migrate and to submit an asylum application in another state.²⁴¹ In Britain it has been observed that some people involved in terrorist activities have, in fact, been asylum seekers and immigration authorities have therefore been reluctant to issue refugee permits.²⁴² In the case of South Africa, it is not only ordinary migrants posing as asylum seekers who abuse the asylum system. It can be submitted that corruption within the Department of Home Affairs (DHA) actually promotes fraudulent claims and abuse of the asylum system. A research on the problems faced by refugees and asylum seekers in South Africa revealed that refugees and asylum seekers are sometimes forced to pay bribes by some officials at the DHA, to obtain service which should otherwise be for free.²⁴³ Some asylum seekers said that frustration and discouragement left them with no option but to go through a third party or bribe a DHA official to have a permit approved on time.²⁴⁴ One can thus argue that such corrupt practices by the DHA officials actually promote fraudulent asylum seekers to abuse the asylum system. Once a fraudulent asylum seeker uses a third party or directly bribes a DHA official, the proper procedures for Refugee Status Determination (RSD) will not be adhered to. This, in turn, will have an adverse effect on access to rights such as health care, which are highly dependent on the availability of state resources. A state's resources will be strained when its asylum system is abused. It is thus evident that the principle of non-refoulement is susceptible to abuse by fraudulent asylum seekers.

Another shortcoming of the Refugee Convention is its failure to address the issue of burden-sharing between the state of asylum and the asylum seeker's country of origin. The absence of such a provision in the Refugee Convention is a liability where there is a mass influx of refugees.²⁴⁵ Countries receiving asylum seekers are themselves often very poor,

²³⁹ Global Commission on International Migration. *Global Commission on International Migration, Migration in an Interconnected World* (2005) 7.

²⁴⁰ R Plender & AIRE Centre (Eds), *Basic Documents on International Migration Law* 2nd Ed (1997) 244.

²⁴¹ J Crisp & D Dessalegn, *New Issues in Refugee Research*. Working Paper No.64 Refugee protection and migration management: the challenge for UNHCR (2002) 4. Available at <http://www.unhcr.org/3d6c9e714.pdf> (Accessed on 4 August 2015).

²⁴² C Bohmer & A Shuman, *Rejecting Refugees: Political Asylum in the 21st Century* (2008) 33.

²⁴³ See note 49 above (E Onouha).

²⁴⁴ *Ibid.* 84.

²⁴⁵ See note 217 above (E Feller).

with inadequate infrastructure and underlying political and social tensions.²⁴⁶ This is especially true pertaining to South Africa, where poverty, inequality and unemployment are regarded as the triple threats to the country.²⁴⁷ In the second quarter of 2015 the unemployment rate of the labour force percent was at 25 per cent.²⁴⁸ According to Oxfam, an international organisation working on eradicating poverty across the globe, more than half of the population in South Africa lives under the poverty line.²⁴⁹ As at April 2015, the poverty rate of South Africa was between 33 and 35.6 per cent.²⁵⁰ This percentage rate of poverty was higher than that of unemployment within the same period, implying that there were some who were employed but still living under the poverty line. Inequality in South Africa is also revealed through lack of access to natural resources; a two-tiered educational system; a dual health system; and other socio-economic dimensions.²⁵¹ Since the democratic dispensation, South Africa has developed policies aimed at poverty reduction and the improvement of the economy, but in spite of all this, the country still remains one of the highest in terms of income inequality.²⁵² Income inequality, poverty and unemployment are some of the factors which lead to hostilities towards foreigners in South Africa due to the belief that foreigners put a strain on the state's resources.²⁵³ Unlike other foreigners, refugees are entitled to the same rights as the host population with regard to public relief and social assistance.²⁵⁴ These entitlements are fair from a human rights perspective, considering that refugees would have fled their countries of origin in a bid to protect their lives and other rights. However, the lack of a burden-sharing provision within

²⁴⁶ Ibid. Also see note 236 above (E Quinn).

²⁴⁷ G Nicolson, 'South Africa: Where 12 million live in extreme poverty' (2015). Available at <http://www.dailymaverick.co.za/article/2015-02-03-south-africa-where-12-million-live-in-extreme-poverty/#.VckHNXGqqkp> (Accessed on 10 August 2015).

²⁴⁸ South Africa Unemployment Rate, 2000-2015. Available at <http://www.tradingeconomics.com/south-africa/unemployment-rate> (Accessed on 13 August 2015).

²⁴⁹ Z Merrington, 'More than half of South Africa's population lives below the poverty line.' (1 August 2015). Available at <http://www.sabc.co.za/news/a/2de2af004951afd089559fd6df653832/More-than-half-of-South-Africas-population-lives-below-poverty-line> (Accessed on 12 August 2015).

²⁵⁰ World Bank Poverty and Inequality Statistics, April 2015. Available at <http://knoema.com/WBPS2015Apr/world-bank-poverty-and-inequality-statistics-april-2015> (Accessed on 12 August 2015).

²⁵¹ JD Triegaardt, 'Poverty and inequality in South Africa: Policy considerations in an emerging democracy.' (year unavailable), 1. Available at <http://www.dbsa.org/EN/About-Us/Publications/Documents/Poverty%20and%20inequality%20in%20South%20Africa%20Policy%20considerations%20in%20an%20emerging%20democracy.pdf> (Accessed on 13 August 2015).

²⁵² Ibid. 2. See also The World Bank and Oxford University Press, world development report 2006 Equity and Development (2005) 39. Available at http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2005/09/20/000112742_20050920110826/Rendere d/PDF/322040World0Development0Report02006.pdf (Accessed on 13 August 2015). See also SAinfo reporter, 'Poverty levels in South Africa dropping: report.' (2014). Available at <http://www.southafrica.info/about/social/poverty-040414.htm#.VcxseHGqqko> (Accessed on 13 August 2015).

²⁵³ See note 152 above (L Sisulu) 6.

²⁵⁴ See note 219 above. See also section 27(g) of the Refugees Act 130 of 1998.

the Refugee Convention strains the socio-economic resources of receiving states, as they would have to provide for the refugees as per their international obligations, despite their limited resources.

The definition of refugee in the Refugee Convention probably presents another challenge to refugee law. In the Refugee Convention a refugee is defined as:

a person who, due to a founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear is unwilling to avail himself of the protection of that country; or who, not having a nationality or being outside the country of his former habitual residence as a result of such event unable or, owing to such fear, is unwilling to return to it.²⁵⁵

This definition is probably too narrow, as there are plenty of factors which lead people to unwillingly leave their homes. Morrison S, a member of the Australian parliament, stated that the Convention is becoming more and more inadequate in dealing with modern migration patterns, which will worsen due to things such as climate change, financial collapse, natural disasters or growing societal inequalities.²⁵⁶ It means that any persons who would have been forced to flee their countries for any other reason not recognised in the Refugee Convention will not be entitled to public relief and assistance, despite the need. Asylum seekers failing to prove persecution and the asylum seekers fleeing non-persecution related factors of migration will both fail to access things such as health care services, education and other rights. Other forms of forced human migration, such as human trafficking, ought to be considered as well. Human trafficking victims who would have escaped from their captors could be included under the definition of a refugee. For example, if a South African citizen is trafficked to Namibia and then escapes to Botswana, such a victim should be allowed to claim asylum in Botswana if there is enough reason to believe that their return to South Africa could lead them into the hands of the traffickers again. Human traffickers can manipulate the Refugee Convention in cases of mass influx of refugees and go with the victim undetected, as receiving states are burdened by individual determination systems in such cases. An example could be that of a human trafficker who poses as the guardian of a small child. The narrowness of the definition of refugee contributes to the abuse of the asylum system, as it does not really consider most of the

²⁵⁵ Article 1A (2) 1951 Refugee Convention. See also section 3(a) of the Refugees Act 130 of 1998.

²⁵⁶ Scott Morrison, 'A real solution: An international, regional and domestic approach to asylum policy.' (Speech to the Lowey Institute, Sydney, November 30, 2010).

realities that force people to migrate to other countries. It also places genuine asylum seekers at a disadvantage as they might be denied asylum for failing to prove persecution. On the other hand, maybe the definition of refugee in the Refugee Convention is not too narrow after all. The Refugee Convention was drafted at the end of the Second World War and persecution was so rife in that period that it was one of the leading causes of forced migration in Europe.²⁵⁷ It is known that one of the effects of war is the alteration or collapse of a country's economy²⁵⁸ and probably the Contracting States of the instrument did not want to broaden the definition of refugee, as their economies were still recuperating. The instrument was drafted based on what was going on in Europe at that time. If the drafters of the instrument had broadened it to include other factors of forced migration outside persecution, millions of people would have reasons to migrate to other countries as asylum seekers.

Another notable shortcoming of the Refugee Convention is its lack of sensitivity when it comes to persecution based on gender. The instrument was written in a different era and is silent on the rights of specific groups of vulnerable people such as women and children.²⁵⁹ The fact that the instrument does not specifically focus on the rights of vulnerable people such as women and children, does not mean that these groups of people were not fleeing to other states due to persecution in that time. During and after the Second World War, women and girls were being persecuted and were seeking asylum in other countries.²⁶⁰ The Refugee Convention was only drafted six years after the cessation of the Second World War. With all the happenings in Europe, it cannot be said that the drafters of the instrument were not aware of the gender-based persecution. The grounds of seeking asylum in other states, as stipulated by the instrument, are mainly based on persecution.²⁶¹ It can be said

²⁵⁷ J Friedmann, 'The 'Dishonourable' German Girls: The Forgotten Persecution of Women in World War II.' (2010). Available at <http://www.spiegel.de/international/germany/the-dishonorable-german-girls-the-forgotten-persecution-of-women-in-world-war-ii-a-672803.html> (Accessed on 14 August 2015). See also, 'Ethnic Cleaning of Germans after WW2.' Available at <http://uncensoredhistory.blogspot.com/2012/12/ethnic-cleansing-of-germans-after-ww2.html> (Accessed on 14 August 2015). See also 'Migration Citizenship Education.' Available at <http://migrationeducation.de/13.0.html> (Accessed on 14 August 2015). See also Robinson N, *Convention Relating to the Status of Refugees: Its history, contents, interpretation I* (1953) 3.

²⁵⁸ I Kesternich, B Siflinger, JP Smith, & JK Winter, 'The Effects of World War II on Economic and Health Outcomes across Europe' (2012). Available at http://www.rand.org/content/dam/rand/pubs/working_papers/2012/RAND_WR917.pdf (Accessed on 15 August 2015). See also, C Sailus, 'Economic Reconstruction in Europe after WWII: Recovery Programs & Their Effect.' Available at <http://study.com/academy/lesson/economic-reconstruction-in-europe-after-wwii-recovery-programs-their-effect.html> (Accessed on 15 August 2015).

²⁵⁹ See note 217 above (E Feller).

²⁶⁰ See note 257 above (J Friedman).

²⁶¹ See note 227 above.

that the main aim of the instrument is the protection of the lives of people facing persecution in their home countries through granting them asylum in other countries. One then cannot comprehend how the drafters of the instrument could have overlooked the inclusion of gender-based persecution under the applicable grounds for seeking asylum in other states. Considering the nature and the purpose of the instrument, one can say that the drafters of the Refugee Convention simply undermined the importance of refugee women's rights. Some scholars feel that gender-based persecution, especially that faced by women, was overlooked because the drafters of the instrument were all male.²⁶² Other scholars state that the depiction of women as harmless victims needing protection results in them being marginalised from the decision-making bodies that deliver humanitarian assistance and may result in some of women's most basic needs being overlooked.²⁶³ At times women could not even tell their stories of persecution, as the issue was given little thought.²⁶⁴ In other words, the exclusion of gender-based persecution in the instrument could not have been solely due to the dominance of the male drafters, but somewhat to that perception of women being victims in need of help and protection.

On the other hand, it ought to be considered that the drafters of the Refugee Convention did not really have a foresight of how the instrument was going to be used globally as an instrument of refugee protection, as evidenced by the emergence of the 1967 Protocol.²⁶⁵ In today's world, human rights advocates see the importance of protecting the rights of refugee women too, due to instruments such as the Millennium Development Goals (MDGs) (especially 4 and 5),²⁶⁶ which seek to combat certain challenges such as poverty, maternal mortality and infant mortality on a global scale. For all these things to be achieved, states ought to ensure that the rights of everybody, including vulnerable groups such as refugee women (who are often forgotten), are realised and protected.

²⁶² J Kumin, 'Gender-based persecution leaves the shadows'. (2001) 12. See note 223 above (50th Anniversary) Available at www.unhcr.org/3b5e90ea0.pdf (Accessed on 18 August 2015).

²⁶³ M Haeri & N Puechguirbal, 'From helplessness to agency: examining the plurality of women's experiences in armed conflict.' *International Review of the Red Cross*, Vol 92, Number 877, (2010) 106. Available at <https://www.icrc.org/eng/assets/files/other/irrc-877-haeri-puechguirbal.pdf> (Accessed on 18 August 2015).

²⁶⁴ See note 262 above (J Kumin).

²⁶⁵ See note 204 above.

²⁶⁶ MDG 4 Aimed at reducing child mortality by 2015; MDG 5 Aimed at improving maternal health by 2015. Available at www.undp.org/content/undp/en/home/mdgoverview.html (Accessed on 18 August 2015).

3.2.2 *The 1967 Protocol*

As highlighted earlier on, the Refugee Convention was drafted in order to address the problem of refugee movements which were as a result of the occurrences before 1951 in Europe. It is thus evident that its provisions did not extend to other continents and were subject to the time limit of 1951. However, after 1951, people on other continents were also seeking asylum in other countries. Though it had been hoped that the UNHCR would help solve the refugee problem three years after the Second World War, the refugee crisis worsened.²⁶⁷ The crisis spread from Europe in the 1950s to Africa in the 1960s and then to Asia and by the 1990s, back to Europe.²⁶⁸ The 1967 Protocol was then drafted. It removes geographical barriers²⁶⁹ and allows the provisions of the Refugee Convention to be applicable in any location at any time.²⁷⁰ The phrase ‘...new refugee situations have arisen...’ indicates the intention of the drafters of the 1967 Protocol to make the provisions of the Refugee Convention applicable in different states faced with problems of people seeking asylum due to other reasons initially excluded in the Refugee Convention.

Scholars opine that non-specific mention of the context of new refugee situations and the removal of the January 1951 limitation point out that the 1967 Protocol sought to extend the protections laid down in the 1951 Convention.²⁷¹ It is clear that the drafters of the 1967 Protocol considered that the new refugee situations that had led to its drafting were not going to be the last ones. Several other situations were going to emerge, causing people to seek refuge in other countries too. This shows the evolving nature of refugee law.

²⁶⁷ See note 225 above (M Achiron) 12.

²⁶⁸ *Ibid.*

²⁶⁹ Article 1.3 states, “The present Protocol shall be applied by the States Parties hereto without any geographic limitation, save that existing declarations made by States already Parties to the Convention in accordance with article 1 B (1) (a) of the protocol relating to the status of refugees shall, unless extended under article 1 B (2) thereof, apply also under the present Protocol.”

²⁷⁰ The Preamble states:

The States Parties to the present Protocol,
Considering that the Convention relating to the Status of Refugees done at Geneva on 28 July 1951 (hereinafter referred to as the Convention) covers only those persons who have become refugees as a result of events occurring before 1 January 1951,
Considering that new refugee situations have arisen since the Convention was adopted and that the refugees concerned may therefore not fall within the scope of the Convention,
Considering that it is desirable that equal status be enjoyed by all refugees covered by the definition in the Convention irrespective of the dateline 1 January 1951,
Have agreed as follows...

(See note 205 above).

²⁷¹ AG Pizor, ‘Sale v. Haitian Centers Council: The Return of Haitian Refugees.’ *Fordham International Law Journal*, Article 6, Vol 17, Issue 4 (1993) 1105.

Accordingly, it could be acceptable to make the provisions of the Refugee Convention applicable to persons who seek refuge in other countries due to reasons such as climate change, drought and other reasons.

3.2.3 1969 OAU Convention

The 1969 OAU Convention is the regional instrument that governs the protection of refugees in Africa. It complements the Refugee Convention.²⁷² Though complementary to the Refugee Convention, it could be said that the instrument came into existence as a way of dealing with problems which are mainly faced by refugees in Africa. Some scholars support this view by stating that the 1969 OAU Convention was created to address, as the name suggests, specific problems of refugees which could not be addressed by the Refugee Convention.²⁷³ One could agree with this view, as there could have been no need to come up with this regional convention if the Refugee Convention had addressed all aspects of refugee problems. This instrument is unique, as it is the only regional instrument for refugee protection which is binding. It was created to find strategies of alleviating the misery and suffering of refugees and to give them a better life, considering their increasing numbers.²⁷⁴ There are other regional refugee protection instruments²⁷⁵ enforceable on other continents, but for the purposes of this study, focus will be on the 1969 OAU Convention, as this study is centered on refugee women in South Africa. South Africa is a member state of the Organisation of African Unity (OAU). It ratified the instrument in December 1995,²⁷⁶ meaning that it is bound by its provisions.

