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# A health impact assessment of international migrants following the xenophobic attacks in Gauteng and the Western Cape

**January 2009**

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# EXECUTIVE SUMMARY

Beginning in Gauteng in May 2008, escalated xenophobic violence resulted in the deaths, disability and displacement of migrant populations across South Africa. This discrimination and violence against migrants needs to be viewed in the context of broader structural or institutional discrimination, which in turn contributes to broader societal xenophobia and discrimination.

The South African Government's response to the recent xenophobic attacks centred on the provision of temporary shelters and camps, which were intended to meet the basic needs of shelter and security. Several non-governmental organizations also made provision for housing displaced migrants outside of camps, which resulted in further complexity and a variety of associated public health risks. Although several rapid assessments were conducted no systematic public-health based assessment of the health impacts of the xenophobic violence has been undertaken.

***Aims and objectives***

The aim of this study is to identify and understand the public health impact of violence and displacement on international migrants affected by violence and displacement in Gauteng and the Western Cape from May to August 2008. An additional aim is to identify gaps in the current responses and provide recommendations for a research agenda to inform preparedness in the event of a re-occurrence of the xenophobic attacks in these areas. The study is guided by the following objectives:

a. To describe the range of likely health impacts following internal displacement caused by community violence, based on a review of the international literature;
b. To determine the socio-demographics of the migrant population placed in temporary camps in Gauteng and the Western Cape following the xenophobic attacks
c. To identify the major public health risks associated with the xenophobic violence on International migrants who were displaced to temporary shelters/camps, displaced to other homes, families and communities and remained self-settled in the study population in order to assist with planning appropriate long and medium-term responses;
d. To understand the impact of violence against foreigners on access to and experiences of using public and NGO health services with special reference to HIV positive migrants' ART adherence and;
e. To describe the best approach to mitigating the negative health impact associated with displacement to temporary shelters/camps as a result of violence based on international literature and best practices.

## METHODOLOGY AND ASSESSMENT FRAMEWORK

A rapid assessment was conducted in the form of a health impact assessment methodology that was informed by (1) a brief literature review of scientific papers and international guidelines and policies pertaining to migration health and humanitarian disasters, (2) publicly available and media reports describing the status of migrants following the xenophobic attacks, (4) analyses of unpublished data collected by humanitarian aid agencies and (5) key informant inputs collected via questionnaire from

key actors in Government and NGOs. International minimum benchmarks against which health conditions were rapidly assessed were extracted from the Sphere Project's Humanitarian Charter and Minimum Standards in Disaster Response Handbook, the United Nations High Commission on Refugees' *Handbook for Emergencies* and a minimum norms and standards document compiled by the Treatment Action Campaign and the Aids Law Project.

The key systems that informed the assessment recommendations are constituted by a: a) socio-demographic assessment, b) health determinants assessment, c) health status assessment, and d) health systems assessment.

The primary limitation of this study relates to the logistical and time constraints, which limited the amount of primary research that could be undertaken. Secondary data sources were also limited especially with regard to quantitative data on the health determinants and health status of migrants. Also, the absence of ongoing, systematic surveillance of health conditions during the violence and within the camps themselves, may have introduced a bias through the reliance on secondary data. However, every attempt has been made to verify and assess the plausibility of information obtained and re-analyse original data where possible.

The study shows that the impacts of violence and displacement magnify pre-crisis health risks among the immigrant population in South Africa. There were also several information gaps that prompted the sub-optimal response to the recent crisis. Recommendations for enhanced preparedness in meeting the challenges of health impacts on migrants both generally and post-crisis include a) increased intersectoral oversight and coordination, b) mandatory data collection and benchmarking for evidence-based comparisons of responses and c) the provision of widely accessible guidelines to all actors involved in profiling and responding to the health need of immigrants in South Africa.

**KEY FINDINGS**

***Socio-demographic, development and economic factors influencing health***

- ***Food security and nutrition:*** Many of the migrants forced into the camps and temporary shelters originated from informal settlements and many would have suffered nutritional duress prior to migration. The immediate needs for food following the attacks were met through the food donations of various religious organizations, local philanthropists and government. An analysis of food aid provided by these organizations suggested that the quality and nature of available foodstuffs at the camps met the minimum standards for food security and nutrition. The immediate response following the xenophobic attacks may thus have had a positive effect on nutrition, although this would not have applied to all refugees as it was not only migrants of low socio-economic status who were displaced. In addition, it was clear that any improvements in nutrition were temporary and quickly eroded by the irregularity of meals and threats to food security in the following months. During this period, the nutritional quality and availability of food across camps was highly variable with reports of nutritionally inadequate or expired food in camps dominating media reports on health risks and a major concern for stakeholders. However, while diarrhoea and acute

dehydration among children was common and may be related to undernutrition, very few cases of overt malnutrition were detected. Another area of concern is that many of the supplementary exercises related to food security, advocated by the UNCHR such as conducting an initial nutrition, food and nonfood needs assessment, and arranging community education on use of food-aid were not undertaken (UNHCR, 2007). In both Gauteng and the Western Cape, cooked foods were provided by outside catering companies or voluntary organizations, which further complicated access to their records.

- ***Housing:*** Urbanisation can be a positive health determinant, if good services and social support are provided. Unfortunately local governments in the majority of LMICs have very limited resources and require financial support in key areas such as housing, basic services and health services. Public housing is especially difficult for foreign immigrants to access; stakeholders maintained that two-thirds of the camp residents faced housing challenges and that these endured after the residents had left the camps. The living conditions in the camps themselves have been a major criticism of the government response to the refugee crisis and this was confirmed by stakeholder responses.

- ***Safe water, sanitation and hygiene facilities:*** Access to safe water and adequate sanitation are essential for the prevention of a number of infectious diseases, particularly those affecting children and young women. Given that gastroenteritis was commonly reported to the media by camp residents and is a leading cause of under-five mortality in South Africa, negatively affecting health and development outcomes, intervention in this area is crucial.

- ***Social capital:*** For migrants living in low-income urban areas there are significant obstacles to forming social capital, which may include the lack of public spaces for social interaction, ethnic tension and an atmosphere of fear resulting from high crime rates and discrimination . However, the recent crisis served to highlight the plight of refugees in the country and the massive mobilization of support for refugees from a large number of Non-Governmental Organisations, the Human Rights Commission and International Organisations such as the United Nations and Oxfam has the potential to increase the social capital of migrants if their interest in their concerns is sustained.

- ***Livelihood insecurity:*** Transportation to work and school was severely compromised by the attacks, impacting on the migrants' freedom of movement, a Sphere Project minimum standard in such cases. Access to income and education, both essential to short, middle and long-term livelihood security and health was severely disrupted. The situation was reportedly worse in the Western Cape with camps being established in remote areas. While some shelters and camps did provide transport during the crisis, overall there did not appear to be any systematic measures in place to address these needs once the residents had left the camps.

### *Health status of migrants*

- ***Infectious diseases (such as tuberculosis and HIV/AIDS):*** We were unable to obtain any accurate data on HIV seroprevalence amongst migrants displaced by

the xenophobic attacks, although based on the high prevalence of HIV in the communities from which the migrants were displaced and many of the countries of origin, it would not be unreasonable to assume that at least 11% were HIV positive. In addition, the high incidence of TB and its risk factors, particularly in the Western Cape is a strong motivator for a more determined response to arrest the spread of respiratory infections in the camp environment.

- ***Violence and mental health:*** Clearly the situation in the camps to some extent mirrors a broader malaise in South African with regard to the state and societal response to violence and violent crime and the attitudes and feelings with regard to foreigners. It should be recognized that a law enforcement and security-based response to violence is but one of numerous strategies that can be used to prevent and avoid violent confrontations, and one that in isolation has been shown to be rather ineffective. Common mental disorders such as depression and post-traumatic stress disorders affect approximately 16.5% of South Africans and evidence indicates that migrants have a significantly higher risk for mental illness, particularly after experiencing trauma and discrimination. Added to the effects of the violence itself, they faced further stressors in the camps, with numerous reports of severe psychological distress, anxiety and fear related to poor communication from the government and the prolonged sense of waiting to find out what their future holds. Stakeholders confirmed the widespread emotional and physical trauma that manifested in feelings of low self-esteem and hopelessness.

- ***Non-infectious chronic diseases (such as diabetes, heart disease, and cancer):*** Among the key intervention programmes aimed at addressing cardiovascular disease in South Africa, most focus on improved dietary habits and increase physical activity. Both are already compromised in South Africa, where there is an over reliance on processed foods, high cholesterol foods, such as meat, and sugar, and low intakes of fruit and vegetables. Opportunities for physical activity are also limited. The confinement of refugees to camps is likely to have further compromised these risks, especially with the reliance on local donor aid in providing food that was likely to mirror local diets and eating habits.

***Health systems, responses and service delivery***

Rapid health assessments to inform health system responses are required for best-practice disaster management. Such systematic assessments were lacking, leading to a fragmented and uncoordinated health system response. This compromised access to healthcare and other essential services as detailed below. and thus access to healthcare and services

- ***Decentralised incident management:*** Efforts to form a central incident management forum were thwarted by poor co-ordination between different tiers of government and their resistance to co-operation with civil society agencies.

- ***Insufficient funding:*** Insufficient government funds were released to deliver the services required by a crisis of such magnitude. In Gauteng's case funding was exhausted within one week, with Civil Society and I/NGO agencies having to provide the shortfall.

- ***Lack of capacity:*** Both quantity and quality of government services were insufficient. There were too few personnel to respond to the events and as the military did not release troops, private contractors had to be deployed. The available personnel were inexperienced and untrained in disaster management and wholly reliant on UN and international NGO expertise to formulate and implement solutions.

- ***Lack of pre-positioned inventory:*** There were inadequate pre-positioned stocks to meet the requirements of any major displacements or disaster. Even the SANDF was under stocked and the government was dependent on the UN for tents. The balance of facilities and materials were almost exclusively acquired out of the trade, which makes a rapid response within 72 hours impractical.

- ***Lack of political will:*** Reluctance by Ministers and MEC's to act decisively and implement solutions formulated by specialists wholesale exacerbated security concerns, compounded health risks and increased the level of indignities suffered by the displaced. Government intervention was delayed and prone to meddling and micro management and only the readiness of Civil Society and I/NGO agencies averted a major tragedy in the first two weeks of the event.

- ***Lack of security:*** Persons in camps were vulnerable to external and internal threats. *Externally,* displaced persons were threatened by the community even after entering shelters. Internally, displaced persons were attacked, robbed and exploited within the shelters by fellow residents.

- ***Prejudicial attitudes:*** Public sector workers, particularly in the health services were not always willing to treat foreigners, and this may persist if left unchecked. Health professionals need to be trained to treat people regardless of nationality and need to be prepared to mobilize resources in response to crisis situations.

- ***Poor planning:*** There were no strategic or tactical plans to respond to the crisis and solutions were formulated on an ad hoc basis. Furthermore, this oversight does not seem to have been addressed and it is unlikely that there will be a better prepared response should there be a similar reoccurrence of the xenophobic violence.

## RECOMMENDATIONS AND ACTIONING

### *1. Intersectoral oversight and management*

It is clear that any future attempt at oversight and management of a humanitarian crisis of the scale as the one that developed in May 2008 will benefit from better co-ordination between various governmental (e.g. Health, Social Development, Community Safety, and Foreign and Home Affairs Departments), NGO, community and corporate stakeholders.

***Action:***

A shadow committee should be established and buy-in sought from the various role-players to ensure better future preparedness.

**2. Mandatory data collection, response documentation and benchmarking**

In order to improve preparedness, it is necessary for comprehensive migration data to be collected that describes the full range of pre and post migration factors relating to the migrants. Currently, neither demographic details nor information on health status is recorded in a sustainable, intervention oriented manner. Collected data needs to be used for the improvement of services and the design of interventions.

***Action:***
Sustainable surveillance systems should be designed to clarify emerging health threats and provide continuous data on hazards and sentinel health outcomes.

**3. Guidelines and legislation**

The current guidelines and legislation need to be reviewed and communicated to the various stakeholder groups. A range of evidence-based multi-agency guidelines have been developed that can be tailored to a variety of health threats arising out of population displacement. To date, the Sphere Project's Humanitarian Charter and Minimum Standards in Disaster Response Handbook (Sphere Project, 2004), the United Nations High Commission on Refugees' (UNCHR) *Handbook for Emergencies* (UNCHR, 2007) are the most comprehensive such guidelines available. The standards and action strategies detailed in these texts span the full gamut of possible health threats and appropriate modes of response. However, such detail and volume could in fact hinder rapid short-term dissemination of their contents. A two-fold stakeholder dissemination strategy that would optimize familiarity with these guidelines is therefore recommended. Firstly, a stakeholder analysis should be conducted in order to identify information and training targets.

***Action 1:***
All stakeholders should be apprised of and equipped with the guidelines. Formal training and points of contact with the relevant agencies should then be pursued.

***Action 2:***
Key South African agencies should consider the compilation of a set of refined action strategies that synthesize and better integrate information contained in the more comprehensive texts. The TAC/ALP's development of a summarized minimum standards and norms document (TAC/ALP, 2008) provides a good example of such a synthesis.

***Action 3:***
The model should be extended into a succinct South African-specific set of evidence-based strategic responses to disaster management for rapid dissemination and widespread use amongst all stakeholders in the future.

**4. Extensive and ongoing research**

The scope and of the current study was limited by time and the availability of data resulting in its focus on residents of camps.

***Action:***
Conduct a broader quantitative study in order to assess the various public health and social impacts of displacement into (1) camps versus, (2) homes and families versus (3) new communities/informal settlements.

## Health impact assessment: motivation for the research and value of the report

## Motivation for the Research

South Africa has an integrative urban asylum policy. No refugee camps exist and individuals are encouraged to self-settle and integrate within the host population. Rights are afforded to refugees, asylum seekers, and international migrants. This includes the right to work, go to school, and access public health services. In practice, however, access to these rights has long been problematic.

Recently the situation for international migrants in South Africa has become more problematic. In May 2008, xenophobic violence in urban South Africa resulted in estimates of 100,000 international migrants being internally displaced. Responses within Gauteng province involved the provision of temporary shelter and safety through non-governmental organisations (NGOs) and state-coordinated responses.

It is essential that adequate (temporary) spaces of safety and shelter are provided to displaced persons. Displaced persons require continued access to their places of work, schools and healthcare facilities. In addition, it is essential that responses are created that effectively address increased public health risks associated with displacement and the (temporary) settlement of individuals within shelters and camps. This includes: the need for clean water and adequate sanitation; the need to access basic food and shelter; the need for appropriate onsite trauma management services; the need to address potential sexual violence with appropriate onsite services; and the importance of ensuring continued access to ART and TB treatment is available onsite.

The violent events against foreigners of May 2008 and the subsequent displacement of migrants had several health related impacts.

### Livelihood and food insecurity

Displacement has a far reaching impact upon livelihoods as individuals – particularly the main breadwinner of a household – are unable to maintain access to their income generating activities. This results in increased poverty and resultant food insecurity for displaced households. This compounds the existing difficulties migrants have in meeting basic needs.

**Non-citizen access to ART: the impact of displacement**

South African Constitution and the Refugee Act (1998) guarantees 'access to healthcare for all'. A welcome addition to the current HIV and AIDS and STI Strategic Plan for South Africa (2007 – 2011) is the specific inclusion of non-citizen groups, outlining their right to HIV prevention, treatment and support. Additionally, in September 2007, the National Department of Health released a Revenue Directive[1] clarifying that refugees and asylum seekers – with or without a permit – shall be exempt from paying for ART services. This is particularly appropriate given the right that individuals have to access ART, and the challenges that asylum seekers face in accessing documentation from the Department of Home Affairs.

A key guiding principle to the successful implementation of the 2007 – 2011 Plan is towards 'ensuring equality and non-discrimination against marginalised groups'; refugees, asylum seekers and foreign migrants are specifically mentioned as having 'a right to equal access to interventions for HIV prevention, treatment and support'[2].

However, recent research conducted by the FMSP in Johannesburg indicates that non-citizens in need of ART – including refugees and asylum seekers - report challenges in accessing ART within the public sector[3]. Priority area 4 of the Plan encompasses human rights and access to justice, with goal 16 being to ensure 'public knowledge of and adherence to the legal and policy provision'[4]. This study indicates that protective frameworks and NDOH policies are not applied uniformly; public institutions appear to determine their own policies that may counter existing legislation.

Reasons for denial of access to ART include not being in possession of a green bar-coded South African identity booklet, as well as 'being foreign'. Rather than referring to an appropriate government ART roll-out site, local government clinics refer refugees, asylum seekers and other non-citizens out of the public sector and directly into an already overburdened and resource limited non-governmental sector in order to access ART. Many non-citizen individuals, regardless of immigration status, who test positive for HIV at government clinics are referred out of the public health sector as soon as they are in need of ART (which in many cases is at the time of testing). This has resulted in a challenging dual-health care system, public and NGO, providing ART through separate routes, to different groups of people.

[1] Ref: BI 4/29 REFUG/ASYL 8 2007

[2] HIV and AIDS and STI Strategic Plan for South Africa, 2007 – 2011, p56

[3] Vearey, J. and Palmary, I. (2007) Assessing non-citizen access to antiretroviral therapy in Johannesburg, Forced Migration Studies Programme, University of the Witwatersrand

[4] HIV and AIDS and STI Strategic Plan for South Africa, 2007 – 2011, p119

**HIV and food insecurity**

The context of HIV provides additional public health impacts in relation to violence, displacement and camp-based responses. This includes impacts upon management of HIV infection and continuation of treatment for those already infected, as well as potential changes in HIV risk. HIV-positive individuals are more susceptible to infectious diseases that may be associated with camp-based responses than those who are HIV negative – this is linked to the provision of adequate and safe water and sanitation. In addition, the impact of food insecurity is greater upon HIV positive individuals.[5]

**Humanitarian responses**

Internationally agreed standards, such as the Sphere standards[6] exist to guide appropriate humanitarian responses in times of crisis. In addition, South Africa has a set of protected rights as outlined within the Constitution and various legal frameworks. These standards and frameworks should be used to guide and assess interventions.

The possibility of moving towards the establishment of longer-term (permanent) refugee camps raises critical concerns as displaced persons are moved from their communities and away from their place of work, school and regular healthcare facilities. This response moves away from reintegration to segregation.

