

**“HUMAN DIGNITY HAS NO
NATIONALITY”**

**A SITUATIONAL ANALYSIS OF THE
HEALTH NEEDS OF EXILED TORTURE
SURVIVORS LIVING IN
JOHANNESBURG, SOUTH AFRICA**

By

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In closing we urge our readers to think deeply about what is contained in this report and to take up the difficult challenges of improving service delivery to torture survivors.

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EXECUTIVE SUMMARY

Introduction and literature review

South African law provides for the protection and care of those who have been tortured in their home countries and wish to seek political asylum in this country. This study explores the health needs and health seeking behaviours of tortured exiles (both asylum seekers and refugees) in order to assist planners and service providers to offer accessible, high quality, specialist services to this group.

At the end of 2005, the global number of refugees was estimated by the UNHCR as 8.5 million people. Africa accounts for 2.5 million refugees, approximately 30% of the total. The vast majority of African refugees come from the Great Lakes region and Eastern Africa. The number of refugees coming to South Africa from other African countries has been steadily increasing over the past decade. The United Nations High Commission on Refugees (UNHCR) reports that there were 29,714 refugees and 140,095 asylum seekers in South Africa at the end of 2005. It is estimated that approximately 35,000 of these have been tortured. These people are mostly found within the major metropolitan areas of Johannesburg, Tswane, Durban and Cape Town.

In recent years a great deal of attention in both popular and scientific literature has fallen on the abuse of asylum seekers and refugees by officials, service providers and indeed ordinary South Africans. Such abuse includes reliance on arbitrary and stereotypical physical and social attributes in the apprehension of undocumented African persons, people being prevented from fetching documents and personal property following arrest, the destruction of documentation, as well as bribery, extortion, theft, physical abuse and other forms of torture. This work draws attention to the fact that the South African government has not yet met its obligations with respect to the domestication, implementation and monitoring of the principles laid down and ratified under the *United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (UNCAT). Human rights and civil society organisations must continue to advocate strongly for these changes to the country's legal framework and government policy.

The large number of asylum seekers waiting for a decision about their status is an enormous problem for the Department of Home Affairs. In June 2006, the Minister launched the *Refugee Backlog Project* which aims to increase the rate at which status determination happens in the country (Department of Home Affairs, 2006). In the meantime, however, 140,000 people are forced to live in South Africa with temporary documentation, limited access to basic services, and no legal way to earn a living.

The physical impact of torture includes damage to the dermatological, cardiopulmonary, gastrointestinal, musculoskeletal, neurological, urological and genital, gynaecological, ophthalmological, and dental systems of the human body. PTSD, Complex PTSD, other anxiety disorders, depression, sleep disorders, substance abuse, sexual dysfunction and somatic disorders are all psychological problems associated with torture. Many torture survivors also experience a profound sense of alienation from their communities, members or their families and indeed their closest loved ones.

At a time when torture survivors most need the support of their own people, they are forced into a strange and often hostile world. Refugees and asylum seekers tend to be very poor, extremely vulnerable and are often ostracized from the general community. These conditions can only exacerbate problems with torture survivors' physical health, psychological wellbeing and social functioning.

To assess the impact of torture on an individual it is necessary to consider all aspects of that person's functioning: physical, emotional, and social. Moreover, torture nearly always takes place against a backdrop of war, terrorism, separation from community, death of loved ones, loss of home and employment, and many other significant stressors. It is also important to bear in mind that human beings typically bring tremendous resources to coping with adverse experiences, including torture.

Many torture survivors require the skills of competent and experienced medical personnel who have some knowledge of torture and its consequences. These personnel must be able to work in multi-disciplinary ways to provide services ranging from general health care, through emergency services, to elective surgery.

Methodology

In line with the commitment to community participation and empowerment that CSVN and RCT share, this study was built around an extensive consultation process. Important issues included the definition of torture, access to target populations, selection of research personnel, and the inclusion of asylum seekers and refugees from Zimbabwe.

This study provides a qualitative overview of the histories, current lives, current health status and experience of health services in South Africa of refugees and asylum seekers. The interview protocol combines highly structured items with semi-structured items to ensure a basic level of standardization across the sample without unnecessarily limiting the content and scope of the responses. 77 adult asylum seekers and refugees from Burundi, the DRC, Ethiopia, Somalia, Uganda and Zimbabwe took part in the study. Data was analyzed using thematic content analysis.

Results

In this sample of tortured exiles 48 people (62%) are male and 29 (38%) female. Despite being tortured only 8% had been granted refugee status, with 80% currently listed as asylum seekers. The majority of the sample have been in the country for at least two years with some having been in the country for six years or more.

All had been tortured using a variety of methods. Most common were being threatened with pain or death, being beaten, and being forced to listen to the torture of others. Women were more likely to have been sexually tortured than men. Men were more likely to have experienced other forms of physical torture.

The most commonly expressed needs in this group were for accommodation, refugee status and employment. Access to medical assistance and health care was the fourth most commonly mentioned need. 65% of the sample mentioned needing health care and 66% wanted assistance with mental health issues. Of those who mentioned specific medical needs, 19 people (45%) listed health problems directly related to their torture histories. Of these only one had received

assistance. Fifty people (69% of the overall sample) reported one or more severe and chronic psychological symptom resulting from the torture.

Experiences of health services in South Africa ranged widely. Although most tortured exiles rate South African health facilities highly, they rate health service providers very negatively. While a few people recounted positive stories about service delivery, the majority are much more negative. Tortured exiles narrated incident after incident of people being turned away from health institutions and being badly treated.

Experiences of the asylum seeking process produce very similar results. Although a few people were processed relatively efficiently, the majority recounted stories of great inconvenience, cost and in some cases distress arising from the asylum seeking process. This may be one of the reasons why so few torture survivors in this sample have refugee status. Of the tortured exiles that described their asylum seeking experiences in South Africa, approximately half informed refugee reception officers that they had been tortured. Others did not either because they had not been asked or because they were afraid to talk about those experiences.

Summary of recommendations

The data collected in this study suggests that there are between 5,500 and 13,500 tortured exiles living in South Africa and in need of health services, and that very few of those are receiving appropriate treatment. Better health care to tortured exiles living in South Africa in future depends upon strong collaboration between government departments (specifically the departments of Home Affairs, Health and Social Development), civil society organisations concerned with the care and support of tortured exiles, international agencies with similar concerns (including UNHCR and RCT), and representative structures of the various exile communities themselves. As such, a range of recommendations is listed below and organised in terms of the major role players.

Recommendations for the Department of Home Affairs:

The South African government is not obliged to provide health and social services services to foreigners who are in the country illegally or under false pretences. For this reason, the refugee status determination process is fundamental to the provision of health and social services to tortured exiles. The current backlog in cases and the rate at which new cases are being processed is unacceptable. It produces a large and growing group of exiles who as asylum seekers have a legitimate claim on services even though they might not eventually meet the criteria for refugee status, in which case they would have to return home. It also subjects applicants to an unnecessarily arduous, costly and distressing application procedure which should be avoided. Therefore it is recommended that the DOHA urgently undertake each of the following:

1. The DOHA's programme to reduce the backlog of unprocessed applications for asylum should be given highest priority and be well managed to ensure its effective implementation.
2. The DOHA should streamline existing procedures for the processing of applications to reduce the amount of time that asylum seekers are forced to spend waiting to be seen. Such adjustments must include the provision of more, well trained and better equipped Refugee Reception Officers.

3. Because some waiting is inevitable, the DOHA should provide better facilities for the comfort and protection of those waiting. Such facilities should include shelter from the elements, somewhere to sit, effective security, as well as access to clean water, affordable food and hygienic toilet facilities.
4. Refugee Reception Officers to routinely and consistently enquire into possible torture histories at the time of the first application for an asylum seeker's permit.
5. Refugee Reception Officers should be trained to ask about torture experiences in an appropriate manner. Asylum seekers should receive reassurance that information relating to torture will remain secret and will not jeopardise the applicant's chances of receiving refugee status.
6. The DOHA should fast-track the asylum seeking process for exiles who report experiences of torture in a consistent manner. Since members of this group are more likely to meet the criteria for refugee status, such processes will assist in the reduction of the current backlog and will prevent tortured exiles from having to repeat the arduous process again and again when their temporary status expires.
7. Refugee Reception Centres should maintain a short referral list of local mental health personnel to whom tortured asylum seekers may be referred should recounting their experiences prove too traumatic.
8. Existing supervisory systems should ensure that such policies are rigorously and competently implemented.
9. The DOHA should record in a systematic and comprehensive manner the full details of asylum seekers' histories and current situation. In this way, a growing data base will be available which will enable more effective and efficient service provision to this group.
10. Analysis and reporting on this data should be achieved through collaboration between DOHA and Statistics South Africa (StatsSA) whose responsibility it is to analyze and distribute such information.

Recommendations to Departments of Health and Social Development:

Although a great deal of the services that tortured exiles in South Africa today receive are provided by non-government and private organizations, the delivery of these services remains the responsibility of the state, specifically the Departments of Health and Social Development. Challenges like the AIDS pandemic and poverty have placed these departments under enormous strain. For this reason it is essential that services to tortured exiles are structured in the most cost-effective and efficient manner possible. Recommendations to these departments are organized to reflect both the need for urgent action and the importance of a longer term, comprehensive strategy.

Quick wins (immediate):

1. Support local Refugee Reception Centers by taking emergency referrals of tortured exiles from the centers.

2. Clarify departmental policies regarding service provision to asylum seekers and refugees. Policies need to clearly articulate which services are available to asylum seekers and refugees, at which sites, and at what cost. Policies should also specify who is responsible for the provision of various services.
3. Build national and regional networks with non-government and faith-based organizations who offer services to tortured exiles.
4. Use these networks to implement longer term strategies in a coordinated manner and to build referral lists of local torture experts to be lodged at institutions that see many exiles.
5. Contract in local torture experts on an hourly basis to support departmental personnel in caring for torture survivors.

Medium term strategy (2 years):

6. Establish a small, multi-disciplinary torture clinic within a general hospital in each major centre. Use these clinics to provide specialist, accessible and holistic services to tortured exiles.
7. Extend the capacity and expertise of these clinics through formalized service provision relationships with existing non-government and private expert service providers.
8. Use these clinic structures to develop awareness of torture among all service providers in the institution, and to combat xenophobia among health service providers.

Long term strategy (5 years):

9. Ensure that all service providers (especially frontline personnel including nurses and social workers) are educated about the prevalence and consequences of torture among exiles. Service providers should be able to recognize possible indicators of torture and discuss the topic with their clients in an appropriate and reassuring manner.
10. Personnel induction processes at all sites must deal explicitly with the policies and practicalities relating to the provision of general and emergency services to refugees and asylum seekers.
11. Managers and supervisors need to recognize that such policies run contrary to the beliefs and values of many service providers. As such it is important to ensure that policies are clearly and repeatedly discussed with service providers so that ignorance of policies cannot be used as an excuse for the exercise of xenophobia.
12. Supervisors and managers in all institutions should take responsibility for ensuring that departmental policies relating to refugees and asylum seekers are consistently implemented.
13. Managers and supervisors need to act decisively to prevent unfair discrimination, and to appropriately discipline employees who discriminate against asylum seekers and refugees.

Recommendations to human rights and faith-based organisations concerned with the care of torture survivors

Existing services to tortured exiles are spearheaded by a range of civil society organisations. Whether religious or secular in nature these organisations have accumulated a degree of expertise in the support and care of tortured exiles. Ultimately such organisations should hold as their highest priority the role of assuring that the human rights of tortured exiles are protected and that they receive the highest quality care possible. This can be achieved through supporting government service provision to build capacity and ongoing advocacy and lobbying on behalf of tortured exiles.

Monitoring, lobbying and advocacy functions:

1. Lobby DOHA for the policy changes to the initial stages of the asylum seeking process listed in the recommendations to that department.
2. Monitor and support the implementation of such policies. Monitor the proportion of tortured asylum seekers' whose torture history is documented at the beginning of the asylum seeking process.
3. Continue to monitor the conditions of the asylum seeking process and where appropriate bring cases of secondary victimization to the attention of the relevant authorities as well as the general public.
4. Ensure that cases in which refugees and asylum seekers are denied access to health and social services are carefully documented and reported to the relevant authorities.

Service delivery and support functions:

5. Organisations offering emergency services and shelter to exiles should ensure that their staff are trained to recognize indicators of torture and to explore such experiences with their clients in an appropriate manner.
6. Encourage asylum seekers to share their torture histories with refugee reception officers while ensuring that asylum seekers know that accounts of torture will be kept secret and will not jeopardize their chances of securing refugee status.
7. Where appropriate, take referrals from Refugee Reception Centres for emergency mental health support services.
8. Collaborate in the establishment of a national refugee advice desk to provide information to exiles.
9. Contribute to the establishment through this advice desk of a national referral database of organisations (government and non-government) and individuals who provide services (including care for torture survivors) to refugees and asylum seekers. Continually maintain and develop the national referral database.

Recommendations to representatives of exile communities in South Africa:

1. Collaborate in the establishment of a national refugee advice desk to provide information to exiles.
2. Develop local referral lists of government, non-government and private torture service providers to whom tortured exiles may be referred.
3. Run, in collaboration with the departments of home affairs, health and social services as well as civil society, human rights and faith-based organisations, an education campaign for exiles about the need to discuss torture experiences during the asylum seeking process. Most importantly asylum seekers need to know that their reports will remain secret and will not jeopardize their chances of receiving refugee status.

Recommendations to tertiary training institutions and professional associations:

1. Ensure that the training of all medical, social and psychological personnel includes significant input relating to the indicators and impact of torture as relevant to their chosen field.
2. Explicitly explore the ethical issues relating to prejudice and xenophobia in the provision of health services.
3. Create opportunities for health professionals to develop and share their expertise in service provision to torture survivors through local conferences, journals, and continuing professional development programmes.

Recommendations for future research:

1. Detailed demographic data on asylum seekers and refugees is already being collected through the asylum seeking process. This information should be consistently captured, analyzed and reported upon by the DOHA in collaboration with Statistics South Africa (StatsSA).
2. Researchers in civil society should continue to lobby for regular release of accurate statistical information pertaining to asylum seekers and refugees living in South Africa.
3. Future research should investigate and compare the psychosocial position and needs of tortured asylum seekers with those of tortured refugees. While social researchers understand something of the situation and needs of tortured refugees, relatively little is known about how those needs are exacerbated by the precariousness of the asylum seekers' situation. Findings from such work may have important implications for service provision to this group.
4. South African research providers together with human rights organisations, representatives of refugee communities and service providers should continue to collaborate on detailed and applied studies of the population of tortured refugee and asylum seekers in order to better understand the changing health seeking behaviours and other dynamics of this important group of people. In particular, researchers should conduct similar studies in different centres within South Africa and look at the outcome of different treatment modalities.