3.2.3.1 Protection of health rights in the 1969 OAU Convention

Like the Refugee Convention, the 1969 OAU Convention does not have a clause which directly mentions the health rights of refugees. Nonetheless, there are a few articles within the instrument whose construction can be used to refer to the right of access to health care

²⁷² See note 206 above, (article 8.2).

²⁷³ JD Mujuzi, 'The African Commission on Human and Peoples' Rights and the promotion and protection of refugees' rights.' *African Human Rights Law Journal (AHLJ)*, Vol 9, No 1 (2009) 160-182. Available at <http://www.ahrlj.up.ac.za/mujuzi-jd2> (Accessed on 4 September 2015).

²⁷⁴ See note 206 above (preamble).

²⁷⁵ These include: the 1984 Cartagena Declaration on Refugees, the 1966 Bangkok Principles on Status and Treatment of Refugees, the 1976 Council of Europe's Recommendation 773 (1976) on the situation of *de facto* Refugees, the European Union's Council Directive and the Almaty Process of 2011.

²⁷⁶ African Commission on Human and Peoples' Rights Ratification table: AU Convention Governing Specific Problems of Refugee Problems in Africa. Available at www.achpr.org/instruments/refugee-convention/ratification/ (Accessed on 3 September 2015).

services. These are articles 2.1, article 4 and article 5.3. These shall be analysed one after the other.

Article 2.1 of the 1969 OAU Convention places an obligation on member states of the OAU to use their best endeavours, consistent with their respective legislations, to receive refugees and to secure the settlement of those refugees who, for well-founded reasons, are unable or unwilling to return to their country of origin or nationality.²⁷⁷ This article can be construed to be a provision aimed at the protection of health rights. To come up with a comprehensive construction of this article, one may look at the key phrases and words used, which include, ‘best endeavours’, ‘receive refugees’ and ‘settlement’.

In the law of contract, the best endeavour requirement places *onus* on a contractual party to make every reasonable effort to achieve the anticipated aim, as held in the case of *Sheffield District Railway v Great Central Railway*.²⁷⁸ The Court further said that using the best endeavour in a contractual obligation meant leaving no stone unturned.²⁷⁹ This did not mean leaving the ground of reason; but that a party had to reasonably fulfil the contractual object given the prevailing circumstances.²⁸⁰ Other scholars hold the view that a best endeavour requires action that is commercially practicable and financially feasible, and requires a high level of commitment, but not guaranteeing an absolute level to perform.²⁸¹ The views mentioned above shed more light on what the phrase ‘best endeavours’ means in international treaty law. The phrase may perhaps be construed to mean that a contractual party to a treaty ought to exhaust all the available options in the fulfilment of its obligations under a treaty. In the reception of refugees, this could mean that state parties like South Africa, which are parties to the 1969 OAU Convention have a duty to try their level best to fulfil their obligations towards refugees within the available state resources. It does not mean that contractual parties have to go out of their way to fulfil the treaty obligations, but

²⁷⁷ See note 206 above.

²⁷⁸ *Sheffield District Railway Co v Great Central Railway Co*; 1911 27 TLR 451. Available at <http://swarb.co.uk/sheffield-district-railway-co-v-great-central-railway-co-1911/> (Accessed on 7 September 2015).

²⁷⁹ *Ibid.*

²⁸⁰ *Terrell v. Mabie Todd and Co. Ltd* (1952) 69 RPC 234. 7 (1952) 69 RPC 234. Cited by C Kehoe & J Keillor in ‘In it for the long haul?’ in the *New Law Journal (NLJ)*, Issue 7524 (2012). Available at <http://www.newlawjournal.co.uk/nlj/content/it-long-haul> (Accessed on 7 September 2015).

²⁸¹ ‘Reasonable endeavours versus best endeavours.’ (2009). Available at www.nortonrosefulbright.com/news/45469/reasonable-endeavours-versus-best-endeavours (Accessed on 7 September 2015).

that the efforts and such fulfilment should be relative to their national budgets and available resources.

Furthermore, the best endeavours obligation should be achieved within the stipulations of the municipal law of a particular state party, since the article 2.1 of the 1969 OAU Convention includes the words ‘...consistent with their respective legislations...’ after best endeavours. Therefore a member state of the OAU Convention may leave no stone unturned in the protection of refugees only within the scope of its municipal law regarding the refugees. In simpler terms, the best endeavour obligation of the member state shall be nothing more or less than its municipal law.

The phrase ‘receive refugees’ in article 2.1 of the 1969 OAU Convention could be understood as protecting the right to health care. Elements of reception include, amongst other elements; the basic practical orientation, including orientation into banking systems, registering with relevant government programmes such as income support, *health care* (emphasis added), public housing and school enrolment.²⁸² This aspect clearly shows that the granting of refugee status does not come on its own, but with a whole lot of other fundamental rights, such as access to the public health care system and information. However, granting of such rights should be consistent with the state’s municipal laws relating to refugee protection.

In South Africa, the provision of health care services to refugees as a group and to refugee women in particular, has to be consistent with the Refugees Act,²⁸³ the Promotion of Access to Information Act 2 of 2000 (PAIA), the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (PEPUDA) and other relevant legislation aimed at equality and making the reception process a reality. This shows the tie between international and municipal law. Municipal law ought to always comply with international law, while international law provisions may only be implemented through a country’s municipal law.

²⁸² UNHCR “Chapter 2.2 Welcoming and Receiving Resettled Refugees” in *Applying the Framework in Key Program Areas* (2002). Available at www.unhcr.org/3d985ec04.html (Accessed on 7 September 2015). See also article 4 of the 1998 SADC Declaration which mandates state parties to fulfil their international obligations towards refugees. Available at http://www.sadc.int/files/2013/5292/8381/Declaration_on_Refugee_Protection_within_Southern_Africa.pdf (Accessed on 7 September 2015).

²⁸³ See note 254 above.

As noted above, article 2.1 of the 1969 OAU Convention requires a member state to secure the settlement of refugees. Settlement of refugees is sometimes referred to as the local integration of refugees. The process involves granting refugees the full legal rights in the country to which they have fled.²⁸⁴ With this definition, it cannot be disputed that the full legal rights would also include the health care services to refugees and to refugee women who have special rights by virtue of them being women. The close link between reception and settlement of refugees cannot be overlooked, because settlement follows reception and at times they happen simultaneously. Settlement in a host member state would mean that such a state would be willing to realise the rights of the received refugees. In short, the summary construction of article 2.1 is that a member state must, within its available resources, explore every viable option within the scope of its municipal law to realise the basic rights of refugees, so as to make their local integration easy. This provision is in line with the instrument's preamble, which sets one of its objectives as the reduction of the suffering faced by refugees.²⁸⁵

Similar to article 3 of the Refugee Convention, article 4 of the 1969 OAU Convention is an undertaking of member states to apply the provisions of the 1969 OAU Convention to all refugees, without discrimination concerning race, religion, nationality, membership of a particular social group or political opinions.²⁸⁶ This article encourages the access to basic rights, such as health care for refugees, in host states. Most of the grounds limited are less difficult to define, but membership to a particular social group has been deemed the most difficult to define and is subject to many legal arguments.²⁸⁷ The most probable reason is that the Refugee Convention has not defined what membership to a particular social group is. In the same way the 1969 OAU Convention does not define the concept. Fortunately, the UNHCR has formulated a definition from combining the two approaches (“protected characteristic” and the “social perception”)²⁸⁸ used in the state practice of a number of

²⁸⁴ See <http://definitions.uslegal.com/l/local-integration-refugee/> (Accessed on 7 September 2015).

²⁸⁵ See note 206 above.

²⁸⁶ Ibid.

²⁸⁷ DR Myslinska, ‘What a “Particular Social Group” Means for Asylum Purposes.’ Available at <http://www.nolo.com/legal-encyclopedia/what-particular-social-group-means-asylum-purposes.html> (Accessed on 10 September 2015).

²⁸⁸ The “protected characteristics approach” recognises whether a group is united by an immutable characteristic or by a characteristic that is so fundamental to human dignity that a person should not be compelled to forsake it. Through the application of this approach, courts and administrative bodies have concluded that women, homosexuals and families, for example, can constitute a particular social group within the meaning of Article 1 A (2) of the Refugee Convention. The “social perception” approach examines whether or not a group shares a common characteristic which makes them a cognizable group or sets them apart from society at large. This approach also recognises women, families and homosexuals as particular

jurisdictions. It defines membership to a particular social group as a group of persons who share common characteristics other than their risk of being persecuted, or who are perceived as a group by society. The characteristic will often be one which is innate, unchangeable, or which is otherwise fundamental to identity, conscience, or the exercise of one's human rights.²⁸⁹ Using this definition, it can be said that women form a particular social group. One can argue that their reproductive role due to their biological makeup makes them unique and is a fundamental aspect in their exercise of rights of access to maternal health care, such as obstetric care, contraception and abortion. Thus refugee women are protected against unfair discrimination under article 3 of the 1969 OAU Convention.

From the construction of articles 2.1 and 3 of the 1969 OAU Convention, it is clear that the instrument protects the health rights of refugees in the hosting member states, by placing on them an obligation to leave no stone unturned and not to discriminate against refugees. The instrument extends the right to health care to when refugees voluntarily repatriate to their country of origin. This is stipulated in article 5.3 of the instrument, which provides that the country of origin, shall, on receiving back refugees, facilitate their resettlement and grant them the full rights and privileges of nationals of the country and subject them to the same obligations.²⁹⁰ One can reason that this article is one of the aspects that make the instrument unique, as the Refugee Convention does not provide for such. It should be remembered that voluntary repatriation is one of the grounds on which refugee status ceases.²⁹¹ Cessation of refugee status does not mean the cessation of the rights of the refugees, but that the host state would not be under obligation to recognise them any longer. The refugees cease to be protected by the host country and assume their rights in their country of origin. For example, if a pregnant Rwandese refugee woman in South Africa voluntarily repatriates to her country of origin, South Africa ceases to have an obligation under international law to realise her maternal service rights. It is Rwanda which will have the duty to reinstate the rights of that woman as its returning citizen, so that she will enjoy the rights enjoyed by other Rwandese nationals.

social groups, depending on the circumstances within the society they live in. From: UNHCR, Guidelines on International Protection: "Membership of a particular social group" within the context of Article 1A (2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees, (2002), 3. Available at <http://www.unhcr.org/3d58de2da.pdf> (Accessed on 10 September 2015).

²⁸⁹ Ibid. 3.

²⁹⁰ See note 206 above.

²⁹¹ Article 1.4 of the 1969 OAU Convention. See also article 1C of the Refugee Convention. See also article 10 of the 1998 SADC Declaration.

3.2.3.2 *A critique of the 1969 OAU Convention*

Though this instrument has a framework which is very similar to that of the Refugee Convention, it has some unique features. It complements the Refugee Convention²⁹² and upholds the core principles of refugee law such as non-refoulement,²⁹³ non-penalisation²⁹⁴ and non-discrimination.²⁹⁵ Despite upholding the core values of refugee law, the provision of some of them slightly vary from those provided in the Refugee Convention. Perhaps the most significant difference is that the 1969 OAU Convention is only binding on member states of the OAU which have ratified it, whilst the Refugee Convention can be used in any geographical location, as enabled by its protocol of 1967.²⁹⁶ The unique features of the 1969 OAU Convention shall be discussed below.

Article 5.4 of the 1969 OAU Convention provides that upon a refugee's return to his or her country of origin, such a refugee should not be penalised for having left the country for any of the reasons giving rise to refugee situations. This non-penalisation clause protects refugees against victimisation from their home governments. It could be said that this particular article helps to ensure that the full rights of refugees are reinstated upon return to their home countries. This could explain why this article directly follows article 5.3, which provides for the resettlement of refugees and the granting of their full rights after voluntary repatriation.²⁹⁷ Unlike the Refugee Convention, this particular instrument does not provide for the non-penalisation of asylum seekers for illegal entry into a host country. Thus, both instruments contain non-penalisation clauses, which are applied differently.

One of the most notable features of the 1969 OAU Convention is its provision of another refugee definition, in addition to that provided in article 1A(2) of the Refugee Convention.²⁹⁸ This definition is found in article 2.2 of the instrument.²⁹⁹ Other scholars say

²⁹² See note 206 above.

²⁹³ Article 2.3.

²⁹⁴ Article 5.4.

²⁹⁵ Article 4.

²⁹⁶ See note 270 above (Preamble).

²⁹⁷ See note 206 above.

²⁹⁸ Article 1.1 of 1969 OAU Convention. See also note 253 above.

²⁹⁹ The term "refugee" shall also apply to every person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or

that this definition is perhaps the most important portion of the 1969 OAU Convention.³⁰⁰ One could agree with this view as this definition can be said to follow a realistic approach towards the issues that influence refugee movements on the African continent. As highlighted above, the 1969 OAU Convention was created to specifically deal with refugee problems on the African continent which the Refugee Convention could not address.³⁰¹ The definition is therefore befitting, as it considers the specific aspects of refugee movements in Africa. It is flexible and considers the various factors which influence refugee migration. It could be argued that such a definition significantly reduces fraudulent asylum claims, as a person would not have to be forced to prove persecution to acquire refugee status.

Non-refoulement is a feature of both the Refugee Convention and the 1969 OAU Convention. It has, however, been pointed out that the latter instrument provides a wider scope of non-refoulement, as it has expanded the definition of refugee to include people fleeing war and internal disturbances.³⁰² Article 2.3 of the instrument extends the principle of non-refoulement to admission to state territory and not merely limited to those already within the territory, as provided for in the Refugee Convention.³⁰³

3.3 Declaration on Refugee Protection within Southern Africa (1998) (SADC Declaration)

The SADC declaration does not make specific mention of the right of access to health care services. However, some of its provisions can be construed in line with the right to health care. The declaration states that when addressing the needs of refugees and the challenges of refugee protection, African *values and hospitality* (emphasis added) must be considered as well as human rights and relevant humanitarian principles of refugee protection enshrined in international instruments.³⁰⁴ One of the cultural values upheld in African society and in South Africa is *ubuntu*. *Ubuntu* has been described as a philosophy of life

nationality, is compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality.

³⁰⁰ K Jastram & M Achiron, *Refugee Law: a guide to international refugee law*. (2001) 13. Available at http://www.ipu.org/pdf/publications/refugee_en.pdf (Accessed on 11 September 2015).

³⁰¹ See note 273 above (JD Mujuzi).

³⁰² O Bueno, *Perspectives on Refoulement in Africa*. (2006) 2-3. Available at <http://www.refugee-rights.org/Publications/Papers/2006/RefoulementinAfrica.April2006.pdf> (Accessed on 20 July 2015). See also note 280 above article 1 of the 1998 SADC Declaration.

³⁰³ Non expulsion clause- Article 32 (1) of Refugee Convention.

³⁰⁴ Paragraph E (i) of the Preamble. Available at http://www.sadc.int/files/2013/5292/8381/Declaration_on_Refugee_Protection_within_Southern_Africa.pdf (Accessed on 19 November 2015).

which represents personhood, humanity, humaneness and morality.³⁰⁵ *Ubuntu* aims at aiding other people in the spirit of service, respecting others, honesty and trustworthiness.³⁰⁶ It is an African value which regulates interpersonal relationships and dispute resolution within communities.³⁰⁷ It cannot be denied that the three fundamental values (human dignity, freedom and equality),³⁰⁸ on which the 1996 Constitution rests promote *ubuntu*. Though not a binding principle, *ubuntu* was used as a guiding principle by the Constitutional Court to reach its decision in the case of *S v Makwanyane*.³⁰⁹ With that in mind, it can be said that the provision of health care services to refugees in South Africa ought to be in line with the principles of *ubuntu* as an African value. Health care workers ought to respect refugee women and treat them with the dignity deserved by every human being.

3.4 *The right to health under international law*

The right to health is protected in various human rights treaties, soft law and international declarations. Though there are several international instruments and policies relating to health, the main focus will be on instruments and policies that focus on women and the right to health. These include the International Covenant on Economic, Social and Cultural Rights (1966) (ICESCR), the Convention on the Elimination of All Forms of Discrimination Against Women (1979) (CEDAW), the African Charter on Human and People's Rights (1981) (Banjul Charter) and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003) (Women's Protocol). Brief reference will be made to other instruments which indirectly make provision of maternal health care services to women. These are discussed below.