In light of the above described scenario, the health impact assessment was conducted to respond to the urgent need to gain an understanding of the situation after the xenophobic attacks and to make recommendations for effective public health responses. The research has included:

1) An analysis of the situation post violence: changes in the public health needs and risks profiles on international migrants associated with displacement, violence and provision of temporary shelter with the possibility of future recurrence of xenophobic attacks.

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[5] A recent study has found that women in food insecure southern Africa are putting themselves in danger of contracting HIV in their struggle to feed themselves and their families (Weiser *et al*, 2007). The study investigated the association between food insufficiency and inconsistent condom use, sex exchange, and other measures of risky sex among 1,255 adults in Botswana and 796 adults in Swaziland. The study argued that insufficient food for people's daily needs and infection with HIV were inextricably linked and major causes of illness and death. The study found that women in both countries who reported food insufficiency were nearly twice as likely to have used condoms inconsistently with a non-regular partner or to have sold sex. This clearly reinforces the point that as a result of severe food insecurity, people develop negative coping mechanisms, or ways of survival that have harmful effects on their lives, which include eating fewer meals, migration, pulling children out of school and often, girls and women exchanging sex for food.

[6] Sphere, 2004 For more details, see www.sphereproject.org

2) The multiple social, health and macro-economic determinants of health prior to and following the attacks.
3) An estimation of the future public health implications for this population group given the government responses and suggested responses.

The broad aim of the study has been to gain understanding of the public health impact of violence and displacement on international migrants in Gauteng and the Western Cape provinces. The study assessed both changed public health needs and changes in access to services.

## The value of the report

### What the report includes

The report employs a formal and systematic health impact assessment methodology to evaluate the overall public health effects of the May 2008 attacks in Gauteng and the Western Cape provinces. A concise yet comprehensive systematic approach is applied that provides a holistic understanding of the factors affecting migrant health. The report considers pre-migration, transit and displacement factors common to cross-border migrants within South Africa. In addition, the multiple social, health and macro-economic determinants of health prior to and following the attacks are considered. It illustrates how many of the factors underlying xenophobia, such as discrimination and poor access to housing and quality employment, are likely to have compromised the health of migrants both before, during and after the attacks.

### Relevance and use of the report

A set of workable recommendations for intervention at multiple entry are presented. By highlighting the *drivers* of ill health rather than exclusively focusing on particular diseases, the analysis and recommendations provide policy makers and non-governmental organisations the tools to advocate for intersectoral migrant health programmes that are likely to improve migrant health in a sustainable manner. The report addresses both immediate and long-term health needs of migrants and is therefore useful for both frontline organisations and policy makers.

### Briefing on HIV and access to ART

A policy brief has been drafted that provides recommendations relating to non-citizens access to ART in the public sector. The policy brief incorporates key recommendations relating to the management of ART in emergency situations within South Africa, as experienced during the xenophobic attacks in 2008.

**Dissemination**

- OCHA
- Disaster management
- Frontline NGOs such as Oxfam, MSF
- Advocacy organisation such as CoRMSA
- Atlantic Philanthropies
- Local government departments

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# 1. INTRODUCTION

South Africa has an integrative urban asylum policy. No refugee camps exist and individuals are encouraged to self-settle and integrate within the host population. Rights are afforded to refugees, asylum seekers, and international migrants. This includes the right to work, go to school, and access public health services. In practice, however, access to these rights has long been problematic. In as early as 2004, protests erupted at Lindela Deportation Centre (on Johannesburg's West Rand) over claims of gross human rights violations of immigrants (CSVR, 2008; Star, 2004). In addition to the institutional and logistical obstacles to securing these rights, migrants have, prior to and since the promulgation of such legal frameworks been subject to discrimination, prejudice and violence (Harris, 2002). Beginning in Gauteng in May 2008, escalated xenophobic violence resulted in the deaths, disability and displacement of migrant population across South Africa.

This discrimination and violence against migrants needs to be viewed in the context of broader structural or institutional discrimination. Institutional or structural discrimination is evident in discriminatory government policies and/or abuse of migrants by civil servants (e.g. police, border control or repatriation centre staff). Governments in Africa, Latin America and Asia have been criticized for violating the rights of migrants and for using migrants as scapegoats to explain unemployment and crime. Examples of this include mass repatriation programmes at short-notice and abuse of migrants in repatriation facilities (Ratha & Shaw, 2007; Zoomers & van Naerssen, 2006). Indeed, migrants who travel to other developing countries are more likely to be expelled than are those who migrate to industrial countries (Ratha & Shaw, 2007). The current situation in the Ivory Coast where many Ivorians must show documentation of local ancestry to enjoy full citizen rights is a prime example of institutional discrimination. It is important to recognize that discriminatory policies both result from and contribute to broader societal xenophobia and discrimination.

It appears therefore that discrimination against migrants and xenophobia is commonplace internationally and is experienced by both internal and international migrants. Local inhabitants of developing countries tend to perceive migrants from poor countries or areas as taking away jobs from locals and being responsible for crime and

violence (Adepoju, van Naerssen, & Zoomers, 2006; Dodson & Oelofse, 2000). Yet these xenophobic attitudes seldom provoke wide-scale interpersonal violence on the scale witnessed in South Africa earlier this year (HSRC 2008).

### 1.1. Recent xenophobic violence in South Africa

South Africa is characterized by a long history of violence as a means of protest, with foreigners being common targets thereof (HSRC 2008). Recently the situation for international migrants in South Africa has become more acute. Xenophobic violence in urban South Africa from May 2008 resulted in the deaths of at least 62 people, 670 were injured, and more than 1300 people were arrested. About 100 000 people were displaced, according to estimates from the UN High Commissioner for Refugees (UNHCR) (Capp, 2008). CoRMSA (2008) reports displacement at double this figure. Against the backdrop of sporadic xenophobic violence and reports of institutional discrimination the South African Government's response to in May 2008 centred on the provision of temporary shelters and camps, which were intended to meet the basic needs of shelter and security. However, a number of non-governmental organizations (NGOs) made additional provision for the housing of displaced migrants outside of camps. Thus displacement resulted in a complex relationship between urban migrants housed within and outside camps and the urban populations in which such temporary shelters were established and sustained.

This complex displacement resulted in a variety of public health risks arising from a wide range of factors. While a number of rapid assessments during the period were conducted by civil society groups and NGOs and supplemented by UN task team reports compiled and distributed by UNICEF, OCHA and UNHCR (Capp, 2008, p. 1987) included health status descriptions and risk factor identification. As yet, no systematic public-health based assessment of the health impacts of the xenophobic violence has been undertaken.

### 1.2. Aims and objectives

The aim of the study is to identify and understand the public health impact of violence and displacement on international migrants affected by violence and displacement in Gauteng and the Western Cape from May to August 2008. In addition, the study will identify gaps in the current responses and provide recommendations for a research

agenda to inform preparedness in the event of a re-occurrence of the xenophobic attacks in these areas (health risks in other areas of SA may be different e.g. in KZN malaria would be an issue).

The study is guided by the following objectives:

a. To describe the range of likely health impacts following internal displacement caused by community violence, based on a review of the international literature;
b. To determine the socio-demographics of the migrant population placed in temporary camps in Gauteng and the Western Cape following the xenophobic attacks
c. To identify the major public health risks associated with the xenophobic violence on International migrants who were displaced to temporary shelters/camps, displaced to other homes, families and communities and remained self-settled in the study population in order to assist with planning appropriate long and medium-term responses;
d. To understand the impact of violence against foreigners on access to and experiences of using public and NGO health services with special reference to HIV positive migrants' ART adherence and;
e. To describe the best approach to mitigating the negative health impact associated with displacement to temporary shelters/camps as a result of violence based on international literature and best practices.

## 1.3. Definitions and terminology

### *1.3.1. Migration*

Migration is defined as a process of social change where an individual or a group because of reasons of economic betterment, political upheaval, education or other purposes, leaves one geographical area for prolonged stay in another (Bhugra 2004a). The process can be trans-national or rural–urban (Thomas & Thomas, 2004).

### *1.3.2. Displacement*

It is important to distinguish between migration, which refers to both voluntary and forced processes, and displacement, which typically refers to involuntary or forced migration,

either of refugees and asylum seekers (displaced beyond their borders) or internally displaced people (IDPs) (displaced within their own borders). (Thomas & Thomas, 2004).

#### *1.3.3. Violence*

This report follows the definition of violence put forward in the *World report on violence and health* namely: *the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation* (Krug et al 2002, p. 5).

#### *1.3.4. Health*

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948).

#### *1.3.5 Mental health*

Mental health is “a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2005, p. 2)

#### *1.3.6. Food insecurity*

The American Society for Nutritional Sciences defines food insecurity as the lack of “availability of nutritionally adequate and safe foods or (where) the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain” (Hamelin, 2002).

#### *1.3.7. DALYs*

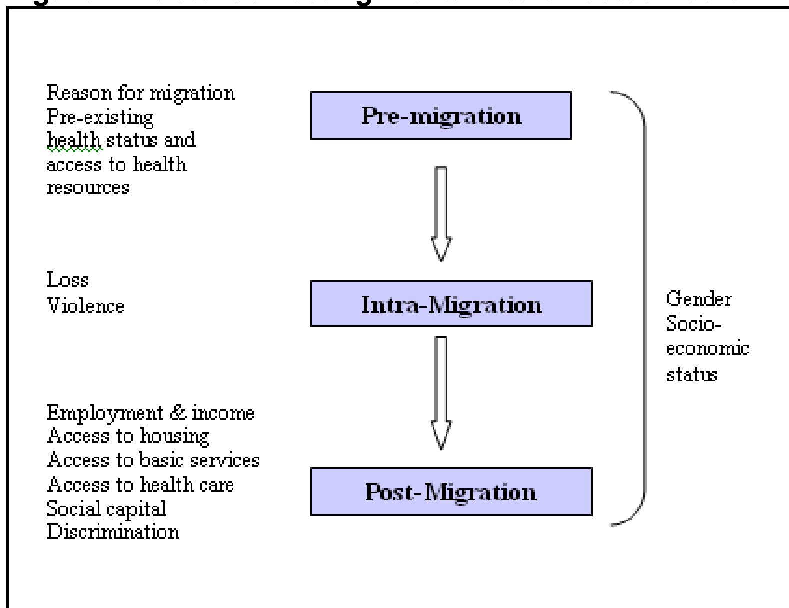
DALYs refer to disability adjusted life years. This burden-of-disease measure takes into account the age of the injured or deceased to calculate a combined measure that includes the potential years of life lost and the number of years lived with a disability.

## 2. METHODOLOGY AND ASSESSMENT FRAMEWORK

Migration itself implies a number of public health risks. If one considers the socio-economic determinants of health and the forces governing south-south and rural-urban migration, as well as the relative lack of resources in developing countries, it would follow that migrants in developing countries are at greater risk than their counterparts in developed countries. As public health has a major impact on development outcomes such as education and employment, it is important to ameliorate risk factors in migrants and identify related interventions so that migration can enhance rather than hinder development.

Factors affecting the health of migrants have been classified in relationship to the stages of migration: pre-migration, migration, and post-migration factors as shown in Figure 2. This classification enables a consideration of the source of risk factors as well as highlighting the changes in the nature of distress experienced over the duration of the migration process (Carta et al., 2005). Risk factors may be directly related to migration (e.g. the reason for migration or level of integration in the host community) or may relate to migrant characteristics such as socio-economic position, gender and personality (Carta et al., 2005).

**Figure 1. Factors affecting mental health outcomes of migrants**




**Source**: Adapted from Bhugra & Jones (2001)

In addition, characteristics of the migrants themselves, their reasons for migrating, exposure to health risks in their pre-displacement location and access to health services will have a large impact on the nature of health risks that migrants face when displaced.

Due to the limitations of currently available data and the retrospective nature of the research it was decided to conduct a rapid assessment in the form of a health impact assessment methodology that has frequently been utilized to project health impacts following changes to health systems, environmental projects and disaster scenarios.

Although Health Impact Assessments (HIAs) are typically used prospectively, the framework can also be used to systematically assess the health effects of past interventions and or events. This study therefore uses the HIA framework described by Lerer (1999) to assess the health impacts of the recent xenophobic attacks on international migrants.

### 2.1. Data sources

The data utilized to inform the HIA consisted of (1) a brief literature review of scientific papers and international guidelines and policies pertaining to migration health and humanitarian disasters, (2) publicly available and media reports describing the status of migrants following the xenophobic attacks, (4) unpublished data collected by humanitarian aid agencies and (3) key informant inputs collected via questionnaire from key actors in Government and NGOs. A list of the organizations from which these key actors were drawn is provided in Table 1.

**Table 1. Organisations consulted**

| | |
|---|---|
| **NGO** | Nazareth House |
| | TAC/AIDS Law Project |
| | United Nations Office for the Coordination of Humanitarian Affairs (OCHA) |
| | Salvation Army |
| | Red Cross |
| | Usindiso |
| **Government** | City of Cape Town |
| | Gauteng Provincial disaster management |

International minimum benchmarks against which health conditions were rapidly assessed were extracted from the Sphere Project's Humanitarian Charter and Minimum Standards in Disaster Response Handbook (Sphere Project, 2004), the United Nations High Commission on Refugees' (UNCHR) *Handbook for Emergencies* (UNCHR, 2007) and a minimum norms and standards document compiled by the Treatment Action Campaign (TAC) and the Aids Law Project (ALP)[7] (TAC/ALP, 2008). The first source is the official handbook of the Sphere Project an initiative launched in 1997 by a group of humanitarian organizations. The handbook describes the minimum standards to be attained in disaster assistance across 5 key areas. These include water supply and sanitation, nutrition, food aid, shelter and health services, The TAC/ALP compilation report represents a synthesis of minimum norms and standards in disaster response provided by the United Nations High Commission on Refugees (UNHCR), the World Health Organisation (WHO), the World Food Programme (WFP), and the Sphere Project. While these documents provide useful minimum thresholds against which to assess the various health determinants following the violence, the type of data required for accurate comparison is lacking. Comparisons are therefore limited to extrapolations from secondary data in assessing the degree to which health conditions in the camps met these minimum standards.

The publicly available information sourced from three agencies in the form of site reports from

- http://www.saemergency.info/site-reports

[7] Available at www.tac.org.za/community/files/file/xenophobia/IntnlNormsStandards.pdf

- http://www.tac.org.za/community/node/2380
- http://ochaonline.un.org/rosa/HumanitarianSituations/AttacksonForeignersinSA/tabid/4613/language/en-US/Default.aspx

**2.2. Health Impact Assessment (HIA) methodology**

Both local data and literature were analyzed under each of the key systems that inform the HIA recommendations. These are constituted by a: a) socio-demographic assessment, b) health determinants assessment, c) health status assessment, and d) health systems assessment.

***2.2.1. A socio-demographic assessment*** provides the context for the HIA and therefore requires the compilation and collation of available secondary data drawn largely from government and local authorities and development agencies on:

- *Migration trends*
- *Population demographics*
- *Socioeconomic status*
- *Vulnerable groups*
- *Institutional capacity*

***2.2.2. A health determinants assessment*** aims to quantify access to and quality of:

- *Food and fuel security*
- *Nutrition*
- *Housing*
- *Transport*
- *Social and family structures*
- *Education*
- *Water, sanitation and waste management*
- *Pollution*

***2.2.3. A health status assessment*** relies on health status data that are mainly descriptions (both numerical and/or qualitative) of morbidity and mortality due to diseases, conditions and injuries. The health status assessment aims to describe

important diseases and conditions to assist in determining health needs The methodology can be loosely based on rapid epidemiological studies (Smith 1989; Manderson and Aaby 1992; Anker et al. 1993) in order to succinctly and accurately describe a wide range of health indicators. In this HIA we use a burden of disease approach to highlight the major health problems in South Africa that were most likely to affect migrants arriving in camps as well as the conditions that might arise in camps, i.e.:

- *Violence*
- *Mental illness*
- *Diarrhoeal disease*
- *HIV*
- *TB*
- *Non-infectious chronic diseases*
- *Malnutrition*

This component of the system should be especially sensitive to the generation of health data on major groups at risk, including the very young, women, adolescents, the disabled and the elderly as these groups are often the most vulnerable to health impacts following critical events. In migration studies however, the parameters of vulnerability are conventionally much wider than these and include access to documentation and people already on treatment for conditions such as TB and HIV who are at risk of defaulting. In addition young men are internationally at high-risk for as both perpetrators and victims of fatal violence (Krug et al., 2002).

***2.2.4. A health systems assessment*** is undertaken in order to profile the quantity and quality of health care services and facilities during the critical intervening event, and in this report provides a brief overview of access to important health services.

### 2.3. Limitations

The primary limitation of this study relates to the logistical and time constraints, which limited the amount of primary research that could be undertaken. Furthermore, secondary data sources were also limited in several respects. While there is a significant body of international literature on migrant health, quantitative data on the health determinants and health status of migrants in South Africa is extremely limited. Secondly, no ongoing, systematic surveillance of health conditions was initiated during the xenophobic violence and within the camps themselves. The reliance on secondary data may also have introduced certain biases, although every attempt has been made to verify and assess the plausibility of information obtained. Where possible, original data has been re-analysed. Due to problems with data quality and logistical constraints, much reliance has been placed on personal communications from key informants.