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LIST OF ABBREVIATIONS

ANC	African National Congress
AU	African Union
CASE	Community Agency for Social Enquiry
CBRC	Coordinating Body for the Refugee Community
CSVR	Centre for the Study of Violence and Reconciliation
DESNOS	Disorder of Extreme Stress Not Otherwise Specified
DOH	Department of Health
DOHA	Department of Home Affairs
DOSD	Department of Social Development
DRC	Democratic Republic of Congo
NGO	Non-Government Organisation
OAU	Organisation for African Unity
PTSD	Post Traumatic Stress Disorder
RCT	Rehabilitation and Research Centre for Torture Survivors
SA	South Africa
SAHRC	South African Human Rights Commission
SANDF	South African National Defence Force
SAPS	South African Police Services
UN	United Nations
UNCAT	United Nations Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment
UNHCR	United Nations High Commission for Refugees
VEP	Victim Empowerment Programme
WHO	World Health Organisation

CHAPTER 1 Introduction and Background

The principles upon which contemporary South African society is based are laid down in the Constitution. These include a commitment to:

Recognize the injustices of our past;
Honour those who have suffered for justice and freedom in our land; ... [and to]
Heal the divisions of the past and establish a society based on democratic values,
social justice and fundamental human rights.

Preamble to the Constitution of the Republic of South Africa (1996)

In the same way as South African activists were protected and cared for in other countries in Africa and further abroad during the struggle against apartheid, South African law provides for the protection and care of those who have been tortured in their home countries and wish to seek political asylum in this country. If we are to judge our society on how we care for its most needy members, then we must judge ourselves on how we care for torture survivors who have come to South Africa in search of sanctuary. These values are strongly taken up in the Supreme Court Judgment from which the title of this report is taken:

Human dignity has no nationality. It is inherent in all people – citizens and non-citizens alike – simply because they are human. And while that person happens to be in this country – for whatever reason – it must be respected, and is protected, by s 10 of the Bill of Rights.

Nugent in *Watchenuka and Another vs Minister of Home Affairs* (2003, para 25)

The group referred to as “exiles” includes several subgroups defined in terms of their legal position under South African law. Refugees are exiles who have been recognized as refugees under South African law and provided with the appropriate documentation. Asylum seekers are people who have applied for refugee status but who have not as yet been granted or denied refugee status (see below for details of this process), and undocumented people refers to people from other countries who are living in South Africa but who have not applied for asylum. Many people in each of these subgroups have been tortured and as a result are in need of specialized health services.

At the end of 2005, the global number of refugees was estimated by the UNHCR as 8.5 million people. Africa accounts for 2.5 million refugees, approximately 30% of the total. The vast majority of African refugees come from the Great Lakes region and Eastern Africa (UNHRC, 2006). Although the majority of these refugees remain close to their countries of origin, often in refugee camps in neighbouring states, a significant number head for South Africa.

In fact, the number of exiles coming to South Africa from other African countries has been increasing steadily over the past decade. The UNHCR (2006) reports that there were 29,714 refugees and 140,095 asylum seekers in South Africa at the end of 2005. Torture survivors in exile are among the poorest, most marginalized, disadvantaged and under-served members of our society. Experiences of torture commonly leave exiles in need of specialized medical, psychological and social services.

Responsibility for the implementation of this law lies primarily with the Department of Home Affairs (DOHA), but also with the South African Police Service (SAPS), several metropolitan police services, and various other government service providers including the Departments of Health (DOH) and Social Development (DOSD).

Effective health service provision depends upon accurate information about the size, location, health needs and health seeking behaviours of the intended beneficiaries. Unfortunately, accurate information as to what proportion of this large group of exiles has a legitimate claim on refugee status and thus to health services is limited. A recent statement by DOHA shows that of 7,743 cases recently adjudicated 909 (roughly 12%) were given refugee status. This would suggest that if DOHA were to catch up the entire backlog (103,410 cases in April 2006) a further 12,409 refugees would be added to the existing total of 29,714. As such, around 42,000 people have a legitimate and long term claim on health and social welfare services as refugees in South Africa. These people are mostly found within the major metropolitan areas of Johannesburg, Tswane, Durban and Cape Town.

This report is however, concerned with the need for special health services for *tortured* exiles. Unfortunately, there are no accurate figures for the proportion of African exiles who have been tortured. However studies of refugees seeking asylum in Europe and the United States of America show that between 20% and 50% of refugees from Africa have been tortured (Genefke, 1999). These figures suggests that there are currently between 8,400 and 21,000 tortured exiles residing in the metropolitan areas of South Africa.

The significant size of this population is such that health and welfare service planners are obliged to develop special service delivery strategies to cater for their particular needs. At the same time the numbers are not so large (relative to the general population) that the provision of such services would impact negatively upon service provision to the general population. Thus, although tortured exiles present particular challenges to health and social service providers, these challenges are by no means insurmountable given the available resources. This study aims to explore the health needs and health seeking behaviours of this group in order to assist planners and service providers as to how best to offer appropriate services to exiled torture survivors.

Refugees, asylum seeking and South African Law

Internationally, refugees are protected under the United Nations Convention Relating to the Status of Refugees of 1951, the United Nations Protocol Relating to the Status of Refugees of 1967, and the Organisation of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa of 1969. Since South Africa is a signatory to all three of these international agreements, the South African government is obliged to offer the same services to refugees that are available to South African citizens.

These international agreements are domesticated in South African law primarily through the Refugees Act, Number 130 of 1998. This act lays down the conditions under which refugee status will be granted by the South African government as well as the process whereby asylum seekers should apply to be recognized as refugees. Any person who has been forced to flee their own country as a result of well-founded fear of individual persecution, human rights abuse or armed conflict may apply for refugee status.

Upon entry through any recognized port a person wishing to apply for refugee status in South Africa will be issued with a non-renewable asylum transit permit which is valid for 14 days. During these two weeks, the holder of this permit is required to register in person as an asylum

seeker at one of the country's several refugee reception centers. There they receive an asylum seeker's permit in terms of Section 22 of the Act which is valid for a further 30 days. This permit is renewable for further periods of 30 or 90 days. During the first 30 days after registration, the asylum seeker is required to attend an interview with a Refugee Status Determination Officer. This officer, possibly in consultation with a representative of the United Nations High Commission for Refugees (UNHCR), will grant or reject refugee status. In the case of a rejection, it is possible for the asylum seeker to appeal to the Standing Committee for Refugee Affairs. The entire process of status determination including appeal should take less than six months.

A refugee identification document is granted to those whose applications are successful. This document is valid for an initial period of two years and grants the holder full legal protection under the South African constitution and law. The holder is entitled to study, to seek employment and enjoys the same rights to basic health care and primary education that South African citizens do. A refugee also has the right to United Nations travel documents. After five continuous years of residence in South Africa, refugees may apply for an immigration permit and may ultimately be granted South African citizenship.

The extent to which the government is obliged to provide such services to asylum seekers is a debate of much importance given the enormous backlog in case determination and the large numbers of asylum seekers living in the country for long periods of time. Originally, asylum seekers did not enjoy access to services. However, DOHA policy was changed to allow asylum seekers to apply to the Standing Committee for Refugee Affairs for authorization to work or study if their status has not been decided within 6 months of registration.

Recently this has been further challenged. In 2003 Muriel Watchenuka won a case against DOHA and gained permission to work and for her son to study within the first six months after registration. The judgment is strongly worded and speaks clearly to the attitude of the courts on matters pertaining to service delivery to asylum seekers.

In my view the Standing Committee's general prohibition of employment and study for the first 180 days after a permit has been issued is in conflict with the Bill of Rights. I consider the general prohibition in the regulations is unlawful for the same reasons which constitutes further ground for setting it aside.

Nugent in *Watchenuka and Another vs Minister of Home Affairs* (2003, para 24)

While this Act provides strong legal grounds for the protection of tortured exiles its application has been sharply criticized. These criticisms are dealt with in more detail below.

African refugees and asylum seekers in South Africa

Asylum seekers coming to South Africa have left their countries as a result of wars and human rights abuses which have their roots in the continent's complex history of colonization, wars of independence, oppressive and brutal rule by African dictators, civil wars as well as ethnic conflicts.

It was only after the first democratic elections of 1994 that South Africa under the African National Congress (ANC) government engaged effectively with the need to protect refugees fleeing human rights abuses in other countries. Such action was particularly appropriate in the light of the many ANC leaders and members who had relied on the protection provided by other

countries during the struggle against apartheid. Without the support of the many countries who accepted and protected refugees from South Africa, the liberation of the people of our country would have been an even more difficult struggle.

While there has been virtually no systematic research of tortured exiles in South Africa, there has been some work done on the population of refugees and asylum seekers in general. A recent survey conducted by the Community Agency for Social Enquiry (CASE) included approximately 1,500 refugees and asylum seekers living in the cities of Johannesburg, Pretoria, Cape Town and Durban. Refugees participating in this study originated from Angola, DRC, Somalia, Burundi, Congo-Brazzaville, Ethiopia, Rwanda, Uganda, Cameroon, Sierra Leone and Sudan. Approximately 60% of the participants in this study were asylum seekers, and over half the total sample had waited more than four years for their status to be determined. The average age of asylum seekers was 31 years and approximately half were married. The median income of this group was R650-00 per month. While this study was not focused specifically on services to asylum seekers and refugees it was noted that 60% of the sample had tried to make use of emergency health care while in South Africa. Of those who had tried, 17% reporting having been denied care (Belvedere, Mogodi and Kimmie, 2003).

The fact that so many people are waiting several years for a decision as to their legal status when the law states that this process (including appeals against negative decisions) should take less than six months is symbolic of the enormous chasm that exists between the law and its actual implementation. Sadly, this is only one way in which South African officials have failed to translate good laws and policies into real protection and services for tortured exiles. In recent years a great deal of attention in the popular and scientific literature has fallen on the abuse of asylum seekers and refugees by officials, service providers and indeed ordinary South Africans. Human Rights Watch published a report in 1998 that presented evidence that in many cases the apprehension of undocumented persons in South Africa relied on arbitrary and stereotypical physical and social characteristics. It was also noted that this unlawful process is only applied to African people. This study also shows that suspected undocumented persons are often not given opportunity to fetch their documents and that in some cases documentation, including South African identity documents, is destroyed by officials. Cases of bribery, extortion and theft during the arrest process are also discussed in detail in this report. The authors conclude that arrests are in some cases motivated purely by the opportunity that is thereby created for extortion. The Human Rights Watch data also documents cases of physical abuse by police and military personnel. Their analysis suggests that both South African Police Service (SAPS) and South African National Defence Force (SANDF) personnel are responsible for these actions. This data suggests that as many as 20% of people arrested as undocumented persons are wrongly arrested and later released (Human Rights Watch, 1998).

South African civil society is also aware of these problems. In 1999, the South African Human Rights Commission (SAHRC) undertook an enquiry into the treatment of undocumented people at Lindela Repatriation Centre. Interviews with 149 detainees produced results that supported much of the findings of Human Rights Watch. In many cases people had been arrested without reasonable grounds and virtually no participant had been given the opportunity to collect personal possessions or documentation. Extortion and bribery were reported frequently and complaints of inadequate nutrition, the withholding of medical care, and having sleep interrupted were common. Detainees also described acts designed to humiliate and intimidate. Of the people interviewed at Lindela, 6% were asylum seekers (South African Human Rights Commission, 1999).

Of course the poor treatment of refugees and asylum seekers in South Africa is not limited to police and army personnel. Many service providers (including in the health, mental health and social services sectors), as well as ordinary South Africans display xenophobic attitudes and behaviour in their interactions with people from other countries (Harris, 2002; Palmary, 2002). Landau (2006) argues that xenophobia in South Africa is driven in large part by a set of myths relating to African immigration. These myths are that South Africa is being deluged by illegal immigrants; that foreigners are always needy public wards; that the state's ethical and moral responsibilities are limited to its citizens; that immigration is structured and controlled by public policy; and, that migration policy is the concern only of national government structures. He demonstrates that each of these myths is substantively incorrect and goes on to document how this mythology is perpetuated by statements of senior government spokespersons and well as the South African media. He argues that public opinion of foreigners as well as people's responses to them are shaped by this public discourse.

The vast number of asylum seekers waiting for a decision about their status is an enormous problem for the Department of Home Affairs. In June 2006, the Minister launched the *Refugee Backlog Project* which aims to increase the rate at which status determination happens in the country (Department of Home Affairs, 2006). In the meantime, however, 140,000 people are forced to live in South Africa with temporary documentation, limited access to basic services, and no legal way to earn a living. This is clearly an untenable situation. Until such time as asylum seekers' applications for refugee status can be processed at an acceptable rate, other systems must adjust in order that asylum seekers are assured of the necessary protections and provisions that support life in our society. There are important implications for the provision of basic welfare services and support, health services as well as for education and employment. In order that both asylum seekers and refugees receive appropriate services enabling policies must be created within each of these government departments at both national and provincial level. Furthermore, it is necessary that government service providers on the ground are made aware of such policies and are adequately prepared for their implementation.

Torture

Torture is defined in Article 1 of the United National Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (UNCAT) of 1985 as,

any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act which he or a third person has committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

(United Nations, 1989, pg 17)

By necessity this is a relatively narrow definition of torture requiring (1) an intentional act that (2) causes suffering, is (3) inspired by very particular motives, and (4) committed by an agent of the State. Of these several components the most problematic within the African context is the third. In several countries in Africa non-state actors (such as militias and rebel groups) are the controlling forces in particular regions and the UNCAT definition is extended to include actions by such groups. This interpretation of the definition was supported by the Organisation for

African Unity (OAU, now the African Union) through the Robben Island Guidelines Concerning the Prevention of Torture in Africa (2002).