³⁰⁵ Y Mokgoro, 'Ubuntu and the law in South Africa'. A paper delivered at the first Colloquium Constitution and the Law held at Potchefstroom on 31 October 1997, 2. *Potchefstroom Electronic Law Journal/Potchefstroomse Elektroniese Regsblad* - Vol 1, No 1 (1998). Available at <http://www.ajol.info/index.php/pelj/article/view/43567/27090> (Accessed on 19 November 2015).

³⁰⁶ K Chaplin, 'The Ubuntu spirit in the African communities'. Available at <http://www.coe.int/t/dg4/cultureheritage/culture/Cities/Publication/BookCoE20-Chaplin.pdf> (Accessed on 19 November 2015).

³⁰⁷ C Himonga, M Taylor & A Pope, 'Reflections on Judicial Views of Ubuntu'. *Potchefstroom Electronic Law Journal* 2013 Volume 16 No 5 [2013] PER 67. Available at <http://www.saflii.org/za/journals/PER/2013/67.html> (Accessed on 19 November 2015).

³⁰⁸ Section 1 (a) and section 39 (1) (a) of the 1996 Constitution.

³⁰⁹ See note 69 above. In paragraph 224 Madala J stated that *ubuntu* is a culture which recognises a person's status as a human being, entitled to unconditional respect, dignity, value and acceptance from the members of the community such person happens to be part of. It also entails the converse, however. The person has a corresponding duty to give the same respect, dignity, value and acceptance to each member of that community. More importantly, it regulates the exercise of rights by the emphasis it lays on sharing and co-responsibility and the mutual enjoyment of rights by all.

Article 14 of the Women's Protocol provides for the health and reproductive rights of women.³¹⁰ It places an obligation upon state parties to respect women's health rights, including their sexual and reproductive health care.³¹¹ State parties are further obliged to take all appropriate measures to 'establish and to strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding.'³¹² This provision in article 14.2 of the Women's Protocol shows the importance placed on the realisation of maternal health care services by the international community. State parties like South Africa have to institute and improve the facilities which offer maternal health care services. Such improvements would be in line with General Comment No.2 of Article 14 of the Women's Protocol which obliges state parties to improve health care facilities. Regardless of being an instrument on child protection, the Convention on the Rights of the Child (1989) (CRC) indirectly promotes access to maternal health care by placing states under obligation to ensure appropriate pre-natal and post-natal health care for mothers.³¹³ The purpose of this provision is the reduction of avoidable maternal and infant mortality as they violate human rights.³¹⁴

It ought to be considered that these provisions do not distinguish between the different categories of women or mothers. They simply state that women and mothers should receive appropriate maternal health care services. This non-differentiation between the categories of women and mothers shows that the provisions have to be uniformly applied to every woman in her reproductive phase. This, in turn, promotes article 12.1 of the CEDAW, which articulates that state parties have to take all appropriate measures to eliminate discrimination against women in the field of health care, in order to ensure, on a basis of equality with men and women, access to health care services, including those related to

³¹⁰ Available at <http://www.achpr.org/files/instruments/women-protocol> (Accessed on 14 September 2015).

³¹¹ Ibid. Article 14.1.

³¹² Ibid. Article 14.2.

³¹³ Article 24.2(d) of the Convention on the Rights of the Child (CRC) available at http://www.unicef.org/crc/files/Rights_overview.pdf (Accessed on 14 September 2015). See also Article 6 of the CRC which states that a child has the right to life and that states ought to ensure survival and development of the child. This provision, places an obligation on state parties to provide appropriate pre and post natal care to an extent.

³¹⁴ Conference A- National Model United Nations. Available at http://www.nmun.org/ny_archives/ny15_download (Accessed on 14 September, 2015). See also Committee on the Rights of the Child, General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24). Available at <http://www.refworld.org/docid/51e9e134.html> (Accessed on 17 January 2016).

family planning.³¹⁵ What makes this article interesting is that it does not only prohibit discrimination between members of the opposite sex but amongst individuals of the same sex. It obliges state parties to ‘...eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality with men *and women*...’³¹⁶ (emphasis added) to improve access to health care services. Therefore there should not be any differentiation amongst women when state parties provide health care services. All women should be treated equally regardless of their nationality, religion, race, or any other feature that may be regarded as grounds for unfair discrimination.

The ICESCR provides that state parties must recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.³¹⁷ The use of the word ‘everyone’ shows that the right is to be enjoyed without discrimination by all, including vulnerable groups such as racial minorities, women, children and refugees.³¹⁸ The states’ obligation to respect the right to health implies that the state must not deny or limit equal access to rights of all persons including asylum-seekers.³¹⁹ The vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes even in times of severe resource constraints.³²⁰ In the preamble to the World Health Organisation Constitution (WHO Constitution) it has been stipulated that all people are to enjoy the highest attainable standard of health, without discrimination.³²¹

The African Charter on Human and Peoples’ Rights (1981) (ACHPR) stipulates that individuals shall enjoy the right to the best attainable state of physical and mental health.³²² The standard to be achieved in the ACHPR is lower than the one provided for in the ICESCR, since what is “best” is likely to be evaluated within the context of the economic

³¹⁵ CEDAW, Article 12(1). Committee on the Elimination of Discrimination Against Women, General Recommendation No.24, Article 12: Women and Health, UN Doc CEDAW (1999). Available at http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/INT_CEDAW_GEC_4738_E.pdf (Accessed on 14 September 2015). See also article 18.3 of the African Charter on Human and Peoples’ Rights (1981). Available at http://www.achpr.org/files/instruments/achpr/banjul_charter.pdf (Accessed on 14 September 2015).

³¹⁶ Ibid. See also, General Recommendation No. 24.

³¹⁷ Available at <http://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf> (Accessed on 15 September 2015).

³¹⁸ M Ssenyonjo, *Economic, Social and Cultural Rights in International Law*. (2009).

³¹⁹ United Nations, ‘Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.’ Available at <http://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx> (Accessed on 17 January 2016).

³²⁰ See note 85 above. Para 18.

³²¹ WHO Constitution. Available at <https://archive.org/details/WHO-constitution> (Accessed on 15 September 2015).

³²² Article 16.1 Available at <http://www.achpr.org/files/instruments/achpr> (Accessed on 15 September, 2015).

difficulties prevalent in many African states.³²³ This view could be correct in that, socio-economic rights such as health care are highly dependent on the availability of state resources.³²⁴ Without the resources such rights can hardly be realised. Using the “highest attainable standard” as the yardstick for physical and mental health makes the realisation of such rights difficult, as state parties might be forced to overspend on their health budgets, thus isolating other areas needing their attention. Thus the standard set for the attainment of physical and mental health set in the ACHPR is more realistic when used within Africa as it is a regional instrument which was created to suit African states.

The challenge comes when trying to determine what the “best” is from one African country to another. How is a state party of the ACHPR deemed to have provided people such as refugee women with the best attainable standard of maternal health care services? One wonders how that can be measured. At this point, the “highest attainable standard” set out in the ICESCR, WHO Constitution and other instruments can be seen as more appealing than the one in the ACHPR. The ICESCR and the WHO Constitution are international instruments, as opposed to the ACHPR, which is a regional instrument. Therefore using the highest attainable standard of health will ensure uniformity and fairness amongst member states, even when dealing with refugee women as a vulnerable group of people.

Lastly, the Universal Declaration of Human Rights (1948) (UDHR) makes provision for everyone’s right to a standard of living which is adequate for his or her family, including food, clothing, housing and medical care.³²⁵ Article 25.1 is relevant in that it recognises health to be more than medical care and includes preconditions for health that are central to achieving an adequate standard of living.³²⁶ Motherhood and childhood have an entitlement to special care and assistance.³²⁷ Though the articles neither directly refers to the right to health nor maternal health care services, the provisions may be constructed widely, so as to include these aspects. Article 25.2 of the UDHR is closely related to article 24.2(d) of the CRC.³²⁸ It can be said, therefore, that it is aimed at the reduction of infant and maternal mortality.

³²³ See note 318 above (M SSenyonjo).

³²⁴ As in the case of *Soobramoney v Minister of Health KwaZulu-Natal* 1998 (1) SA 765 (CC).

³²⁵ Article 25.1. Available at <http://www.ohchr.org/EN/UDHR?Documents> (Accessed on 16 September 2015).

³²⁶ A Chapman, “Core Obligations Related to the Right to Health and their Relevance for South Africa” in D Brand & S Russell (eds), *Exploring the Core Content of Socio-Economic Rights: South African and International Perspectives*. (2002) 38.

³²⁷ See note 325 above (UDHR (1948)) Article 25.2.

³²⁸ See note 313 above (CRC).

3.5 The Sexual and Reproductive Health and Rights Continental Policy Framework (SRHRC Policy Framework)

The SRHRC Policy Framework was created by the African Union (AU). It was created to provide a model for bringing together national, sub-regional and continental efforts to promote and prioritise reproductive health and rights.³²⁹ According to the framework, the various sexual and reproductive health legislations of the AU member states are inadequate.³³⁰ To strengthen their legislations member states ought to adopt sexual and reproductive laws which are in line with the specific sexual and reproductive health care needs of the African continent.³³¹ By so doing, African countries will be able to reduce the problems of high maternal and infant mortality. Scholars hold the view that a state's commitment, political will and resources are the driving force behind the realisation of the MDGs.³³² As a member state of the AU, South Africa has an obligation to implement policies and laws which promote the sexual and reproductive health of all women within its territory. Such laws and policies will be able to address the sexual and reproductive health care needs of refugee women. In turn this will make the right of access to maternal health care services a reality to refugee women.

3.6 Landmark cases on maternal health care

3.6.1 Domestic cases

In South Africa there have not been many reported cases on the right of access to maternal health care services. Despite not having many cases relating to the right of access to maternal health care services in South Africa, the courts have adjudicated on some cases of medical negligence arising out of the provision of maternal health care services.

*3.6.1.1 Sonny and Another v Premier of the Province of KwaZulu-Natal and Another*³³³

A man and his wife sued the Premier of KwaZulu-Natal and the *eThekweni* municipality for medical negligence. Whilst the second plaintiff (Mrs Sonny) was pregnant, she received ante-natal care at a provincial hospital which was headed by the first defendant (the

³²⁹ African Union, 'Sexual and Reproductive Health and Rights Continental Policy Framework' (2006) 9.

Available at http://pages.au.int/sites/default/files/SRHR%20English_0.pdf (Accessed on 18 November 2015).

³³⁰ Ibid 27.

³³¹ Ibid.

³³² V Tallis, 'Sexual and reproductive health and rights: a useful discourse for feminist analysis and activism?' 23 October 2012. Available at <http://www.osisa.org/buwa/regional/sexual-and-reproductive-health-and-rights-useful-discourse-feminist-analysis-and-activ> (Accessed on 16 January 2016).

³³³ See note 38 above.

Premier). At the hospital, she underwent an ultra-sound, which showed that it was rather difficult to assess the medical condition of the foetus due to its position.

Mrs Sonny was then referred to a clinic under the *eThekweni* municipality for her second scan. However, she did not do the second scan at the clinic, as the nurse told her that she only had to do it towards the end of the pregnancy. The nurse did not provide any reasons to Mrs Sonny as to why the scan had to be postponed until then. Due to this, Mrs Sonny trivialised the scan and missed the appointment.

She later delivered a child with Down's syndrome. She and her husband then instituted a claim against the defendants for the costs of caring for the child until she reached about 55 years of age. They based their claim on the fact they would have terminated the pregnancy if they had been informed about the condition of the foetus.

The Court held that the failure of the health care workers to tell Mrs Sonny about the importance of the scan was negligent. The result of the scan, coupled with the failure of the nurse at the clinic to tell Mrs Sonny why the scan had to be done towards the end of the pregnancy gave a sense of security and relaxation. Ineffective communication on the part of the health care workers resulted in the premier being liable for the child's care.

3.6.1.2 *H v Fetal Assessment Centre*³³⁴

A woman instituted a claim for damages against the Fetal Assessment Centre (the Centre) on behalf of her minor child. The damages were based on the fact that the woman's child had been born with Down's syndrome, due to the Centre's failure to interpret the scan of the foetus in a bid to identify the possibilities of being born with abnormalities. The Centre maintained that the child (though a minor being represented by his mother) did not have any claim as 'wrongful life'³³⁵ actions were not recognised within South African common law.

The High Court had to answer whether a child could claim compensation for being born with a disability. The High Court upheld the Centre's exception that a child could not claim for wrongful life and the particulars of claim did not disclose the cause of action as claims of such nature were not recognised under South African common law. Leave was granted to

³³⁴ See note 38 above (*H v Fetal Assessment Centre*).

³³⁵ A claim brought on behalf of a child born with defects alleging that the child would not have been born save for the negligent advice to, or treatment of the parents. From the Free Dictionary. Available at <http://legal-dictionary.thefreedictionary.com/Wrongful+Life> (Accessed on 22 November 2015).

appeal and H appealed to the Constitutional Court. The question was whether the concept of wrongful life could be developed under South African common law. The Constitutional Court found that the failure of medical experts to figure out that a child would be born with disabilities disadvantages the mother, in that she will not have the choice of terminating the pregnancy. This often results in patrimonial loss which can give rise to a delictual claim by the parents from the medical experts under South African law. However, it is not in all cases that parents would claim compensation for the congenital disabilities of their child. It is not only the parents who suffer but also the disabled child. The Court then held that common law could actually be developed to include wrongful life claims relying on section 28(2) of the Constitution which stipulates that the best interests of the child are paramount in all matters concerning the child.³³⁶ Furthermore, if the elements of delict could be proven in such cases then claims could be made.³³⁷ The High Court was then given the discretion to determine whether such a claim existed.³³⁸ In other words, the High Court had to review the matter using the guidance of the Constitutional Court. The Constitutional Court then granted H leave to amend the particulars of claim within a fortnight.³³⁹

3.6.1.3 Significance of the cases of Sonny and H v Fetal Assessment Centre

The decision of the court in the case of *Sonny* holds great significance in that it reinforces the duty of health care workers to keep health care users informed about their health conditions, to avoid liability for any undesired results. It shows the importance of not overlooking any details pertaining to the health care of the health care user. The decision of this case is also relevant with regard to the right to information that refugee women have when accessing maternal health care services. As seen in Chapter Two, language is one of the greatest barriers faced by refugee women as they try to access maternal health care services within South African public health facilities. As a result, some of them undergo C-sections without consent being obtained from them.³⁴⁰ This implies that they are not given any explanation as to why the procedure is being performed, its pros and cons, nor a choice to accept it or not. Several refugee women who receive maternal health care services without being given information by the health care workers might institute costly legal proceedings against the South African government if care is not taken.

³³⁶ Para 46.

³³⁷ Para 81.

³³⁸ Para 83.

³³⁹ Ibid.

³⁴⁰ See note 143 above (Apalata).

The decision of the Court in the case of *H v Fetal Assessment Centre* is important as it transformed the South African law of delict. It shows that even if parents fail to claim for compensation through wrongful life claims, a child can still claim compensation for being born with a disability. This can only be done if all the elements of delict (wrongfulness, causation, harm and negligence) are there. The decision of the Court in this case is relevant to the development of South African refugee law in the long run. It has been submitted that at times, refugee women do not know where to lodge complaints for ill-treatment in the health care facilities. This implies that, even where they have claims for the wrongful life of their children, they might not be able to do so due to ignorance. However, in the long run, children of refugee women born could still sue the South African government for the children being born with disabilities which could have been avoided if the mother had terminated the pregnancy.

3.6.2 Foreign cases

However, in other jurisdictions, many women claiming the right of access to maternal health care services have brought cases of such nature before their domestic courts and even before international tribunals. Since there are not many reported cases on the right of access to maternal health care services, South African courts may refer to foreign law as a guideline. In terms of the 1996 Constitution, the courts *may* (emphasis added) consider foreign law in the construction of the Bill of Rights.³⁴¹ The use of the word ‘may’ in section 39 (1) (c) of the 1996 Constitution shows that the courts have the discretion to consider foreign law.³⁴² In other words, foreign law is to be used merely as a tool of persuasion and the following cases may be used as guidelines should the need arise. They are not based on refugee rights, but they do touch on maternal health care services and the barriers thereof.

3.6.2.1 *Alyne da Silva Pimentel v. Brazil*³⁴³

A 28-year-old Afro-Brazilian pregnant woman died due the negligence of health care workers, racial discrimination, poor medical care and insufficient emergency medical treatment. The deceased had been given a wrong diagnosis at a medical facility and delays

³⁴¹ Section 39 (1) (c).