## 3. SOCIO-DEMOGRAPHIC ASSESSMENT

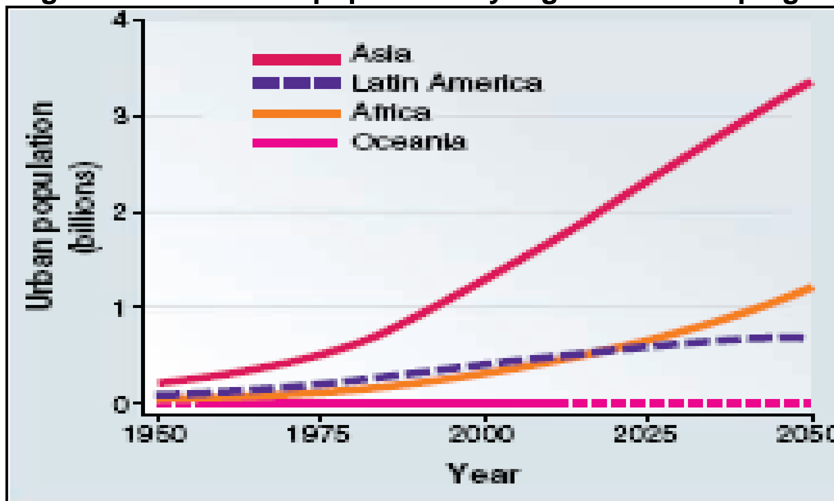
Xenophobic violence is integrally linked with competition for scarce resources including access to land, housing and basic services. Mass migration and rapid urbanization are major factors affecting the availability of resources and the consequent experiences of migrants,

> *Conflict between immigrants and "locals" in Mizamoyethu* [an area in Cape Town inhabited by rural-migrants ("locals") and international migrants] *has occurred at irregular intervals since the settlement's establishment. In an incident in 1993, South African residents broke into the houses of Namibians and removed their possessions "as a symbolic message that they did not belong in the area". People were reportedly unhappy that Namibians and Angolans were getting access to land and services, however rudimentary, when many South Africans remained homeless. Violence erupted in 1994, when "locals" launched a pre-dawn raid on the houses of Namibian fishermen. The Namibians retaliated, injuring a number of their assailants. The South Africans claimed that the Namibians were stealing their jobs on the fishing boats, being prepared to work for half the normal rate and refusing to engage with collective bargaining with employers over wages and work conditions. After this incident, Namibian residents found themselves "living under a virtual state of siege", moving around in groups for personal safety and forced to take measures to guard against theft or destruction of their homes and possessions. A peace settlement was brokered by the local civic body and peace monitors, but relations between locals and immigrants remained strained.*
> (Dodson & Oelofse, 2000, p.133.)

### 3.1. Migration trends

International migration together with internal (rural-urban) migration has resulted in unprecedented urban growth. It is estimated that between 40-60% of urban growth in developing countries is due to migration and spatial expansion of cities into rural areas. Hundreds of large cities have emerged with populations exceeding 10 million, particularly in Asia and Latin America (Montgomery, 2008). However, there is enormous variation in the pattern of urbanization. In 2000, for example, 75% of people in Latin America lived in urban areas, compared to 37.1% of people in Asia and Africa. This pattern is changing however, with the largest rates of urban population growth expected in Africa and Asia as illustrated in Figure 1 below (Cohen, 2006; Montgomery, 2008).

**Figure 2. Total urban population by region in developing countries**




**Source:** Montgomery (2008, p.762)

Indeed, of the expected 1.76 billion global population growth, 86% will be absorbed into the cities and towns of developing countries so that between 2000 and 2030 the urban populations of these countries will have doubled (Montgomery, 2008). When the West underwent urban transition, this happened at a far slower pace and in concert with economic and infra-structural development which enabled cities to absorb the growth in population and its needs for services. By contrast, rapid urban population growth in many cities of developing countries has outstripped the ability of governments to provide housing, and basic[8] and essential[9] services. Furthermore, the supply of quality employment is also insufficient to meet the growing demand with the proportion of the urban poor increasing faster than the urban population growth rate (Cohen, 2006; Montgomery, 2008).

The nature of migration varies greatly; people migrate over varying distances for different periods of time and the reasons for migration and benefits and risks involved differ substantially between localities, countries and regions and from migrant to migrant. However, the majority of migrants from developing countries move from rural to urban areas in their own country or to other developing countries in the region ("South-South migration").

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[8] Water, sanitation and waste removal services

[9] Access to Health, education and housing

Accurate information on voluntary migration is not always available for developing countries, particularly for within-country movements and where migration occurs through irregular or illegal channels. Irregular migration is common in South-South migration due to strict immigration restrictions with limited enforcement, the expense of travel documents and unclear immigration rules in many of these countries (Ratha & Shaw, 2007). Despite these limitations there is little disagreement on the trends observed in the available data (Cohen, 2006; Montgomery, 2008).

The majority of international migration from countries of the South comprises short-distance movement to neighbouring countries or countries within the region. Indeed, at least half of international migrants from developing countries move to other developing countries and almost 80 percent of these migration flows take place between neighbouring countries (Deshingkar & Grimm, 2004). Important changes have also occurred in the composition of migrants. Whereas migration was for a long time almost exclusively undertaken by young men, migration has “feminised” now, with approximately half of current migrants being female (Adepoju, 2002 in Moppes, 2006).

### 3.1.1. Migration trends in South Africa

As is the case internationally, tracking migration patterns in South Africa is difficult. This is largely due to the very different types of migration both into and within the country’s borders. Cross-border migration must therefore be understood in the context of internal population movements such as rural-urban migration and circular migration. However, reports detailing trends in movement of international migrants into South Africa (Singh, 2005) are available and especially pertinent to this study. Historically, South Africa has been a common destination for migrant labour and movements driven by economic incentive or need. Such motivations for migration continue to drive cross border human movement today. More recently however, drivers for migration into South Africa have included conflict, poverty, violence, and political, religious and gender-based persecution (Singh, 2005). Migrants that crossed into South Africa as a result of these factors are considered asylum seekers until such time as their application for refugee status has been accepted. According to the 2007 Community Survey (StatsSA, 2007), international migrants only constituted 2.7% of all households surveyed. Although international migrants move towards urban centres, they still make up a relatively small proportion of the urban population. For example, Landau & Gindrey (2008) report that 2.4% of

Gauteng's 2001 population were not born in South Africa. More locally, foreign-national comprised only 7.9% of the population of the city of Johannesburg in 2007. A Centre for Development and Enterprise (CDE) (2008) study drawing on 1002 interviews with a household representative respondent found that 8.6% of the sample was foreign. Country of migrant information sourced from this study is provided in Table 2 below.

**Table 2. Distribution of JHB migrants by country/region of origin, 2008**

| **Country/Region of origin** | **%** |
|---|---|
| Zimbabwe | 39 |
| Mozambique | 14 |
| BLNS countries (Botswana, Lesotho, Namibia and Swaziland) | 15 |
| Britain | 7 |
| Europe | 5 |
| Nigeria | 4 |
| Malawi | 4 |
| Somalia | 1 |
| Egypt | 1 |
| Africa (Other) | 8 |

**Source:** Adapted from CDE (2008)

There are some differences in the demographic profile of non-nationals and the local South African population. On average, non-nationals are older and comprise more males than females. The average age in a national study of international migrants by Belvedere et al. (2003) was 31 while the median age of the South African population is 24 (UN, 2008). In a survey study carried out by Landau & Jacobsen (2004) over 2 years some 70.6% of non-nationals were male while male constituted 46.9% of South Africans at the time. However, the increasing feminization of migration is set to shift this figure in the future. Immigrants within these studies tended to be well educated and almost one third had completed tertiary education in the Belvedere et al. (2003) study. In addition, research has shown that migrants are frequently self-employed in the informal economy and tend to create jobs quicker than South Africans (Landau et al, 2004).

More specific data on migration trends is provided by the Health Environment and Development study, a multi-partner study of urban health in Johannesburg conducted under the auspices of the World Health Organization Collaborating Centre for Urban Health (WHOCCUH) in 2006. The study represented a household survey of 5 sites

within the Johannesburg area (Table 3). Data was collected on socio-demographic status & expenditure patterns, migration patterns, perceptions of housing and neighbourhood conditions, hygiene behavior, quality of life & social cohesion, food procurement and insecurity, exposure to violence, physical activity and health status (acute, chronic and mental) (Barnes, 2008). The majority (54%) of those non-South African households was of Zimbabwean origin. The sample also reflected households that had migrated to South Africa from Mozambique (7%) and Lesotho (7%). The remainder of the sample was constituted by migrants from Somalia, Burundi, Ethiopia, Ghana, Namibia, DRC, Swaziland, Botswana and Malawi.

**Table 3. Sites by number of dwellings, response rate, and percentage of households of non-South African origin, HEAD study, 2006 (n=533)**

| Sites | No. of dwellings | Response rate (%) | Households of non-SA origin (%) |
|---|---|---|---|
| **Hillbrow** | 131 | 87.3 | 30 |
| **Braamfischerville** | 123 | 82 | 2 |
| **Hospital Hill** | 104 | 69 | 7 |
| **Riverlea ext 1** | 102 | 68 | 0 |
| **Bertrams** | 73 | 48.7 | 14 |

**Source:** Barnes (2008)

### 3.2. Population demographics

Our review of available data did not reveal a concise and coherent summary of the extent or demographic profiles of migrants to South Africa prior to the xenophobic attacks. Instead, we have had to make several assumptions based on data pertaining to the refugees at camp sites immediately following the attacks. Although the camp residents may not be representative of all migrants to South Africa, they are more likely to represent groups most at risk.

It is difficult to estimate the total number of people displaced by the xenophobic attacks, as many people may have sought refuge with friends, family or associates outside of the official system. The number of migrants in the former categories can only be estimated via key informants and so our analysis is chiefly based on the number of migrants enumerated in a selected set of reports. Where possible we do however reflect on the public health impacts on non-camp migrants.

The summary table (Table 4) provided by the UN, Office of the Resident Coordinator's situation report number 13 provides an indication of several important features. First, the displacement centred mainly on two provinces, Gauteng and the Western Cape, and although the most serious outbreaks of violence were recorded in Gauteng, more people in the Western Cape were affected. Second, although the event was of limited duration there were prolonged effects, as shown by the large numbers of people still displaced some three months after the attacks. The numbers also indicate that reintegration appeared to be more of a challenge in Gauteng than in the Western Cape, possibly due to the more severe nature of the attacks in this province.

**Table 4. Location, number of sites and displaced population as of 19/09/2008**

| Province | Sites | | Population displaced | |
|---|---|---|---|---|
| | **May** | **Aug** | **May** | **Aug** |
| Gauteng | 48 | 6 | 17,548 | 3,465 |
| Western Cape | 90 | 3 | 19,654 | 2,290 |
| Kwa-Zulu Natal | 2 | 3 | 1,650 | 35 |
| TOTAL | 140 | 35 | 38,762 | 5,790 |

**Source:** DMCs from GP, Western Cape and KZN and TAC (WC), cited in UN (2008).

Whereas there were a greater number of sites in the Western Cape, the size of the population in each of the major camps (Table 5a) were considerably lower than in Gauteng (Table 5b). The larger number of males was indicative of the nature of migration into South Africa, i.e. primarily for economic reasons. The utilization of the camps was also indicative of the migrants need to be located close to employment opportunities and basic services, with far flung camps, such as those at Wit Road and Wadeville experiencing considerably less overcrowding

**Table 5. Composite IDP demographics disaggregated for the Western Cape**

| Site name | Population | | | | Tents | | Source |
|---|---|---|---|---|---|---|---|
| | Females | Males | Children | Total | # people | # people per tent | |
| Silver stream | 39 | 135 | 25 | 202 | | | Rapid assessment on the humanitarian situation of displaced populations in the Western Cape 06/06/08[10] |
| Summer Greens | 47 | 142 | 20 | 209 | | | |
| Table View | 2 | 75 | 1 | 78 | | | |
| Harmony | 169 | 667 | 35 | 871 | | | |
| Sarepta | 76 | 14 | 12 | | | | |
| Desmond Tutu | 95 | 128 | 27 | 250 | | | |
| Site B Khayalitsha | 43 | 35 | 37 | 115 | | | |
| Andile Msizi | 62 | 104 | 16 | 182 | | | |
| Solomon Mahlangu | 48 | 71 | 25 | 144 | | | |
| Masibambane | | 46 | 0 | 46 | | | |
| Zolani | 78 | 76 | 38 | 192 | | | |
| Phillipi East | 48 | 68 | 11 | 127 | | | |
| KTC | 80 | 145 | 25 | 250 | | | |
| Blue Waters | 56 | 190 | 50 | 246 | | | |
| Portland mosque | | 150 | | 150 | | | |
| Bothasig | | | | 150 | | | |
| His People | 80 | 104 | 40 | 224 | | | |
| Light House | 59 | 165 | 59 | 283 | | | |
| Soetwater | | | 300 | 2801 | | | |
| Youngsfield | 150 | 350 | 130 | 630 | | | |
| Bellville mosque | | 300 | | 300 | | | |
| Knysna | 12 | 162 | 11 | 185 | | | |
| Sedgefield | | 18 | | 18 | | | |
| **WC TOTAL** | **1144** | **3145** | **862** | **7653** | | | |

[10] Available at http://ochaonline.un.org/OchaLinkClick.aspx?link=ocha&docId=1090798

**Table 6. Composite IDP demographics disaggregated for Gauteng**

| Site name | Population | | | | Tents | | Source |
|---|---|---|---|---|---|---|---|
| | Females | Males | Children | Total | # people | # people per tent | |
| Klerksoord | | | | 2000 | 360 | 5.5 | OCHA 09/06/08 |
| River Road | | | | 233 | 56 | 4.2 | OCHA 09/06/08 |
| Rifle Range | | | | 2346 | 397 | 5.9 | OCHA 09/06/08 |
| Wadeville | | | | 918 | 230 | 3.9 | OCHA 09/06/08 |
| Rand Airport | | | | 1800 | 300 | 6 | OCHA 09/06/08 |
| DBSA | | | | 300 | 69 | 4.35 | OCHA 09/06/08 |
| Wit Road | | | | 282 | 120 | 2.35 | OCHA 09/06/08 |
| **GAUTENG TOTAL/AVG** | | | | **7879** | **1532** | **4.6** | |

### 3.3. Socio-economic status

People from low-income countries tend to migrate to other low-income countries where migration costs are less but where employment opportunities are less lucrative (Ratha & Shaw, 2007). Given the well-established relationship between health and employment, it is clear that migration is likely to increase the health of the better off and may decrease the health of poorer migrants, already at greater risk for illness.

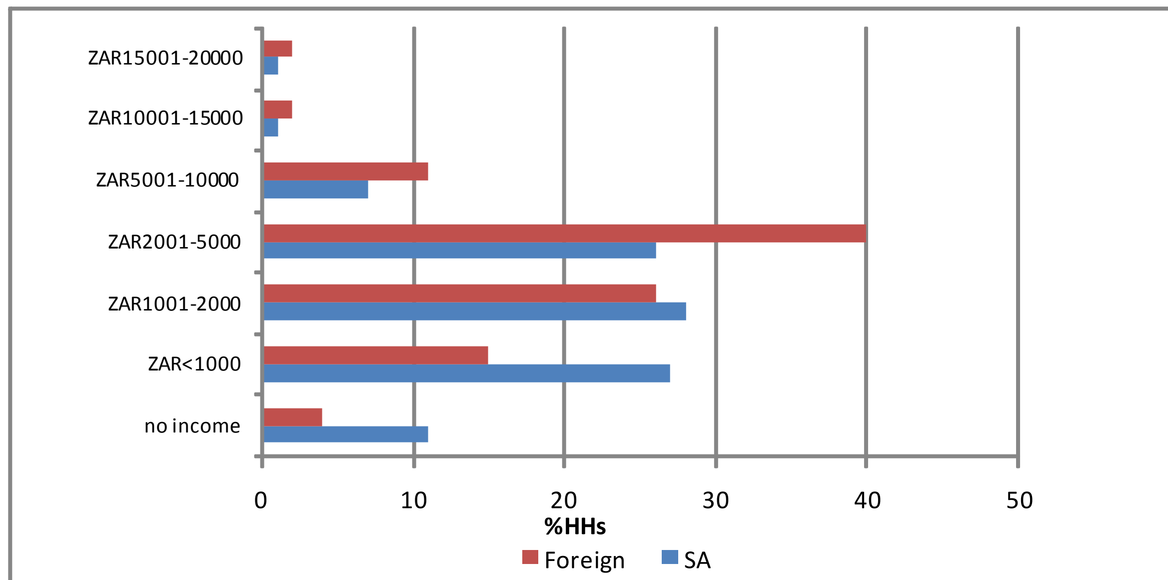
While better employment and increases in income are enjoyed by certain migrants, the appalling conditions under which many migrants from developing countries work are well documented (Ludermir & Harpham, 1998; Mosse, Gupta, Mehta, Shah, & Rees, 2002; Ratha & Shaw, 2007; Rogaly & Rafique, 2003; Waddington, 2003; Zoomers & van Naerssen, 2006). Migrants are often desperate to earn an income and are therefore liable to accept jobs with meager wages and in hazardous or harsh work environments. Migrants without the necessary documentation are particularly vulnerable to exploitation due to the threat of deportation. Indeed, there are countless reports of employers who employ migrants on a casual basis and then refuse to pay them or report them to deportation authorities on completion of work.

The lack of effective labour and occupational health regulation and enforcement in developing countries aggravates the situation. Migrants enjoy even less protection than non-migrant workers and have greater difficultly accessing their rights and entitlements (Zoomers & van Naerssen, 2006).

Furthermore, as migrants move into the cities of developing countries, the formal labour market becomes over-supplied. How quickly this occurs depends on the relationship between economic growth and in-migration. Oversupply of labour decreases demand for labour and reduces wages, pushing many migrants into the informal sector (Lipton, 1980; Ludermir & Harpham, 1998; Waddington, 2003). As Ludermir et al (1998) explain, the socio-economic status (SES) of migrants in the urban structure of developing countries is mostly pre-determined by their previous SES and kinship links; the majority is excluded from the formal labour market and end up working as informal traders and domestic workers. The UN Rapporteur on the Human Rights of Migrants has highlighted the problems faced by domestic workers, including, sexual and physical abuse, under-nourishment and seizure of passports (World Health Organisation, 2003).

Many migrants are vulnerable to exploitation by contractors and people smugglers or traffickers who target poorer and less educated migrants. For example, a study evaluating economic outcomes of contract migrants in Hoglakandi, Bangladesh who had signed up with contract agents for work in Singapore found that due to the high start-up costs of migration, they ultimately incurred a net loss (Rahman, 2000). According to the ILO report on the Global Alliance Against Forced Labour (2005) (ILO, 2005), there are approximately 2.45 million people in forced labour at any given time as a result of human trafficking. The majority of trafficked migrants are women and girls and they are often sexually exploited, further adding to their health risks. HEAD study data however showed that on average, migrants reported being in a better socio-economic position that their South African counterparts.