In fact the convention is an agreement against torture *and other cruel, inhuman and degrading treatment or punishment*. Thus while the definition of torture is relatively narrow the provisions of the convention can arguably be applied much more broadly. The South African government ratified UNCAT in 1998 and as such is obliged to ensure that no acts of torture occur in territories over which it has jurisdiction. In order to achieve this the South African government is obliged to ensure that acts of torture are defined as criminal offences. This fundamental of UNCAT domestication has still not become a reality in South Africa. Furthermore, testimony given in situations of coercion must be inadmissible as evidence in a court of law. In the case of alleged perpetrators over whom the South African legislature does not have jurisdiction the government is obliged to act in cooperation with other countries and international bodies to ensure that the principles of UNCAT are upheld. The South African government is also required to ensure that all public officials are educated as to what constitutes torture in order that they are able to competently identify and report suspected cases. This specifically includes public officials responsible for the detection and investigation of crime; for arrest, detention and imprisonment of law breakers; and for the provision of health and social services. In order to facilitate this it is necessary that appropriate reporting structures are in place and that regular reviews of the policies and practicalities of incarceration and interrogation take place. The government is further required to submit regular country reports to the international Committee Against Torture.

The South African government has not yet met its obligations with respect to the domestication, implementation and monitoring of the principles laid down and ratified under UNCAT and human rights. Civil society organisations must continue to advocate strongly for these changes to both the country's legal framework and government policy.

Importantly in the case of torture survivors in exile, UNCAT grants protection against refoulment (forced repatriation) where there are substantial grounds for believing that a person might be tortured upon return to their home country. As a result UNCAT has direct implications for law and policy governing the granting (or refusing) of political asylum in South Africa. These laws are all that protect tortured exiles from forced repatriation, further torture and possible murder. As such both their substance and their application are critically important to this analysis.

Torture survivors in exile

This study is concerned with the provision of services to people who have been forced into exile as a result of torture and other human rights abuses. It is concerned with the protection of people who are struggling to recover from some of the most damaging experiences imaginable, in a world that is foreign and often hostile. The struggles that refugees experience in building a new life far from home are compounded by the impact that torture has made upon their bodies, their psychological health and their relationships with other people.

As a group these people have very special needs to which our humanitarian and rights-based society is obliged to respond. To do this as well as we are able it is necessary that we learn from the people that we are hoping to assist. Each person who participated in this study has shared their personal story with researchers. They have told us of their early lives in their home country and the conflicts and wars that led to their being tortured. They have described to us their decisions to leave their homes and the difficult journeys that they endured to reach South Africa.

They have described their struggles to make a place for themselves in South African society and their experience of various service providers in this country.

This report represents a summary of all those stories presented in a way that will facilitate more effective and respectful service provision in future. It is hoped that the content of this report will influence the thinking of decision-makers in the determination of policy and law, as well as the attitudes and care of actual service providers in their dealings with refugees and asylum seekers who have been tortured. It is also hoped this study will teach researchers a great deal about the challenges of working with this particular population group in South Africa, and will guide future studies of torture survivors in South Africa and abroad.

Torture, Exile and Health

A great deal of work has been done on the impact of torture on the lives of individuals and it is beyond the scope of this study to document all this research in detail. However, it is appropriate to remind readers that in order to assess the impact of torture on an individual it is necessary to consider all aspects of that person's functioning. Torture has a profound effect on the physical, emotional, and social aspects of individual health. In the past some service providers and activists have proposed developing a diagnostic category specifically for torture survivors labelled "torture syndrome". This assumes however that nearly all survivors of torture respond in similar ways and that the effects of torture are completely distinct from other kinds of physical, psychological and social concerns. Neither of these is true. In fact torture survivors commonly suffer from combinations of existing and relatively well understood health problems.

Moreover, torture nearly always takes place against a backdrop of war, terrorism, separation from community, death of loved ones, loss of home and employment, and many other significant stressors. As a result it is often difficult to separate out the consequences of the torture from that of all the other stressors impacting negatively on a person at the same time.

Of course it is also important to bear in mind that human beings typically bring tremendous resources to coping with adverse experiences, including torture. Such resilience may also take the form of physical, psychological, and social strengths. Coping resources are located within the individual, the family and other intimate relations, and within the community at large. Individual coping resources include personality factors such as endurance, courage and hope, skills such as problem solving, decision-making and the ability to ask for assistance, as well as a strong sense of personal meaning and identity. Families and other intimates often provide love, affirmation and care. Having someone who will listen with compassion and without judgment to traumatic events, is as important as having someone who can distract one from endless and distressing rumination. Finally, a sense of purpose and identity that is shared with others remains a strong source of resilience for many torture survivors. The community at large may also play an important role in survivors' response to torture. Acknowledgement of suffering, respect, protection and appropriate assistance are all enormously helpful. A comprehensive assessment of a torture survivor must look at all these aspects of human functioning and allow for both negative impacts and areas of resilience.

Physical consequences of torture

Rasmussen (1990) provides a useful overview of the physical impact of torture, looking at the various systems of the human body: namely, dermatological, cardiopulmonary, gastrointestinal, musculoskeletal, neurological, urological and genital, gynaecological, ophthalmological, and dental.

Dermatological damage includes skin lesions from severe beatings, burns and electrical torture. Burns and electrical torture produce the most characteristic and lasting lesions. Damage to the cardiopulmonary system includes fractures in the chest due to beatings and lung damage from suffocation and drowning. Poor prison conditions may also lead to lung infections and tuberculosis. The most common damage to the gastrointestinal system in torture victims comprise internal injuries resulting from severe beating. However chronic diarrhoea, vomiting and weight loss are also associated with poor prison conditions. Musculoskeletal damage is extremely common in torture victims and associated with beatings as well as suspensions and other forms of long-term immobilizations. Specific torture methods result in very particular musculoskeletal consequences. Neurological symptoms are sometimes difficult to separate from psychological consequences of torture. Nevertheless, chronic headaches, loss of consciousness are likely to indicate skull fractures, concussions and possible brain lacerations. In addition peripheral nerve damage related to tight binding or beating is a common consequence of torture. The urological and genital systems are most affected by beatings as well as unhygienic torture instruments. Uterine bleeding is the most common of gynaecological symptoms in torture victims. Menstrual irregularities and genital tract infections are also common and relate to rapes and genital torture. Ophthalmological damage is most commonly conjunctivitis resulting from the use of dirty blindfolds. Acute dental injuries are also common in torture survivors. Typically these involve fractures and loss of teeth resulting from beatings, extraction or from poor oral hygiene in prison.

Psychological consequences of torture

The psychological consequences of torture are extremely diverse and depend greatly upon the characteristics of the victim; the nature, severity and circumstances of the torture itself; as well as the care and support that the victim receives following the torture (Başoğlu et al., 1993; 1994; 1995; and 1996).

Discussions of the impact of torture on individuals most commonly focus around post-traumatic stress disorder (PTSD). PTSD is characterized by three sets of symptoms namely, intrusive symptoms, avoidance symptoms and symptoms of hyper-arousal. The first category includes intrusive images, memories and thoughts, flashbacks, and nightmares. The avoidant symptoms include avoiding contact with places, people and activities associated with the torture, actively trying not to think about or remember what happened, traumatic amnesia, and social isolation. Hyper-arousal symptoms include hyper-vigilance, exaggerated startle response, difficulty falling and staying asleep, and strong physiological and emotional responses to triggers associated with the torture (American Psychiatric Association, 2000).

While it is true that many torture survivors meet the diagnostic criteria for PTSD (see for example, Juhler, 1993; and, Thompson and McGorry, 1995), many practitioners and researchers argue that this diagnostic category does not on its own adequately capture the diversity of psychological responses to torture (see for example, Turner and Gorst-Unsworth, 1993; and, Gerrity, Keane, Tuma and Ortiz, 2001). The notion of Complex PTSD, sometimes referred to as Disorders of Extreme Stress Not Otherwise Specified (DESNOS), is associated with situations in which the victim experiences prolonged trauma and is trapped, either physically or by circumstance. Hence complex PTSD is found in people who have survived child abuse by an older family figure, victims of spousal violence, survivors of concentration camps and people who have been tortured. While Complex PTSD shares many of the same features as PTSD, it is also characterized by various dissociative symptoms. Torture is also strongly associated with other anxiety disorders (for example, generalized anxiety disorder and agoraphobia, with or without

panic attacks), and depression. Sleep disorders, substance abuse, sexual dysfunction and somatic disorders are also important.

There is some evidence that psychological disorder is more likely to be expressed through the body in the form of somatic symptoms in African populations than in the so-called “Western” populations (see for example, Coker, 2004; and, Zungu-Dirwayi, Kaminer, Mbanqa and Stein, 2004). Somatic disorders create a potential difficulty for health care professionals. Symptoms like chronic headaches, stomach aches, back pain, and muscular pain in other parts of the body may result from the somatic expression of emotional distress, or may be chronic and subtle consequences of physical damage resulting from torture. While in many cases careful medical testing and ongoing care would clarify this possible point of confusion, survivors who are not receiving such attention might well be wrongly diagnosed by both nurses and mental health personnel. This results in a breakdown in the relationship between helpers and survivors with helpers sometimes suggesting that their clients are malingering, and survivors feeling that their problems are unsolvable or that service providers are not really trying to assist them.

Social consequences of torture

A key theme in understanding the nature and consequences of torture is that of distrust and betrayal. The social contexts in which the practice of torture are most rife are characterized by secrecy and suspicion. It is difficult to know who is trustworthy and who is not. Many torture survivors feel strongly that they have been betrayed by others, and some feel ashamed and afraid that others might think that they themselves had not been trustworthy.

A sense of betrayal has been shown to be an important predictor of psychological responses to some kinds of complex trauma, especially in its effects on dissociation, memory and somatization. Although the majority of this work has been conducted with victims of child abuse, the same principles may well apply to torture survivors (DePrince and Freyd, 2002).

Regardless of the exact psychological mechanisms, it is clear that many torture survivors experience a profound sense of alienation from their communities, members or their families and indeed their closest loved ones. This may be expressed through fear and distrust of certain groups (often determined along gender or ethnic lines) or of people in general. It may also take the form of sexual dysfunction.

Implications for the provision of health services

As the previous sections make plain, torture survivors present with a very broad set of health needs. While survivors typically seek out health services around some particular and often pressing problem, a detailed assessment will often uncover a range of other needs. Such assessments are difficult to conduct in over-crowded general facilities in which it more common that assessments are cursory and treatment very brief. In fact torture survivors health needs are often multi-layered and as the more urgent or distressing problems are dealt with others emerge.

Although some health problems are obviously related directly the torture that a person has experienced (for example, injuries from beatings etc.), others may not be so obviously connected (for example, chronic menstrual problems). It must not be assumed that survivors will volunteer details of their torture experiences to medical personnel, and it may be necessary to ask very sensitive questions. Also, some problems may only emerge at a later stage as a result of other life events (for example, subtle uterine damage which only becomes apparent during pregnancy).

Many torture survivors require the skills of competent and experienced medical personnel who have some knowledge of torture and its consequences. These personnel must be able to work in multi-disciplinary ways to provide services ranging from general health care, through emergency services, to surgery.

The cumulative impact of exile

The support and shared resources of family and community are core to successful coping with war, violence, torture and other human rights abuses. This is particularly true in cultures in which greater value is placed on community life, shared problem solving and interpersonal responsibility, features that characterize traditional African societies (Summerfield, 1999; Higson-Smith, 2002). While the material costs of being forced into exile (the loss of land, possessions, employment, pensions, access to savings, etc.) are relatively easily calculated, the costs of separation from family, friends, political compatriots, and community members are almost impossible to quantify.

At a time when torture survivors most need the support of their own people, they are forced into a strange and often hostile world. In this world they lack many of the resources which people typically employ when faced with serious adversity. There is no local knowledge of organizations and individuals who can provide particular kinds of expertise, there are few trusted people with whom problems can be discussed and strategies formulated, and there are extremely limited financial resources with which to buy assistance. Service providers are at best distanced by language and cultural differences, and at worst are hostile and rejecting.

From a mental health point of view, exile is most often described in terms of loss and depression. However, in the case of the torture survivor, although refugee status confers a kind of protection, life in a new country also represents a whole new set of struggles. As was described above refugees and asylum seekers living in South Africa tend to be very poor, extremely vulnerable and typically ostracized from the general community. These conditions can only exacerbate torture survivors' physical health, psychological wellbeing and social position.

CHAPTER 2: Aims and Methodology

In 2004, the Centre for the Study of Violence and Reconciliation (CSV), and the Rehabilitation and Research Centre for Torture Victims (RCT) embarked on a partnership project which had as its objective “to contribute to an improved access for tortured exiles in South Africa to safe, torture specific, legal- and health rights-based rehabilitation”. In order to achieve this objective, the project sought to first understand the nature of the issue, and out of this to develop recommendations around a strategy to improve access to health and legal assistance and rehabilitation for tortured exiles.

Between 2004 and 2006, the project undertook a range of activities, including:

1. a descriptive qualitative study with tortured exiles to determine their expressed needs as it may relate to the types of torture experienced and the context of the torture survivor, as well as the different types of coping strategies of tortured exiles with specific attention to their experience with accessing health services,
2. a description of available health services, involving key informant interviews to understand the types of services available, the capacity of those providing the services, as well as the challenges faced;
3. a review of a shelter file system, in order to understand the way in which torture is documented by service providers; and capacity building with service providers and health professionals; and,
4. capacity building with service providers, health professionals and representative structures within various refugee communities in South Africa.

Aims of this study

The study described in this report was conducted in pursuance of activity one above. It is a descriptive analysis of the experiences and needs of tortured exiles currently living in Johannesburg. Specifically, the study explores:

- The nature of torture experiences in the refugee and asylum seeking population in South Africa;
- Tortured exiles’ expressed needs for health assistance;
- Tortured exiles’ experiences of the South African health system;
- The impact of the status determination process on health, including possible revictimization;
- The impact of the status determination on access to health services, and;
- The social support available to tortured exiles.

Development of the study design

In line with the commitment to community participation and empowerment that CSV and RCT share and due to the critical importance of cooperation from the communities in question, this study was built around an extensive consultation process. Leaders of various refugee communities in Johannesburg have knowledge and experience that is crucial to this project and also serve as important gate-keepers to extremely vulnerable groups of people. For these reasons, CSV approached the Co-ordinating Body for the Refugee Community (CBRC) and set up a mini-workshop for the planning of this study. The following issues were discussed in the workshop.