³⁴² C Rautenbach, “South Africa: Teaching an ‘Old Dog’ New Tricks? An Empirical Study of the use of Foreign Precedents by the South African Constitutional Court (1995-2010)” in T Groppi & M Ponthorean, (eds) *The Use of Foreign Precedents by Constitutional Judges*. (2013). Available at [https://books.google.co.za/books?id=tGp6BAAAQBAJ&pg=PT170&dq=interpretation+section+39+\(1\)\(c\)+of+South+African+constitution&source=gbs_toc_r&cad=3#v=onepage&q=interpretation%20section%2039%20\(1\)\(c\)%20of%20South%20African%20constitution&f=false](https://books.google.co.za/books?id=tGp6BAAAQBAJ&pg=PT170&dq=interpretation+section+39+(1)(c)+of+South+African+constitution&source=gbs_toc_r&cad=3#v=onepage&q=interpretation%20section%2039%20(1)(c)%20of%20South%20African%20constitution&f=false) (Accessed on 17 November 2015).

³⁴³ Committee on the Elimination of Discrimination against Women (CEDAW) Communication No. 17/2008.

at another medical facility led to her death. When the matter was brought before the Committee on the Elimination of Discrimination against Women (CEDAW Committee), it was found that the government of Brazil had violated the constitutional rights to life, health and legal remedy which the deceased had. The deceased also had the same rights under the CEDAW and they had also been violated. Furthermore, the deceased's rights related to pregnancy granted in article 12.2 of the CEDAW.³⁴⁴ The CEDAW Committee found that the government of Brazil had an obligation to immediately enforce the maternal health care rights, to reduce maternal mortality. The decision of the CEDAW Committee strengthened the recognition of reproductive rights as an obligation of all states which has to be immediately enforced.³⁴⁵ It also strengthened the duty of states to be accountable for providing health care of good quality to all women, without any unfair discrimination, and without any regard to race, income or geographical location.³⁴⁶

This case is very important, as it was the very first case regarding maternal death to be decided by the CEDAW Committee. While it exposes the sad reality of some women failing to access maternal health care services due to discrimination, it stresses the obligation that states have in making such services available. All states, including South Africa, ought to remove the barriers which prevent women within their territory from accessing maternal health care services to prevent unnecessary deaths and meet the MDGs 4 and 5.³⁴⁷

3.6.2.2 *Laxmi Mandal v Deen Dayal Hari Nager Hospital & Others*³⁴⁸

A poor migrant woman fell off the stairs of her home whilst she was pregnant. This led to the deterioration of her health and the death of the unborn child. Though she qualified for free emergency medical treatment provided by various policies of the Indian government, she was denied maternal health care. She was then referred to one hospital where the dead foetus was removed from her womb for a fee, which her husband and her brother paid. However, she did not receive full follow-up care. Upon the intervention of the Human Rights Law Network (HRLN), she was readmitted to hospital in order to get full care. The woman was told that any future pregnancy would put her life at risk. Regardless of the

³⁴⁴ State Parties have to ensure to women proper services regarding pregnancy, confinement and the post-natal period, granting free services, where necessary, and satisfactory nutrition during pregnancy and lactation.

³⁴⁵ See the significance of the case available at <https://www.escri-net.org/docs/i/1623066> (Accessed on 16 November 2015).

³⁴⁶ Ibid.

³⁴⁷ See note 66 above.

³⁴⁸ See note 37 above (*Laxmi*).

advice, she fell pregnant again and gave birth prematurely. She died from obstetric haemorrhage, because she had given birth at home without the help of a skilled birth attendant. The deceased had been afraid to go to hospital due to her previous experience. The family of the deceased (Shanti Devi) approached the courts for a legal remedy. They sued the respondents and claimed compensation for the death of Shanti. The Court found that the respondents had violated the right to life and health of the deceased guaranteed in section 21 of the Indian Constitution. The respondents were then ordered to pay damages to the deceased's family as compensation for her death, which could have been avoided but for the refusal of the respondent to treat her.

In the case of Fatima,³⁴⁹ a case similar to that of Shanti, a destitute woman was continually denied pre-natal care by a public hospital. She ended up giving birth under a tree in public view, as she did not have money to go to the hospital to get proper care. The New Delhi High Court stated that the hospital had violated her rights to free health care services for women living under the poverty datum line. The respondents were ordered to compensate Fatima for failing to provide her with maternal health care services, as well as violating some of her rights such as the right to human dignity and non-discrimination. These cases are very important as they proved how the implementation of India's maternal health care policies had failed.³⁵⁰ They also brought to light the gap in the policies, as they did not make any room for compensation for women who were unjustly denied their benefits.³⁵¹

With regard to the accessibility of maternal health care services for refugee women in South Africa, a similar approach can be adopted as refugee women sometimes give birth under very harsh conditions such as on the floor or on benches.³⁵² In the same way, refugee women can claim damages for ill-treatment in health care facilities. However making such claims can prove challenging, as refugee women sometimes do not know how to lodge complaints.³⁵³

³⁴⁹ See note 37 above (*Jaitun*). Please note that the case of Fatima and Shanti were decided jointly by the court.

³⁵⁰ Center for Reproductive Rights, 'Delhi High Court stands up against cruel treatment of pregnant women'. Available at <http://www.reproductiverights.org/press-room/delhi-high-court-stands-up-against-cruel-treatment-of-pregnant-women> (Accessed on 18 November 2015).

³⁵¹ *Ibid.*

³⁵² See note 157 above (Lawyers for Human Rights).

³⁵³ See note 156 above (Human Rights Watch).

3.7 Conclusion

From the above discussion on international human rights law, it is clear that South Africa has obligations to realise the maternal health care rights of refugee women. As a state party to the discussed treaties, South Africa should incorporate the principles of the instruments into its municipal law, to fulfil its international obligations. Therefore, Chapter Four will be an analysis of South African municipal law relating to refugees. It will identify, amongst other issues, the extent to which South Africa is incorporating international human rights law into its municipal law regarding refugees.

CHAPTER FOUR

SOUTH AFRICA'S DOMESTIC POLICY ON REFUGEE WOMEN AND THE RIGHT TO ACCESS MATERNAL HEALTH CARE SERVICES

4.1 Introduction

Based on the preceding chapter, it is clear that South Africa has obligations under international law to protect, promote and fulfil the health rights of refugee women. The ratification and signing of international instruments only places a state party under obligation to adhere to its objects and purposes. All state parties have to adhere to the principle of *pacta sunt servanda*, which stipulates that a state party ought to respect international agreements. For such obligations to be met, state parties like South Africa have to incorporate the objects and purposes of international law when promulgating their municipal laws and policies.³⁵⁴ General Comment No.2 of Article 14 of the Women's Protocol provides that state parties have to take necessary measures to protect the sexual and reproductive rights of vulnerable groups of women such as refugees from third party interference.

Apart from the 1996 Constitution,³⁵⁵ South Africa has promulgated legislation which aims at protecting refugee rights, non-discrimination and the protection of women's rights. Examples include the Refugees Act 130 of 1998, the National Health Act 61 of 2003 (NHA), the Immigration Act 13 of 2002, Promotion of Access to Information Act 2 of 2000 (PAIA), the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (PEPUDA), the Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition in South Africa 2012 – 2016 (MNCWH), the National Patients' Rights Charter (NPRC),³⁵⁶ amongst other policies, which shall be discussed in this chapter. Brief reference will be made to the judicial interpretation on the right of access to maternal health services. This chapter seeks to establish whether the legislation and policies under scrutiny uphold the principles of international refugee law. If so, one would be able to establish to what extent they have been successful, at the end of the chapter.

³⁵⁴ See General Comment no.2 of Article 14 of the Women's Protocol. See also section 231 (4) of the Constitution, which states: Any international agreement becomes law in the Republic when it is enacted into law by national legislation; but a self-executing provision of an agreement that has been approved by Parliament is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament.

³⁵⁵ The Constitution of the Republic of South Africa, 1996.

³⁵⁶ See note 115 above.

4.2 Refugees Act 130 of 1998

The Refugees Act was created to give effect to the relevant international legal instruments, principles and standards relating to refugees within the Republic of South Africa.³⁵⁷ Through it, the country has incorporated the principles of international refugee law within its municipal law.³⁵⁸ These principles emanate from the the 1951 Convention Relating to Status of Refugees (Refugee Convention), the 1967 Protocol Relating to the Status of Refugees (1967 Protocol) and the 1969 Organization of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa (1969 OAU Convention), as well as other human rights instruments to which south Africa is a signatory. The Refugees Act is there to regulate the procedure for seeking asylum, refugee status determination, the rights and obligations of refugees, cessation of refugee status, amongst other issues. Nonetheless, focus will mainly be on the rights and obligations of refugees, stipulated in the Refugees Act in South Africa. The rights and obligations greatly influence the right of access to maternal health care services.

4.2.1 Right to full legal protection

Refugees in South Africa have the right to enjoy full legal protection, which includes the rights set out in Chapter 2 of the 1996 Constitution and the right to remain in the Republic in accordance with the provisions of the Refugees Act.³⁵⁹ This right entails the obligation the state has towards the refugees to protect and fulfil their rights, in terms of international and municipal law. This provision in the Refugees Act is in line with section 9(1) of the 1996 Constitution, which provides that everyone is equal before the law and should receive equal benefit and protection under the law. The use of the word “everyone” means that even refugees are to benefit from the equal protection of South African laws, given that they are within the country.³⁶⁰ Chapter 2 of the 1996 Constitution guarantees the basic human rights of people residing in South Africa. These include everyone’s right to access

³⁵⁷ Refugees Act 130 of 1998. Available at http://www.saflii.org/za/legis/consol_act/ra199899/ (Accessed on 23 September 2015).

³⁵⁸ Ibid. Preamble.

³⁵⁹ Ibid. Section 27 (b).

³⁶⁰ In the case of *Khosa and Others v Minister of Social Development and Others* 2004 (6) SA 505 (CC), the Constitutional Court construed the word “everyone” to mean citizens and foreign nationals having permanent residence. However, it should be remembered that in section 27 (g) of the Refugees Act, refugees even without permanent residence, are entitled to the same basic health care services and primary education as accorded to the indigenes of south Africa.

health care services, including reproductive healthcare.³⁶¹ As highlighted in Chapter One of this work, maternal health care services fall within the scope of reproductive healthcare. The right to full legal protection, as recognised in the Refugees Act upholds the principle of equality in the 1996 Constitution.³⁶²

The state may not unfairly discriminate against anyone on the basis of ethnic or social origin, language or birth.³⁶³ Similarly, the PEPUDA prohibits unfair discrimination against any person.³⁶⁴ This implies that refugees in South Africa and the indigenes are to be treated in the same way with regard to the state's protection of the rights accorded in the Bill of Rights. When sections 9 (3) and 27 (1) (a) of the 1996 Constitution are read together with section 6 of the PEPUDA, as well as section 27 (b) of the Refugees Act, it is clear that refugee women should be able to access the same maternal health care services as South African women. These provisions are in line with article 3 of the Refugee Convention and article 4 of the 1969 OAU Convention, which stipulate that their provisions are to be applied without discrimination as to race, religion or country of origin.³⁶⁵ As learnt in the previous chapter, the non-discrimination clause is a measure for refugees to receive equal treatment regarding basic human rights. It is clear that the right to full legal protection accorded to refugees in the Refugees Act is in compliance with the Refugee Convention.

4.2.2 Health care services

Refugees in South Africa are entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time.³⁶⁶ The 1996 Constitution provides that everyone has the right to have access to health care services, including reproductive health care.³⁶⁷ This is in line with article 23 of the Refugee Convention, which stipulates that the Contracting States shall accord to refugees lawfully residing in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals.³⁶⁸ Section 27 (1) (g) of the Refugees Act is perhaps the most

³⁶¹ Section 27(1) (a), Constitution of the Republic of South Africa, 1996.

³⁶² Ibid. Section 9, see also section 1 (a).

³⁶³ Ibid. Section 9 (3).

³⁶⁴ Section 6. Available at <http://www.justice.gov.za/legislation/acts/2000-004.pdf> (Accessed on 29 September 2015).

³⁶⁵ Convention and Protocol Relating to the Status of Refugees. Available at www.unhcr.org/3b66c2aa10.pdf (Accessed on 29 September 2015) and the 1969 OAU Convention Governing the Specific Aspects of Refugee Problems in Africa available at www.unhcr.org/45dc1a682.html (Accessed on 29 September 2015).

³⁶⁶ Section 27 (g).

³⁶⁷ See note 361 above.

³⁶⁸ See note 366 above.

important provision in relation to access to maternal health care services of refugee women in South Africa. In South Africa, pregnant and lactating women, and children below the age of six years, who are not members or beneficiaries of any medical aid schemes, are entitled to free health services offered by the public sector.³⁶⁹ This remission of service fees has greatly improved the affordability of maternal health care services, making them more accessible.

If refugees have to be given the same treatment with regard to basic health services, then refugee women also qualify for the free health services offered within the public sector. They should have access to information on these health care services. The 1996 Constitution and the PAIA provide for the right of everyone to have access to information held by the state or another person which is necessary for the exercise or protection of a particular right.³⁷⁰ There should be no unfair discrimination towards refugee women in accessing the health services, as the NHA does not make any distinction between the categories of women who are eligible for the free health services. The only limitation in access to the free health services prescribed in the NHA would be membership or being beneficiaries of medical aid schemes.³⁷¹ Therefore section 27 (1) (g) of the Refugees Act is in compliance with the provisions of international law.

4.2.3 The principle of non-refoulement in South Africa

Similar to the Refugee Convention, the 1969 OAU Convention and the 1998 SADC Declaration, the Refugees Act contains a non-refoulement clause.³⁷² The principle is a

³⁶⁹ A National Health Plan for South Africa (1994). Available at <http://www.anc.org.za/show.php?id=257> (Accessed on 29 September 2015). See also section 4 (3) (a) of the National Health Act 61 of 2003 available at http://www.saflii.org/za/legis/consol_act/nha2003147/ (Accessed on 29 September 2015). See also note 117 above (section 2.3 (c) of the NPRC) 'everyone has the right to access to health care services and that includes provision for special needs in the case of new-born infants, children, pregnant women,...'. See also Recommendation 24, of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which enjoins states to 'ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.' Available at <http://www.refworld.org/docid/453882a73.html> (Accessed on 2 October 2015).

³⁷⁰ Section 32 of the 1996 Constitution and the Preamble of the PAIA available at http://www.dfa.gov.za/department/accessinfo_act.pdf (Accessed on 2 October 2015).

³⁷¹ See note 369 above, (National Health Act 61 of 2003).

³⁷² Section 2 of the Refugees Act:

General prohibition of refusal of entry, expulsion, extradition or return to other country in certain circumstances

Notwithstanding any provision of this Act, or any other law to the contrary, no person may be refused entry into the Republic, expelled, extradited or returned to any other country or be subject to any similar measure, if, as a result of such refusal, expulsion, extradition, return or other measure, such person is compelled to return to or remain in a country where:

safeguard against being returned to a country where one may face or fears persecution.³⁷³ The wording of the Refugee Act is very similar to that of the 1969 OAU Convention and this is probably because South Africa is a member state of that particular organisation. The 1969 OAU Convention was created to deal with problems within the African context.³⁷⁴ The provisions of the Refugees Act thus resemble those in the instrument, as South Africa faces similar problems as those faced by other African countries. Like the 1969 OAU Convention, the Refugees Act in section 3(b) provides an additional definition of a refugee which is unlike the one provided in the Refugee Convention, which is merely based on persecution.³⁷⁵ It is clear that this second definition of the term refugees provides a wider scope of non-refoulement in the same way as the 1969 OAU Convention as it has expanded the definition of refugee to include people fleeing war and internal disturbances.³⁷⁶ The Refugees Act provides an even wider scope of non-refoulement, as opposed to the 1969 OAU Convention, in that it extends the scope of refugee to include the dependants of the refugees.³⁷⁷ In the Refugees Act, a dependant of an asylum-seeker or a refugee includes the spouse, any unmarried dependent child or any destitute, aged or infirm member of the family of such asylum seeker or refugee.³⁷⁸ This implies that such dependants should be able to access basic services, including maternal health care. By not refouling refugees they are able to have access to their basic rights, thus complying with international law provisions.

(a) he or she may be subjected to persecution on account of his or her race, religion, nationality, political opinion or membership of a particular social group; or
 (b) his or her life, physical safety or freedom would be threatened on account of external aggression, occupation, foreign domination or other events seriously disturbing or disrupting public order in either part or the whole of that country.