**Figure 3. Monthly household income, Foreign vs. South Africa, HEAD Study, 2006**




Media reports confirm that one of the major stressors for refugees in camps in Gauteng and the Western Cape has been the loss of employment, with many refugees indicating that they had been summarily dismissed from their jobs (Caelers, Smook, &Samodien, 2008; Yung, 2008a). Others had their businesses destroyed in the violence or felt unsafe to trade in the areas they were attacked (Yung, 2008a;Radler, 2008). One camp resident summed up the sentiment saying, “There is every kind of tradesman here, willing to work. Instead we do nothing” (Radler, 2008). Others, needing to support families back in their countries of origin, set up shop in and around the camps selling airtime, food and

other wares in makeshift stalls (SAPA, 2008a). Given Landau & Jacobsen's (2004) findings that many migrants rely heavily on the informal economy and are self employed, displacement will have resulted in the disruption of regular income and extractions from customary places of trade for those in the camps. The socio-economic impact of migrants housed by family and friends or NGO shelters is not clear but there is no reason to believe that their sources of income were unaffected.

### 3.4. Vulnerable groups

Vulnerable migrants are at increased risk of developing illness and so their health is doubly compromised by pre-existing vulnerability in addition to greater exposure to migration-associated health risks (Yearwood, Crawford, Kelly, & Moreno, 2007). The most vulnerable groups tend to comprise people of low socio-economic status, marginalized or socially excluded groups, women, youth and the elderly, people with previous exposure to violence or abuse, people with existing mental and/or physical illness, people with poor access to health and social services. Although in South Africa it was most commonly men who were displaced, it is important to recognize that the xenophobic attacks were concentrated primarily in informal settlements on the urban periphery and that it was mainly people of low socio-economic status who were targeted. Moreover, as mentioned previously, there are a number of at-risk groups particular to migrants. Undocumented migrants appeared to have left the camps following the government's attempts to register camps residents. Such actions would have increased the threats to safety and health of these migrants. Secondly, given the high prevalence of both HIV (15%) in Sub-Saharan Africa and South Africa (18.3% of adults) (WHO, 2007) and Tuberculosis (998/100 000 population in South Africa) as well as the substantial health threats resulting from their interaction (WHO, 2007), migrants requiring treatment for these infectious diseases must be considered especially vulnerable to displacement. These health impacts are dealt with in section 5.3. below.

### 3.5. Legal status

The handling of the displaced foreigners by the Home Affairs Department raises many questions about the South African Government's attitude towards foreigners and its contribution towards xenophobia through institutional discrimination. According to media reports, the refugees were asked to register with the Department of Home Affairs to establish their legal status in the country and were given a six month period in which to

do so (Laun, 2008). However, the Department of Home Affairs was reported to be very slow in the processing of these applications, not having increased staffing for the purpose with refugees sleeping near Home Affairs Department in order to get their applications processed in time (Yung, 2008a). This led to protests by the refugees and a call by several organizations including the Human Rights commission for a 6 month moratorium on deportations (Laun,2008; Yung, 2008a).

By October, it had become clear that the intention was to deport large numbers of refugees. While the chief director of communications of home affairs, Siobhan McCarthy, denied that refugees remaining in the camps faced deportation, she indicated that 98% of foreigners in camps in Johannesburg have been denied refugee status (Joubert, 2008). According to Marti Weddepohl , one of the volunteer camp co-coordinators in the Western Cape, home affairs officials were using the camps to gather information about refugees to deport them and said, "I've been strong-armed by the police crowd control unit to identify refugees who were arrested and put in Pollsmoor prison without being charged. They were intimidated and accused of being members of al-Qaeda by immigration officials. These are false arrests and I've been made party to them" (Joubert, 2008).

## 4. HEALTH DETERMINANTS ASSESSMENT

Health determinants are the direct or indirect causes of a disease or health condition (Lerer et al. 1998). Ideally, this section would attempt to determine whether relocation to refugee camps has had a positive or negative impact on health determinants such as water and sanitation, food and fuel security and nutrition. However, the absence of reliable baseline data made it necessary to make certain assumptions about the pre- and post-migration circumstances prior to the attacks.

**Table 7. Summary of the situation in the CoSS, 17 June 2008**

| CoSS | Shelter Facilities | Medical Services | Water and Sanitation | Other / Comments |
|---|---|---|---|---|
| **DBSA** Johannesburg 69 tents 305 Displaced | 1 x Large cooking Tent<br>1 x Office Building<br>1 x Medical Station<br>1 x Storage Containers<br>1 x Crèche Tent | •Gauteng Health mobile clinic on scheduled visits<br>•MSF Clinics attending on routine basis<br>•SA Red Cross facilities on site | • 2 Water Tankers<br>• 17 Toilets<br>• 2 Waste skips<br>• Washing basins and buckets delivered<br>• Hot water and shower solution to be provided by 21/06 | •2 meals per day by delivery service<br>•15 security guards + 1 horse + 1 quad<br>•Sleeping bags + mattresses provided<br>•Grey water management to be implemented by the municipality |
| **River Road** Johannesburg 56 tents 240 Displaced | 1 x Large cooking Tent<br>1 x Office Building<br>1 x Medical Station<br>3 x Storage Containers | •Gauteng Health mobile clinic on scheduled visits<br>•MSF Clinics attending on routine basis | • Municipal piped water<br>• 23 Toilets + 20 urinals<br>• 2 Waste skips<br>• Washing basins and buckets delivered<br>• Hot water and shower solution to be provided by 21/06 | •2 meals per day by delivery service<br>•15 security guards + 3 horses + 1 quad<br>•Sleeping bags + mattresses provided<br>•Grey water management to be implemented by the municipality |
| **Rifle Range** Johannesburg 420 tents 2,300 Displaced | 1 x Feeding Tent<br>1 x Cooking Tent<br>1 x Office Building<br>1 x Medical Station<br>3 x Storage Containers<br>1 x School tent<br>1 x Creche Tent | •Gauteng Health has District Health staff on site with support from mobile clinics<br>•MSF Clinics attending on routine basis | • Municipal piped water<br>• 102 Toilets<br>• 5 Waste skips<br>• Washing basins and buckets delivered<br>• Hot water and shower solution to be provided by 21/06<br>• 6 showers not deployed yet | •2 meals per day by delivery service<br>•20 security guards + 2 horses + 1 quad<br>•Sleeping bags + mattresses provided<br>•Grey water management to be implemented by the municipality |
| **Rand Airport** Ekurhuleni 232 tents 1,266 Displaced | 1 x Large Creche Tent<br>1 x Feeding Tent<br>1 x Cooking Tent<br>1 x Office Building<br>1 x Medical Station<br>3 x Storage Containers | •Ekurhuleni Metro Clinic staff on site<br>•Gauteng Health mobile clinic on scheduled visits<br>•Red Cross and MSF Clinics operating on routine basis | • 4 Water Tankers<br>• 95 Toilets + 40 urinals<br>• 4 Waste skips<br>• Washing basins and buckets delivered<br>• Hot water and shower solution to be provided by 21/06 | •2 meals per day by delivery service<br>•20 security guards<br>•Sleeping bags + mattresses provided<br>•Grey water management to be implemented by the municipality |
| **Wadeville** Ekurhuleni 230 tents 880 Displaced | 1 x Office Building<br>1 x Medical Station<br>3 x Storage Containers<br>1 Creche Tent<br>1 x Cooking Tent | •Ekurhuleni Metro Clinic staff on site<br>•Gauteng Health mobile clinic on scheduled visits<br>•Red Cross and MSF Clinics operating on routine basis | • 4 Water Tankers<br>• 80 Toilets<br>• 4 Waste skips<br>• Washing basins and buckets delivered<br>• Hot water and shower solution to be provided by 21/06 | •2 meals per day by delivery service<br>•15 security guards + 3 horses + 1 quad<br>•Sleeping bags + mattresses provided<br>•Grey water management to be implemented by the municipality |
| **Wit Road** Ekurhuleni 120 tents 279 Displaced | **On-site**<br>1 x Large Tent<br>**Planned**<br>1 x Office Building<br>1 x Medical Station<br>3 x Storage Containers | •Ekurhuleni Metro Clinic staff on site<br>•Gauteng Health mobile clinic on scheduled visits<br>•Red Cross and MSF Clinics operating on routine basis | • Municipal piped water<br>• Wheelie Bins delivered Washing basins and buckets delivered<br>• Hot water and shower solution to be provided by 21/06 | •2 meals per day by delivery service<br>•15 security guards<br>•Sleeping bags + mattresses provided<br>•Grey water management to be implemented by the municipality |

**Source:** Gauteng Provincial Disaster Management Centre cited by UNICEF, June 2008

### 4.1. Food security

A stable and healthy food supply is essential for health, development and social stability. Access to food, for the poor, is intertwined with macro-economic, political and societal issues. The National Food Consumption Survey (1999) indicated that the majority of

South African households experienced food insecurity, plus there was a high prevalence of stunting (21.6%) and age-related underweight (10.3%) in children aged 1-9. While the Integrated Nutrition Programme has successfully created guidelines for the management of nutritional policy, particularly concerning vulnerable groups, there is a lag in implementation due to resource constraints, which suggests that the nutritional status of vulnerable South Africans is not being addressed (Labadarios, 2005)..

External debt, population pressures, globalisation of food marketing, agricultural policy all combine to create a situation, where despite massive production surpluses, millions go hungry. Economic adjustment programmes have substantially altered access to food at a household level in the world's poorest countries, and it can be assumed that many of the refugees displaced by the recent attacks were themselves subject to food insecurity in their pre-migration countries of residence, further increasing their vulnerability.

Although the immediate needs for food following the attacks were met through the generosity of various religious organizations, local philanthropists and government, records on food utilization at the various sites were not regularly maintained. In addition, in both Gauteng and the Western Cape, cooked foods were provided by outside catering companies or voluntary organizations, which further complicated access to their records.

In some big sites, two meals were provided (see table III). Lunch typically comprised bread and juice or tea and sometimes fruit, and supper varied considerably and included rice, pap (maize meal), spaghetti, and chicken or meat. Smaller sites often run by religious organizations tended to receive better meals in terms of quantity, quality and frequency. However, continuity was a problem as these sites were reliant on donations (UNCHR 2008).

The quality and nature of available foodstuffs at the camps suggests that the minimum standards for food security and nutrition were met. However many of the supplementary exercises related to food security, advocated by the UNCHR such as conducting an initial nutrition, food and nonfood needs assessment, and arranging community education on use of food-aid were not undertaken (UNHCR, 2007).

It was also apparent that food security deteriorated over time, as following the inception of the camps, residents frequently received three regular meals per day, but by August Amnesty International reported that in many Gauteng camps only two meals were provided or were provided irregularly. Furthermore, milk for infants was no longer distributed at the Wit Road, DBSA and Akasia camps. This apparently coincided with the provincial authority's decision to close the camps prior to the Constitutional Court order of 21 August that temporarily interdicted their closure. The absence of food assistance lasted for more than a week, during which time residents had sustained themselves with sugar and water (UNCHR 2008).

### 4.2. Nutrition

Poor nutritional status compromises host immunity, leading to more frequent, prolonged and severe episodes of infections. Measles, diarrhoeal diseases, acute respiratory infections and malaria can result in high morbidity and mortality in malnourished populations (Joseph, 2008) (WHO, 2008). Under-nutrition results in poor physical and cognitive development, exacerbating the cycle of poverty and deprivation. Malnutrition is the single most important risk factor for death and disability worldwide, accounting for about 16% of the global burden of disease (de Onis, 1996; Murray and Lopez, 1996)

Weinreb et al. (2002) found that compared to children with no hunger, children with severe hunger were significantly more likely to have greater stressful life-events, chronic physical illness, higher parental distress and anxiety and higher rates of depression and anxiety themselves (Weinreb, 2002). Studies looking at younger children found a similar pattern of food insecure households associated with both higher rates of maternal mental illness as well as behavioural problems in toddler (Whitaker, 2006).

One of the challenges was the diversity of dietary habits encountered in the camps, as most sites comprised populations from different nationalities. UNHCR (2008) interviewed men and women regarding their food preferences, and the quality and quantity of food received. The UNHCR report (2008) suggests, for example, that whereas most African nationals were content with meat and chicken, Somalis preferred rice and spaghetti.

The poor quality of food in camps in Gauteng and the Western Cape dominated media reports on health risks. Reports about the poor quality of food and receiving expired or

rotten food were made from several camps (Van Gass, 2008; Yung, 2008b; Bramford, 2008; Maphumulo, 2008). In July, police were called in to deal with protests at the poor quality and quantity of food being supplied at a camp in the Western Camp. One of the camp residents indicated the source of their frustrations: “They want to treat us badly, to have us suffer or get sick. This bread is expired” (Yung, 2008b). However, members of the Red Cross, responsible for providing the food to this camp denied that expired or stale was provided to the refugees (Bramford, 2008).

Following consolidation of the camps, it was reported that in some camps the provision of napkins and baby food was discontinued (Joseph, 2008). As infants and young children are considered especially vulnerable to micronutrient deficiencies (UNHCR, 2007), discontinuity of food provision to this group implies a major health risk for migrants.  A camp-co-ordinator in the Western Camp indicated that in her camp they had received no milk, fresh fruit or vegetables for the preceding four months and that baby food had not been supplied for approximately 3 months. She stated that "The government has been supplying dry bread and a small bottle of juice once a day. When I complained about the nutritional value of this -- especially for the kids -- I was told by Adiel Mnyembane, assistant director in the Department of Social Development, that this is what people in the townships eat and the refugees must eat the same." (Joubert, 2008)

Yet despite reservations as to the composition and variety of the meals, very few cases of overt signs of malnutrition were reported. However, diarrhoea and acute dehydration among children was common. The nutritional value of some of the meals was also a concern, as breakfast was seldom provided, soups were reportedly watery and quantities were sometimes insufficient to feed all the migrants. In addition, issues relating to hygiene in food preparation were raised in one site along with corruption in the distribution process (UNCHR 2008).

Stakeholders identified food security and nutrition among the most important challenges facing the camp residents. Nearly all camp residents were affected with the elderly, women and especially children identified as being the most vulnerable groups. Normality was only likely to be restored once camp residents returned to employment and their incomes restored.

### 4.3. Housing

Poor housing is a root cause of health problems in urban areas, which along with unsafe water and poor sanitation, is responsible for 10 million deaths worldwide every year (HABITAT 2). The interaction between these physical conditions and social conditions, such as poverty level or education is an important determinant of urban health status, and access to housing is essential for long-term social and economic well-being (Community and Neighbourhood Services: Social Research Unit, 2005).

In Africa, 72% of urban dwellers live in slums, compared to 43% in Asia (Cohen, 2006) and it is clear that rapid urban growth will continue well into the 21$^{st}$ century.In South Africa, partly due to migration, the proportion of the urban poor has increased faster than the urban population growth rate, and the number of people reliant on government-subsidised housing continues to increase. However, it is the unplanned expansion of low-income "informal" settlements on the urban periphery with poor access to basic and essential services that has demonstrated that the initial health advantages of living in cities have declined as cities have enlarged (Cohen, 2006). People living in slums, defined as low-income settlements and/or poor human living conditions where poverty, disease and in many instances, violence, are rife, suffer far worse health outcomes than the rest of the urban population (Vlahov et al., 2007).

It should also be noted that neighbourhood effects need to be considered along with housing improvements (Catalano & Kessell, 2003; Evans et al., 2003; Howden-Chapmen, 2004), as residents located in socially fragmented neighbourhoods with poor housing, schools and services are more likely to experience ill health, lower levels of education and occupational attainment, as well as less access to resources and choices. In the Moving to Opportunities (MTO) Programme in five cities across the United States, participants that were relocated from poor areas into areas with greater opportunities experienced improved quality of life; greater mental and physical health; less use of harsh parenting techniques; and increased employment compared to controls that remained in the poor areas even though both groups had similar housing in the different settings (Saegert and Evans 2003).

Housing conditions show improvement between 2001 and 2007 in Gauteng and the Western Cape.

**Table 8. Housing types in JHB and Cape Town Metros: C2001 vs. CS2007**

| | **JHB Metro** | | **Cape Town Metro** | |
|---|---|---|---|---|
| **Type** | **C2001** | **CS2007** | **C2001** | **CS2007** |
| House or brick structure on separate stand or yard | 50.8 | 52.5 | 58.6 | 65.9 |
| Traditional dwelling/hut/ structure made of traditional materials | 1.2 | 0.4 | 1.9 | 0.4 |
| Flat in block of flats | 10.1 | 9.4 | 9.9 | 9.1 |
| Town/Cluster/Semi-detached house | 6.2 | 6.3 | 7.0 | 6.4 |
| House/flat/room in backyard | 8.3 | 7.4 | 2.5 | 1.2 |
| Informal dwelling/shack in backyard | 7.8 | 8.4 | 4.3 | 6.2 |
| Informal dwelling/shack NOT in backyard (informal settlement) | 13.3 | 10.4 | 14.5 | 9.3 |
| Room/flatlet not in backyard but on shared property | 2.2 | 1.8 | 0.8 | 0.4 |
| Caravan or tent | 0.3 | 0.1 | 0.3 | 0.1 |
| PVT ship or boat | 0 | 0.1 | 0.0 | 0.0 |
| Worker's hostel/bedroom | 0 | 3.2 | 0 | 0.6 |
| Other | 0 | 0.1 | 0 | 0.3 |
| Total | 100 | 100 | 100 | 100 |

**Source:** Adapted from StatSSA (2007)

Stakeholders maintained that two-thirds of the camp residents faced housing challenges and that these endured after the residents had left the camps. The living conditions in the camps themselves have been a major criticism of the government response to the refugee crisis and this was confirmed by stakeholder responses. Following the xenophobic attacks, displaced people were sheltered in a variety of dwellings including large and small tents, community halls and churches. Common problems included overcrowding, poor lighting and lack of privacy (including in many cases the absence of single-sex accommodation). In the Western Cape the attacks coincided with the worst of the Cape winter, and tents at sites such as Blue Water, Youngsfield and Soetwater were poorly insulated against the wind and rain, which was compounded by many of the camps being located in low-lying areas, which made them vulnerable to flooding (Western Cape Civil Society Task Team 2008).