Talking about torture

It was clear from the workshop that even leaders of the refugee communities were unable to accurately differentiate torture from related concepts. Some listed the failure of the South African government to resolve status determination issues in a timely manner and the denial of basic economic support as examples of torture. While these are without doubt human rights abuses, they are not technically forms of torture. (Although describing them as such no doubt helps to draw attention to their seriousness). As discussed in the previous chapter, torture is a very specific concept defined by international law and it is important that interviewers and interviewees develop a shared understanding of the concept. Also, most African languages do not have a specific word or phrase for torture. As a result it is even more difficult to distinguish torture from such concepts as assault, suffering and harassment.

It became clear in this workshop that interviewers would need to discuss the definition of torture (see chapter 1) with interviewees. Where necessary interviewers would need to explain precisely what is meant by torture to the interviewees. This decision had important implications for the development of the instrument and training of interviewers.

Access to tortured refugees and asylum seekers

Leaders in the refugee communities raised several concerns about access to tortured refugees and asylum seekers. These are discussed below.

Firstly, many people in this population group are afraid of abduction and forced repatriation by enemies from their home countries. As a result they are particularly concerned about possible informers and the protection of data. It was envisaged that this would prevent some participants from disclosing some information and might lead to a lower participation rate. This also meant that public advertisement of the study calling for participants would be unlikely to be successful, would result in a very particular sample that was not representative of the diversity in the refugee community at large, and might potentially endanger people. The sampling procedures described below were designed around this understanding.

Secondly, it became clear that nearly all members of the population of refugees and asylum seekers (with or without experiences of torture) are extremely poor and would be attracted to the study by promises of financial remuneration. This might result in some people misrepresenting themselves in order to be included in the study. At the same time it is important to value participants' time and input. It was agreed that participants should be promised compensation for transportation costs up front and should receive an additional honorarium upon completion of the interview. Participants would not be informed of the honorarium before the interview. A small percentage of the honorarium would be given to the refugee community through the CBRC.

Selection of research personnel

The complex language demands of this study were discussed at length. It was agreed that community leaders would assist the CSVR in identifying suitable interviewers from the asylum seeking and refugee communities themselves. Leaders were provided with a set of selection criteria to assist them in this task.

Inclusion of refugees and asylum seekers from Zimbabwe

Although it had initially been decided not to include Zimbabweans in the sample, this decision was reversed after the CSVr was urged by the CBRC to include this group. Zimbabweans had been denied access to the asylum seeking process until 2004 due to the fact that there is no actual conflict or war in Zimbabwe. However, an increasing number of Zimbabweans have been seeking asylum in South Africa alleging systematic human rights abuse and torture in their home country.

Design

This study is designed to provide a qualitative overview of the histories, current lives, current health status and experience of health services in South Africa of refugees and asylum seekers. As such the design is largely cross-sectional. However, the retrospective nature of some aspects of the data provides an appropriate longitudinal perspective and historical context. The interview protocol combines highly structured items with semi-structured items to ensure a basic level of standardization across the sample without unnecessarily limiting the content and scope of the responses. Each of these dimensions is discussed in more detail in the following sections.

Sampling

The sampling demands of this study are extremely challenging. A minimum sample size of 50 was set. This number is manageable within the budget and time frame of the study but also allows for simple statistical treatment. The following inclusion criteria were set. All participants should:

- Be current asylum seekers or refugees in South Africa;
- Be currently living in Johannesburg;
- Have experienced torture in their home country;
- Be 18 years or older; and,
- Come from Burundi, Democratic Republic of Congo (DRC), Ethiopia, Rwanda, Somalia, Uganda, or Zimbabwe.

These seven countries were selected as a result of them being among the ten top refugee producing countries and being conflict areas on the African continent. Angola was excluded from this list as a result of that country's civil war ending and many Angolans living in South Africa being repatriated. It was decided that the sample should represent each of these countries in roughly equal proportion. In addition, neither men nor women should comprise less than 30% of the sample. Participants who meet the above criteria were automatically included in the sample unless the quota into which they fit (based on country of origin and gender) was complete.

The sampling technique was purposive in nature and proceeded in large part by way of the "snowball" strategy. Purposive sampling requires finding participants who match the inclusion criteria as specified above. Sampling in this way enables researchers to collect data from diverse members of the population thereby mapping out as many of the different experiences and views in that population as possible. Snowball sampling involves using existing participants to identify further ones. At the end of each interview participants were asked whether they knew any other asylum seekers or refugees who might be able to assist the researchers. In this way more and more participants who met the inclusion criteria were identified as the study continued.

In fact, pulling together this sample turned out to be even more difficult than anticipated. In large part this was due to the fact that torture is largely invisible even within refugee communities and among the service providers who assist them. Although both the CBRC and appropriate service providers were able to introduce researchers to lists of refugees, they were unable to identify many who had been tortured. This is not because the number of tortured refugees is insignificant, but because torture survivors prefer to keep their torture experiences secret. Community organisations collude with this by not asking important questions which might enable them to better understand and address the needs of their intended beneficiaries. This silence and collusion remains one of the major obstacles to understanding and advocating for torture survivors' needs and rights.

Instrument

Data was collected through private individual interviews that included both highly structured and semi structured items. The interview protocol was structured around six separate sections as detailed below.

Section 1: Informed Consent Form

This section provided prospective participants with detailed information about the aims and methodology of the project and informed them of their rights in respect of the research. Based on this participants were asked to sign the informed consent form.

Section 2: Participants' Demographic Data

This was a highly structured section that included information relating to participants' country of origin, gender, age, legal status in South Africa, home language, ethnic and religious identity, marital status, children, current living conditions, as well as income in South Africa.

Section 3: Participant's narrative

This section included a range of open-ended questions that explored details of participants' lives before coming to South Africa, the reasons for and nature of their torture experiences, their journey to South Africa, their current living conditions in Johannesburg, as well as their experiences of the asylum seeking process and health services in South Africa. This section also looked at sources of support in South Africa.

Section 4: Expressed Needs and Recommendations

In this semi-structured section participants were invited to list their current needs and to offer recommendations on how services to asylum seekers and torture survivors might be improved in South Africa.

Section 5: Recontact information

In this section participants were asked whether the researchers could stay in touch with them, and if so they were asked to provide contact information to enable this.

Section 6: Interviewer information and remarks

In this section, the interviewers were asked to comment on the length and tone of the interview. This section was completed when the interviewee was no longer present.

The complete instrument is included as Appendix B of this report.

Personnel selection and training

Because of the large number of languages spoken by participants from the various countries targeted in this study, a larger number of interviewers, translators and transcribers was needed that would usually be used in a study of this size. Ten interviewers were responsible for data collection. This group comprised three Burundians, one Rwandan, one Kenyan, two people from the DRC, one Somalian and two South Africans.

The selected interviewers were trained in an intensive five day workshop by senior personnel of the CSV. This workshop introduced the interviewers to the concepts of torture and traumatic stress. Interviewees were trained in interview skills with vulnerable groups, the implementation of the research protocol, as well as the sensitive ethical issues involved in this study.

Data collection

Once a potential participant had been identified, he or she was contacted by the lead researcher who explained the nature and purpose of the study. If the person agreed to participate in the study they were asked which language they would prefer to use. The lead researcher then assigned an appropriate interviewer to meet and interview the person. Interviews were conducted in English, French, Kinyarwanda, Kirundi, Kiswahili, Lingala, Somali, and isiZulu.

Due to the sensitive nature of this material, interviews were conducted in a place and at a time convenient to the participant. As far as possible, interviews were conducted in private although in some cases participants requested that a family member or close friend sit in on the interview. This was allowed.

The interviewers began by introducing themselves and then explaining the nature of the study and people's rights as research subjects. Any questions that the participant might have were answered in detail. Participants were then asked to sign the consent form. Thereafter the interviewer took the participant through the demographic section of the interview. Following this the interviewer asked permission to bring recording. When permission was granted the tape recorder was switched on and the participant's narrative was recorded with prompting from the interviewer. Respondents were not asked to say their names on the tape. The section on recommendations for the improvement of services was also recorded.

At the end of the interview respondents were reimbursed for any transport costs that they may have sustained and were also given an honorarium.

Interviewers completed the final section reviewing the interview process once they were no longer in the company of the participant.

Tape recordings were translated into English and transcribed verbatim for further analysis. This proved to be an extremely difficult task for many reasons. These included: poor audio quality on some recordings, poor translation by some interpreters, poor transcription by some transcribers,

and poor quality control due to the fact that supervisors were not available who spoke all the necessary languages. As a result of these difficulties some data in the interview section of the study was lost.

Data Analysis

Case studies: The methods of data analysis discussed below aggregate information from all the individuals who participated in this study. While such methods provide important insight into overall trends and patterns within the sample, there is a danger that the human stories from which these findings are drawn may be lost. For this reason two case studies are presented at the beginning of the results chapter. The selected case studies are neither the most brutal, nor the most sanitized. The individuals' experiences of health services are neither the most difficult nor the best in the sample. Names and other information that might potentially result in the particular respondents being recognized have been changed.

Thematic content analysis: Participants' narratives and other unstructured items (see sections three and four of the instrument outlined above and included in the appendix) were analyzed using thematic content analysis. Through thematic content analysis the researcher identifies common themes and sub-themes emerging in the data and then codes the presence or absence of each theme in each transcript. It is then possible to measure the relative prevalence of each theme in the sample as a whole. Common experiences and viewpoints have high frequencies in the sample and more unusual responses have low frequencies.

Of course the results depend largely upon how the particular themes are selected and differentiated. In this analysis a hierarchy of themes emerged from the data. In large part these were the logical outcome of the structure of the interview schedule. The thematic analysis was conducted by the primary author and an associate researcher. The associate researcher read each transcript carefully taking note of themes that were emerging regularly as well as unusual and striking aspects of the transcripts. Based on this she developed a broad structure of themes which was added to during a second reading of all the transcripts. As often happens, this stage of the analysis produced a bewildering profusion of themes and sub-themes. This structure was presented to the primary author who in consultation with the associate researcher rationalized the thematic structure into the clear and manageable arrangement presented in table 1 below.

Table 1: Content Analysis: Thematic Structure

<i>Participants' general narratives</i>		
Life in country of origin	Quality of life relative to life in SA today	Better About the same Worse
	Reasons for being better	Relative security Relative prosperity Family integrity
	Reasons for being worse	Poverty War / persecution Family problems

Decision to leave country of origin	Events leading up to decision to leave	War Persecution Death of loved ones
	Planning to reach SA	Arrived in SA by chance Following family or friends Stepping stone to other countries SA protects refugees
	Leaving family behind	Leaving family behind
Journey to South Africa	Length of journey	Number of months Temporary settlements in other countries
	Countries passed through	Number of countries Which countries
	Hardships on journey	Attack and robbery Arrest and imprisonment Hunger / Exhaustion
	Means of travel	Foot Taxi / Bus / truck Aeroplane / ship / train
	Travel companions	Alone Family members and/or close friends Strangers
Arrival in South Africa	Port of entry	Unknown Specific ports
	Initial contacts	Officials Strangers Family / Friend Countrymen
	Initial experiences	Lost and lonely Immediate arrest Met by others Accessed help swiftly
Current life in South Africa	General comparison with previous life	Easier Harder
	Family structure	Living with spouse Children in care Children in country
	Housing situation	Living in other people's homes Own or rent own place Temporary shelters
	Economic and employment situation	Nature of income generation Difficulties earning a living

<i>Experiences and impact of torture</i>		
Experiences of torture	Perceived motives for torture	Punishment for political opposition Needed information about individuals Needed information about groups Ethnic / religious persecution Punished as "informer" Punished for alleged criminal activities Sexual pleasure
	Descriptions of torture	Descriptions of torture

Impact of torture	Physical	No lasting physical impact General ill health Pain from torture related wounds Disability Chronic headaches General body pain
	Psychological	No lasting psychological impact Intrusive symptoms Depressive symptoms Hyper arousal symptoms Dissociative symptoms Avoidance symptoms
	Social	No lasting social impact Inability to trust other people generally Inability to trust opposite sex Functioning in intimate relations

<i>Community resources that have assisted coping</i>		
Sources of support	Availability and reliability	Family Refugee community Service providers Religious community Refugee community leaders Religious leaders Neighbours

<i>Experiences of health services in South Africa</i>		
Usage	Have never used	Have never used
	Have used	Institution attended Public or private
	Reasons for seeking health care	General ailments General ailments of children Surgery Giving birth Torture specific assistance
Access	Difficulties in access	Language difficulties Waiting time Cost of care
	Denied access	Xenophobia / prejudice No money No papers
Evaluation	Of health services	Positive Negative
	Reasons for evaluation of health services	Available services Standards of facilities Availability of medication
	Of health service personnel	Positive Negative
	Reasons for evaluation of health service personnel	Xenophobia / prejudice Generally uncaring

<i>Experiences of asylum seeking process</i>		
General experience	Overall evaluation	Positive Negative
Time frames	Asylum seeker application and permit	Time taken
	Status determination decision	Time taken
Problems	Reasons for negative evaluations	Long queues / waiting lists Being sent away repeatedly Lack of information Lack of facilities Incompetence among personnel High costs of process Language difficulties Corruption Discrimination
Impact on access to health services	Experienced impact	No impact Lack of refugee status limits access

<i>Current needs</i>		
General needs	General needs	Shelter / accommodation Status determination Employment Health services Food Education Basic financial support Counselling Assistance with relocation
Specific needs	Specific health needs	Care of torture related injuries Chronic health conditions Surgery Resources to secure future health care if needed
	Specific mental health needs	Trauma therapy Supportive counselling Parenting support
	Specific legal needs	Support with status determination Assistance to deal with incidents that had happened in SA Protection of refugee rights

The presence or absence of each of these themes was recorded in each of the transcripts. Verbatim quotes that typify each theme are presented in the results chapter as illustration of the content of each them and to ensure the authentic presence of refugees' voices within the report.

Statistical treatment: The results of the structured items and thematic content analysis were coded and entered into a spreadsheet. The completed spreadsheet was then imported into the *Statistical Package for the Social Sciences* (SPSS) version 10.1 for basic statistical analysis. The sampling method employed in this study does not ensure a representative sample. For this reason the analysis is limited to descriptive statistics (frequencies, means, modes, medians, ranges, and standard deviations) for each of the variables. These are presented in tabular and graphic form as appropriate in the following chapter.

Both the extreme sensitivity of the material being discussed as well as the enormous logistical challenges of collecting data (interviewing, translating and transcribing) in many different languages resulted in high levels of missing data in the overall data set. This presents some challenges for analysis. Valid sample sizes for each section of the analysis are included in the

results so that the reader is at all times clear of the nature of the group from which conclusions are being drawn. Although these descriptive results are suggestive of patterns in the general population of tortured exiles, they must be read with caution.