³⁷³ See note 42 above (F Khan) 3.

³⁷⁴ See note 273 above (JD Mujuzi).

³⁷⁵ Section 3 of Refugees Act:

Refugee status

Subject to Chapter 3, a person qualifies for refugee status for the purposes of this Act if that person:

- (a) owing to a well-founded fear of being persecuted by reason of his or her race, tribe, religion, nationality, political opinion or membership of a particular social group, is outside the country of his or her nationality and is unable or unwilling to avail himself or herself of the protection of that country, or, not having a nationality and being outside the country of his or her former habitual residence, is unable or, owing to such fear, unwilling to return to it; or
- (b) owing to external aggression, occupation, foreign domination or events seriously disturbing or disrupting 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 elsewhere; or
- (c) is a dependant of a person contemplated in paragraph (a) or (b).

³⁷⁶ See note 302 above (O Bueno).

³⁷⁷ See note 375 above, (section 3 (c)).

³⁷⁸ Chapter 1 of the Refugees Act.

4.2.4 The principle of non-penalisation in South Africa

Under South African refugee law, a refugee may not be penalised for unlawful entry into the country, provided the person has applied for asylum, has appealed or had the decision reviewed, or has been granted asylum.³⁷⁹ Similar provisions are found in the Refugee Convention³⁸⁰ and the 1969 OAU Convention.³⁸¹ The significance of the non-penalisation principle is that it recognises the fact that refugees are victims of forced migration, who, if they had a choice, would have probably stayed in their countries of origin. However due to circumstances resulting in the loss of state protection, refugees do not have time to get the necessary documentation, such as visas, to go to other countries. That is where the line can be drawn between asylum-seekers and illegal migrants. Illegal migrants simply migrate to other countries by way of evading immigration procedures at the ports of entry. The non-penalisation principle is prone to abuse, however, in that even people without any valid claim for asylum, who would otherwise be considered as illegal migrants, will still apply for one as a way of buying time and trying their luck. Asylum applications are rejected on the basis of being unfounded, manifestly unfounded, abusive, or fraudulent.³⁸² This probably explains why, in South Africa once an asylum application is rejected, the applicant will start to be regarded as an illegal foreigner who has to be deported in terms of the Immigration Act 13 of 2002.³⁸³ Thus it is clear that South Africa complies with international law by not penalising refugees for illegal entry into the country.

4.2.5 Right to permits

After applying for asylum, an applicant is issued with an asylum seeker permit (section 22 permit), which is issued in terms of section 22 of the Refugees Act. This permit is issued whilst awaiting the second interview with a Refugee Status Determination Officer (RSDO). If the interview is successful, the asylum-seeker is then recognised as a refugee and is issued with a refugee permit issued in terms of section 24 of the Refugees Act. The refugee permit is important as it enables the holder to access the same rights as the citizens and permanent residents of South Africa. Nevertheless, the refugee is not given the freedom to exercise other rights such as the right to vote. Refugee permits are presented to health care

³⁷⁹ Section 21 (4) of the Refugees Act.

³⁸⁰ Article 31.

³⁸¹ Article 5.4.

³⁸² Section 24 (3) (b) and (c) of the Refugees Act.

³⁸³ Section 32. Available at <http://www.treasury.gov.za/legislation/acts/2002/act13-02.pdf> (Accessed on 5 October 2015).

workers by refugees when they go to public health institutions, to be exempted from fees which are paid by other foreign migrants for service in public hospitals.³⁸⁴ A Congolese asylum seeker requiring pre-natal care was denied service at Addington Hospital for not having a permit, leading to the loss of her unborn child.³⁸⁵ Another Congolese woman ended up giving birth without receiving any pre-natal care as she had continually failed to produce a permit.³⁸⁶ It is noteworthy that for anyone needing medical attention in South Africa, producing an identity document is not a requisite for accessing health care services, as the right has nothing to do with documentation.³⁸⁷ If the documentation is requested, it is merely to confirm the name and the residential address of the patient, not to determine their eligibility for treatment, nationality or legal status as, done in some public health care institutions.³⁸⁸ Such practices show that identity documents are sometimes abused and used as a basis for unfair discrimination.

However, having a refugee permit does not always guarantee that a refugee will get the required assistance in medical facilities. Health care workers in some public hospitals do not understand refugee permits, such that refugees end up paying service fees which are applicable to every other foreigner, instead of receiving treatment free of charge.³⁸⁹ Even with valid permits, refugees may be rejected by health care workers; females are more frequently rejected than males.³⁹⁰ This shows that refugee women may not be able to access maternal health care services. The Refugee Convention and the 1969 OAU Convention are silent on the issue of refugee permits. Nonetheless, this requirement in the Refugees Act is still in line with international refugee law, in that refugees in South Africa cannot access basic rights enjoyed by citizens and permanent residents without the refugee permits.

³⁸⁴ G Zihindula, 'Perceptions of Medical Doctors on Refugees' Health Seeking Behaviours in Durban South Africa'. *European Scientific Journal* (2015) 102, vol.11, No.26. See also note 85 above (C Kaplan) 34.

³⁸⁵ *Ibid.* 35.

³⁸⁶ *Ibid.* 35.

³⁸⁷ E Jansson, 'Migrant workers: The human right to access health care' 3 May 2013. Available at <http://mg.co.za/article/2013-05-03-00-the-human-right-to-access-health-care> (Accessed on 16 January 2016).

³⁸⁸ See note 155 above (Crush & Tawodzera) 15.

³⁸⁹ See note 143 above (T Apalata) 13.

³⁹⁰ *Ibid.*

4.3 The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (PEPUDA)

The PEPUDA was promulgated in cognisance of the equality clause in the 1996 Constitution,³⁹¹ international treaties prohibiting unfair discrimination, as well as to redress the inequalities brought about by apartheid, colonialism and patriarchy.³⁹² It aims to promote democracy through equality, freedom, human dignity, amongst other factors.³⁹³ Though the government of South Africa has improved access to maternal health care services for women through the remission of service fees for all pregnant and lactating women who are not beneficiaries or members of any medical aid scheme, refugee women still face unfair discrimination.³⁹⁴ Chapter Two of the PEPUDA is on the prevention, prohibition and elimination of unfair discrimination, hate speech and harassment. This thesis will focus on prohibition of discrimination on the grounds of gender and the prohibition of hate speech and harassment, as these have an impact on refugee women's access to maternal services in South Africa.

4.3.1 Prohibition of unfair discrimination on ground of gender (Section 8)

Section 8 of the PEPUDA is in line with article 12.1 of the Convention on the Elimination of Discrimination Against Women (CEDAW).³⁹⁵ Refugee women are often rejected by health care workers compared with their male counterparts.³⁹⁶ This is perhaps as a result of the general belief that foreigners put a burden on state resources,³⁹⁷ and since pregnant women qualify for free health care services, the health care workers might be hostile towards refugee women. Health care workers who are responsible for the screening process mostly disregard the laws protecting refugees and as a result, refugee women have had to give birth on the floor.³⁹⁸ Such attitudes conflict with the prohibition of unfairly discriminating against another person on the grounds of gender, including limiting

³⁹¹ Section 9.

³⁹² PEPUDA Preamble. See note 353 above.

³⁹³ Ibid.

³⁹⁴ See note 369 above (National Health Plan for South Africa).

³⁹⁵ Article 12.1 of the CEDAW: State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality with men and women, access to health care services, including those related to family planning.

³⁹⁶ See note 143 above (T Apalata) 13.

³⁹⁷ See note 152 above (L Sisulu) 6.

³⁹⁸ C Smith, 'Africa's displaced people'. Presented at the Hearing of the Subcommittee on Africa, Global Health, Global Human Rights and International Organizations Excerpts of Remarks on 9 July 2015, 2. Available at http://chrissmith.house.gov/uploadedfiles/2015-07-09_subcom_on_africa_refugee_crisis.pdf (Accessed on 7 October 2015).

women's access to social services or benefits, such as health (including reproductive health), education and social security.³⁹⁹ There have not really been many reported cases of unfair discrimination between the treatment of male and female refugees in health care institutions. Most of them are generalised. However, the fact that access to health care services for refugee women is an issue which is highlighted every now and then in the media and by human rights organisations,⁴⁰⁰ probably shows that there is a certain degree of unfair discrimination between male and female refugees. As seen in Chapter Two, sometimes refugee women are scolded by refugee workers for increasing the number of foreigners in the country, as they are the ones who give birth.⁴⁰¹ Such treatment possibly emanates from knowledge of the reproductive role of women in society. Rejection may influence refugee women to shy away and sometimes this may be detrimental to their health or that of their unborn children, if pregnant. With all these challenges, unfair discrimination against refugee women in South Africa ought to be eradicated, so that the country may be in compliance with international law.

4.3.2 Prohibition of hate speech

Section 10 of the PEPUA prohibits hate speech. Hate speech is defined in this legislation as any words published, propagated, advocated or communicated based on one or more of the prohibited grounds against any person that could be construed to demonstrate a clear intention to be hurtful; be harmful or to incite harm; promote or propagate hatred.⁴⁰² The prohibited grounds are listed in section 1 of the PEPUA.⁴⁰³ Grounds such as birth, language and ethnic or social origin can be applied to protect refugee women against hate speech. As pointed out in Chapter Two, the xenophobic attitude of health care workers

³⁹⁹ Section 8 (g).

⁴⁰⁰ Human Rights Watch, ““Stop making excuses.” Accountability for maternal health care in South Africa.” (2011). Available at <https://www.hrw.org/report/2011/08/08/stop-making-excuses/accountability-maternal-health-care-south-africa> (Accessed on 9 October 2015). See also Human Rights Watch, ‘South Africa: Failing maternal care’. (2011). Available at <https://www.hrw.org/news/2011/08/08/south-africa-failing-maternity-care> (Accessed on 9 October 2015).

⁴⁰¹ See note 89 above (C Kaplan).

⁴⁰² Section 10 (1). See also section 16 (2) (c) of the 1996 Constitution which states that the freedom of expression may not extend to advocacy of hatred that is based on race, ethnicity, gender or religion, and that constitutes incitement to cause harm.

⁴⁰³ ‘Prohibited grounds are’:

- a) race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth; or
- (b) any other ground where discrimination based on that other ground-
 - (i) causes or perpetuates systemic disadvantage;
 - (ii) undermines human dignity; or
 - (iii) adversely affects the equal enjoyment of a person's rights and freedoms in a serious manner that is comparable to discrimination on a ground in paragraph (a).

which is sometimes portrayed through verbal abuse is one of the barriers faced by refugee women in accessing maternal health care services in public health care institutions. An example is that of a Congolese refugee woman who, already having had seven children was insulted and told to stop having more children by the health care workers at Addington Hospital, as she was merely increasing the population of foreigners in South Africa.⁴⁰⁴ In some instances, foreign women are told that they do not deserve care for pregnancy because they are migrants.⁴⁰⁵ Migrant and refugee women seeking maternity care are sometimes called derogatory names such as *kwerekwere* (a slur meaning foreigner).⁴⁰⁶ The use of such language can be construed to promote or propagate hatred, as by implication, foreigners are not welcome and thus constitutes hate speech. Hence, this provision in the PEPUDA is there to reduce such practices, to make maternal health care services accessible to refugee women, as required under international refugee law.

4.3.3 Prohibition of harassment

Another significant provision of the PEPUDA is the prohibition of harassment, which is found in section 11 of the legislation. It simply states that no person may subject another to harassment. Harassment is defined as unwanted conduct which is persistent or serious and demeans, humiliates or creates a hostile or intimidating environment, or is calculated to induce submission by actual or threatened adverse consequences.⁴⁰⁷ Such harassment could be due to a person's membership or presumed membership of a group identified by one or more of the prohibited grounds, or a characteristic associated with such group.⁴⁰⁸ It is clear that the legislation protects refugee women against harassment as they are a part of the refugee community which is a vulnerable group.

South Africa has several cases of harassment of refugee women in public health institutions. A refugee woman from Ethiopia reported that she was insulted when she was weak and had blurred vision due to pregnancy related hypertension.⁴⁰⁹ She was also ordered

⁴⁰⁴ See note 89 above (C Kaplan).

⁴⁰⁵ See note 400 above ('South Africa: Failing maternal care').

⁴⁰⁶ Human Rights Watch, 'II. Maternity Care Failures and Patient Abuse'. Available at <https://www.hrw.org/report/2011/08/08/stop-making-excuses/accountability-maternal-health-care-south-africa#8b55b5> (Accessed on 14 October 2015).

⁴⁰⁷ Section 1.

⁴⁰⁸ Ibid.

⁴⁰⁹ See note 400 above ('South Africa: Failing maternal care').

to clean up her blood from the floor.⁴¹⁰ It is evident that such conduct on the part of health care workers violates the right to human dignity.⁴¹¹

In 2008, a refugee woman needing maternal care in Ngaka Modiri Molema (NMM) district was denied medication by three nurses and was only assisted when her husband bought them lunch, as per their request.⁴¹² A Somali refugee woman mentioned that watchmen and receptionists at Eastern Cape health facilities demand money before allowing them to enter the premises or opening a file for them.⁴¹³ Such requests by health care workers constitute harassment under PEPUDA, as the refugee women are threatened of being denied the care that they need unless they yield to their wishes. This provision aligns with international law, as its protection of refugee women against harassment will make access to maternal health care services a reality to them.

4.4 The Promotion of Access to Information Act 2 of 2000 (PAIA)

The 1996 Constitution recognises the right of access to information held by the state and any information held by another person that is required for the exercise or protection of any rights.⁴¹⁴ The PAIA was therefore created to give effect to the aforementioned constitutional right to access information.⁴¹⁵ Access to information is pivotal in the exercise of rights, such as access to maternal health care services, in that lack of information can become a barrier in accessing such services. Without the right of access to information, the affirmation, and more concretely, the realisation of all other rights is fundamentally compromised.⁴¹⁶ Health care users such as refugee women ought to have knowledge about factors such as the costs involved, the location of the facilities and the procedures. The PAIA is in line with article 19.2 of the International Covenant on Civil and Political Rights (ICCPR) 1966, which provides that everyone has the right to freedom of expression; this right includes freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of their choice. It also aligns with General Comment No.2 of the Women's

⁴¹⁰ Ibid.

⁴¹¹ Section 10 of the 1996 Constitution. See also note 61 above (*Watchenuka* .Para 25).

⁴¹² Human Rights Watch interview with Dhuuxo F, Port Elizabeth, November 23, 2010. Available at <https://www.hrw.org/report/2011/08/08/stop-making-excuses/accountability-maternal-health-care-south-africa> (Accessed on 14 October 2015).

⁴¹³ Ibid. Interview with Aziza I, Port Elizabeth, November 23, 2010.

⁴¹⁴ See note 370 above.

⁴¹⁵ Ibid.

⁴¹⁶ DT McKinley, 'The State of Access to Information in South Africa' (2003), 1.

Protocol which states that women should be duly informed of reproductive health care services such as family planning and safe abortion. This legislation is very important in the realisation of the right to health, as it greatly influences other legislation and policy aimed at the realisation of the right to health. These are the NHA and the NPRC.

4.4.1 *The National Health Act 61 of 2003 (NHA)*

Health care users must have full knowledge of the range of diagnostic procedures and treatment options generally available to them.⁴¹⁷ This corresponds with the first principle of the *Batho Pele*⁴¹⁸ principles, which states that citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered.⁴¹⁹ With regard to maternal health care, this means that women ought to be informed by the health care providers about the different contraception methods, the different methods of giving birth, such as normal birth and C-section and other options.

Health care users are entitled to have full knowledge of the benefits, risks, costs and consequences generally associated with each option.⁴²⁰ This requirement is quite important, as it will help a health care user to be aware of the different effects of each medication or procedure on his or her body. It also complies with the constitutional right to bodily and psychological integrity, enshrined in section 12 (2) of the 1996 Constitution. For instance, a woman undergoing a C-section should be informed about its risks, benefits, costs and consequences. Such knowledge will help health care users to make informed decisions pertaining to their health in relation to their financial standing. Importantly, the knowledge of the benefits, risks, costs and consequences of the various options will enable the health care user to exercise their right to refuse such health services, after which the health care user must explain the implications, risks and obligations of such refusal.⁴²¹ The information must be given in a language which the health care user understands, taking into account her

⁴¹⁷ See note 370 above (National Health Act). Section 6 (1) (b).