The Treatment Action Campaign reported that the tent shelters were "below the minimum standards for privacy, dignity, protection and safety" Van Gass, 2008. Overcrowding has also been reported with one camp reporting up to 15 families staying in one tent. Such reports suggest that the living conditions did not in fact meet the international minimum standard of 4.5 – 5.5 square meters of tent space for each person (TAC/ALP, 2008). The location of some camps was also not ideal for the weather

conditions of the Cape with camp residents in one instance having to dig trenches to ward off rising water levels Residents complained of being cold and camp co-ordinators confirmed that tents were leaking and falling apart in the bad weather with reports of wet mattresses and belongings (Joseph, 2008; Hermanus, 2008).

**4.4. Transport**

"The primary function of transport is in enabling access to people, goods and services. In doing so it also promotes health indirectly through the achievement and maintenance of social networks" (Gorman, Douglas, & Conway, 1998). For example, particular problems relating to urban development and transport in Cape Town are raised by Turok (2001) who describes in detail the 'spatial mismatch' between where the majority of Cape Town's residents live and the areas where jobs and facilities are found: "The Cape Town CBD, together with the northern and southern arms, houses some 37% of the population but contains over 80% of all jobs in the city…The result is a huge daily movement of people between home and job". This mismatch impedes access to economic, social, cultural and recreational opportunities. For those who are able to travel, the longer distances from southern 'township' areas mean that the lowest economic strata pay up to 10% of their household income on transport. An analysis of the trends in Cape Town's urban development powerfully illustrates the ability of market-lead development to entrench spatial segregation inherited from apartheid. According to Turok, achieving urban integration requires appropriate housing and transport policies. While this issue is perhaps less of a concern outside of the Metropolitan district, spatial segregation along racial lines is evident throughout most of the Western Cape.

Public transport has been described as one of the most palpable ``creatures of apartheid'' (Matzopoulos & Lerer 1998) and insufficient investment in public transport is a major structural risk factor for South Africa's poor road safety record (Matzopoulos, Myers & Jobanputra 2008). In addition, poor investment in safety and enforcement, has made public transport and trains in particular an unsafe mode of travel.

The camps proximity to work and education was raised in several media reports. The situation was reportedly worse in the Western Cape with camps being established in remote areas (Shonisani, 2008). This was seen to impact on the residents' freedom of movement, a Sphere Project minimum standard in such cases (Sphere Project, 2004)

and refugee coalitions had requested the government to open civic centres and school halls in closer proximity to the camps (Yung, 2008a).It was reported that some camps were more than 50km from their schools, universities or workplaces and that many had lost their jobs as a result of being able to go to work (Caelers,Smook & Samodien, 2008). Stakeholders confirmed that workers and learners were primarily affected by the lack of transport options. Although some shelters and camps did provide transport during the crisis there did not appear to be any systematic measures in place to address these needs once the residents had left the camps.

**4.5. Social and family structures**

The availability of social support, particularly from one's own cultural group, is an important protective factor for illness in migrant groups and migration with partners or a group, family connectedness and high ethnic density are associated with better mental health outcomes in migrants (Li et al., 2007; Yearwood et al., 2007). Conversely, if ethnic density is sparse, the risk of illness will increase (Carta et al., 2005).

New immigrants prefer to live in "ethnic enclaves" that offer inclusion into a familiar cultural and linguistic group, greater access to housing and employment opportunities, and important knowledge about the host community, such as how to access services. These migrants are then less likely to integrate with the broader host community (Balbo & Marconi, 2006; Community and Neighbourhood Services: Social Research Unit, 2005). Migrants in these ethnic enclaves report greater economic gains compared to those who are more isolated (Community and Neighbourhood Services: Social Research Unit, 2005), although this does depend on a range of factors, such as the size, class status and existing financial capital of the ethnic enclave (Li, 2004b). (Community and Neighbourhood Services: Social Research Unit, 2005).

The protective effects of social networks have more recently been described as social capital. For migrants living in low-income urban areas there are significant obstacles to forming social capital, which may include the lack of public spaces for social interaction, ethnic tension and an atmosphere of fear resulting from high crime rates and discrimination (Cheong 2006). Consequently migrants have been identified as a group most likely to benefit from increases in social capital (Almedom, 2005) and in some settings slum dwellers have responded to social exclusion by creating community-based

organisations partnering with NGO's, mobilising the migrant population and advocating for resources (Vlahov et al., 2007).

The situation of the refugees in South Africa following the xenophobic attacks appears to have decreased their social capital. Inside the camps, social support was not enhanced: it was reported that displaced families were split between camps and that in some instances families within the same camp were sleeping in separate tents (Caelers,Smook & Samodien, 2008). This was confirmed by stakeholder responses, which recognized severe social, emotional and physical stresses associated with the crisis as being among the main challenges facing the camp residents along with inadequate nutrition and food insecurity. Sleeping arrangements in many centres were not conducive to normal family life as men had to sleep separately from women and children. As a result family relationships may have been compromised in the long-term. At a broader level, for those already integrated in South African Society, their separation away from the communities in which they lived would have a major impact on their social capital in the country. For some, this loss was more close to home; one refugee, for example, had to leave behind his South African girlfriend and their child and was unsure as to how this relationship would continue in the future (Radler, 2008).

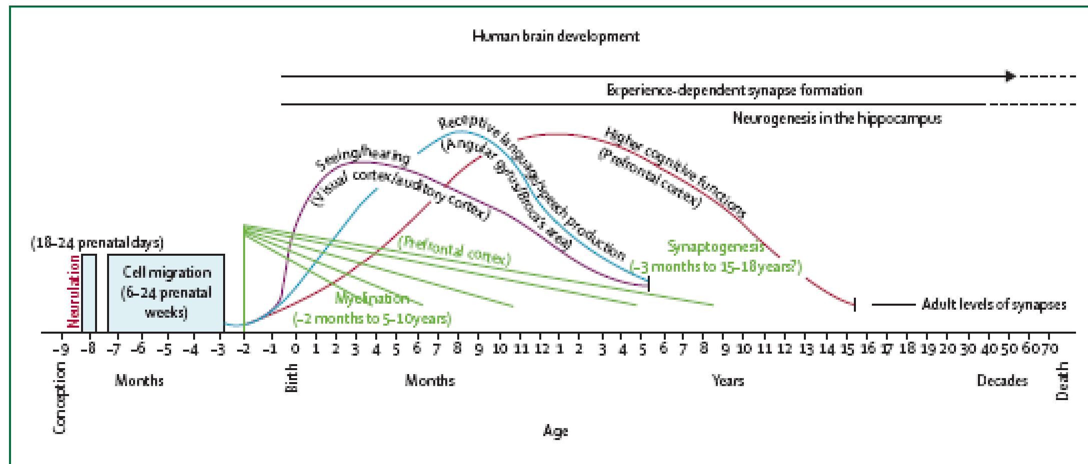
### 4.6. Education

Access to education is well recognised as an essential building block of human and economic development due to its wide-ranging impact, including that on health, employment, poverty and social capital. The Director General of the United Nations Educational, Scientific and Cultural Organization (UNESCO) explains that education should provide learners with the necessary skills to fulfil their potential and to live a full human life and includes the effective acquisition of numeracy, literacy and essential life-skills (Matsuura, 2001).

Early childhood is a critical period in human development with the bulk of brain development occurring before 5 years of age as shown in Diagram 1. The period between birth and 5 years is thus an important and transient window of opportunity as brain development after this period occurs at a significantly slower pace and builds on the base achieved in early childhood such that competencies acquired here become cumulative. Similarly, lack of optimal cognitive and psychological development in this

critical period becomes increasingly difficult and costly to address as children get older. Thus, without intervention, gaps between better and worse-off children widen over time; the earlier the intervention, the less it costs and the lower the gap (Grantham-McGregor, 2007; Heckman, 2006).

**Figure 4. Human brain development**




**Source:** Grantham-McGregor et al. (2007)

The Lancet series identifies the major risk factors impeding child development in developing countries; inadequate cognitive stimulation, maternal depression and violence are identified among these and are directly relevant to mental health (Walker, 2007). The reviews estimate that 39% of children under 5 years in developing countries are not fulfilling their developmental potential in terms of cognitive, sensory-motor and socio-emotional development (Grantham-McGregor, 2007). Related to this finding it is important to consider children's access to pre-school programmes in developing countries. The gross enrolment ratio for pre-school in developing countries is 34.3%, compared to 81.1% in developed countries. Again, the lowest pre-school enrolment rates are to be found in the poorest regions; in Sub-Saharan Africa, for example, only 5.6% of young children attend pre-school programmes (Engle, 2007).

In terms of older children, education consistently predicts the likelihood of a person having a common mental disorder (CMD). This finding comes from a series of cross-sectional studies investigating the risk factors for common mental disorders in adults living in India, Zimbabwe, Chile and Brazil. The study found that, after adjusting for age and sex, people with less than 8 years of education were up to 3 times as likely to have

a common mental disorder (Patel, 1999). In another study, investment in education of female children was found to result in a decrease in infant mortality rates (Caldwell & Caldwell, 1985). It appears then that female education is an excellent means of improving “social capital” with consequent positive health impacts.

The displacement of foreigners would, according to the various findings of the literature reported above, predict potentially deleterious impacts on the education/health nexus of foreign children. In the Western Cape camp sites, there were large numbers of young children between 1 -10 years in the sites. Children mostly played unattended with no educational stimulation or visible structured activities (UNICEF, 2008).

Formal schooling was disrupted as displacement resulted in children either being too far from the schools which they attended before, or parents fearing attacks on their children. The camp response therefore aversely affected education potential, deviating markedly from the Sphere minimum standard expected of intervention (Sphere, 2004). In some sites, elementary schooling activities were organized by volunteer groups and at Harmony Park, an educational tent was set up to accommodate children.

The media highlighted the problem of children in camps being unable to attend school (Van Gass, 2008; Laun, 2008; Shonisani, 2008). Stakeholder responses confirmed that most children’s education was severely disrupted to the extent that most had to repeat grades, even though some camps did initiate camp-based schools. Following their re-emergence from the camps and shelters, numerous learners continued to search for parents and guardians which further compromised their access to education.

The TAC review of the camps in the Western Cape reported that more than 200 children in the camps did not have access to education, describing this as a disturbing and deliberate breach of the right to education indicating, furthermore claiming that the Department of Education had made no attempt to provide transport or a reintegration process (Laun, 2008). One camp resident was due to write his Matriculation exams had his study materials burnt in the violence and asked “ How can you prepare for exams in a place like this? All that work, and now it may be for nothing. I’ll have to wait, I guess. Everything is waiting now.” (Radler, 2008).

### 4.7. Water, sanitation and waste management

Available studies indicate that water, electricity and toilets are not affordable or accessible to many people and that "Low-income households faced an often desperate situation, either to pay for services on meager incomes, thereby compromising other essential needs, or face the constant uncertainty of disconnection" (Smith & Green, 2005) p.436. In India and South Africa, hostility and conflict between community members due to competition for resources has also been reported (Parkar, Fernandes, & Weiss, 2003; Swartz, Breen, Flisher, & al, 2006). A cross-sectional study in India found that 'chronic strain' (from substandard housing and inadequate access to water) was associated with greater levels of psychosomatic symptomatology and that this association was independent of income (Lepore, Palsanee, & Evans, 1991). This finding is confirmed by a qualitative study in South Africa which found that inadequate services (as described) are a significant stressor for the mentally ill and their families (Swartz et al., 2006).

Large-scale population displacement often results in poor access to safe water and to adequate sanitation facilities, facilitating water-borne and food-borne transmission of pathogens. In these settings, diarrhoeal diseases such as cholera, typhoid fever and shigellosis can cause epidemics with high rates of mortality (Waldner & Mariechen, 2008). Hepatitis E, which is also spread by the faecal–oral route, can result in jaundice and increased mortality in pregnant women (Shonisani, 2008). Furthermore, infection with leptospirosis is associated with displacement after flooding and the resulting proximity of rats to humans on shared high ground (WHO, 2007).

Huttly (1996) has reviewed the extensive literature on the role of poor water supply, sanitation and hygiene practices as causes of diarrhoea and helminthic disease. Murray and Lopez (1996) estimate that poor water supply, sanitation and personal hygiene account for approximately 7% of all morbidity and mortality wide. Infants and children carry the main burden of inadequate water and sanitation-related disease. Benefits from improved water supply occur only in the presence of improved sanitation and this makes a case for incremental improvements in infrastructure services in the less developed world (Esrey, 1996).

Diseases related to inadequate water supply and sanitation include communicable diseases which may be water-borne (spread through water supply), water-washed (lack of water for personal and food hygiene) or water-based, as well as non-communicable diseases due to water-borne toxins (Table IV). In addition, inadequate sanitation can result in the spread of intestinal parasites through contact or ingestion of soil contaminated by human faeces. As the transmission of many of the above diseases depend on access of human wastes to water or people's mouths, the chain of transmission can be broken by safe disposal of excreta, personal and domestic hygiene (washing hands after defecating and before preparing food), improving water quality and preventing recontamination of water supplies. Diarrhoeal disease is the most important water related disease worldwide both in terms of morbidity and mortality (WHO, 1996). Most of the pathogens causing diarrhoea are transmitted via the faecal-oral route. It is important to note that a large component of faecal-oral disease is not water-borne but food-borne or directly transmitted via fingers, eating utensils or dirt, and can be classified as water-washed. Flies also play a role in transmitting pathogens from faecal material to food and utensils. Water-washed infections may be reduced by increasing the quantity, availability and utilisation of water, almost irrespective of its quality. Here distance to the water source is of the utmost importance as well as the promotion of positive water-use behaviour.

**Table 9. Main types of water-borne diseases**

| | |
|---|---|
| *Water-borne and/or washed*: | Cholera, Typhoid, diarrhoeas, dysenteries, polio, Hepatitis A, amoebiasis, giardiasis |
| *Water-washed*: | Trachoma, conjunctivitis. scabies |
| *Water-based*: | Schistosomiasis |
| *Water-vectored*: | Malaria, Yellow Fever |
| *Defective Sanitation*: | Hookworm, Ascariasis, Trichuriasis, Taeniasis |

**Table 10. Water source: JHB and CT Metros, C2001 vs. CS2007**

| | **JHB Metro** | | **Cape Town Metro** | |
|---|---|---|---|---|
| **Type** | **C2001** | **CS2007** | **C2001** | **CS2007** |
| Piped water: | | | | |
| Inside the dwelling | 49.6 | 70.8 | 69.4 | 80.5 |

| | | | | |
|---|---|---|---|---|
| Inside the yard | 34.9 | 20.8 | 15.1 | 10.6 |
| From access point outside the yard | 12.5 | 6.7 | 14.3 | 8.4 |
| Borehole | 0.1 | 0.2 | 0 | 0.2 |
| Spring | 0. | 0 | 0 | 0 |
| Dam/pool | 0.1 | 0 | 0.1 | 0 |
| River/stream | 0.1 | 0.1 | 0 | 0.1 |
| Water vendor | 0.4 | 0.9 | 0 | 0 |
| Rainwater tank | 0.2 | 0.1 | 0 | 0 |
| Other | 2.1 | 0.4 | 1.0 | 0.2 |
| Total | 100 | 100 | 100 | 100 |

**Source:** Adapted from StatSSA (2007)

The distribution of water sources in both Johannesburg and Cape Town is presented in table. Access to piped water has increased by 1.3% and 0.7% between 2001 and 2007 in the two Metros respectively. The increase brought access to piped water to 98.3% and 99.5% of households in the two cities. It is therefore unlikely that displaced migrants were not able to access potable water. In general, access to water in the camps was adequate as safe drinking water was provided by the various municipalities in which the camp sites were situated.

Sanitation assessments reports were far more varied. Household access to flush toilets in the two cities is 89.5% and 92.8% respectively (see table 9). Thus non-camp migrants may have been displaced to city areas that did not have optimum ablution facilities. In the camps, toilet facilities consisted of permanent latrines or mobilettes, the former cleaned daily and the latter twice weekly. Only some toilet sites contained soap (WC Civil Society Task Team, 2008). Showering facilities were however very limited. In addition, wastewater and rainfall drainage infrastructure was poor. The media reported several criticisms linked to the lack of appropriate facilities in many camps, particularly toilet and bathing facilities for women. This was confirmed by the Human Rights Commission (Van Gass, 2008; Joseph, 2008). One journalist described the state of latrines in one camp, saying that “the compounding amount of faeces has created a smell akin to manure that is omnipresent along half the camp. At 10m away it is overpowering” (Radler, 2008). In addition, UN reports confirmed problems with solid waste management (UN, SR2, 2008).

Stakeholder responses confirmed that poor sanitation in the camps was more of a problem than water quality, and that women, the elderly and children were particularly vulnerable. Poor personal hygiene among the camp residents was also observed, which

stakeholder responses surmised could be attributed to low self-esteem brought about by physical and emotional trauma.