Ethical considerations

The nature of this study is such that ethical considerations are of paramount importance. Artz and Themba Lesizwe (2005) discuss in detail the ethics of research with victims of violence and other vulnerable groups.

Voluntary participation and informed consent was ensured through detailed explanation of the study before each interview and participants were ensured that they could stop their participation at any time. Written consent forms were signed by all participants. In two interviews the interviewees became visibly distressed and the interviewer suggested stopping the interview. In both cases participants chose to continue, reflecting some torture survivors' strong desire to tell their stories even though the telling is painful.

Although the nature of the data collection process (face to face interviews) prevents the possibility of anonymity, interviewees were ensured of confidentiality. Only research staff had access to the tapes, transcriptions and data files.

In order to prevent harm to people through participation in the research, all participants had access to free and specialized counselling through the social workers and psychologists of the Victim Empowerment Programme (VEP) of the CSV. Participants could also access other services on a referral basis through CSV. Several participants did take up the offers of counselling and referral.

An initial feedback session was held with the CBRC to which all participants and interviewers were individually invited. Thirty participants attended this meeting and the researchers shared the preliminary findings with the group. Study participants asked many questions about the findings and communicated their appreciation for the work and the feedback to themselves. They asked for access to the final report upon completion. Such access has been arranged and the executive summary will be translated into French and KiSwahilil and sent to each participant.

The creation of false expectations is a potential problem with very marginalized and poor communities. In this case the researchers were concerned that asking detailed questions about torture survivors' health needs would lead to unrealistic expectations that surgical procedures and other forms of health care would be organised and paid for by the study. In fact, the feedback session revealed that the study had not created such expectations. Only one participant argued that the researchers should respond to his health concerns, and he was reminded by other participants that this not what had been promised.

CHAPTER 3 RESULTS AND ANALYSIS

Description of the sample

Once the data had been sorted and checked, a total of 77 people were included in the final sample. Of this group, 48 (62%) are male and 29 (38%) female. In line with the study design, participants came from seven different countries on the African continent in the following proportions.

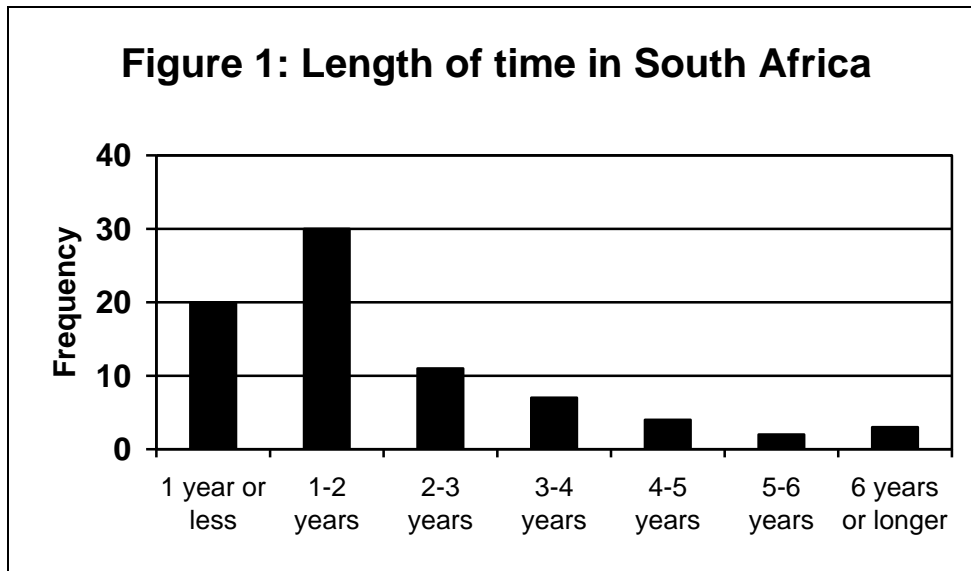
Country	Men	Women	Total (%)
Burundi	7	8	15 (19.5)
Democratic Republic of Congo	6	5	12 (15.5)
Ethiopia	3	1	4 (5.2)
Rwanda	5	6	11 (14.3)
Somalia	10	0	10 (13.0)
Uganda	10	7	17 (22.1)
Zimbabwe	7	2	8 (10.4)
Total	48	29	77 (100)

While for countries like Burundi, DRC, Rwanda and Uganda the gender distribution is fairly balanced, in the remainder of the countries women are underrepresented. The Somalian group is comprised only of men, a result most likely arising from the particularly rigid gender role differentiation in Somali culture and society.

Legal status under South African law is of central importance since it determines people's eligibility for a range of services in South Africa. As can be seen from Table 3 below, the vast majority of participants are still going through the process of status determination. The reasons for this are discussed in greater detail below. However, it is likely that this will influence the way participants present themselves in this study, something that should be kept in mind while interpreting these results.

Legal Status	Frequency	Percentage
Undocumented (illegal immigrant)	8	10.4
Asylum seeker (temporary documentation)	62	80.5
Refugee status	6	7.8
Resident	1	1.3
Total	77	100.0

With respect to the length of time that they had been in South Africa, respondents ranged from 3 months to 6 years and 6 months. More than 80% of the sample have been in the country for between 1 and 3 years, with the modal time in South Africa being 18 months. The following chart illustrates this distribution more clearly.



There are clear differences in the length of time that people from different countries of origin have been in South Africa. People from Somalia, Ethiopia and Rwanda have been in the country the longest. People from Zimbabwe and Uganda are more likely to be recent arrivals.

Case study 1:

Cécile

To understand me properly you need to understand something about my past. I was born in Kigali, Rwanda to Tutsi parents. When I was a child there was a lot of ethnic tension and conflict in my country and my parents had become involved in the problems in our community. Although I didn't really understand what it meant at the time, I knew it was a very bad thing when my mother and father were called traitors in public. I remember how upset and frightened they were. Once when I was still small they were arrested and my brother and I had to stay at our aunt's house for a few days. When they came back we never spoke about what had happened in prison but we were always afraid of police and soldiers. We knew bad things had happened but we didn't know what.

While I was in secondary school my father passed away and my mother was getting very old. My older brother was supporting the family. When I finished secondary school and got a good job in a large international company and was able to start contributing to the family. I was fortunate because thanks to my parents I speak good French and some English, as well as my native Kinyaranda. This helped me get my job.

During this time my older brother had become very involved in politics. When things got difficult for him he was forced to leave the country. We stayed behind but the authorities thought he would try to make contact with us and so they kept my mother and I under constant surveillance, often asking other people on the street about us. I think it must have been very difficult for my mother.

One night shortly after my twenty second birthday, soldiers broke down the door to our house while we were sleeping. The sudden noise gave me a terrible fright. To this day I often wake up in the middle of the night thinking that those soldiers are bursting in on me again. They pulled me from my bed in my night clothes and took me away from the house. It was nearly a week before my mother and friends were able to find out where they had taken me.

They drove me to a prison outside of town and started to ask me questions about my brother. I told them that I didn't know where he was. They said that they knew that it was me that had helped him leave the country. This wasn't true at all. In fact we were very

hurt when we discovered that he had left the country without a word to any of us. Looking back I know why he left like that, but I didn't understand at the time. To this day I don't know where he is or even if he is alive.

When I couldn't answer their questions they would punch me in the face and in the stomach. Once they held my head under the water. I was screaming and struggling but they wouldn't let me go. I thought they were trying to kill me. At night they put me in a cold cell which had water on the floor nearly up to my knees. I was freezing cold and couldn't lie down. I wasn't given anything to eat and wasn't allowed to see anybody. It was a terrible time for me.

When they realized that I couldn't tell them where my brother was, they released me. After I came out from prison I couldn't see properly. Something was wrong with my brain and my eyes, but after a time that got better. Still today I get terrible headaches that make me sick. When the headaches come my vision gets blurred and I have to sleep for several days before I recover.

Once I was released I knew that I had to get away from Rwanda. I had friends in South Africa and hoped that I would be able to make a safe life with them here. I traveled by car and bus through Tanzania, Malawi and Mozambique. I had very little money and so I only ate a little bit each day so that it would last until I got to safety. The journey took nearly six weeks and although nothing terrible happened I was very tired and hungry for all of that time.

I arrived in Johannesburg in March 2003. Unfortunately I have not been able to find my friends so have been forced to struggle to make a life for myself here. When I first arrived I knew nobody but a person on the street showed me to a shelter run by a white lady. I stayed there for three weeks but after that they threw me out and told me that I have to find some other way to survive. I tried to sell some vegetables on the street.

At that time I was also going to the Home Affairs office every day to get my papers. I queued every day for a month. Each day they would only take one or two people and the rest of us were turned away. They would never give us any reason or tell us why they could not help us. Eventually I was given my temporary papers which was an enormous relief. For the last three years I have gone back every three months to stand in the queues and have my papers renewed. I have given up hope of ever getting proper refugee papers but at least with the temporary papers I don't think I will be arrested and sent back to Rwanda.

Through some other Rwandans that I have spent time with here I met my husband. Things are much better with him. We found a room to rent in another person's home and we are both selling stuff on the streets. Together we earn around R1,000 per month which pays for our rent and food. We also go to church and sometimes the people there help us with food too. Since meeting my husband and having our own place to stay I have started to feel safe now in South Africa.

In 2004 I discovered that I was pregnant. For the first six months everything was fine but after that I started having bad pains. I didn't have anyone to talk to about this problem except for my friends at church. They told me that the last months are always difficult and so I didn't go to the hospital or to a doctor. I would just close my eyes and lie still until the pain passed. But when it came time for my baby to be born the pain became unbearable. I remember I was screaming and crying for people to help me.

My husband took me to the general hospital. They said we must pay R1,800 because we were not from South Africa. My husband showed them my papers but they said that those papers were not the right ones and that we had to pay. We had nowhere else to go but had no money to pay them. Eventually they said that no we must pay half now and then the rest after the baby was born. That was still so much money for us. We gave the hospital all the money we had which was R200. Then they helped me and delivered my baby and then everything was ok.

After a few weeks I needed to go back to the hospital to have the stitches removed. When I went back they said they would not help me because I had not paid the rest of the money that I owed. I left the hospital not know what I was going to do. Some people from church got a private doctor to help me by removing those stitches. He was very kind to me.

Anyway, today I am much better. But I am scared of getting ill because I cannot go back to the hospital. They will tell me that I still owe them money. I think the medicines and doctors are very good but they don't want to help us and treat us badly.

So today I am 25 years old and living with my husband and one year old son. I speak to my mother sometimes on the telephone. She is getting very old and is all alone now. I sometimes don't know what to say to her.

Case study 2:

Kabika

Five years ago I was living in Kinshasa and had a good job and a nice home. I was living with my wife and four children, as well as some of my cousins and in-laws. We were not wealthy but I was able to support the whole family. I had also had a small trading business which family members helped out in which supplemented my salary. For the most part we had what we needed.

I worked for a non-government organization concerned with torture in prisons. I always knew that there were dangers in getting involved in human rights work but I never really believed it would destroy me and my family like it has. My job was to visit prisons and document prisoners' complaints about prison conditions and the treatment of prisoners. I had been doing this work for several years and although the authorities were always suspicious of us they had mostly left us alone.

One of the prisoners I spoke to had been a senior government official who had been sent to prison for treason. He was under suspicion for being involved in a plot to assassinate the president. He claimed to be innocent but asked that I go to his home to tell his family how he was doing. There is no law against that and so I did as he asked. I went to the address that he gave me but when I got there nobody was home. As I came walking out of the house I was stopped on the street by two officers. They arrested me at gunpoint and took me to the police station. There I was searched and my identify documents were taken away. For the rest of that day and night the police asked me questions about why I was visiting that house. I told them the truth over and over again but they did not believe me.

That night I spent the night in the police cells. Nobody had told my family where I was but I was still confident that in the morning I would be released and that everything would be alright.

However, in the morning I was transferred to a prison outside of the city which was run by the army. There I was questioned by the head of internal affairs who wanted to know why I had been brought there. I told him the same things that I had told the police the day before. He said that the police would not have brought me to him unless I had done something wrong. There was nothing I could say that would make him believe me.

I stayed in that prison for several weeks. During that time I was questioned and tortured nearly every day. During questioning they would beat me and hold my head under water until I was almost drowned. At night I slept in a tiny cell which was very cold and I was given very little food or water. After a few days I was sure that I was going to die there. It was a terrible time which I still prefer not to talk about.

When I was released I knew that I needed to leave DRC. I took my wife and my youngest children who were not yet schooling and we went first to Zambia and then to

Mozambique. In those countries we were not safe because there are agents from DRC in both. We had to come to South Africa where there are laws to protect refugees.

When we first came to South Africa four years ago we met up with another man from Congo who took us to home affairs and helped us get our asylum seekers' permits. He also took us to an organization that supports refugees and they supported us for the first three months. After that though we were on our own. I have managed to start a small business and earn about R1,000-00 or R1,5000-00 per month. Every few months we have to go back to home affairs in order to have our permits renewed. It is a long and difficult process. I have had two interviews and eight months ago refugee status was denied. They were going to send us back to DRC. I went to the human rights lawyers and we appealed and we won. But still today my status has not been determined. I have given up hope that I will ever receive my refugee papers.

Over the past few years my family has used South African health services on several occasions. When I have had small problems like headaches and coughs I have gone to the clinics and they have given me medicine which helped. However, my torture has left me with some problems. I cannot stand for long periods and often have very bad pains in my back and legs. When I try to explain this they give me headache pills which don't help at all.

My son needs to have a small operation. The people at the clinic referred him to the general hospital. At the hospital they told me that because I am a foreigner I have to pay R2,800-00. I showed them my asylum seeker papers which they accepted but said that asylum seekers still have to pay. I cannot afford that at the moment and so my son has not been able to have the procedure.

When my daughter got sick we went to the hospital and the nurses were very ugly. They said that foreigners like us were bringing sicknesses from our country into South Africa. That is so stupid since we have been here for years. Also language is a problem. I can speak some English and if the nurses were patient we could understand each other. But because I am foreign they do not try to understand. It is easier for them just to say that they don't understand and push us away.

Today my life is so different to what it used to be. I have only my wife and two children with me. The oldest of these children should be in school but he is not. I can barely make enough money to shelter and feed my family and I don't know when they are going to send me back to DRC. It could be any day and that makes me very afraid. Also I am worried about my family in Kinshasa. Without me to support them they must be struggling very badly. It is very hard to live like this.