⁴¹⁸ *Batho Pele* means people first and it is the national government's White Paper for Transforming Public Service Delivery. It is all about giving good customer service to the users of government services. *Batho Pele* - "People First" was conceived with the intention of transforming service delivery in the public sector. Good service delivery leads to happy customers and employee satisfaction for a job well done. Available at http://www.dsd.gov.za/index.php?option=com_content&task=view&id=13&Itemid=55 (Accessed on 17 October 2015).

⁴¹⁹ *Batho Pele* Principles. Available at <http://localgovernmentaction.org.dedi6.cpt3.host-h.net/content/batho-pele-principles> (Accessed on 17 October 2015).

⁴²⁰ See note 370 above. (National Health Act) Section 6 (1) (c).

⁴²¹ *Ibid.* (Section 6 (1) (d)). See also note 115 above, (section 2.2 of the NPRC).

level of literacy.⁴²² This provision in the NHA complies with various provisions under international law.⁴²³

There ought to be effective complaints mechanisms to highlight discrimination for vulnerable women such as refugees.⁴²⁴ This is probably the reason why the NHA provides that a health care user has the right to make a complaint about the manner of treatment received at a health institution and have it investigated.⁴²⁵ Of particular interest is the provision that the procedures for making complaints must be displayed by all health establishments in a manner that is visible for any person entering the establishment and the procedure must be communicated to users on a regular basis.⁴²⁶ This could also imply that such display of the procedures to be followed when taking down complaints should be in a language that is understood by all and, if not, measures should be taken to ensure that a health care user understands the procedures. Refugee health care users are abused in health care institutions, as they do not know how to make complaints or are hesitant to do so.⁴²⁷ Such ignorance could perhaps be a result of their not understanding the language on display for the making of complaints. For instance, a refugee woman from a Portuguese background will most likely face challenges in interpreting the procedures for making complaints if they are written in Xhosa, isiZulu or even in English. In such instances, it will be necessary for the health care workers to explain to such a health care user about the procedure for making complaints.

4.4.2 The National Patients' Rights Charter (NPRC)

The NPRC was created by the Department of Health to ensure the realisation of the right of access to health care services as guaranteed in the Constitution and, as a common standard, for achieving the realisation of this right.⁴²⁸ It stipulates that everyone has the right to access health care services, which include information such as the availability of health services and how to best utilise them; such information should be in a language understood

⁴²² Ibid. (Section (2)).

⁴²³ Article 7 of the International Covenant on Civil and Political Rights 1966 (ICCPR), Article 3 of the Universal Declaration of Human Rights 1948 (UDHR), and Article 14 of the Women's Protocol 2003.

⁴²⁴ See note 370 above ("Stop making excuses").

⁴²⁵ See note 369 above (National Health Act). Section 18 (1). See also principle 7 of the Batho Pele Principles which states that if the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic, positive response.

⁴²⁶ Ibid. (Section 18 (3) (a)).

⁴²⁷ See note 400 above ('South Africa: Failing maternal care').

⁴²⁸ See note 115 above (Preamble of the NPRC).

by the patient.⁴²⁹ Like the NHA, the NPRC provides for the right of everyone to be given full and accurate information about the nature of their illnesses, diagnostic procedures, the proposed treatment and risks associated therewith and the costs involved.⁴³⁰ Upon receiving such information, the patient has the right to refuse the proposed treatment.⁴³¹ The NPRC also provides that a patient has a right to complain about the treatment received from a health care provider.⁴³²

4.5 Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa 2012 – 2016

As one of the of the countries represented at the Millennium Summit held in the year 2000, South Africa committed to the millennium development goals (MDGs), which were time-bound targets aimed at the eradication of poverty by 2015.⁴³³ The MNCWH was created to reduce mortality and morbidity of mothers and children,⁴³⁴ so as to this meet MDGs 4 and 5. The MNCWH is in line with the provision of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa 2003 (Women's Protocol), which places an obligation on all state parties to establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding.⁴³⁵

The MNCWH emphasises the importance of basic antenatal care. It recommends that women should get up to four ante-natal visits, as prescribed by the World Health Organisation (WHO).⁴³⁶ Antenatal care (ANC) is quite broad, but basically it is the care given to a woman during pregnancy and it is important, as it helps to ensure that both the

⁴²⁹ Ibid. Section 2.3 (g). See also section 5.3.2 of the Health Professions Guidelines for Good Practice in the Health Care Professions (2008). Available at http://www.hpcs.co.za/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_1_guidelines_good_prac.pdf (Accessed on 19 October 2015).

⁴³⁰ Ibid. Section 2.8 of NPRC. See also section 5.3.3 of the Health Professions Guidelines for Good Practice in the Health Care Professions (2008).

⁴³¹ Ibid. Section 2.9.

⁴³² Ibid. Section 2.12.

⁴³³ Millennium Summit (6-8 September 2000). Available at http://www.un.org/en/events/pastevents/millennium_summit.shtml (Accessed on 19 October 2015).

⁴³⁴ *Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa 2012 – 2016*. Available at <https://extranet.who.int/nutrition/gina/sites/default/files/ZAF%202012%20MNCWHstratplan.pdf> (Accessed on 19 October 2015).

⁴³⁵ Article 14.2 (b).

⁴³⁶ WHO Antenatal Care Randomized Trial: Manual for Implementation of the New Model, Geneva (2002) cited in the *Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa 2012-2016*, 12.

mother and the unborn child are in good health and it helps to reduce complications during delivery.⁴³⁷ As important as ANC is, some women do not attend the required four visits.⁴³⁸ One wonders why some pregnant women would fail to attend all the visits when the ANC, like the other maternal health care services, is free of charge in public health care institutions. This could be explained by the different barriers to accessing maternal health care services discussed in Chapter Two. One such barrier is that of language. Many refugee women complain that they cannot attend ANC sessions offered at the public health institutions as they are conducted in local languages such as isiZulu, which they do not understand as interpreters are not available.⁴³⁹ Other barriers could be lack of access to information, as well as the negative attitudes of health care workers towards foreigners, discouraging them to go for ANC. Most refugees have resolved not to go to public hospitals.⁴⁴⁰

Another aim of the MNCWH is to improve access to care during labour. This would be achieved through the use of waiting areas for women experiencing delays and through the expansion of obstetric services in remote areas, where responding to medical emergencies might take a long time.⁴⁴¹ Improving and expanding obstetric services in this way would increase access, but it would even be more effective for refugee women if there were refugee camps in South Africa and such services were provided within those particular camps without the refugee women having to go to the other health care facilities. It would be effective if the South African government considered establishing refugee camps in which waiting areas are utilised. The strategy also prioritises the intrapartum care improvements as a way of reducing maternal deaths.⁴⁴² Such improvements would involve access to C-sections and blood transfusion services.

Provision of post-delivery care (post-partum care) to women is important. In the United States of America (USA), post-partum care is a neglected area of women's health, as

⁴³⁷ Antenatal care identifies and manages obstetric complications, intermittent preventive treatment for malaria and the identification and management of infections including HIV, syphilis and other sexually transmitted infections (STIs). It promotes the use of skilled birth attendants and healthy behaviors like breastfeeding, early postnatal care and planning for optimal pregnancy spacing. By O Lincetto, *et al* 'Antenatal Care' (year unknown). Available at http://www.who.int/pmnch/media/publications/aonsectionIII_2.pdf (Accessed on 19 October 2015).

⁴³⁸ See note 434 above (MNCWH).

⁴³⁹ See note 89 above (C Kaplan) 12.

⁴⁴⁰ *Ibid.* 13.

⁴⁴¹ See note 434 above (MNCWH) 13.

⁴⁴² *Ibid.* Intrapartum care refers to the medical and nursing care given to a pregnant woman and her family during labour and delivery. BR Stright, *Maternal Newborn Nursing* (2005), 126. Available at <https://books.google.co.za/books?isbn=1582553599> (Accessed on 20 October 2015).

evidenced by the limited national health policies and data related to the issue.⁴⁴³ The MNCWH is silent on the issue of post-partum care, so the same could be said for South Africa. Some refugee women in South Africa even face death due to lack of effective post-partum follow up.⁴⁴⁴ However, there is room for improvement in the area as this will help achieve MDG 5, which is aimed at reducing maternal mortality and achieving universal access to reproductive health.

4.6 The 2007 Revenue Directive from the Department of Health

In the 2007 Revenue Directive to provincial health revenue managers, the Department of Health ordered that refugees and asylum-seekers requiring anti-retroviral treatment (ART) should be provided with such, whether they have permits or not.⁴⁴⁵ Refugees and asylum seekers are exempted from paying fees for ART, regardless of any institution they choose to obtain such treatment or its level.⁴⁴⁶ This directive is very important, in that it will help in the prevention of mother-to-child transmission of HIV amongst refugees. It also helps to achieve MDG 4, aimed at the reduction of child mortality. Furthermore, a similar directive with regard to other maternal health care services would be highly relevant.

4.7 The National Committee for Confidential Enquiry into Maternal Deaths (NCCEMD)

In 1998, the South African government introduced the NCCEMD. The main purpose for this was to address the problem of high maternal mortality by recording and analysing maternal deaths.⁴⁴⁷ The NCCEMD comprises of health care professionals such as obstetrics, gynaecologists and midwives from all the provinces of South Africa.⁴⁴⁸ Each maternal death recorded in health care facilities is recorded and then the members of the NCCEMD analyse the results. The reason for these recordings is to investigate the leading causes of maternal deaths within the South African health care institutions. For now, maternal deaths which occur within the communities are not recorded. The only maternal deaths which are recorded are those which occur in health care facilities. This implies that the confidential enquiries are not very accurate since it is not every woman who will give

⁴⁴³ C Cheng, ER Fowles & LO Walker, 'Postpartum Maternal Health Care in the United States: A Critical Review.' 1. *Journal of Perinatal Education*, (2006) Vol 15 Number 3, 34–42.

⁴⁴⁴ See note 89 above (C Kaplan) 12.

⁴⁴⁵ See note 200 above (par 1.2.1 of the 'Revenue Directive').

⁴⁴⁶ Ibid.

⁴⁴⁷ WHO, 'Confidential enquiry into maternal deaths in South Africa.' Available at http://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/case-studies/south-africa/en/ (Accessed on 16 November 2015).

⁴⁴⁸ Ibid.

birth in a health care facility, due to various reasons. At times refugees feel that unwelcome in public health institutions and so they avoid going there.⁴⁴⁹ The reports are based on the primary causes of death amongst pregnant women such as obstetric haemorrhage, embolism and hypertension. However, the reports do not further categorise the different reasons which affect the categories of women who rely on the public health care system.

4.8 The extent to which the incorporated international principles are being practised in South Africa

From the discussion above it is clear that South Africa has incorporated the provisions of international and regional law into its municipal law. While this is important, it is merely the first step towards the fulfilment of international obligations. Mere incorporation of international instruments into municipal law is not enough. The question is not whether South Africa has incorporated the principles of international law or not, but whether such principles are being put into practice. This section seeks to establish the extent to which South Africa is practising the international principles of refugee protection in relation to maternal health care services.

According to South African immigration law, once an asylum-seeker application is rejected, such person will begin to be treated as an illegal migrant.⁴⁵⁰ While this helps reduce the abuse of the asylum system, it should not be overlooked that there are some corrupt practices going on at Refugee Reception Offices (RROs), which tend to disadvantage genuine asylum-seekers. A lot of RSDOs at RROs ask for bribes or ‘cool drink’ money in order to issue asylum seekers with refugee permits.⁴⁵¹ This implies that if an asylum seeker does not have the money to pay a bribe; their claim will be rejected, regardless of its validity. Such corrupt practices undermine and reduce the effectiveness of the asylum system in South Africa. These practices also bring the efficacy of anti-corruption legislation such as the Preventive and Combatting of Corruptive Activities Act

⁴⁴⁹ See note 143 (T Apalata) 15.

⁴⁵⁰ See note 383 above (Immigration Act).

⁴⁵¹ See note 143 above (T Apalata) 12. See also R Amit, ‘Queue here for corruption. Measuring irregularities in South Africa’s asylum system’ (2015). Available at <http://www.lhr.org.za/publications/queue-here-corruption-measuring-irregularities-south-africa%E2%80%99s-asylum-system> (Accessed on 21 October 2015). See also P De Wet, ‘Money for papers at Home Affairs’ published on 24 July 2015. Available at <http://mg.co.za/article/2015-07-23-money-for-papers-at-home-affairs> (Accessed on 21 October 2015). See also, Lawyers for Human Rights, ‘LHR welcomes the promise of change at Marabastad refugee reception office’. Available at <http://www.lhr.org.za/news/2014/lhr-welcomes-promise-change-marabastad-refugee-reception-office> (Accessed on 21 October 2015).

12 of 2004 (PRECCA)⁴⁵² into question. Consequently, the country will not be able to fulfil its obligations towards refugees under international law, as asylum-seekers return to face problems without any help from South Africa as a country of asylum.

While issuing refugee permits to refugees complies with international law, it seems refugees are not informed of their rights when they gain refugee status. Some refugees are unaware of human rights and the rights that refugees have in South Africa.⁴⁵³ They know that they have rights in South Africa, but no one has ever told them about them, save for the rights to asylum and refugee permits.⁴⁵⁴ This is an indication that RSDOs are not informing refugees of the rights that they have as refugee permit holders. There is no point in being a refugee permit holder but not being able to exercise the rights that come with it. The refugee permit enables the holder to access basic services such as health care as it is presented at the health care facility before service can be rendered. Thus, ignorance of the rights that a refugee permit holder has can adversely affect refugee women requiring maternal health care services. Though an awareness of refugee rights does not guarantee their realisation, refugees ought to be notified about their entitlement to them as refugee law seeks to revive their rights.

Both international and municipal law and policies require that health care workers should obtain informed consent when dealing with health care users. However, in South Africa, health care workers do not follow this requirement, especially when treating refugee women. Some refugee women have reported that C-sections were performed on them by force or without their consent.⁴⁵⁵ This could be attributed to the language barrier, but in any

⁴⁵² The objects of the PRECCA are as follows:

1. to provide for the strengthening of measures to prevent and combat corruption and corrupt activities;
2. to provide for the offence of corruption and offences relating to corrupt activities;
3. to provide for investigative measures in respect of corruption and related corrupt activities;
4. to provide for the establishment and endorsement of a Register in order to place certain restrictions on persons and enterprises convicted of corrupt activities relating to tenders and contracts;
5. to place a duty on certain persons holding a position of authority to report certain corrupt transactions;
6. to provide for extraterritorial jurisdiction in respect of the offence of corruption and offences relating to corrupt activities;
7. and to provide for matters connected therewith.

See introduction of the PRECCA. Available at <http://www.acts.co.za/prevention-and-combating-of-corrupt-activities-act-2004/index.html?business.php> (Accessed on 26 October 2015).

⁴⁵³ C Johnson, 'Failed Asylum Seekers in South Africa: Policy and Practice.' African Human Mobility Review (AHMR), Vol.1 No2, May- August, (2015) 6. Available at <http://sihma.org.za/wp-content/uploads/2015/09/Final-Article4.pdf> (Accessed on 19 November 2015). See note 49 (EC Onouha) 108. See also note 164 above (Human Rights Watch).

⁴⁵⁴ Ibid.

⁴⁵⁵ See note 143 above (T Apalata).

case that does not justify the performance of such procedures without obtaining the consent of the patient. As noted in Chapter Two, refugee women requiring antenatal care are still ignored, even if they bring their own interpreters in a bid to reduce the language barrier.⁴⁵⁶ This undermines their right to make informed decisions, as held in the landmark case of *Castelle v De Greef*.⁴⁵⁷ *In casu*, the Court held that a doctor is obliged to warn a patient of pertinent and inherent risks of any proposed treatment and or surgery.⁴⁵⁸

Despite the incorporation of various international and regional instruments into South Africa's municipal law, much still needs to be done in practice. It is clear that, to a greater extent, the government of South Africa is not practising the international principles of refugee protection in relation to maternal health care services. The government of South Africa has relevant legislation in place, as well as policies to ensure the realisation of the right of access to maternal health care services, but refugee women are still faced with challenges in accessing them. The failure of refugees to access maternal health care services has both immediate and long-term effects on the realisation of other rights.

4.9 The impact of the violation of the right to access maternal health care services on other rights of refugee women

It should be remembered that human rights are interdependent and indivisible.⁴⁵⁹ The realisation or violation of a single right will have a positive or negative effect on another one. Access to maternal health care services is an essential right to refugee women. Violating this right negatively affects the other rights of refugee women, as discussed above. From the discussion in the current and previous chapters it is evident that the violation of the right to access maternal health care services for refugee women adversely affects other rights such as the right to equality, life, bodily and psychological integrity and human dignity. However, other rights enshrined in the Bill of Rights have been overlooked

⁴⁵⁶ See note 89 above (C Kaplan).