**Table 11. Type of toilet facilities: JHB and CT Metros, C2001 vs. CS2007**

| | JHB Metro | | Cape Town Metro | |
|---|---|---|---|---|
| **Type** | **C2001** | **CS2007** | **C2001** | **CS2007** |
| Flush toilet (connected to sewerage system) | 82.2 | 86.8 | 85.4 | 91.2 |
| Flush toilet (with septic tank) | 2.6 | 2.7 | 1.9 | 1.6 |
| Dry toilet facility | 0 | 1.6 | 0 | 0.5 |
| Chemical toilet | 1.8 | 2.1 | 0.2 | 0 |
| Pit latrine with ventilation (VIP) | 1.3 | 3.2 | 0.3 | 0 |
| Pit latrine without ventilation | 5.5 | 0.8 | 0.6 | 0.2 |
| Bucket latrine | 3.8 | 1.5 | 4.5 | 2.9 |
| None | 2.8 | 1.2 | 7.3 | 3.5 |
| Total | 100 | 100 | 100 | 100 |

**Source:** Adapted from StatSSA (2007)

**Table 12. Type of refuse disposal: JHB and CT Metros, C2001 vs. CS2007**

| | JHB Metro | | Cape Town Metro | |
|---|---|---|---|---|
| **Type** | **C2001** | **CS2007** | **C2001** | **CS2007** |
| Removed by local authority/private company | | | | |
| At least once a week | 91.2 | 90.2 | 94.4 | 94.2 |
| Less often | 2.7 | 1.6 | 1.1 | 1.0 |
| Communal refuse dump | 1.4 | 2.3 | 1.3 | 2.6 |
| Own refuse dump | 3.5 | 3.3 | 1.8 | 1.1 |
| No rubbish disposal | 1.3 | 1.9 | 1.4 | 1.0 |
| Other | 0 | 0.6 | 0 | 0.2 |
| Total | 100 | 100 | 100 | 100 |

**Source:** Adapted from StatSSA (2007)

### 4.8. Pollution

Extensive literature is available on the relationship between air pollution and ill-health (see Hong et al, 1996). In the Former Socialist Economies, air pollution accounts for about 2,5% of all burden of disease (Murray and Lopez, 1996). In countries undergoing rapid economic growth, air pollution related mainly to urban transportation, is becoming an important health hazard. Initially observed in cross-sectional studies, the association between air pollution and ill-health has been demonstrated by a substantial body of high-quality longitudinal data connecting respirable particulate air pollution and deaths from respiratory disease, cardiac disease and lung cancer. Cumulative exposure to fine particulates increases the incidence of childhood respiratory disease and one should conclude that there are sufficient data to warrant urgent attention to the high levels of indoor pollution associated with coal and biomass fuel use. Smoking is a recognised cause of childhood respiratory disease and often has a cumulative effect with other air pollutants. Groups at high risk in polluted environments include children, asthmatics, and people with pre-existing lung disease. Increased morbidity and mortality has been

associated with air pollutant levels of well below World Health Organisation (WHO) recommendations (See Community Health Research Group, 1995). In addition, there is a growing body of international evidence linking air pollution with adult respiratory disease (Lave and Seskin, 1977; Ostro. Lipsett, Mann et al., 1993).

## 5. HEALTH STATUS ASSESSMENT

Health status data are numerical or qualitative descriptors of a health problem and can be quantified as the burden of disease attributable to a particular health condition. Sub-Saharan Africa is one of only two places in the world where gains in life expectancy are being reversed (Caselli et al., 2002, McMichael et al., 2004). In South Africa the disease and death profile predominantly reflects the protracted polarised model proposed by Frenk et al. (1989), in that infectious diseases (such as HIV/AIDS and tuberculosis) affect the poor, non-infectious chronic diseases (such as diabetes, heart disease, and cancer) related to an urbanised lifestyle affect both the rich and poor, and there is a large burden of morbidity and mortality from non-natural causes, i.e. trauma and violence, particularly amongst the poor. Thus the poor suffer from all three patterns of mortality simultaneously and along with the unprecedented HIV epidemic are under the yoke of what Bradshaw et al, (2003) have termed a “quadruple burden of disease”. In addition to fatal and non-fatal injury, victims of violence have been shown to have numerous non-injury health consequences. These include high-risk behaviors such as alcohol and substance misuse, smoking, unsafe sex, eating disorders. These in turn contribute to such leading causes of death as cardiovascular disorders, cancers, depression, diabetes, and HIV/AIDS (Matzopoulos, Bowman, Butchart & Mercy, 2008). In this section we review major contributors to the burden of disease in South Africa, namely violence and mental illnesses, infectious diseases (with HIV/AIDS discussed separately), non-infectious chronic diseases and malnutrition. Again, baseline data against which to measure the possible health impacts on migrants that were displaced have been drawn from the 2008 HEAD study.

**Table 13. Prevalence of chronic illnesses, SA vs. Foreign migrants, HEAD Study, 2008**

| Illness | SA (n=-469) | Migrant (n=58) | Sig. Level |
|---|---|---|---|
| Cancer | 1.1% | 1.7% | 0.63 NS |
| Asthma | 10.0% | 0 | 0.01 |
| Tuberculosis | 3.8% | 5.2% | 0.58 NS |
| Diabetes | 8.7% | 1.7% | 0.07 NS |
| Hypertension | 17.5% | 5.2% | 0.02 |
| Heart disease | 5.1% | 1.7% | 0.27 NS |
| High cholesterol | 4.5% | 0 | 0.11 NS |
| Stroke | 3.2% | 0 | 0.17NS |
| HIV/AIDS | 2.1% | 1.7% | 0.8 NS |
| Obesity | 4.1% | 1.7% | 0.4 NS |

| Disability | 7.2% | 0 | 0.03 |
| --- | --- | --- | --- |

**Source:** Barnes (2008)

In this section we describe some of the major health conditions facing migrants displaced by internal conflicts, namely violence, mental illness, HIV/AIDS, other infectious diseases, chronic disease (such as diabetes, heart disease, and cancer) and malnutrition. Stakeholders identified violence and infectious diseases as the primary health challenges facing migrants displaced by the xenophobic attacks. Next were mental illness and chronic disease, followed by HIV/AIDS and malnutrition.

### 5.1. Violence

The use of violence against foreigners and South Africa's violent history has already been alluded to elsewhere in this report. A disproportionate number of injury deaths in South Africa are due to violence (Norman et al., 2007). The country is amongst the most violent in the world and has even been described as having a "culture of violence" (Vogelman and Lewis, 1993).

As well as accounting for a large percentage of deaths in South Africa 5.3 percent of deaths as an underlying cause, it is also an important contributor to mortality, when its contribution to other health outcomes such as those resulting from child sexual abuse and intimate partner violence are included. Thus, as a risk factor interpersonal violence accounts for at least 6.7 percent of mortality when some of these additional outcomes are included and more than 8.5 percent of DALYs (Norman et al., 2007).

Unsurprisingly, there were several media reports of violence in the camps themselves. In some instances, the violence was between camp residents. Basic goods such as food and clothing were often the source of violence according to stakeholders. The notorious Red Ants were deployed in certain camps to control alcohol-fueled fights between residents. In one instance, a woman was beaten after old war-conflicts were reignited by her identification from the identity card that residents were asked to wear (Tshabalala, 2008). The situation at the Central Methodist Church in Gauteng was cited as an extreme example in stakeholder responses, with women being raped and abused and coerced into sex. Exploitation by camp security guards was also reported.

In other instances, the violence occurred between the state and residents. A woman stripped off her clothes during a stand-off with the police who had threatened to open fire on the residents if they didn't move out of the way. The woman pulled up her skirt and started screaming in tears, saying, 'Go right ahead, shoot,'" according to a witness (Tshabalala, 2008). A more insidious form of structural violence from state actors has become increasingly evident, with the Lawyers for Human Rights issuing a statement expressing concern about reports that coercion and intimidation have been employed in the camps to force residents to leave the sites. They report that the methods have included the removal of identity cards, property (including clothes), arresting residents for 'trespassing' and then withdrawing the charges after a weekend in detention (Joubert, 2008). In addition, stakeholders were concerned about the lack of safety guarantees for camp residents returning to communities from which they had been displaced.

**5.2. Mental illness**

The burden of mental illness in South Africa has largely been unrecognised as a result of the scarcity of population based data. Recently, however, the South African Stress and Health (SASH) survey revealed that some 16.5% of South Africans report having suffered from a common mental disorder in the last year (Laun, 2008). A review of existing studies revealed that 17% of children and adolescents suffer from mental disorders (6). The National Burden of Disease Study conducted by the South African Medical Research Council, using disability-adjusted life years (DALY) as a measure of the health impact (Joseph, 2008; Yung, 2008a), ranks neuropsychiatric conditions third in their contribution to the overall burden of disease in South Africa and the Comparative Risk Assessment Study identifies alcohol abuse as the third leading risk factor for death and disease in South Africa.

Corrigall (2008) argues that migrants experience losses that affect their mental health by contributing to depression, disorientation, and marginalization. Depending on whether the migration is internal or international, losses may include loss of home, separation, from family and community, loss of a sense of belonging, loss of a job, career, position in society, loss of identity, loss of support networks, loss of traditions and values
(Carta et al., 2005). Furthermore, for those already under strain, additional stressors faced in the host country may result in mental illnesses such as schizophrenia or depression (Bhugra, 2003). For example, Bhugra's (2003) review of the literature on the

prevalence of depression in various migrant groups found that rates depends on a number of factors and concludes that a degree of biological or psychological vulnerability, combined with social vulnerability after migration, can lead to depression.

Major stressors in for example, migrants whose lives are threatened or who witness the death of their family members or travel companions will be at high risk of developing mental illness. There is considerable evidence from around the world that violent or abusive experiences are associated with mental health problems including depression, suicidality, posttraumatic stress disorder and other anxiety disorders, and substance abuse (Acierno et al., 2000; Anda et al., 2006; Kaplan, Pelcovitz, & Labruna, 1999; Kilpatrick, Ancierno, Saunders, Resnick, & Best, 2000; Krug, Dahlberg, Mercy, Zwi, & Lazano, 2002; Lesserman, 2005; Pelcovitz, Kaplan, DeRosa, Mandel, & Salzinger, 2000; Resnick & Acierno, 1997) Indeed, there is a dose-response relationship between exposure to life-threatening situations and PTSD symptoms, with greater exposure associated with more and/or more severe symptoms (Golding, 1999; Van der Kolk, B., MacFarlane, & Weisaeth, 1996). Furthermore, as one might expect, it has been found that people who are forced to migrate develop higher levels of mental health problems than those who migrate voluntarily (Bhugra, 2004b).

The barrage of mental stressors that the refugees have faced since the beginning of the xenophobic violence are hard to contemplate. Media reports give some indication of the extent of mental health problems shown by the refugees. Following the violence, many people lost relatives, in many instances not knowing whether they were dead or alive. One mother said “every day my kids want to know when their father will come home and I don’t have an answer for them. I don’t even know if he is still alive” (SAPA, 2008b). Many others expressed the sense of loss they had suffered after losing everything they owned including their homes and all their belongings, many having left only the clothes on their backs (Radler, 2008). Added to the effects of the violence itself, they faced further stressors in the camps, with numerous reports of “severe psychological distress”, anxiety and fear related to poor communication from the government and the prolonged sense of waiting to find out what their future holds (Shonisani, 2008; Van Gass, 2008).

Many camp residents have expressed feeling helpless and feel they have been lied to, reporting that many promises made to them by government have been broken (Joseph,

2008). Stakeholders confirmed the widespread emotional and physical trauma that manifested in feelings of low self-esteem and hopelessness. Fear of further attacks if forced to re-integrate or return to their countries of origin have added to these feeling of helplessness (Laun, 2008; Shonisanu, 2008). The poor conditions of the camps undoubtedly exacerbate this and it is unsurprising that several threats of suicide have been made. In one camp, a group undertook a hunger-strike to protest at the intolerable camp conditions and threatened to drown themselves in the sea (Bramford, 2008). It should be borne in mind that many of these refugees have a long history of exposure to trauma which is likely to be evoked in the context of xenophobic violence and aggravated by the subsequent structural violence in the camps. This cumulative exposure is likely to trigger significant psychological fall-out in those vulnerable to mental illness. A comment from a camp resident potently illustrates the conflation of traumatic experiences: "We come from countries that have a lot of wars and we still have to face this here. You know what, we are not going anywhere, so they may as well bring in an army that will kill us all and they should bury us all here, since this place is big enough for a mass grave anyway" (Tshabalala, 2008).

### 5.3. Infectious diseases

Based on the model of Murray and Lopez (1996), substantial declines can be expected in global deaths due to infectious disease and parasitic infections. Whilst infectious disease deaths will have declined by about 25% by 2020, they will still account for approximately 39% of deaths in SSA. Emerging infectious diseases constitute a global health threat, especially in the light of climate change, conflict and easier trans-border travel. In South Africa, the major infectious diseases threats faced by migrants would be those diseases most prevalent in the host population and in particular those associated with overcrowding, unsafe water and poor sanitation.

South Africa has the third highest incidence of Tuberculosis (TB) in the world with approximately 340 000 cases recorded in 2006. Concurent with the high prevalence of HIV, the prevalence of TB has increased 85% over the last 5 years and is highest in the Western Cape and Kwa-Zulu Natal. Transmission is direct through respiratory droplets containing mycobacterium tuberculosis. Risk factors include immuno-suppression, overcrowding, poorly ventilated housing, poverty and poor access to quality health services. In South Africa there have been outbreaks of multi-drug resistant and

extremely drug-resistant tuberculosis which occurs as a result of treatment interruption in the context of poor adherence and/or poor quality health services. TB remains the leading cause of death for those infected with the Human Immunodeficiency Virus.

Gastro-enteritis is a leading cause of death in children under five, accounting for approximately 11% of under-five mortality in South Africa. It has been estimated that approximately 88% of this burden is attributable to unsafe water, inadequate sanitation and poor hygiene practices. The major causative organisms include Escherechia Coli, Rotavirus, Giardia Lambilia and Camplobacter. However, outbreaks of cholera and dysentery occur periodically, usually following heavy rains and flooding. Certain diseases like polio remain a threat particularly in situations where immunisation rates are below 80%. Transmission occurs indirectly from person to person through water or food contaminated by pathogen-containing faeces. Young children are particularly vulnerable due their behavioural practices. Children who are immuno-suppressed, such as those who are malnourished or infected with the Human Immunodeficiency Virus are most likely to become infected and experience the most severe forms of the illness. Death results from severe dehydration and electrolyte losses and thus the major challenge with diarrhoeal disease in children is to prevent dehydration through administering either oral or intravenous rehydration solutions. Access to health services and maternal knowledge of the signs of dehydration and how to constitute oral rehydration solution are important in this regard.

Also related to the lack of water and adequate sanitation, soil-transmitted helminth infections are endemic in South African children. Infection results from the ingestion of water or soil contaminated by faeces containing roundworm (ascaris lumbricoides) or hookworm (trichuris trichuria) larvae. These worms mature to adulthood in the gastro-intestinal tract and may lead to malnutrition and iron deficiency in the host, significantly impairing both cognitive and physical development. National prevalence figures are not available, however smaller studies indicate an extremely high prevalence particularly in informal settlements; a study from the Western Cape, for example, found a prevalence of 90% of school-aged children in informal settlements. Given the high baseline prevalence of helminth infections it is highly likely that children will become infected in camps without adequate facilities for hygiene and sanitation.

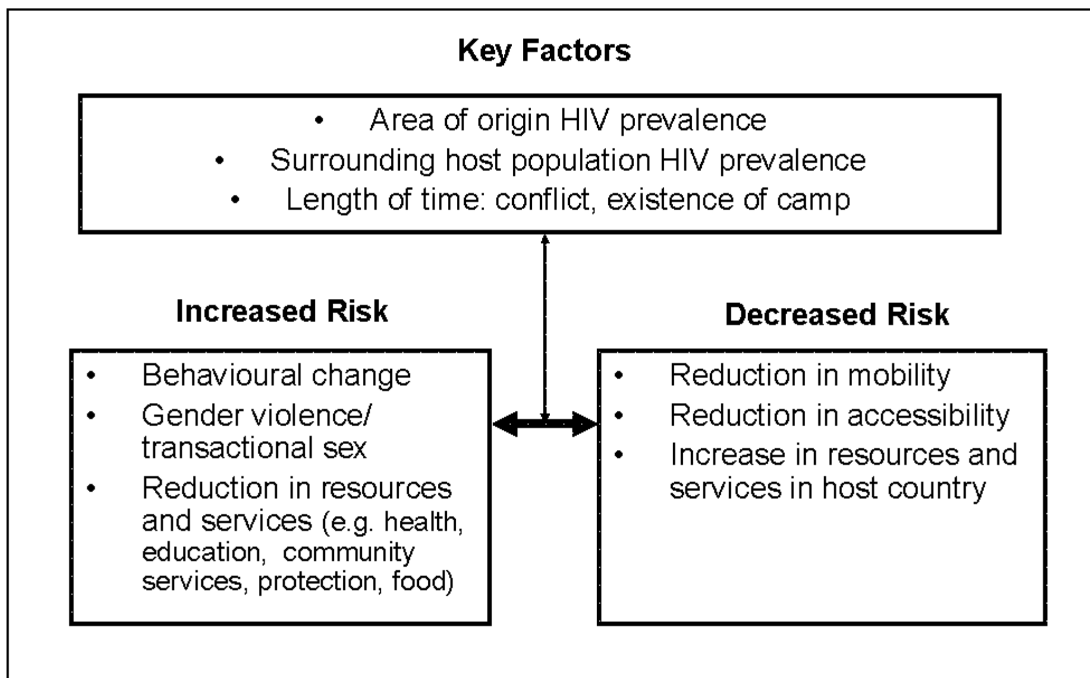
Measles, occurring in populations with low levels of immunization coverage, spreads easily in the crowded conditions associated with displacement, and outbreaks are common. Crowding can facilitate the transmission of meningococcal disease and may also contribute to the high prevalence of acute respiratory infections in displaced persons (WHO, 2007). In addition to measles and meningitis, displaced populations are at increased risk for vaccine preventable diseases such as polio, tetanus, pertussis and diphtheria when levels of baseline immunization coverage are low.

In terms of data from the camps, many cases of infectious diseases were reported in the press; the main diseases reported were diarrhea, flu and lower respiratory tract infections including pneumonia, (Yung, 2008a; Joubert, 2008; Maphulumo, 2008; Thakali, 2008). Medicins Sans Frontiers indicated that these were likely a result of the poor sanitation, hygiene and overcrowding in the camps (Thakali, 2008). Residents themselves have reported illness to the media, with one woman indicating that the food they served is half-cooked and that all seven of her children have diarrhoea (Maphumulo, 2008). A camp coordinator in the Western Cape alleged that refugees were malnourished with sores around their mouths (Joubert, 2008). Other camp residents indicated that many had stopped eating the food as a result of diarrhoea. One resident said “everyone has a cough. When we went to the mobile clinic they gave us children’s cough mixture because there was nothing else” (Thakali, 2008).

**5.4. HIV**

A review of the effects of displacement on HIV transmission and infection patterns in sub-Saharan Africa by Spiegel et al. (2007) found that the data cited in the surveyed studies could not support the commonly held belief that displacement drives HIV infection rates upward. In an earlier article, Spiegel identified a number of intersecting factors that would theoretically mediate the relationship between violence, displacement, HIV risk and HIV prevalence. These factors are described in figure 2 below. Each of these factors is then assessed within the context of the available literature and data available in the present study.