Expressed needs of tortured exiles

Before focusing on health needs specifically, respondents were asked about their most pressing needs in general. The 77 people participating in the study produced a set of 109 responses to questions about their needs. These are listed in order of frequency in table 15 below.

Area of need	Responses	Percentage
Shelter / accommodation	26	33.8
Documentation confirming refugee status	19	24.7
Employment	17	22.1
Medical Assistance / Health care	12	15.6
Food	10	13.0
Education	9	11.7
Financial support to meet basic needs	8	10.4
Counselling	7	9.1
Assistance relocating to other country	1	1.3

The number of times that different areas of need are mentioned provides some approximation of how important that need is to the refugee population in Johannesburg. Of course for some people, health needs were the most pressing, and for many they were not mentioned at all. In general the need for medical attention was ranked fourth, with the need for counselling falling in eighth position.

While the above list was generated spontaneously in response to general questions about participants' most important and pressing needs, much higher levels of need were reported when participants were asked about specific areas of need. Participants were asked specifically if they had health care needs, mental health care needs, and legal needs. The following table details the percentage of participants who said yes to each of these specific questions.

Area of need	Responses	Percentage
Health care	50	64.9
Mental health care / counselling	51	66.2
Legal assistance	39	50.6

When asked for more specific information under each of these three broad categories, respondents provided the following details. With respect to health needs, 42 participants listed specific health needs. Of these 19 (45%) required health care for injuries sustained during torture, although only one had actually sought treatment for these injuries. Fifteen people (36%) wanted assistance with more general health problems. These problems included chronic health conditions such as blood pressure problems and diabetes, as well as care for bouts of influenza, toothache or chronic headaches. The remaining responses included three people who were in need of surgery, one person who needed assistance for a sick child, and four people who were anxious to find sufficient resources so that they could access health care in future should the need arise.

With respect to mental health needs 46 people provided more detail of their needs. Of these, 39 (85%) said that they needed assistance to deal with traumatic experiences in the past. Four people (9%) asked for assistance in coping with their children, and the remaining three people (6%) wanted counselling assistance to help them sort out the practicalities of their new life in South Africa, specifically accommodation and employment.

Finally, in regard to legal assistance, 34 people provided more details of their needs. As expected, the majority (26 people, 76.5% of those who answered this question) wanted assistance towards being recognized officially as refugees. Four people (12%) needed legal advice relating to specific incidents that had occurred since they had arrived in South Africa. The remaining twelve percent comprised one person each wanting assistance to locate children, better understanding of refugees' rights, to secure access to housing and education, and to increase personal safety.

Another area of need which emerged in a number of the stories told by respondents is the need for greater security. In total, 39 respondents expressed some concern about their safety in Johannesburg. Of these, 11 (28%) had been victims of violent crime, 7 (18%) spoke of fears of being arrested, 6 (15%) described xenophobic reactions on the part of South Africans and 6 (15%) felt that they had been trailed by informants. A further 9 (23%) pointed out that their lack of documentation and shelter made them especially vulnerable to crime and exploitation.

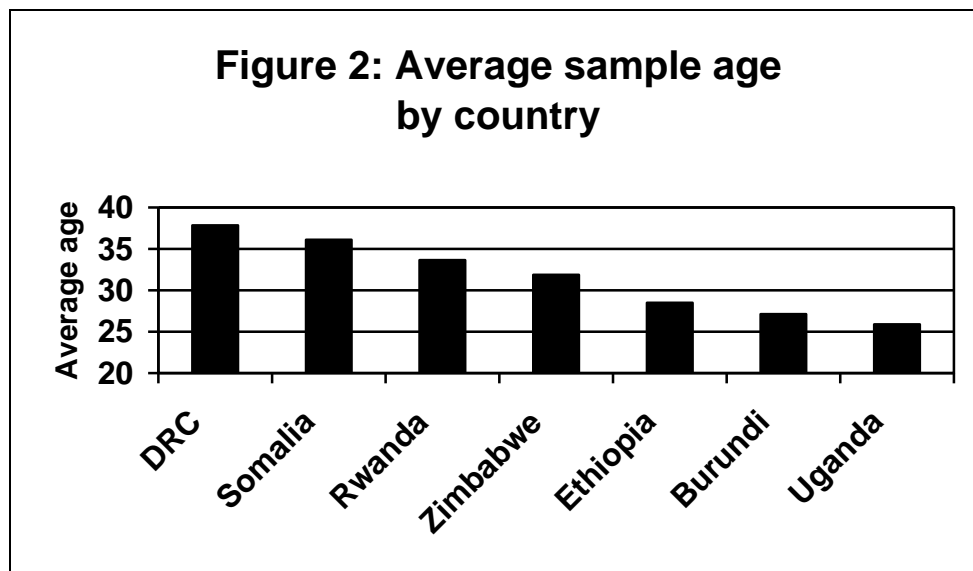
There is no security in this country because the population do not like refugees and refugees do not have security. If you have a problem and you go to the police they will tell you they do not deal with the refugees' case.

Female, Rwanda, 48

Demographic details such as the age, ethnicity, language, marital state, and responsibility for dependents are also important aspects of a comprehensive assessment. Each of these dimensions is explored in greater detail in the following sections.

Demographic information:

Health needs are in part predicted by the client's age and life stage. The youngest person included in this sample is 19 years old and the oldest is 53. The average age is approximately 31 years (standard deviation is slightly over 7 years). It is interesting to note that the mean age differences between people who have originated in different countries. Figure 1 illustrates the average ages for the different countries represented in the sample.



Social networks represent an important aspect of emotional health and also contribute greatly to access to health services. Common social networks are organised around language groups, ethnic identification, and faith groups.

A total of 24 different home languages are spoken by study participants. Of these the most common were Kinyarwanda (11), Somali, (10), Kirundi (9), Swahili (8), Luganda (7), Ndebele (6), Tshiluba (5) Ahmaric (4), and Lusoga (2). Shona, Kikongo, French, Xhosa, Mashi, Kikasai, Longugo, Lingala, Ruyoro, Lukinga, Runtoro, Choli, Kinyankole, Lomgo and Ruganda are each spoken by a single participant.

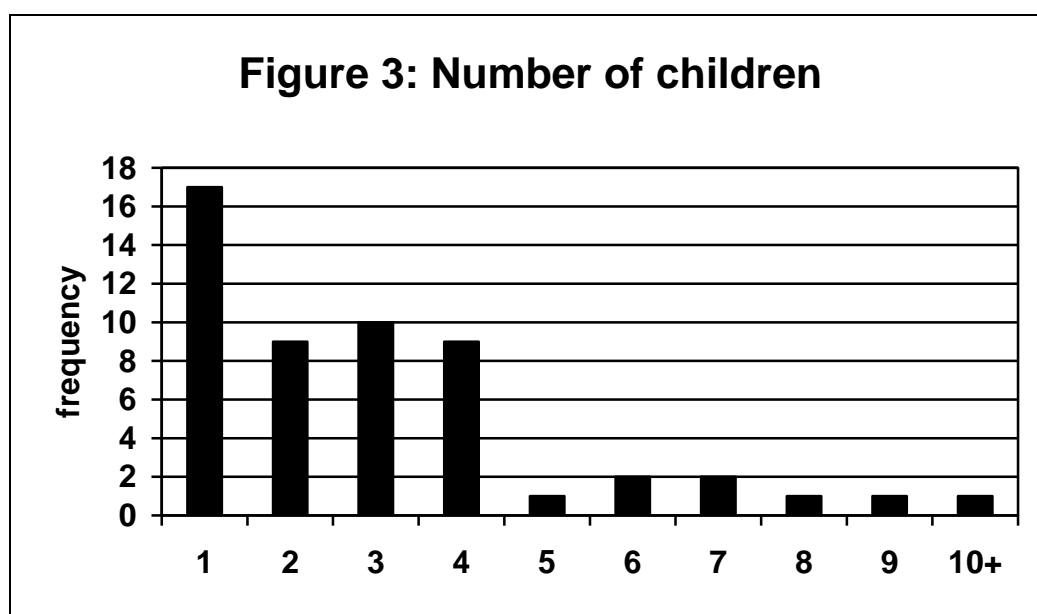
Questions about ethnicity produced a similarly large array of categories not helped by the fact that 18 people (nearly a quarter of the sample) describe themselves as “Bantu”, a collective noun used to describe several hundred different cultural and linguistic groups spread across most of the continent. Five participants describe themselves as being of “mixed” ethnicity. Other responses in order of prevalence include Hutu (10), Tutsi (9), Ndebele (5), Luba (4), Tigrie (3), Baganda (3), Acholi (2), Amhara (2), Luluwa (2). Mukongo, Karanga, Twa, Sotho, Tunni,

Xhosa, Kasai, Logungo, Bashilakasanga, Opala, Yaka, Mukinga, Musoga, and Melange are all represented by a single person.

With respect to religious belief, the vast majority of participants identify themselves as either Christian (46 people making up approximately 60% of the sample) or Muslim (30 people or 39% of the sample). One person identifies himself as a non-believer. It is interesting to note that not a single person in this sample describes themselves as primarily following a traditional African religion. As expected, different religions have different prevalence in different countries. The sample from Somalia is entirely Muslim, the samples from Zimbabwe, Ethiopia and DRC are entirely Christian, and the samples from Rwanda, Burundi and Uganda are mixed.

For many people the greatest social support is provided by a spouse or partner. Approximately half the sample is single (35 people or 45.5% of the sample) with the other half being married (36 people or 47% of the sample), or in a long-term, steady relationship (3 people or 4% of the sample). A further 3 people (4%) are widowed.

Although children are a great source of comfort for many people, the need to provide for and protect dependents may also be a heavy burden. Nearly 70% of the sample have one or more children. There is no difference between the proportion of men and women with children, but as expected people with children are older (mean age of 33 years 6 months) than people without children (mean age of 26 years). Although participants were not asked the ages of their children, the ages of the parents suggests that the majority of children must be teenagers and younger. Young children have many and specific health needs which must also be taken into consideration in a discussion of health service provision to this group. The following chart presents a distribution of the number of children that participants with children have.



During the interviews researchers probed needs resulting from the respondent being exiled and those resulting directly from experiences of torture. For the greatest part respondents were unable to distinguish between the two in any useful way, and the lists of needs generated were virtually identical. This highlights the extent to which participants in this study view their torture and exile as inseparable. In fact when assisting exiled torture victims, service providers should conduct an assessment across multiple dimensions which take into account the actual experiences of torture,

possible injuries, traumatic events and stressors sustained during the journey into exile, as well as experiences and living conditions as an exile in South Africa.

Exiles' stories

Exiles' life stories represent a great diversity of experience. The common themes that emerge from these stories are described in this section. These themes are presented in the order dictated by the overarching narrative itself: memories of life in their home country, events leading up to the decision to leave, memories of the journey to South Africa, memories of arrival in South Africa, and general reflections upon life in their adopted country today.

Life before coming to South Africa

Inevitably, exiles compare their life in South Africa today with the life that they left behind in their country of origin. Drastic changes in life circumstance is itself a significant stress factor. Sixty three participants (82% of the sample) shared their memories of life before coming to South Africa. Not unexpectedly there were important differences in the ratings of previous quality of life depending upon participants' country of origin. People from Rwanda were most likely to comment that life had been good before the events that caused them to leave their home, while people from Uganda were most likely to say that their previous quality of life was low. This finding highlights the very different historical contexts of these two countries.

Nevertheless, the majority (62% of those that answered this question) shared fond memories of healthy and secure lives lived with the support of loving family and community.

I was brought up in a very well to do family. My father was an economist and during those days such people were well respected in their society. ... I was staying with my family until when I left school and only left them when I was grown up and had my own place. ... [I was] surrounded by friends. As you can see, cultures are quite different. For us back home, we were very hospitable. We welcomed and accommodated each other. You will realise that once you get a place to stay, it's not a place for you alone, but also for your friends and relatives, brothers and sisters.

Male, Rwanda, 41

Before I came to South Africa my life was very good. At home I was living with my family without any problem. ... I was buying everything by myself. Now I cannot do anything.

Female, Burundi, 33

Those that said that their previous lives were good attributed this to several different causes: being economically self-sufficient and being able to provide for one's family (60%), being able to attend school (26%), and being with one's family (14%).

A smaller group of exiles (38%) described their lives before coming to South Africa as being very difficult. For many of these, their entire early lives were bound up in the poverty, insecurity, and fragmentation of family and community which are the inevitable results of ongoing political and ethnic conflict.

Me, I was taught like that to be a farmer. It was hard. That is why I ran away to go to the capital city of Uganda, Kampala. I got friends who taught me how to get money to start to buy things to sell on the streets to survive.

Male, Uganda, 27

You see my family is not good. If my family is good I would not come to South Africa. Just I come in to change my life, you see. It is difficult to change my life. ... You see I sell in the street in the sun, there is no water and I am getting nothing.

Female, Ethiopia, 21

Unfortunately my parents died when I was still young – I don't have parents, I don't have a sister. So I grew up with my uncles and aunties. ... When they joined politics is when we started getting some problems. Our grandfather was too much into politics.

Male, Uganda, 28

Those that said that their previous lives had not been good attributed this to: being very poor (46%), having lost family members in conflicts and violence (30%) and living under circumstances of war (13%). Conflict within the family, being in jail, and putting others at risk were also mentioned.

Participants' memories of their previous lives serve as the historical backdrop against which their current expectations, circumstances and ambitions are viewed. They set the context in which their experiences of torture are given meaning, and their lives and treatment in South Africa are evaluated.

Events leading up to the decision to leave

At some point each of the people who shared their stories made a decision to leave their country of origin. In some cases this decision was taken over time and people were able to prepare for and plan their departure. For others, the necessity of leaving overtook their lives extremely precipitously and had they not moved when they did it is very likely that they would have died.

The level of secrecy and threat around the decision to leave the country of origin is still high for some exiles. As a result, only 53 people (69% of the total sample) spoke freely about events leading up to their departure. Of these, 39 (74%) described themselves as being uninvolved bystanders of conflicts which overwhelmed their communities and families.

I was accompanying my mother to buy goods. We are confronted by soldiers or rebels. I don't know which because they both wear the same camouflage and they act the same. They stopped the bus and ordered everybody out. They searched us and told us to give them everything. One passenger was shot in the leg.