⁴⁵⁷ 1994, (4) SA 408 (C). The plaintiff underwent a subcutaneous mastectomy which was not successful leading to necrosis and deformation of the areolae. The court had to decide whether the doctor had a duty to warn the plaintiff of any relevant and known risks of the surgery which was performed. The court diverted from the reasonable doctor approach to the doctrine of informed consent. The court held that the doctor had the duty to get informed consent from the plaintiff. This case then set precedent under South African law wherein the principles of informed consent were incorporated. The principles are that;

1. correct and accurate diagnosis should be provided to the patient by the treating doctor;
2. alternative methods of treatment should be discussed with the patient;
3. the patient should be informed about the effects of treatment; and
4. the patient should have knowledge of the treatment and be able to appreciate it.

⁴⁵⁸ *Ibid.*

⁴⁵⁹ United Nations High Commissioner for Human Rights (OHCHR), 'What are human rights?' Available at <http://www.ohchr.org/EN/Issues/Pages/WhatareHumanRights.aspx> (Accessed on 7 November 2015).

in the discussion and these shall be discussed briefly, as they have an impact on the right of access to maternal health care services.

In terms of the 1996 Constitution, everyone has the right to an environment that is not harmful to their health or wellbeing.⁴⁶⁰ Individuals are entitled to an environment which does not present health risks to them. It can be argued that such a right could extend even to health care facilities, as environmental rights enshrined in the 1996 Constitution have been said to go beyond the scope of health rights which are constrained to the provision of health care services.⁴⁶¹ Even in a health care facility, everyone should still be protected from things that could be harmful to their health, for instance, the importance of maintaining a sterile environment.⁴⁶² Childbirth experts maintain that during birth, a clean surface should be provided for receiving the baby.⁴⁶³ Furthermore, the place in which the mother will give birth should be scrubbed clean.⁴⁶⁴ However, in South African public hospitals, refugee women have complained of giving birth under very harsh, unhygienic conditions, such as giving birth on the floor.⁴⁶⁵ This poses great infection risks to the mother and the new-born, as infection is amongst the top causes of death after child birth.⁴⁶⁶

A good but sad example is that of an American woman (though not a refugee) who died of meningitis caused by an infection she was exposed to during labour.⁴⁶⁷ This infection was as a result of the USA health care facility's failure to provide a sterile environment for the woman.⁴⁶⁸ As a result, the hospital paid damages to the family of the deceased woman as compensation for her death, which could have been prevented if the environment had been

⁴⁶⁰ Section 24 (a).

⁴⁶¹ South African Human Rights Commission, 'Environmental Rights' in '3rd Economic and Social Rights Report.' 324 (2001). Available at http://www.sahrc.org.za/home/21/files/Reports/3rd%20ESR%20Report%20chapter_9.pdf (Accessed on 12 November 2015).

⁴⁶² World Health Organisation, 'Standard precautions in health care'. Available at http://www.who.int/csr/resources/publications/EPR_AM2_E7.pdf (Accessed on 12 November 2015).

⁴⁶³ The Open University, 'Labour Delivery and Care Module: 3. Care of the Woman in Labour.' Available at <http://www.open.edu/openlearnworks/mod/oucontent/view.php?id=271&printable=1> (Accessed on 12 November 2015).

⁴⁶⁴ Ibid.

⁴⁶⁵ See note 157 above (Lawyers for Human Rights).

⁴⁶⁶ See note 463 above (The Open University).

⁴⁶⁷ Amnesty International, 'Deadly Delivery: The Maternal Health Care Crisis in the USA.' One year update, Spring (2011) 5. Available at <https://www.amnestyusa.org/sites/default/files/pdfs/deadlydeliveryoneyear.pdf> (Accessed on 12 November 2015).

⁴⁶⁸ Ibid.

sterile.⁴⁶⁹ Therefore the violation of refugee women's access to maternal health care services also infringes on their environmental rights.

The violation of access to maternal health care services has an adverse result on the reproductive right of refugee women to procreate. Reproductive health rights are protected in the Bill of Rights.⁴⁷⁰ It is generally accepted within the medical field that once a woman gives birth through a C-section she cannot have as many children as a woman who gives birth vaginally, since the procedure scars the uterus.⁴⁷¹ In South Africa, refugee women have reported that at times C-sections are performed on them without giving prior consent.⁴⁷² In a way, this infringes on their right to procreate and the right to decide how many children to have. If refugee women are informed about the effects of C-sections, they probably would not opt for them. It has also been reported that HIV positive refugee women are sometimes sterilised without giving their consent.⁴⁷³ The report is unclear on whether the refugee women were being sterilised because of their refugee or HIV status. Sterilisation on the basis of the refugee status is a serious offence, which can later translate to the crime of genocide, which is characterised by acts which include the imposition of measures aimed at preventing births within a group, with the intent to destroy such a group in whole or in part.⁴⁷⁴ Furthermore, every person, whether a refugee or not, should be allowed to give informed consent to sterilisation regardless of their HIV status. For these reasons the South African government ought to ensure that the reproductive rights of refugee women are met.

Every person within South Africa has the right to access the courts or alternative tribunals when they are involved in disputes requiring legal remedy.⁴⁷⁵ The discussion on the right to access information shows that refugee women sometimes do not know where or how to report cases of ill-treatment in public health care institutions.⁴⁷⁶ Some of the cases of ill-treatment require legal remedies such as the payment of damages. Examples of such cases

⁴⁶⁹ Ibid.

⁴⁷⁰ See section 27 (1) (a) of the 1996 Constitution.

⁴⁷¹ VBAC or Repeat C-section. Available at <http://www.childbirthconnection.org/article.asp?ck=10210#future> (Accessed on 12 November 2015).

⁴⁷² See note 143 above (T Apalata).

⁴⁷³ I Skosana, 'Gauteng pays after forced sterilisation for HIV-positive woman' (11 April 2014). Available at <http://mg.co.za/article/2014-04-11-gauteng-pays-after-forced-sterilisation-for-hiv-positive-woman> (Accessed on 12 November 2015).

⁴⁷⁴ See article 2 of the 1948 United Nations Convention on the Prevention and Punishment of the Crime of Genocide. Available at <https://treaties.un.org/doc/Publication/UNTS/Volume%2078/volume-78-I-1021-English.pdf> (Accessed on 12 November 2015).

⁴⁷⁵ Section 34.

⁴⁷⁶ See note 403 above ('South Africa: Failing maternal care').

include, but are not limited to, medical negligence, the use of hate speech, unfair discrimination and harassment. However, the fact that refugee women are not informed of their rights as health care users will result in them not being able to approach courts for legal remedies. Such ignorance results in health care workers taking advantage of refugees.⁴⁷⁷ Perhaps at this point it will be important to discuss how the South African courts construe refugee women's right to access maternal health care services.

4.10 Judicial interpretation on the right to access socio-economic rights

Regardless of the fact that the right to realise maternal health care services to refugee women is topical in South Africa, there have not been any cases brought before the courts for refugees. The main reasons for this could be centred on the refugee women's ignorance of their specific rights under international law and as health care users. However, there have been other cases touching on the socio-economic rights of refugees in South Africa. Since maternal health care is a health right, it goes without saying that it falls within the scope of socio-economic rights. For that reason, the cases discussed in this section could shed more light on how the courts are most likely to handle any cases on the violation of the right of access to maternal health care for refugee women, since they are treated in the same way as indigenes with regard to access to basic rights.

4.10.1 Khosa and Others v Minister of Social Development and Others⁴⁷⁸

The applicants in this case were refugees from Mozambique, who had obtained permanent residence in South Africa. They brought their case before the Constitutional Court challenging the constitutionality of section 3 (c) of the Social Assistance Act 59 of 1992 (Act 59 of 1992). The provision disqualified people who were not South African citizens from benefitting from the social grants such as the old age grant, disability grants and child grants (regardless of the citizenship status of some of the children). The applicants based their claim on the following constitutional rights: life (section 11), human dignity (section 10), equality (section 9), health care, food, water and social security (section 27) and children's rights (section 28).

The Court found that the word 'everyone' used in section 27 of the 1996 Constitution referred to any person legally living in South Africa. Furthermore, section 3 (c) of Act 59 of

⁴⁷⁷ See note 156 above (Human Rights Watch).

⁴⁷⁸ See note 58 above.

1992 unfairly discriminated against the children of the applicants based on the nationality of their parents. The Court then held that all the legislative provisions relating to social assistance ought to be understood or construed as being applicable to permanent residents as well. This case is significant, as the decision shows how the 1996 Constitution prohibits discrimination on the ground of nationality. In the light of refugee women's right of access to maternal health care services, the case is pivotal in that it buttresses the right of refugees to the same basic health services that are enjoyed by the citizens of South Africa.⁴⁷⁹ It sheds more light on the reasons why refugees ought to be treated in the same way as indigenes with regards to various socio-economic rights in the Bill of Rights.

*4.10.2 Soobramoney v Minister of Health, KwaZulu-Natal*⁴⁸⁰

The applicant was a man in his forties suffering from chronic renal failure as well as other chronic diseases. He required on-going dialysis treatment to prolong his life and so he approached Addington Hospital to provide him with such. However, the hospital was adamant in providing him with the treatment as there were a few renal units within the facility and many patients with renal failure, thus making it impossible to provide him with on-going treatment. Furthermore, he did not qualify for such treatment as prescribed by the hospital's criteria for renal treatment. He then brought the case before the Court, basing it on the constitutional rights to life (section 11) and right to emergency medical treatment (section 27 (3)). The question before the Court was whether the state had an obligation to provide socio-economic rights, even where the resources were limited.

The Court held that the applicant could not rely on section 27 (3) of the Constitution, as his condition was not a sudden catastrophe to be regarded as an emergency.⁴⁸¹ Instead, his condition was an on-going state of affairs.⁴⁸² He could not rely on section 11 of the Constitution as the right to medical treatment could not be inferred from the right to life.⁴⁸³ The applicant's claim was only enforceable in terms of section 27 (1) and (2),⁴⁸⁴ through

⁴⁷⁹ Section 27 (g) of the Refugees Act 130 of 1998.

⁴⁸⁰ 1998 (1) SA 765 (CC), 1997 (12) BCLR 1696 (CC).

⁴⁸¹ Para 38.

⁴⁸² Para 21.

⁴⁸³ Para 19.

⁴⁸⁴ 27 (1) Everyone has the right to have access to:

(a) health care services, including reproductive health care;

(b) sufficient food and water; and

(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

which the state can only provide socio-economic rights within available resources. This case is applicable to the realisation of maternal health care services in that the right must be met by the state within the available resources. Such realisation ought to be conducted on an equal basis with indigene women. Though state resources might be scarce, refugee women must not be denied maternal health care services due to the notion that foreigners drain state resources.⁴⁸⁵ The resources ought to be distributed without unfair discrimination.

*4.10.3 Government of the Republic of South Africa and Others v Grootboom and Others*⁴⁸⁶

A group of squatters had been evicted from an informal settlement in Wallacedene. They then established plastic shelters in which they did not have sanitation and electricity. The squatters faced eviction from the settlement. They then brought an action against the government, based on the constitutional right to housing⁴⁸⁷ and the right of children to have shelter.⁴⁸⁸

The High Court found that the respondents had taken reasonable measures within the available resources to achieve the progressive realisation of the right to have adequate housing. The respondents were, however, ordered by the Court to provide shelter to the applicant after a consideration of section 28 (1) (c) of the 1996 Constitution, which did not limit the provision of shelter for children to available state resources.

Contrary to the finding of the *court a quo* the Constitutional Court found no violation of section 28 (1) (c) but found instead that section 26 had been violated. The Constitutional Court then held that section 26 places the state under obligation to devise and implement a coherent and co-ordinated housing programme.⁴⁸⁹ It held, further, that by failing to provide for those in most desperate need the state had failed to take reasonable measures to ensure the progressive realisation of the right to housing.⁴⁹⁰ This case is of great significance as it lays a foundation for the justiciability of the obligation to progressively realise socio-economic rights, which can be reviewed by the court on the ground of the test for reasonableness, as well as an exercise of deference at any stage of the remedy.⁴⁹¹ The same

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

⁴⁸⁵ See note 152 above (L Sisulu).

⁴⁸⁶ 2000 (11) BCLR 1169 (CC).

⁴⁸⁷ Section 26 of the 1996 Constitution.

⁴⁸⁸ Section 28 (1) (c) of the 1996 Constitution.

⁴⁸⁹ Para 40.

⁴⁹⁰ Para 95.

⁴⁹¹ Available at <https://www.escr-net.org/docs/i/401409> (Accessed on 14 November 2015).

principle of progressive realisation can be applied to the right of access to maternal health care services for refugee women. The state ought to put measures which ensure that the various factors which act as barriers of access to maternal health care services are removed with the progression of time.

*4.10.4 Minister of Health v Treatment Action Campaign (TAC)*⁴⁹²

In casu, the government had proposed the introduction of the anti-retroviral drugs Nevirapine, into a few pilot stations after a year. The purpose of introducing the drug was to prevent mother to child transmission of the HIV/AIDS virus so as to reduce its prevalence. However, the government only limited the availability of the drug to a few pilot stations and left out its health care institutions. The TAC then sought legal remedy in the High Court to order the government to make the drug available to all of its health care institutions, as the limited availability resulted in preventable infections and numerous deaths. The claim was based on section 27 (1) of the Constitution which, amongst other things, guarantees the right of everyone to health care. The respondents also based their claim on section 28 (1) (c) of the Constitution, which guarantees children's right to health care.

The *court a quo* ordered the government to make the drug available in its health care institutions and to come up with a strategy about how it was going to make the drug available. Leave to appeal was granted and, on appeal, the Constitutional Court held that the appellant's limitation of Nevirapine to pilot stations left out some women represented by the respondent who would otherwise have benefitted from the drug. The appellant was ordered to make the drug available to its health care institutions, provide counsellors and to establish HIV testing and counselling facilities.⁴⁹³

The decision of the Constitutional Court has been commended for making South Africa set the pace for other African countries towards the achievement of sexual and reproductive health.⁴⁹⁴ However, scholars argue that the judgment of the Court was merely focused on the rights of the unborn child and overlooked the mother's reproductive rights.⁴⁹⁵ In a sense, the PMTCT programmes of the government neglected women leaving them to cope

⁴⁹² (2002) 5 SA 721 (CC).

⁴⁹³ Para 17.

⁴⁹⁴ See note 18 above (V Balogun & E Durojaye) 382.

⁴⁹⁵ M Mushariwa, "The right to reproductive health and access to health care services within the prevention of mother to child transmission programme: the reality on the ground in the face of HIV/Aids" in B Goldblatt, and k Mclean (eds) *Women's Social and Economic Rights: Developments in South Africa* (2011) 187.

with HIV on their own.⁴⁹⁶ The Court's decision was criticised for overlooking the gender issues raised in the case.⁴⁹⁷

On the other hand, the Court's decision is quite useful, as it focused on the right to access services in public health care institutions. As such, it sheds more light on the topic of the realisation of refugee women's right of access to maternal health care in South Africa. Some HIV positive refugee women complain that health care workers deny them treatment and that they breach confidentiality, as they sometimes disclose refugee women's status in public.⁴⁹⁸ Some refugee women have also said that HIV tests are conducted without any counselling.⁴⁹⁹ In the 2007 Revenue Directive to provincial health revenue managers, the Department of Health ordered that refugees and asylum seekers requiring anti-retroviral treatment (ART) should be provided with such, whether they have permits or not.⁵⁰⁰ Refugees and asylum-seekers are exempted from paying fees for ART regardless of any institution they choose to obtain such treatment from, or its level.⁵⁰¹

*4.10.5 The case of emergency surgery for a Somali refugee girl*⁵⁰²

In this case, a 12-year-old girl from Somalia with a serious heart condition collapsed soon after her arrival in South Africa. She was not able to apply for asylum and did not have any documentation. When she collapsed she was rushed to the Kalafong hospital. The doctors diagnosed her with a serious heart condition which needed emergency surgery. However, the doctors refused to perform the surgery on her for lack of necessary documentation showing that she was a refugee. Alternatively, the brother of the girl could pay R250 000 as a deposit for the medical procedure. He did not have such an amount of money and so he approached Lawyers for Human Rights, who then applied for an urgent interdict on behalf of the girl in the North Gauteng High Court. The question was whether her lack of documentation excluded her from getting emergency medical services. The Court granted

⁴⁹⁶ Ibid.

⁴⁹⁷ E Durojaye, 'Advancing gender equity in access to HIV treatment through the Protocol on the Rights of Women in Africa: focus on the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' (2006) 6 (1) *African Human Rights Journal*, 203.