**Figure 5. HIV risk factors for conflicts and displaced person's camps**




Source: Spiegel (2004, p. 325)

### 5.4.1. Prevalence at origin, in host population and temporal dimensions of displacement

More than 70% of the global HIV burden is in Sub-Saharan Africa. In South Africa the prevalence of HIV in adults is 16.7% (WHO, 2007) estimated as 11.4% with women in urban informal settlements having the highest rates of infection. Auto-immune Deficiency Syndrome caused by the Human Immunodeficiency Virus remains the leading contributor to the burden of disease in South Africa. Transmission occurs both horizontally from person to person through sexual contact or blood products and vertically from mother to child during pregnancy, labour or breast-feeding. Preventive interventions aim to decrease sexual transmission (through the use of condoms, addressing sexual behaviour and encouraging testing for HIV), mother-to-child transmission (through preventing unwanted pregnancy, prophylactic anti-retroviral treatment and promotion of formula feeding) and blood product transmission (screening blood donations for HIV). Treatment is now available in South Africa but access to treatment remains severely constrained with approximately 30% of those who need treatment accessing treatment. The displacement of international migrants was not prolonged.

#### 5.4.2. Risk assessment

Data from the refugee camps indicated that in most cases HIV status was not disclosed. In the Harmony Park and Sarepta sport complex sites, ARV treatment was administered at both sites. There was also a psychosocial support system in place at these sites.

In the long term however exposure to violence has been shown to increase risk for mental illness which itself has been positively associated with risk-taking behavior (Matzopoulos et al., 2008; Khaw, Salama, Burkholder & Dondero, 2000). These behaviours increase risk for HIV infection and other leading causes of death as cardiovascular disorders, cancers, depression and diabetes. In the context of displacement resulting from exposure to violence, this risk would increase as access to healthcare services, prophylaxis and treatment would be compromised. The extent to which the xenophobic attacks at their resultant displacements disrupted access to healthcare services is difficult to measure. However, selected studies provide starting points to this effect. A recent ART study conducted in inner city Johannesburg (Veary & Palmary) showed that 78% of migrants on ART received their treatment from NGOs in the area. The study also showed that just fewer than 10% migrants sought treatment from the site that was nearest to them. The displacement of HIV positive migrants on treatment implies a negative impact on their treatment regimens. However, without sound surveillance data, such implications remain speculative. This was confirmed by stakeholders, which suggested that although the virus might have spread in camp conditions, there was “silence about HIV”.

### 5.5. Non-infectious Chronic Diseases

Rapid assessments reported the presence of chronic diseases like diabetes, epilepsy and high blood pressure amongst camp residents (WC Civil Society Task Team, 2008). These findings are not unexpected, as risk factors related to unhealthy lifestyles feature prominently among the leading causes of mortality and disability adjusted life years (DALYs) in South Africa. Whereas high blood pressure, diabetes, high cholesterol and physical inactivity were ranked $8^{th}$, $9^{th}$, $10^{th}$ and $12^{th}$ among risk factors for DALYs in South Africa, they were ranked even higher among the risk factors for mortality. Together these four risk factors accounted for 21.2% of mortality and 6.5% of DALYS (Norman et al. 2007).

The interaction of these risk factors is an important driver of the high rates of cardiovascular disease observed in South Africa, and it is worth noting that ischaemic heart disease and stroke rank second and third among South Africa's leading causes of death, and both feature among its top ten causes of DALYs (Norman et al. 2007). It is expected that migrants would be increasingly susceptible to developing these conditions as they spend more time in South Africa and became exposed to the unhealthy lifestyle choices.

### 5.6. Malnutrition

In South Africa in general, risk factors related to poor nutrition feature prominently among the leading causes of mortality and disability adjusted life years (DALYs) in South Africa. Low fruit and vegetable intake and iron deficiency anaemia, vitamin A deficiency were ranked $11^{th}$, $13^{th}$, and $14^{th}$ among risk factors for DALYs in South Africa and accounted for 4.2% of mortality and 2.9% of DALYS (Norman et al. 2007).

Although issues of nutrition and food security have been discussed at length in the health determinants assessment (section 3.2), the general nutrition situation of migrants was reported to have been satisfactory, which was confirmed by stakeholders. Major concerns were however raised regarding the unavailability of infant formula at most sites (UNICEF, 2008) and in certain camps additional food rations were not provided for pregnant and breast-feeding women.

## 6. HEALTH SYSTEMS ASSESSMENT

Collapsing health services as well as the deteriorating living conditions affect health status and contribute to an increase in (health) inequalities.

Inequalities in access to health services (especially primary health care) has a profound health impact. The recent WHO/SIDA publication, *Equity in health and health care,* highlights disparities between class, gender, race, geographical location and age in health care access. This document also summarises available data on the widening health gaps in industrialised countries, the worsening health status in the Former Socialist Economies and SSA, the effects of globalisation, Structural Adjustment Programmes, economic recession and health sector reform.

According to Corrigall, gaining access to good quality health services can be difficult for migrants, especially for the poorer migrants (Waddington, 2003). Illegal immigrants may not be able to access health care at all. Even legal migrants face a variety of obstacles including language barriers, hostile reception by public healthcare staff, and lack of affordability of public and/or private health care. In many cases, migrants have been forced to liquidate what assets they have in order to fund ttreatment they need. The majority of developing countries rely heavily on out-of-pocket payments to fund health care services, and as such, the risks for "catastrophic health expenditure" are high (Chisholm, 2007; Xu et al., 2003).

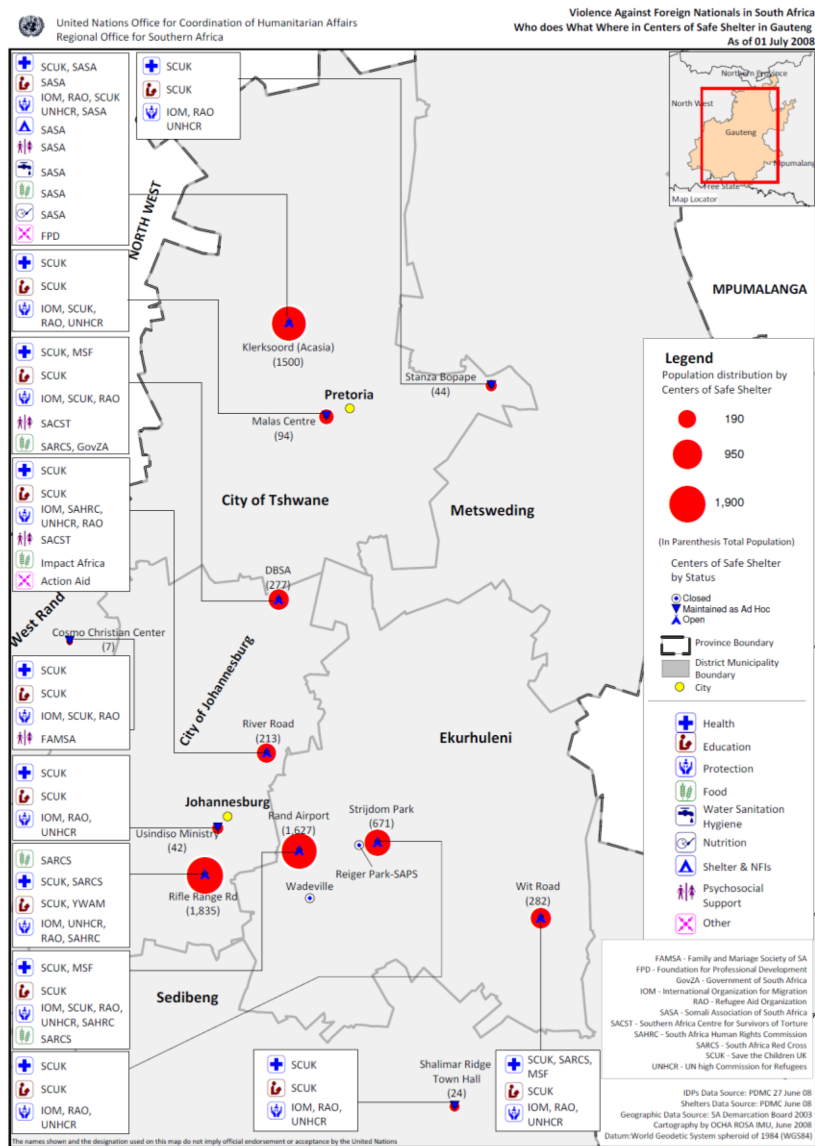
Furthermore, public health programmes such as those for tuberculosis, malaria and HIV/AIDS are at risk of being disrupted by an acute humanitarian emergency. Rapid identification of those on treatment and prompt resumption of services are essential to ensure continuity of care. It is also crucial to reduce the risk of development and spread of drug-resistant strains such as multidrug-resistant tuberculosis (MDR-TB) and extensively drug-resistant tuberculosis (XDRTB) (WHO, 2007).

Accessing mental health services is particularly difficult. Developing countries have few services for mental health care, even for the local population. Globally, more than 50% of people with common mental disorders do not access treatment; in developing countries, the treatment gap is estimated to be 76-85% (Kohn, 2004; Saxena, 2007).

Mental health services in developing countries are constrained by disproportionately low resource allocation, lack of mental health policies, poor access to community-based care, inadequate numbers of in-patient beds, unavailability of essential medicines and shortage of mental health professionals (Saxena et al., 2007).

Importantly, migrants have been found to be less likely than non-migrants to utilize mental health services (Yearwood, 2007; Li, 2007). This trend has been also been demonstrated in rural-urban migrants; Li et al's (2007) study of rural-urban migrants in China found that of those who reported psychiatric symptoms, migrants were least likely to seek help (39% of migrants compared to 67% of non-migrant urban residents and 86% of rural residents). In general, reasons identified for under-utilization include stigma, immigration status (documented vs. undocumented), lack of insurance, cultural and language barriers and frustration with long waiting times (Yearwood et al., 2007). Stakeholders suggested that this was compounded by the absence of systematic and structured mechanisms to follow-up and provide continued support once residents had left camps.

In general access to health services, appeared satisfactory in the camps. However, such access to primary health care facilities in Gauteng (indicated in figure X below) did not take into account the fact that many IDPs expressed feeling unsafe in leaving the camps to seek out medical treatment.




**Source:** OCHA, July 2008.

Aside from broad descriptions of the type of medical services available at the various Gauteng camp sites as reported in table, specific information on human resources for healthcare were unavailable.

In the Western Cape, camp residents expressed concern over limited available medication. 'Proper' health care services were reported to be lacking in centres such Khayelitsha, Desmond Tutu, Site B, Andile Msizi, Solomon Mahlangu, Masibambane and Blue Waters ((WC Civil Society Task Team, 2008). In addition stakeholders

suggested that there were no mechanisms in place to ensure the continuous supply of ARV medicines to HIV patients or mechanisms to monitor adherence.

According to stakeholders, in most camps and shelters medical assistance for the health conditions described in the previous section were seldom available on-site and were usually only available from facilities more than 5km from the sites. Stakeholders also identified the following factors that impacted on service delivery:

- the attitude of health workers, who were often unwilling to treat foreigners;
- the quantity and quality of service capacity, with staff inexperienced and untrained in disaster management and reliant on UN and international NGO supplied expertise to formulate and implement solutions;
- the absence of strategic and tactical plans to respond optimally to a humanitarian crisis of such magnitude; and
- decentralized incident management structures that compromised the ability to provide an effective response.

## 7. HEALTH IMPACT ASSESSMENT AND RECOMMENDATIONS

In this section, we summarise the key findings of the study, and make recommendations for the implementation of mitigation measures and/or further investigations. In assessing the health impacts of the camp-based response to the xenophobic attacks, these recommendations are loosely grouped according to:

- Socio-demographic, development and economic factors influencing health
- Health Status
- Health Systems

The recommendations are designed not to be prescriptive, but rather to provide decision support and enrich the available intervention options.

### 7.1. Socio-demographic, development and economic factors influencing health

#### *7.1.1. Housing*

Urbanisation can be a positive health determinant, if good services and social support are provided (see Satterthwaite, 1996). Unfortunately local governments in many LAMICs have very limited resources and require financial support in key areas such as housing, basic services and health services if they are to improve the health of their populations (Vlahov et al., 2007). Public housing is especially difficult for foreign immigrants to access, particularly illegal immigrants (OSCE et al., 2006).

*Remedial action*

As moving people to better neighbourhoods is seldom practical in resource poor settings, community renewal or regeneration may be a viable option, targeting various aspects of the built and social environments of disadvantaged neighbourhoods. Before-and-after studies of such interventions have consistently shown improvements in mental health, a reduced sense of isolation and fear of crime, an increased sense of belonging, increased community involvement, greater recognition of neighbours and an improved view of the neighbourhood as a place to live (Howden-Chapmen, 2004; Thompson et al., 2003; VicHealth, 2004)

In addition, it is important to build local government capacity to manage rapid urban development and local governments need to understand the dynamics of migration and how slum improvement can be integrated into broader urban planning. Participatory governance, inter-sectoral collaboration and the recognition of the mutual benefits of the social inclusion of migrants are also important to migrant housing issues successfully (Balbo & Marconi, 2006; Vlahov et al., 2007).

In camps themselves, ensuring high quality shelter with adequate ventilation and weather resistance would be an important measure in decreasing the incidence of common respiratory illnesses, including TB. Similarly, overcrowding should be avoided as much as possible. The selection of sites should take account of weather conditions including high winds and potential flood plains. Furthermore, the SPHERE guidelines stipulate that selected locations should be free from hazardous material or debris likely to threaten overall health. Sites should be located in areas where displaced households can access the land, services and markets that will enable them to support their development and livelihoods (Sphere Project, 2004).

Furthermore, proximity to pre-schools, schools, occupation sites and health services should be considered during site selection. Where proximity is not possible, safe and affordable transport should be provided and mobile health and educational services set up where necessary.

#### *7.1.2. Building social capital*

The recent crisis served to highlight the plight of refugees in the country and the massive mobilization of support for refugees from a large number of Non-Governmental Organisations, the Human Rights Commission and International Organisations such as the United Nations and Oxfam has the potential to increase the social capital of migrants if their interest in their concerns is sustained. Furthermore, many meetings were held with Church and community leaders around the reintegration of refugees back into their former communities (Shonisani, 2008) which may also enhance their social capital at a community-level.

*Remedial action*

Interventions to expand the social networks of migrants so that they are better able to access community resources focus on supporting community-based services and organizations that assist migrants with obtaining visas and permits and accessing health, education, employment, housing and social activities (Hernandez-Plaza et al 2006). At a camp-level, this would also require the establishment of a mechanism for representation of different interest groups on a representative governance body.

### *7.1.3. Food security and nutrition*

Many of the migrants forced into the camps and temporary shelters originated from informal settlements and many would have suffered nutritional duress prior to migration. The immediate response following the xenophobic attacks may thus have had a positive affect on nutrition, although this would not have applied to all refugees as it was not only migrants of low socio-economic status who were displaced. In addition, it was clear that any improvements in nutrition were temporary and were quickly eroded by the irregularity of meals and threats to food security in the following months.

*Remedial action*

The SPHERE guidelines set out a clear set of indicators that should guide action to ensure food security and adequate nutrition. Firstly, initial assessments should examine food security in relation to geographical locations and livelihood groupings. These analyses should also take into account seasonal variations in food production. Where possible food security should be assessed and ensured through the participation of local stakeholders (Sphere, 2004). Because food security is only one amongst many determinants of nutritional status, an anthropometric survey should be conducted on the displaced population as early as possible. Best practices in this regard, stipulate that such assessments should children aged 6-59 months as best proxies for the population as a whole. If the surveys indicate micronutrient deficiencies at this level, interventions should include securing access to fresh produce, the inclusion of particular foods known to be rich in particular micronutrients. These could include for example, fortified cereals, blended. If access to adequate nutritional sources is compromised, vitamin supplementation in tablet form should be considered (UNCHR, 2007).

#### *7.1.4. Safe water, sanitation and hygiene facilities*

Access to safe water and adequate sanitation are essential for the prevention of a number of infectious diseases, particularly those affecting children and young women. Given that gastroenteritis was commonly reported to the media by camp residents and is a leading cause of under five mortality in South Africa, negatively affecting both health and development outcomes, intervention in this area is crucial.

*Remedial action*

The Sphere project (2004) identifies three key factors in acting to minimize the health risks posed by unsafe water and compromised sanitation. These are a mutual sharing of information and knowledge, the mobilisation of communities and the provision of essential materials and facilities. These factors must be aligned towards ensuring access to sustainable water sources. Importantly, the development of a safe water infrastructure must prioritise its storage away from potential pollutants and waterborne pathogens (UNCHR, 2004). To limit the spread of fecal-oral infections requires the provision of infrastructure as well as health promotion programmes. Ensuring the availability of safe water and water storage facilities and providing sanitation and waste-removal to camps are essential elements of infection control. Furthermore, facilities that encourage hygiene practices are necessary if hygiene promotion is to be effective, such as the provision of taps in close proximity to shelters and the availability of safe bathing facilities with adequate privacy. Hand hygiene should be actively promoted in camps and should be conducted in a language understandable to the majority of camp residents.

### 7.2. Health status of migrants

#### *7.2.1. Violence and mental health*

Clearly the situation in the camps to some extent mirrors a broader malaise in South African with regard to the state and societal response to violence and violent crime and the attitudes and feelings with regard to foreigners. It should be recognized that a law enforcement and security-based response to violence is but one of numerous strategies that can be used to prevent and avoid violent confrontations, and one that in isolation has been shown to be rather ineffective.

South Africa should rather be following the lead of other countries that have been successful in reducing violence through a greater focus on strategies centered on

improved social citizenry through social development, political empowerment and enhanced social cohesion (Concha et al, 1994). One of the key principles of both successful violence prevention campaigns in the Colombian cities of Cali and Bogota was that the foundations for peace and safety were a culture of tolerance, the promotion of social development to redress inequity and the promotion of human rights.

*Remedial action*

Should there be a future need for refugee camps; a greater emphasis should be placed on the social dimension of human security in addition to physical security. This would mean a large investment in social and community health workers and that the camps themselves have a set of rights-based guiding principles or based on social equity and mutual respect.

In addition, the duties of the security guards at the camps would in future need be limited to ensuring perimeter security and that there a mechanism be established for regular debriefing sessions with camp social workers and the refugee governance bodies. In addition there are a number of specific actions that should be taken with regard to mental health services, as described in section 7.3.