Male, Uganda, 28

Fourteen people (26% of those who answered this question) spoke about their own political or military involvement and how that led to their decision to leave their home country. Nine respondents reported that they were members of an opposition party, three said they were soldiers and two identified themselves as rebels. It is worth noting that two of the three who identified themselves as soldiers said that they were forced to join the military.

In our country when you are in the opposition party you are the enemy of the government. ... The government was hunting and torturing those in the opposition.

Female, Uganda, 24

Somebody will tell you to go and massacre people somewhere ... this is a multi-story building there were you find very undisciplined people. Go there and kill everybody you find there. That is a very bad act, for you to kill a whole population, that is very bad. ... [If] you refuse then you have not executed god's orders ... there are some negative orders that you cannot execute. That is how it is. They will torture you.

Male, DRC, 42

I saw all the bodies of those people who were burned like chickens. It was very bad for me. ... the army was fucked up ... I was beaten up to death ... my back was broken. I joined the military in Rwanda ... to be a rebel. Otherwise there is nothing you can do. ... I couldn't even fight because my back was fucked up.

Male, Burundi, 34

In all cases the circumstances leading up to each person's decision to leave their home country are critical to the status determination process and final decision. Each of the people who shared their story was tortured during the events leading up to their decision to leave their country of origin and travel to South Africa. These experiences are documented in greater detail in a later section.

Journey from country of origin to South Africa

Four out of five of the participants in this study left their home country with the clear intention of seeking asylum in South Africa. The most commonly expressed reason (46% of these) for this was that they had heard that South Africa is a "free country" in which their human rights would be protected.

... we did know that South Africa is a free country now. At least the security is good, there are no wars as in Uganda. We have so many wars it is not easy to live.

Female, Uganda, 27

Smaller groups came to South Africa following family (21%) and friends (10%) who had made the journey before them and whom they were planning on joining up with upon arrival. One person selected South Africa specifically because it is a country in which most people speak English.

Most of the time I have heard that in South Africa refugees get assistance and if I go there, there is a lot of opportunities to travel to other countries where you can get a help if life is complicated.

Female, Burundi, 25

A few of those who did not intend to settle in South Africa had wanted to travel on (typically to the United Kingdom or United States of America) but had got stuck in South Africa. Others described themselves as having nowhere else left to go. These people had often travelled through several other countries, settling in each for a few months before being forced to move on again.

I travelled by lorry from Mogadishu to the Kenyan border ... I stayed six months in Nairobi because I had no clear destination ... [and I was] in Tanzania six months because I had no money to decide my travel

Male, Somalia, 30

One of the most traumatizing experiences of fleeing into exile is having to leave family members behind. Such experiences are even more intolerable when those being left behind are children. The following comments from two fathers illustrate the this:

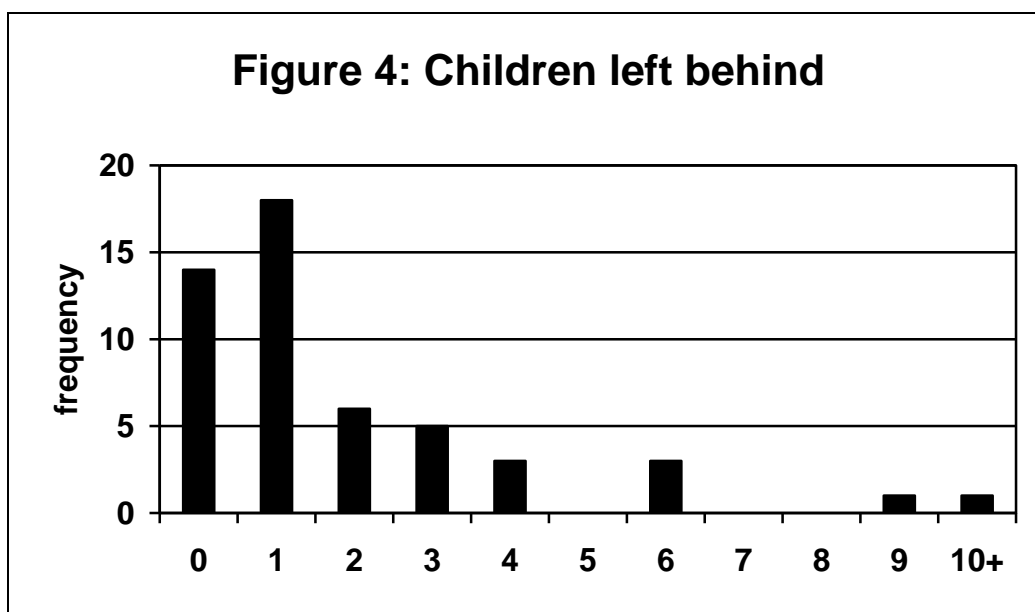
We had to flee and lost each other, and I ran away in order to escape the killing and problems. I don't know where the rest of my family are at the moment!

Male, Somalia, 31

I would have preferred to die. One of the four children was left behind. She was studying. That was a mistake. It was a mistake! So it is very hurtful when I think of it.

Male, DRC, 39

From the data it is possible to estimate the number of children that this group of parents have been forced to leave behind. More than 70% of parents in the sample have been forced to leave at least one child behind. Given the parents' age the vast majority of these children are teenagers or younger.



Regardless of their intention to seek asylum in South Africa specifically, many refugees and asylum seekers have endured long and difficult journeys on their way to this country. A total of 51 participants (66% of the sample) described their journey to South Africa in detail. Each of these respondents had passed through between one and six countries on their journey. The greatest number of respondents had passed through four other countries on their way to South Africa. Countries most commonly passed through en route to South Africa are listed in order of frequency in table 4 below.

Country	Frequency	Percentage
Tanzania	36	70.6
Zambia	31	60.8
Zimbabwe	20	39.2
Kenya	19	37.3
Mozambique	17	33.3
Malawi	13	25.5
Botswana	6	11.8
Uganda	6	11.8
Angola	5	9.8
Democratic Republic of Congo	3	5.9
Namibia	2	3.9
Swaziland	1	2.0
Burundi	1	2.0

The researchers were only able to ascertain reasonably accurate travel times from 33 participants (43% of the total sample). Travel times to South Africa ranged from only a single day (in the case of several Zimbabweans) to journeys of more than three years. Those participants who took several years to reach South Africa settled temporarily in different countries along the way. While the modal time taken to reach South Africa is around two weeks, approximately 30% of the sample were on the road for a month or more.

We walked and walked without eating and even my children had no clothes. On the way somebody wanted to lodge us but they attacked him that night. ... It was very hard feeding a baby without eating.

Female, Rwanda, 41

Only 23 participants described the main means by which they came to South Africa. Of these 78% came to South Africa using some form of road transport (notably on trucks and in busses). The remaining 22% arrived by aeroplane, ship or train. Of the 37 participants who spoke about their travelling companions on the journey to South Africa, 41% travelled alone. Only 24% travelled with family members and 8% travelled with friends and other people from their own country. The remaining 27% travelled with strangers.

Of the 67 participants who spoke about their journey to South Africa, ten (15%) described traumatic experiences that took place en route. Five people described travelling without sufficient food or water, two described being robbed on the journey and two others were imprisoned on the way. Finally, one further person said that a traumatic event had happened but did not wish to speak about it to the researchers.

When we see the border we just pass around and then we don't have any food. We stayed without food for a long time. So it was a bit difficult ... I can say for one months I never eat. I just eat maybe once a day, or after two days. ... So its too hard to come here.

Male, Ethiopia, 24

In Zimbabwe, six young men pretended to offer help as I was struggling to find my way to South Africa. They mugged me. I think since I did not understand their language and am from another country that is why they treated me in that manner. I felt so confused. Did not know what to do and helpless for there was nothing I could do. I was a stranger in a foreign country.

Male, Uganda, 28

Apart from people's experiences of violence and torture leading up to their departure from their countries of origin, the journey into exile itself also contains many threats to physical and emotional health.

Entry into South Africa and experiences upon arrival

Of the total sample, 43 participants (56%) described their first contacts in South Africa. It is likely that many participants preferred not to discuss their entry into the country because they entered illegally. Of those that answered this question, only 10 people (23%) described a customs official, border guard or police officer as their first point of contact. Most people's first contacts were with South African citizens that they were meeting for the first time, although a further 10 people (23%) described meeting up with pre-arranged contacts within the country's borders.

When asked to describe their initial experiences within the country, only 22 people (29% of the total sample) gave a clear response. Virtually all of these responses are negative and describe the struggle that exiles face upon arrival. The most common responses describe the absence of any kind of official assistance or support, as well as the sense of loneliness that such treatment engenders.

So they just drop me there by Park Station now ... then I see that Vodacom and I go there. I remember I just sleep at Shell garage. In the morning just one guy is coming – I don't know now, maybe South African maybe not. I explain to him everything. He just buy for me food. After two or three days I see Ethiopian people there. And then I asked them to help me and then they give me accommodation to stay with them.

Male, Ethiopia, 24

Two mentioned experiences of xenophobia from South Africans, three mentioned language difficulties and one person mentioned being robbed upon arrival.

We have fear of robbery, especially when we remember about my brother who was killed because he was a foreigner.

Male, DRC, 43

Four people (9% of those that answered this question) described being arrested immediately after arrival in South Africa.

When I came to Beit Bridge I was caught by the police so I spent three days in Zeerust police cell and two weeks in Lindela.

Female, Uganda, 26

Experiences of life in South Africa today

Participants were asked several questions about their living conditions in South Africa today. Themes emerging under this heading include family structure, housing conditions, income and employment.

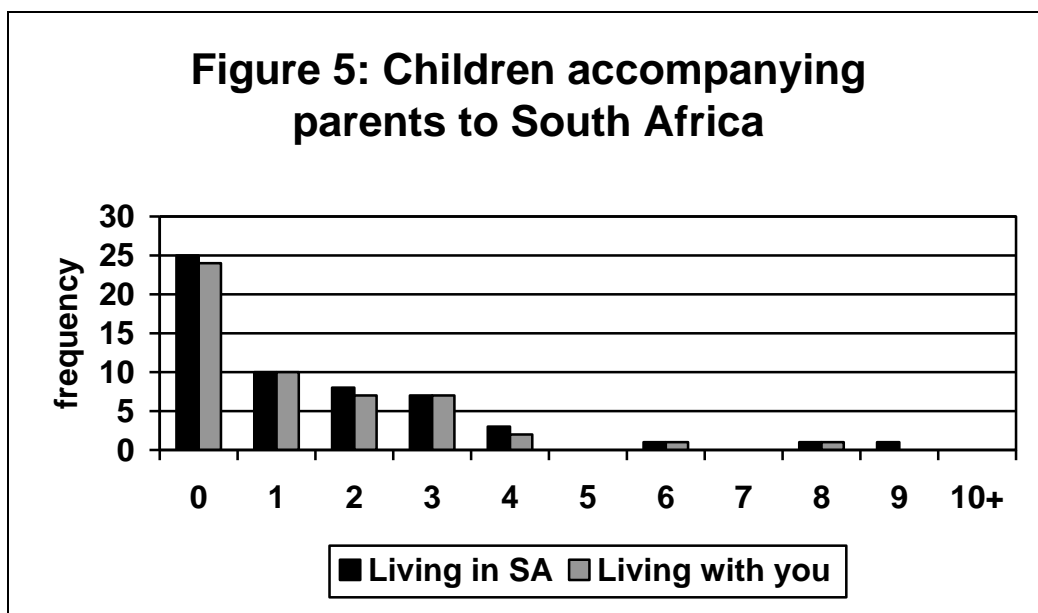
So I am okay here. I feel I am okay ... I do not have any worries around here. Because I can move, I am free to move.

Female, Uganda, 27

I must say that life was not easy back home, but in South Africa it is harder. There is no job, I am sleeping on the floor and I could not even pay the rent myself.

Female, DRC, 33

Of the 52 people who do have children, only about half of them (54%) have any of their children living with them. The following chart shows the number of children staying in South Africa and actually living with their parents in the country. This illustrates that the majority of children who come to South Africa with their parents stay in their parents' direct care. This is not surprising given the average age of these parents is only 33 years 6 months, meaning that the majority of their children are teenagers or younger.



Participants were also asked to describe their living conditions in South Africa at present. The following table lists different kinds of living space organized roughly from most secure to least secure.

Type of abode	Frequency	Percentage
House	3	3.9
Formal outbuilding on another's property	9	11.7
Apartment	21	27.3
Room in another's house	29	37.7
Hostel	2	2.6
Temporary building (shack) on another's property	1	1.3
Temporary building (shack) in informal settlement	3	3.9
Shelter	3	3.9
No fixed abode	6	7.8
Total	77	100.0

This data shows that approximately 20% of the sample are living in temporary accommodation of some kind. A disturbing percentage when one considers how long most of these people have been in the country.

In this sample, only 4 people live on their own. The majority of participants (65%) live with between one and six other people and significant number (12%) share accommodation with more than ten other people. Out of the 77 people who participated in this study, 52 (67.5%) provided details of the people with whom they live. The most common living companions were spouses, friends, children and siblings. It is worth noting, however, that almost half this group have a stranger living with them and their families. These numbers, set against the kinds of housing detailed in the previous table, demonstrate that many people who have been forced to leave their country are living in very crowded and potentially insecure conditions within South Africa.

Several questions were designed to tap respondents' sources of income. Of the 65 participants who answered these questions, 33 (51%) support themselves, while the remainder are supported by others. Only 59 participants told interviewers what their monthly family income was. These results are presented below.

Monthly income	Frequency	Percentage
Less than R250	16	27.1
R250 – R499	14	23.7
R500 – R999	14	23.7
R 1,000 – R 1,999	7	11.9
R 2,000 – R 3,999	6	10.2
R 4,000 – R 7,666	0	0
R 7,667 – R12,499	1	1.7
More than R12,500	1	1.7
Total	59	100.0

Thus although a few people have a good income, the majority (74%) are supporting themselves and often others on less than R1,000 per month. While high levels of unemployment are a great source of frustration for many people living in South Africa, the added burdens of long waiting periods for status determination, xenophobia and racism make it almost impossible for refugees and asylum seekers to find employment.

Companies take only South Africans, they don't take foreigners. Its only the miserable security jobs that are given to refugees.