⁴⁹⁸ See note 89 above (C Kaplan) 40.

⁴⁹⁹ See note 143 above (T Apalata) 20.

⁵⁰⁰ See par 1.2.1 of the 'Revenue Directive- Refugees or asylum seekers with/without a permit.' (2007).

Available at http://www.passop.co.za/wp-content/uploads/2012/07/revenue-directive_refugees-and-asylum-seekers-with-or-without-permit.pdf (Accessed on 20 October 2015).

⁵⁰¹ Ibid.

⁵⁰² Lawyers for Human Rights, 'Press release: LHR and Steve Biko Hospital reach agreement on treatment for 12-year-old asylum-seeker.' Available at <http://www.lhr.org.za/news/2014/press-release-lhr-and-steve-biko-hospital-reach-agreement-treatment-12-year-old-asylum-see> (Accessed on 17 November 2015).

an order giving the 12-year-old girl permission to receive the surgery at Steve Biko Hospital and that her payment assessment will be based on the means test.

4.11 Conclusion

In conclusion, it can be said that South Africa has indeed incorporated international standards on refugee protection, health care and the prevention of discrimination against women into its domestic policies. This is evidenced by the various policies and legislation aimed at refugee protection, equality and the promotion of maternal health care services. Such incorporation is merely the first step towards the fulfilment of the obligation that South Africa has towards the protection of the rights of refugees, particularly refugee women. In this chapter, it has been observed that, though South Africa has complied with the international and regional instruments with regard to refugee rights, there are still gaps in the practice of the incorporated principles. These gaps make the realisation of the maternal health care services of refugee women a challenge. However, the challenge is not without solutions. There are various recommendations which can help to reduce or remove the gap with regard to refugee women's access to maternal health care services. These recommendations are discussed in the next chapter of this work.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

Refugee women are highly disadvantaged with regard to accessing maternal health care services. This thesis has presented the requisites for the realisation of the right of access to maternal health care services within South Africa as a popular destination for asylum seekers. As demonstrated in the previous chapters, international, regional and municipal policies assert the relevance of this right. Regardless of such an assertion, South Africa is not doing much to make sure that refugee women have access to maternal health care services on an equal basis with indigene women. In this thesis, the failure of the South African government to fully realise the access to maternal health care services has been revealed. Various loopholes within international and national policy have been discussed, as well as the barriers to accessing maternal health care services. In this chapter a conclusion shall be drawn upon the findings of the research and thereafter recommendations will follow.

5.2 Conclusion

The aim of this thesis was to try to bridge the gap between policy and practice in access to maternal health care services for refugee women, by investigating the barriers which they face in an environment characterised by xenophobic sentiments. The following research questions were raised:

- a) What are the obligations of the South African government to promote, protect and fulfil the right of access to maternal health care services for refugee women?
- b) To what extent do the perceptions of health care workers influence the right of refugees to access maternal health care services?
- c) What are the barriers to maternal health care services for refugees in South Africa?
- d) What can the government of South Africa do to fully realise the right of access to maternal health care services for refugee women so as to address the gap between policy and practice?

To answer these questions, desk-based research was conducted. Through this method, data sources such as peer reviewed journal articles, international and regional instruments, municipal legislation and case law were used and critically analysed. This analysis led to the discovery of the various barriers with regard to the right of access to maternal health care services. The extent of South Africa's compliance with international obligations towards refugees was also discovered.

South Africa has a duty to protect the rights of refugees within its jurisdiction. Refugees are a vulnerable people and so they ought to have equal protection by the law, even with regard to health care. In short, refugees in South Africa enjoy the rights that are enjoyed by citizens and permanent residents. Therefore, even when it comes to maternal health care services, refugee women have to be treated like the indigene women as discussed in the thesis. The extent to which the perceptions of health care workers influence the right of refugee women to access maternal health care was assessed. This assessment was relevant, in that health care workers in public health care institutions represent the national government during the performance of their duties and the government is held liable for their actions. Furthermore, health care workers are the ones who have contact with the refugee women, as they try to access maternal health care services in the public health institutions. As highlighted earlier on, South Africa is known to be a highly xenophobic society⁵⁰³ and the xenophobia has spread to health care institutions, resulting in medical xenophobia.⁵⁰⁴ This is due to the perception that all foreigners drain state resources.⁵⁰⁵

At the beginning of this thesis, the general assumption was that the South African government has failed to make maternal health care services accessible to refugee women due to some loopholes within the municipal policies, coupled with the xenophobic environment. In-as-much as this assumption is correct, there are several other factors which are barriers. As the research progressed, it was discovered that the failure can neither be solely attributed to the xenophobic environment, nor to the loopholes within the municipal policies as, South Africa has incorporated all its international obligations towards refugees within its own legislation. From the data sources which were consulted and analysed it was found that other factors outweigh the loopholes and the xenophobic environment to a great extent.

⁵⁰³ See note 12 above (Landau).

⁵⁰⁴ See note 155 above (J Crush & G Tawodzera).

⁵⁰⁵ See note 152 above (L Sisulu). See also Note 49 above (EC Onouha).

After an analysis of the different sources of data, it was observed that the root cause of the gap between policy and practice is the lack of accountability in public health care institutions. The existence of most of the factors which act as barriers to maternal health care services is due to the fact that there are no strict accountability measures within the public health care sector. A good example would be that of the language barrier which has been observed to be sometimes a deliberate creation of the health care workers, just to frustrate a refugee health care user who would have made the effort to bring an interpreter to help bridge the barrier.⁵⁰⁶ Such attitudes could largely be perpetuated by disgruntlement and the knowledge of knowing that no one can challenge the health care workers. As highlighted in the fourth chapter of the thesis, at times refugee women do not know where or how to report cases of ill-treatment in public health care institutions.⁵⁰⁷ Accountability is also reduced by the fact that, even if a complaint is made, health care workers shield each other. All this is a reflection of the disregard of the legislation that is in place to promote equality and access to health care services for every woman, regardless of her circumstances.

The findings of this thesis are important, as they show that the inability of refugee women to access maternal health care services in South Africa cannot be attributed to a lack of resources, as maternal health care services are *gratis*. This inability cannot be ascribed to a lack of relevant legislation or policy, as these are in place. The major problem is with the lack of accountability within the public health care institutions. If this is addressed, most of the other barriers will fall away, as they are somehow linked to accountability. The adopted method of research proved to be very effective, but better results could have been achieved had there been funding to conduct field work. If there had been more time to conduct the research, more data could have been obtained. The word limit also proved to be a challenge, as more information could have been incorporated into the thesis. Though this thesis was on bridging the gap between policy and practice in the realisation of maternal health care services for refugee women, it exposed the need for future research on how to improve accountability within the South African health sector, especially with regard to maternal health care services.

⁵⁰⁶ See note 89 above (C Kaplan).

⁵⁰⁷ See note 400 above ('South Africa: Failing maternal care').

5.3 Recommendations

5.3.1 Stricter accountability measures

Regardless of the right that health care users have to lodge complaints of ill-treatment in health care institutions and have them investigated, refugee women have complained that their complaints are disregarded, as health care workers tend to shield each other. Perhaps, in addition to the legislation, a website for refugees could be created through which they can anonymously lodge their complaints of bad service in public health care institutions. Reforms could be introduced which allow for refugees to report directly to the Minister of Health for any cases of ill-treatment in public health care institutions, as in the USA, where the Office of Minority Health reports directly to the Secretary of Health and Human Services, as enabled by the 2010 Health Care Reform.⁵⁰⁸ At other South African institutions dealing with refugees, such as the Marabastad Refugee Reception Office, corrupt officials have been uprooted and the same can be applied to public health care institutions. Where a matter is not investigated and there is evidence of ill-treatment, the staff in charge of receiving complaints should be dismissed, so that each time there is a complaint from a health care user, such a complaint may be handled seriously, regardless of the complainant's background.

5.3.2 Boosting morale of health care workers

In Chapter Two it was observed that a majority of nurses felt that the free health care policy had increased their workload⁵⁰⁹ and was being abused by foreigners such as refugees. The free health care policy is benefitting many South Africans too, and it cannot be phased out. However, the solution to the demoralisation of health care workers would be to increase their salaries and introduce flexible working hours. It has been observed that flexible working hours increase work commitment and reduce absenteeism, as employees are able to attend to their work-life responsibilities.⁵¹⁰ In turn, this could make the public health care institutions attractive to new graduates seeking employment within the health sector. When more graduates seek employment within the public health sector, more health care workers

⁵⁰⁸ See note 467 above (Amnesty International).

⁵⁰⁹ See note 169 above (L Gilson & L Walker).

⁵¹⁰ S Shagvaliyeva, R Yazdanifard, 'Impact of Flexible Working Hours on Work-Life Balance.' 21 *American Journal of Industrial and Business Management*, 2014, 4, 20-23. Available at (<http://www.scirp.org/journal/ajibm>) <http://dx.doi.org/10.4236/ajibm.2014.41004> (Accessed on 17 January 2016).

will be available. The problem of understaffing, which has been noted as one of the causes of demoralisation amongst health care workers,⁵¹¹ will then be solved.

5.3.3 Refugee rights education

Health care workers ought to be educated about the rights that refugees have with regard to access to maternal health care services. They should be taught about the rights that different categories of foreigners have in relation to the access of health care services within the public health institutions. Emphasis should be placed on the entitlements of the section 22 and 24 permit holders. Not only should health care workers be educated about the rights of refugees, but the refugees should be educated about their rights within South Africa. Such education would be in line with the UNHCR guidelines on the protection of refugee women.⁵¹² This should be done by RSDOs upon the issuance of RSD. Access to information on the complaints mechanisms under the NHA and the PEPUDA may assist refugees in accessing maternal health care, as the mechanisms are actually there to ensure that everyone receives the service that they require on an equal basis. Alternatively, such education could be conducted through outreach programmes, in areas where refugees reside. Human rights organisations or the DHA could liaise with social organisations dealing with refugees, such as Refugee Social Services, to hold workshops on the rights of refugees. Though refugee camps are not a policy choice of the South African government, refugee rights education could easily be conducted within the camps.

5.3.4 Training in the treatment of refugees and asylum seekers

As highlighted earlier, refugees experience trauma during the process of displacement, as well as during travel.⁵¹³ Some of them are from war-torn countries. This means that their needs in terms of health care are both physical and emotional. South African health care workers should therefore be trained in a way which caters for the specific health care needs of refugees. An example of where such a strategy worked is that of the Values Clarification Workshop held to encourage health care workers to provide comprehensive reproductive health care such as abortion in their communities regardless of the attached stigma.⁵¹⁴ An

⁵¹¹ See note 167 above (K Cullinan).

⁵¹² Available at <http://www.unhcr.org/3d4f915e4.html> (Accessed on 16 November 2015).

⁵¹³ See note 89 above (UN POPIN).

⁵¹⁴ Mitchell E, Trueman K, Gabriel M, Fine A & Manentsa N 'Accelerating the Pace of Progress in South Africa: An Evaluation of the Impact of Values Clarification Workshops on Termination of Pregnancy Access in Limpopo Province, Johannesburg: Ipas'. Available at: <http://www.ipas.org/~media/Files/Ipas%20Publications/SAvcEval.ashx> (Accessed on 17 January 2016).

outcome of the workshop was that the behaviour of the health care workers changed positively towards patients who were coming to health care facilities in order to terminate pregnancies.⁵¹⁵ A similar approach could include training on how to be sensitive when treating refugees. When providing maternal health care services to pregnant refugee women, care should be taken, as some of their pregnancies resulted from rape.⁵¹⁶ In Sweden, there are guidelines on how mentally-ill adult asylum-seekers should be treated. These guidelines were established to make sure that asylum-seekers receive mental health care in the same way as the Swedes.⁵¹⁷ Though these guidelines were adopted to cater for mentally-ill patients, South Africa can follow a similar approach in the provision of maternal health care services for refugee women. This will help refugee women to have access to maternal health care services.

5.3.5 Establishment of refugee camps

One of the effective ways of realising the right of access to maternal health care services for refugee women is the establishment of refugee camps. Though the government of South Africa has no refugee camps and favours local integration of refugees, the process requires an enabling environment and a welcoming society.⁵¹⁸ Unfortunately the xenophobic attacks of 2009 and 2015 clearly show that the environment is not conducive enough for local integration as the society is generally not welcoming to foreigners.⁵¹⁹ Refugee camps often serve as temporary shelters for refugees for the duration of their refugee status. Life in refugee camps has been described as being close to imprisonment, with little autonomy, and even less dignity.⁵²⁰ This is due to the fact that some of them restrict going outside the camp,⁵²¹ limiting the right to freedom of movement guaranteed in the Bill of Rights.⁵²² Despite such negative criticism of refugee camps there are some countries which have set

⁵¹⁵ Ibid. 31

⁵¹⁶ See note 178 above (M Kimani). See also note 232 above ('Rape as a weapon of war').

⁵¹⁷ B Ginsburg & S Baarnhielm, 'Human Rights and Access to Psychiatric Care for Adult Asylum Seekers: Guidelines to Improve Care Article Options and Tools.' *International Journal of Migration, Health and Social Care*, Volume 4, Issue 1 (2005).

⁵¹⁸ F Khan, 'UNHCR's 2007 Annual Consultations with NGOs Local Integration: Lessons learnt and the way forward', 3.

⁵¹⁹ See note 12 above.

⁵²⁰ AP Wilson, *Trafficking Risks for Refugees*, (2011). Available at <http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1003&context=humtraffconf3> (Accessed on 5 November 2015), 4.

⁵²¹ Lawyers for Human Rights, 'Anyone Who Thinks Refugee Camps Are A Good Idea Has Never Lived In One: The Importance Of Recognising Refugees' Right To Freedom Of Movement.' Available at <http://www.lhr.org.za/news/2015/anyone-who-thinks-refugee-camps-are-good-idea-has-never-lived-one-importance-recognising-r> (Accessed on 5 November 2015).

⁵²² See section 21 of the 1996 Constitution.

up very effective refugee camps, in which where refugees actually have access facilities such as health care, education, internet connections and grocery stores. An example is that of the Turkish refugee camps Kilis and Nizip II. The Syrian refugees residing in these camps are generally satisfied with the facilities offered there and are grateful to the Turkish government.⁵²³ At Kilis, there is a staffed clinic, with Turkish doctors and translators.⁵²⁴ Arrangements are made for pregnant women and for people with serious health issues to go to hospital.⁵²⁵ Research shows that in other countries effective health care programmes have been implemented within the refugee camps.⁵²⁶ It is said that these programmes could even improve the reproductive health care outcomes of the host populations living close to the camps.⁵²⁷ This is a clear indication that, if well organised, maternal health care rights can be easily realised within a refugee camp and the services offered there could even be of a better quality than those offered to the host population. If this could be implemented in South Africa, refugee women would have ease of access to maternal health care services. In other words, it is not enough to establish refugee camps, but they should be conducive for the women. Furthermore, establishing refugee camps helps in the documentation of refugees, as well as the reduction of flare-ups, which can lead to xenophobia.⁵²⁸

5.3.6 Creating interpreter posts

Last but not least, the access to maternal health care services for refugee women can improve drastically through the creation of interpreter posts. As emphasised in Chapter Two of the thesis, there are currently no interpreter posts within the public health care sector. This presents a barrier, thus the urgent need for the creation of such posts. This would help to bridge the language barrier and to ensure that refugee women give informed consent when undergoing medical procedures such as C-sections. In a way this would also help improve accountability amongst health care workers in matters of medical negligence.

⁵²³ M McClelland, 'How to build at a perfect refugee camp.' (13 February 2014). Available at <file:///E:/How%20to%20Build%20a%20Perfect%20Refugee%20Camp%20%20The%20New%20York%20Times.html> (Accessed on 5 November 2015).

⁵²⁴ Ibid.

⁵²⁵ Ibid.

⁵²⁶ M Hynes, M Sheik, *et al* 'Reproductive Health Indicators and Outcomes Among Refugee and Internally Displaced Persons in Post emergency Phase Camps'. *The Journal of the American Medical Association JAMA*. 603 (2002) 288 (5):595-603. Available at <http://jama.jamanetwork.com/article.aspx?articleid=195164&resultclick=1#Abstract> (Accessed on 21 November 2015).

⁵²⁷ Ibid.

⁵²⁸ G Quintal, 'SA needs refugee camps – Mantashe' (Monday, 13 April 2015). Available at <http://www.news24.com/SouthAfrica/News/SA-needs-refugee-camps-Mantashe-20150412> (Accessed on 5 November 2015).

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