#### *7.2.2. HIV, TB and other infectious diseases*

We were unable to obtain any accurate data on HIV seroprevalence amongst migrants displaced by the xenophobic attacks, although based on the high prevalence of HIV in the communities from which the migrants were displaced and many of the countries of origin, it would not be unreasonable to assume that at least 11% were HIV positive. In addition, the high incidence of TB, particularly in the Western Cape as well as the existence of conditions conducive to the spread of the disease are a strong motivator for a more determined response to arrest the spread of these diseases in the camp environment.

*Remedial action*

Although a programme to ensure the availability of adequate supplies and administration of preventive medicine in the camps would seem to be an obvious recommendation, it presupposes that such programmes are widely available in the broader community. Sadly, only 30% of people in need of treatment for HIV are currently accessing

treatment. Furthermore, a minority of people living with HIV receive prophylactic isoniazid treatment for tuberculosis. Actions that would be feasible in camps include the distribution of condoms, the provision of appropriate shelter (proper ventilation and no overcrowding) and access to particular health services described in 7.3. below. In terms of diarrhoea and helminth infections, access to safe water and adequate sanitation and hygiene facilities are crucial. Immunisation and mass treatment programmes are discussed in 7.3. below.

It is naïve to believe that it is possible to maintain small "islands" of good health, if the surrounding communities contain reservoirs of endemic diseases. It is important to consider the identification of short-term priorities to ameliorate health impacts and improve health status of entire peri-urban communities. Nevertheless, it is hoped that such programmes will be replicated more widely in other provinces under the new Health Minister and that the Department of Health and that in future camps would be equipped with a basic package of essential public health services

#### *7.2.3. Non-infectious chronic diseases*

Among the key intervention programmes aimed at addressing cardiovascular disease, most focus on improved dietary habits and increase physical activity. Both are already compromised in South Africa, where there is an over reliance on processed foods, high cholesterol foods, such as meat, and sugar, and low intakes of fruit and vegetables. Opportunities for physical activity are also limited with public transport focusing on motorized modes rather than cycling and walking, and safety threats due to crime and violence limiting the pursuit of outdoor recreational activities. The confinement of refugees to camps is likely to have further compromised these risks, especially with the reliance on local donor aid in providing food that was likely to mirrors local diets and eating habits.

*Remedial action*

Should the need arise again, camps should include adequate recreational facilities, and dietary issues should be a priority (see 7.1.3).

### 7.3. Health Systems, responses and service delivery

In the event of a future emergency that required the establishment of refugee camps, the following gaps have been identified that should be addressed in order to improve service delivery by the health system:

#### *7.3.1. Mental health*

1. Provide access to mental health services including social workers, psychologists and psychiatrists for those requiring mental health care
2. Establish a contact centre and register families to register and get information on missing persons
3. In groups severely affected by trauma establish support groups facilitated by social workers or psychologists trained in trauma counselling
4. Ensure uninterrupted supply if high quality psychiatric medications to those on chronic medication
5. Facilitate employment through engaging employers during crisis periods (such as displacement) and the provision of transport
6. Ensure adequate nutrition and expand national nutritional programmes to include migrants

#### *7.3.2. Infectious diseases and HIV*

1. Strengthen the national HIV and ART programmes
2. Ensure uninterrupted supply of high quality ART to those on treatment.
3. Ensure uninterrupted supply of co-trimoxazole to those with HIV.
4. Ensure access to HIV-related services including reproductive health, voluntary controlled testing, TB services, ART and PMTC services
5. Educate the public/camp residents on the symptoms of TB and the need for treatment compliance
6. Ensure that all those testing positive for HIV are screened for TB

#### *7.3.3. TB and lower respiratory tract infections*

1. Ensure uninterrupted supply of high quality TB medication to those diagnosed with TB.

2. Screen for weight loss and chronic cough and provide referral to screening services of those presenting with these symptoms
3. Enhance TB detection and cure rates nationally
4. Surveillance of TB cases to ensure early detection and response to outbreaks of MDR and XDR TB
5. Monitor adherence and treatment outcomes
6. Educate the public on the symptoms of TB and the need for treatment compliance
7. Ensure that all those testing positive for TB are screened for HIV
8. Maintain high pneumococcal and haemophilus influenza type B vaccination coverage

#### *7.3.4. Diarrhoea*

7. Ensure food safety
8. Promote hand hygiene
9. Promote breast-feeding
10. Provide health education to carers on the signs of dehydration in children, oral rehdration solution and when to seek professional assistance from health services
11. Ensure 80% vaccination coverage of children under one year for polio virus and rotavirus either through mass or mop-up vaccination campaigns and periodic surveillance of immunisation coverage.
12. Ensure access to health services and laboratory facilities that are able to detect important pathogens such as vibrio cholerae and shigella dysenteriae.
13. Develop and maintain surveillance of gastro-enteritis cases to ensure early detection and response to outbreaks of gastro-enteritis.

#### *7.3.5. Helminth infections*

1. Promote hand hygiene
2. Screening programme for helminth infection (faecal samples)
3. Where prevalence is greater than 50% provide prophylactic treatment with benzimidazole to all school-aged children and young women as per WHO guidelines.

## 8. RECOMMENDATIONS AND ACTIONING

Stakeholders identified the following factors as among the causes of the mismanagement during the recent crisis:

1. **Lack of political will:** Reluctance by Ministers and MEC's to act decisively and implement solutions formulated by specialists wholesale exacerbated security concerns, compounded health risks and increased the level of indignities suffered by the displaced. Government intervention was delayed and prone to meddling and micro management and only the readiness of Civil Society and I/NGO agencies averted a major tragedy in the first two weeks of the event. .

2. **Insufficient funding:** Insufficient government funds were released to deliver the services required by a crisis of such magnitude. In Gauteng's case funding was exhausted within one week, with Civil Society and I/NGO agencies having to provide the shortfall.

3. **Poor attitudes:** Public sector workers, particularly in the health services were not always willing to treat foreigners, and this may persist if left unchecked. Health professionals need to be trained to treat people regardless of nationality and need to be prepared to mobilize resources in response to crisis situations.

4. **Lack of capacity:** Both quantity and quality of government services were insufficient. There were too few personnel to respond to the events and as the military did not release troops, private contractors had to be deployed. The available personnel were inexperienced and untrained in disaster management and wholly reliant on UN and international NGO expertise to formulate and implement solutions.

5. **Poor planning:** There were no strategic or tactical plans to respond to the crisis and solutions were formulated on an ad hoc basis. Furthermore, this oversight does not seem to have been addressed and it is unlikely that there will be a

better prepared response should there be a similar reoccurrence of the xenophobic violence.

6. **Decentralised incident management:** Efforts to form a central incident management forum were thwarted by poor co-ordination between different tiers of government and their resistance to co-operation with civil society agencies.

7. **Lack of pre-positioned inventory:** There are inadequate pre-positioned stocks to meet the requirements of any major displacements or disaster. Even the SANDF is under stocked and the government was dependent on the UN for tents The balance of facilities and materials were almost exclusively acquired out of the trade, which makes a rapid response within 72 hours impractical..

8. **Security:** Persons in camps were vulnerable to external and internal threats. *Externally,* displaced persons were threatened by the community even after entering shelters. Internally, displaced persons were attacked, robbed and exploited within the shelters by fellow residents.

There were also several information gaps that prompted the sub-optimal response to the recent crisis. These are briefly highlighted below for consideration should the need arise for a similar emergency response. However, it should also be recognized that the under-preparedness may relate to the unexpected nature or the unexpected extent of the xenophobic attacks and that this is unlikely to alter substantially for any future emergency without careful planning. It is proposed that this role would be undertaken by a dedicated co-coordinating agency, of which the following would be among its key focal areas:

### *8.1. Intersectoral oversight and management*

It is clear that any future attempt at oversight and management of a humanitarian crisis of the scale as the one that developed in May 2008 will benefit from better co-ordination between various governmental (e.g. Health, Social Development, Community Safety, and Foreign and Home Affairs Departments), NGO, community and corporate stakeholders. A shadow committee should be established and buy-in sought from the various role-players to ensure better future preparedness.

### 8.2. Mandatory data collection, response documentation and benchmarking

In order to improve preparedness, it is necessary for comprehensive migration data to be collected that describes the full range of pre and post migration factors relating to the migrants..Currently, neither demographic details nor information on health status is recorded in a sustainable, intervention oriented manner. Collected data needs to be used for the improvement of services and the design of interventions and sustainable surveillance systems should be designed to clarify emerging health threats and provide continuous data on hazards and sentinel health outcomes.

### *8.3. Guidelines and legislation*

The current guidelines and legislation need to be reviewed and communicated to the various stakeholder groups. A range of evidence-based multi-agency guidelines have been developed that can be tailored to a variety of health threats arising out of population displacement. To date, the Sphere Project's Humanitarian Charter and Minimum Standards in Disaster Response Handbook (Sphere Project, 2004), the United Nations High Commission on Refugees' (UNCHR) *Handbook for Emergencies* (UNCHR, 2007) are the most comprehensive such guidelines available. The standards and action strategies detailed in these texts span the full gamut of possible health threats and appropriate modes of response. However, such detail and volume could in fact hinder rapid short-term dissemination of their contents. A two-fold stakeholder dissemination strategy that would optimize familiarity with these guidelines is therefore recommended. Firstly, a stakeholder analysis should be conducted in order to identify information and training targets. Once identified, all stakeholders should be apprised of and equipped with the guidelines. Formal training and points of contact with the relevant agencies should then be pursued. Secondly, key South African agencies should consider the compilation of a set of refined action strategies that synthesize and better integrate information contained in the more comprehensive texts. The TAC/ALP's development of a summarized minimum standards and norms document (TAC/ALP, 2008) provides a good example of such a synthesis. This model should be extended into a succinct South African-specific set of evidence-based strategic responses to disaster management for rapid dissemination and widespread use amongst all stakeholders in the future.

### 8.4. Extensive and ongoing research

It should be recognized that the current study has focused primarily on residents of camps. In order to assess the various public health and social impacts of displacement into (1) camps versus, (2) homes and families versus (3) new communities/informal settlements it would be necessary to conduct a far broader quantitative study.

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## Appendix A: Sources of Baseline Data

| REPORT NAME | PUBLISHER | DATE |
|---|---|---|
| Amnesty International Report on Xenophobia Displacement (September 2008) | Amnesty International | 01/09/2008 |
| CSVR Report 6th June 1830 | CSVR | 06/06/2008 |
| CSVR Report 13th June 1700 | CSVR | 13/06/2008 |
| Cape Town site report 15th June Report for Cape Town 15th June | CSVR | 15/06/2008 |
| Rand Airport_2 | CSVR | 17/06/2008 |
| Rifle Range Rd (Forest Hill)_3 | CSVR | 17/06/2008 |
| River Road (Corlett Dr, Lyndhurst)_3 | CSVR | 17/06/2008 |
| Wit Road (Springs)_2 | CSVR | 17/06/2008 |
| Cape Town site report 18th June | CSVR | 18/06/2008 |
| Olifantsfontein (Midrand)_2 | CSVR | 18/06/2008 |
| Rifle Range Rd (Forest Hill)_1 | CSVR | 19/06/2008 |
| Rifle Range Rd (Forest Hill)_4 | CSVR | 19/06/2008 |
| Wadeville (Heidelburg)_2 | CSVR | 19/06/2008 |
| CSVR Summary Report 20th June | CSVR | 20/06/2008 |
| CSVR Site Report 23rd June 2008 | CSVR | 23/06/2008 |
| Rand Airport_3 | CSVR | 23/06/2008 |
| Report on Food Subcommittee of Crisis Committee 23rd June 2008 | CSVR | 23/06/2008 |
| River Road (Corlett Dr, Lyndhurst)_4 | CSVR | 23/06/2008 |

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| Wit Road (Springs)_ | CSVR | 23/06/2008 |
| Presentation made at the Parliamentary Seminar on Migration and Xenophobia | CSVR | 24/06/2008 |
| CSVR Report 9th June 1600 | CSVR | 09/06/2008 |
| Olifantsfontein (Midrand)_1 | CSVR | 09/06/2008 |
| River Road (Corlett Dr, Lyndhurst)_1 | CSVR | 09/06/2008 |
| Wadeville (Heidelburg)_1 | CSVR | 09/06/2008 |
| Rand Airport_1 | CSVR | 11/06/2008 |
| Rifle Range Rd (Forest Hill)_2 | CSVR | 11/06/2008 |
| River Road (Corlett Dr, Lyndhurst)_2 | CSVR | 11/06/2008 |
| Wit Road (Springs)_1 | CSVR | 11/06/2008 |
| Malawi Humanitarian Update No. 14 (Repatriation from SA) | Disaster Management | 18/06/2008 |
| Western Cape: Mediation Task Team: Planning Session (Presentation) | Govt. | 27/06/2008 |
| Neighbours in Need: Zimbabweans in South Africa | HRW | 03/07/2008 |
| Migration & Social Cohesion Series | IDASA | 21/08/2008 |
| Disaster Relief Emergency Fund Update | IFRC | 09/06/2008 |
| Site Report for Knysna Camp 25th June | IKWA KUTHI | 25/06/2008 |
| Food Assessment Report for DBSA CoSS | Inter-Agency | 18/06/2008 |
| Western Cape: Site Assessment | Inter-Agency | 29/07/2008 |
| Health Cluster Bulletin | Inter-Agency | 31/07/2008 |
| Western Cape: Rapid Assessment Report | Inter-Agency | 09/06/2008 |
| Situation Report | IOM | 26/06/2008 |
| Situation Report No. 3: Violence Against Foreigners in South Africa | OCHA | 03/06/2008 |
| Situation Report No.14: Violence Against Foreigners in South Africa | OCHA | 03/10/2008 |
| CoSS & Ad Hoc Shelters Report no. 2 | OCHA | 04/07/2008 |

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| Situation Report No.12: Violence Against Foreigners in South Africa | OCHA | 05/09/2008 |
| Situation Report No. 1: Violence Against Foreigners in South Africa | OCHA | 24/05/2008 |
| Situation Report No. 2: Violence Against Foreigners in South Africa | OCHA | 28/05/2008 |
| Situation Report No. 5: Violence Against Foreigners in South Africa | OCHA | 23/06/2008 |
| Situation Report No. 6: Violence Against Foreigners in South Africa | OCHA | 27/06/2008 |
| CoSS & Ad Hoc Shelters Report no. 5 | OCHA | 17/07/2008 |
| Situation Report No. 8: Violence Against Foreigners in South Africa | OCHA | 27/07/2008 |
| CoSS & Ad Hoc Shelters Report no. 6 | OCHA | 29/07/2008 |
| CoSS & Ad Hoc Shelters Report no. 3 | OCHA | 08/07/2008 |
| Situation Report No. 9: Violence Against Foreigners in South Africa | OCHA | 16/08/2008 |
| Situation Report No.10: Violence Against Foreigners in South Africa | OCHA | 22/08/2008 |
| Situation Report No.11: Violence Against Foreigners in South Africa | OCHA | 29/08/2008 |
| Situation Report No.13: Violence Against Foreigners in South Africa | OCHA | 19/09/2008 |
| Situation Report No. 7: Violence Against Foreigners in South Africa | OCHA | 10/07/2008 |
| Situation Report No. 4: Violence Against Foreigners in South Africa | OCHA | 11/06/2008 |
| CoSS & Ad Hoc Shelters Report no. 4 | OCHA | 11/07/2008 |
| CoSS & Ad Hoc Shelters Report no. 7 | OCHA | 12/08/2008 |
| SA Human Rights Commission Second Report on Silverstroom Camp 24th June 2008 | SAHR | 24/06/2008 |
| SAHRC Report on Conditions at Blue Water | SAHR | 27/06/2008 |
| Minimum Norms and Standards for Shelter, Nutrition, Sanitation, and Health for Displaced Persons | TAC | 24/07/2008 |
| Report of Requests Made to the Joint Operation Centre (JOC) for the month of July (31 July 2008) | TAC | 31/07/2008 |
| Updated Western Cape Displaced People Report | TAC | 13/08/2008 |
| TAC/ALP "Follow-Up Western Cape Displaced People Report" (24 July 2008) | TAC/ALP | 24/07/2008 |
| UNHCR Message to Refugees and Asylum Seekers in South Africa | UNHCR | 26/06/2008 |
| Relief Update on Victims of Xenophobic Violence | UNICEF | 28/05/2008 |

| The Legal Rights of Non-South African Children to Access Basic Services | UNICEF | 17/06/2008 |
|---|---|---|
| Situation Report | UNICEF | 23/06/2008 |
| Situation Report | UNICEF | 29/06/2008 |
| Compiled Reports on the Current Status of the Refugee Crisis (18 September 2008) | WC Civil Society Task team | 18/09/2008 |
| Youngsfield Organisation Report of Vulnerable People At Risk (15 October 2008) | Youngsfield | 15/10/2008 |

| **MAPS** | **PUBLISHER** | **DATE** |
|---|---|---|
| Gauteng: Protection Working Group Activities | OCHA | 08/07/2008 |
| South Africa: Displaced Population breakdown by Nationality | OCHA | 08/07/2008 |
| South Africa: Displaced Population by Province | OCHA | 08/07/2008 |
| Gauteng: Populations in Centres of Safe Shelters | OCHA | 08/07/2008 |
| South Africa: Displaced Population by Province | OCHA | 04/07/2008 |
| Gauteng: Who is Doing What Where in Centres of Safe Shelter | OCHA | 01/07/2008 |
| South Africa: Displaced Population by Municipality | OCHA | 01/07/2008 |
| Gauteng: Protection Working Group Activities | OCHA | 01/07/2008 |
| Gauteng: Displaced Population in CoSS and Ad Hoc Shelters | OCHA | 27/06/2008 |
| Western Cape: Map of Displaced Population | OCHA | 19/06/2008 |

| MEETINGS | Date |
| --- | --- |
| Protection Working Group Action Points | 01/07/2008 |
| Protection Working Group Action Points | 24/06/2008 |
| Protection Working Group Action Points | 17/06/2008 |
| Child Protection Sub-Cluster Meeting | 10/06/2008 |
| Head of Clusters Meeting | 06/06/2008 |