Female, DRC, 31

Ultimately the picture that exiles paint of life in South Africa today tends to be a very gloomy one. Their existence is most often characterized by ongoing threat, hostility, poverty, loneliness and frustration. Of course, many South African citizens live in very similar conditions and these living conditions represent a significant risk factor for many mental and physical health problems. For exiles with limited community networks and torture survivors with special psychological and medical needs, the negative impact of such risk factors is greatly magnified.

Experiences and impact of torture

Reports on respondents' torture experiences helped researchers to understand the motivations for torture, the nature and extent of these experiences, as well as the lasting impact that torture has had on these people's physical, emotional and social lives.

When asked why they thought that they had been tortured, only 56 participants (74% of the sample) were willing and able to provide a clear reason. Given the sensitivity of this question, this response rate is not surprising. A broad range of responses were received. The following quotations illustrate this diversity.

My husband was a soldier but he didn't like the job so he left. My husband ran from one place to another. They arrested us and took us to the police station. The colonel said since my husband doesn't like and doesn't want to join the military, then he is going to hold me hostage in the camp. The worst incident was the rape. It was done very often.

Female, DRC, 39

They wanted me to give them full information about how Hutu's are organized.

Male, Burundi, 24

We were hiding ourselves and those guys they take my father, my mother, my brothers and one of my sisters and killed them. We were hiding ourselves in the night. We watched how they killed our parents.

Female, Rwanda, 26

The rebels used to come ... Even if they find you at school they rape you ... they wanted to kill, but if you accept to be raped then they leave you ... they force you to marry; maybe today they tell you you have to be wife to this one. After one week they tell you now you are going to be wife of that one. ... I think they wanted to satisfy themselves ... they just wanted to use ladies by force.

Female, Uganda, 26

The following table categorizes and summarizes the responses that asylum seekers and refugees provided.

Motive	Frequency	Percentage
Wanted information about individuals	26	45.6
Wanted information about groups	10	17.5
“Punishing” members of opposing political group	10	17.5
Ethnic or religious persecution	7	12.3
“Punished” as an informer	2	3.5
Accused of criminal activities	1	1.8
Raped for rebels’ pleasure	1	1.8
Total	57	100.0

Some of the descriptions of torture provided by the respondents are extremely vivid while others found it impossible to talk about their experiences. To assist participants in providing some data on their experiences of torture, each person was presented with a list of 25 common forms of torture and simply asked to say whether or not he or she had experienced that form of torture. The results reveal that the exiles participating in this study have experienced between one and 24 different forms of trauma. The modal number of different forms of torture experienced was 15 (mean = 11.8, standard deviation of 5.4). It is important to note that this data does not take into account the frequency, duration or severity of the different forms of torture and so is a very coarse measure of the amount of torture that participants have experienced. More detail about the relative frequency of different forms of torture is provided in table 8 below where the different forms of torture are listed in order of prevalence.

Form of torture	Frequency	Percentage
Threatened with pain, physical harm or execution	70	90.9
Being beaten	59	76.6
Forced to listen to the torture of others	59	76.6
Denied healthcare when needed	53	68.8
Kept in a dark place for long periods	52	68.4
Exposure to extreme heat or cold	52	67.5
Made to remain standing for long periods	51	66.2
Kept isolated from others for long periods	50	65.8
Forced to watch beatings of others	50	64.9
Prevented from sleeping for long periods	49	64.5
Denied food and water for long periods	46	59.7
Forced to work like a slave	42	54.5
Tied with rope in stressful positions for long periods	33	43.4
Forced to watch the killing of others	32	41.6
Forced to watch sexual abuse or humiliation	30	39.0
Exposure to extreme noise levels	27	36.0
Suffocation using drowning	22	28.9
Burnt with objects	20	26.0
Forced to harm others physically	18	23.4
Forced to engage in sexual activities	17	22.1
Suffocation using plastic bag	16	20.8
Electric shocks	15	19.7
Other	13	17.3
Removal of fingernails, toenails, or teeth	12	15.6
Blunt object inserted into vagina or anus	10	13.3

The “other” category included prolonged detention without charge or trial, denial of access to toilet facilities, limbs being amputated, mutilation of genitals, having water poured over them, being pricked under the nails, and being kept in a room with dead bodies. The data reveals several differences in the prevalence of different forms of torture for men and women. These differences are presented in table 9 below.

Form of torture	% males	% females
Higher prevalence in men		
Tied with rope in stressful positions for long periods	54	25
Suffocation using drowning	38	14
Electric shocks	30	3
Suffocation using plastic bag	29	7
Higher prevalence in women		
Forced to engage in sexual activities	15	35

Three forms of torture were found to be highly characteristic of the experiences of the Somali group, and less so of exiles from other countries. These were being forced to watch sexual abuse or humiliation, being forced to work as a slave, and being forced to watch the killing of others. These forms of torture were described by nine out of the ten Somalians participating in the study.

Open ended questions were asked about the long-term psychological, physical and social impact of torture on participants' lives. Of the total sample, 72 participants (94%) provided responses to these questions. Of the participants who responded 13 people (18%) felt that they had fully recovered from their experiences of torture and had no chronic ill effects, yet in some cases even these responses were qualified.

I'm not so much affected. Sometimes I feel it when it's cold, I feel it. I am well now because its long time now. I think now is six years.

Male, Ethiopia, 24

A broad range of psychological symptoms were reported. In total 50 people (69% of the sample) reported some chronic psychological symptoms to interviewers. Although a greater percentage of women reported psychological symptoms than men, this difference did not reach statistical significance. These symptoms were categorized as intrusive, avoidant, hyper-arousal, dissociative and depressive symptoms. The former three are associated with PTSD. Intrusive symptoms refer to experiences such as painful memories, flashbacks and nightmares where the victim relives or re-experiences aspects of their torture experience. Avoidant symptoms arise because reminders of torture evoke painful memories and great distress and so are avoided. Such symptoms include not wanting to talk about torture experiences, and avoiding some kinds of people (for example, people in uniform, or men). Hyper-arousal symptoms arise when torture survivors are particularly sensitive to possible danger and include difficulty falling and staying asleep, lack of concentration and constant, excessive vigilance. Dissociative symptoms are related to complex PTSD and include feeling distanced from the world (derealization) or from one's own body (depersonalization) and depressive type symptoms (including hopelessness and fatigue) are associated with various forms of depression.

Symptom cluster	Frequency	Percentage
Intrusive symptoms	26	33.8
Depressive symptoms	23	31.9
Hyper-arousal symptoms	20	27.8
Dissociative symptoms	7	9.1
Avoidance symptoms	5	6.9

A broad range of physical symptoms was also recorded . These were classified as general bodily pain, pain from wounds inflicted during torture, chronic headaches, disability, and general ill-health. Of the 72 people who responded, 34 (47%) listed some kind of chronic physical symptom.

Symptom cluster	Frequency	Percentage
General poor health	15	20.8
Pain from torture related wounds	13	18.1
Disability	8	11.1
Chronic headaches	4	5.6
General body pain	3	4.2

Finally, participants were asked about the impact of torture upon their social functioning. Responses fell into two broad categories: distrust and fear of all other people; and inability to function properly in intimate relationships (including sexual relationships). Twenty-one people (29%) remarked that their torture experiences had negatively impacted upon the capacity to function socially.

Symptom cluster	Frequency	Percentage
Inability to trust, and fear of others	13	18.1
Loss of functioning in intimate relations	11	15.3

Clearly the amount of torture experienced by this group is significant and the chronic physical, emotional and social impairment presents serious challenges to medical, mental health and social services in South Africa. It is also important to remember that these experiences are only a small part of much longer stories which may include poverty and hardship in early lives within conflict ridden countries, the traumas associated with their journeys into exile, and the dangers, insecurity and adversity that characterize everyday living in South Africa.

Community resources that have assisting coping in South Africa

While the challenges that exiles face are clearly summarized in the previous sections, it is important also to remember the sources of coping and resilience that this group has. For many people, a primary component of such resilience relates to the resources and support that people are able to access within the community in which they settle. Although most exiles described their arrival and early days in Johannesburg as extremely lonely and difficult, many did describe receiving some assistance from various people and agencies.

Overall, the greatest source of support came from Christian and Muslim religious organisations (29% of responses). Other significant sources of support included family and friends (26% of responses) and caring South Africans (26% of responses). A slightly smaller group report support from non-government organisations and charities in South Africa (20% of responses).

When asked about the sources of support available to them on a daily basis, many exiles painted a rather bleak picture. Levels of perceived support are generally very low with 19% of the sample feeling that they have absolutely no reliable support whatsoever. When presented with a list of possible sources of support, relatively low numbers rated these sources as present and reliable in their lives. This data is summarized in table 13 below.

Source of Support	Frequency	Percentage
Members of my family	21	29.2
Members of my community	18	25.0
Orgs. that work with refugees and victims of torture	16	22.2
Members of my church	15	21.1
Leaders from my community	13	18.1
Leaders from my church	11	15.7
Neighbours	10	13.9

It is worth noting that older people tend to have great social support than younger people in this sample, and that Zimbabweans had greater access to social support than people from countries like Burundi, Ethiopia and Uganda. These patterns are most likely related to the length of time that people have spent in South Africa with people who have been here longer having more opportunity to build up a social network, and the size of the refugee communities from different countries on the continent. Also several organisations exist in South Africa for the support of exiles from Zimbabwe, and in fact many exiles would have come to this country through such agencies.

It should not be assumed that networks of people from the same country are necessarily supportive. In many cases expatriate communities in South Africa replicate the divisions and conflicts within the country of origin. In such situations tortured exiles might go out of their way to avoid such networks perceiving them as sources of threat rather than of support.

Experiences of health services in South Africa

Exiles' descriptions of their experiences with health services in South Africa range from the extremely positive to the extremely negative. On the one hand, the sample includes a man who has received reconstructive surgery to his penis which had been severely lacerated by his torturers. This surgery was conducted at a government hospital and the costs were met by a local charitable organisation that supports refugees. Clearly this surgery was of great benefit to his general wellbeing.

... its will never be back to normal and they did their best. They did the best plastic surgery just to bring back a symbol of normality.

Male, Zimbabwe, 40

On the other hand, the sample also includes a story of a person who had been hit by a car and was refused assistance by ambulance personnel as a result of not having the correct papers or sufficient money on his person. As it was his friends were able to transport him to a hospital where his asylum seeking papers were presented and he did receive medical care. At the time this person felt that he had been abandoned by ambulance services to die on the street.

When they called an ambulance the first thing they asked me was, "Are you a South African?" ... They asked for ID and other things that you think are not as necessary at that moment as your life is.

Male, Rwanda, 38

Of the 77 people who participated in this study, only 35 (46% of the sample) had had direct contact with South African health services. This, despite the fact that 50 people (65% of the sample) had previously cited a current need for health services (see table 14 above). The most commonly listed facilities that people had visited were the Hillbrow Clinic (13 people),

Johannesburg General Hospital (6 people), Coronation Hospital (2 people), and Helen Joseph Hospital (2 people). Some respondents had been assisted by private health professionals and several were not able to remember the names of the institutions at which they had sought assistance.

The reasons for seeking out health care were equally diverse. Four people had needed assistance with general ailments, four people needed assistance for their children, three had had surgery and two had given birth. One person each had received dental care and assistance from an optometrist. Only one person in the sample had received health care for injuries arising directly from torture, despite the fact that 19 people had previously described a current need for health assistance for injuries directly related to their torture experiences.

Of those that have made use of health services in South Africa, 65% said that they had been required to pay for those services. The amount paid ranged from R20 to R15,000. This distribution is however greatly skewed with the majority of respondents (70% of those who had received care) paying less than R150 for health care. Only 2 people paid more than R1,000 for their treatment.

It is worth noting that not a single member of the sample sought medical assistance from a traditional healer in South Africa. The reasons given for this were that respondents' religions forbade these forms of treatment, that they did not trust traditional healers, and that traditional healers are too expensive.

[In Zimbabwe I went to] traditional healers but it was useless. But you know most of them are liars ... They would not say they do not know. They try by all means to say that it is a small thing but nothing happens because they are interested in your money.

Male, Zimbabwe, 40

This finding runs contrary to what is often found in health seeking behaviour in Central and East Africa. Possible explanations may be that those who have sufficient resources to travel as far as South Africa from their homes are less likely to uphold or traditional values, or that respondents were reluctant to tell researchers about their interactions with traditional healers.

One person's story highlighted the difference between private and public sector health facilities in South Africa. She first approached government services for assistance with severe gastric problems.

I used to go there and was told that medical treatment is payable so I was refused treatment and I have tried a second time. I found a long queue and I didn't get treated until the third day and my pain was raising up.

Female, Burundi, 25

Ultimately she did not receive effective treatment at the public hospital and went on to seek care at a private institution. She acknowledges the difficulties in treating her and mentions that it took two attempts to find an effective treatment, and yet her overall evaluation of the private institution is very positive.

I was sick. I had a problem of the stomach and was vomiting blood. It was difficult to explain myself because English I was speaking was not understandable and not clear... Eventually I got but unfortunately was not effective. I went back there and was given another medication that was effective. ...They were good people. I was welcomed with open arms.

Female, Burundi, 25

Of those that used health services in South Africa, only 15 gave a clear evaluation of the quality of those services. Of these, 12 (80%) gave the South African health services a strong positive rating, and 20% felt that the service they received was poor.

There is good medical attendance there. If you get there they will treat you. You get all the treatment. I think medical treatment is quite ok.

Male, Zimbabwe, 40

I can say it [health services in South Africa] is good because of the standard ... everything is here. You can get medical – so it makes you nice. But if you do not have that money to be cured, is useless.

Male, Ethiopia, 24

When asked about South African health care providers, however, the pattern was reversed. In this case 79% gave health care providers a negative rating, while only 21% said that they were helpful and approachable. Those that gave a negative rating described rudeness and verbal abuse, xenophobia and lack of care. Language problems were also mentioned.

If you are a foreigner that are not nice. Because I go too for my friends. I can see for them how they treat them. Its not well.

Male, Ethiopia, 24

Experiences of asylum seeking process

When respondents were asked about their overall experience of the asylum speaking process 24 comments (31% of the sample) were received. 18 respondents (75% of those who answered this question) said that the process was extremely difficult for them. 3 people complained that the process was corrupt and 1 described it as extremely disorganized. Only 2 respondents (8% of those who responded to this question) described the asylum seeking process as being problem free.

I went to Home Affairs ... they were taking only two people every day. If you were not taken you were requested to come back. I queued every day for a month before I got it.

Female, Rwanda, 25

I left without a permit. Next day when I went back I was given a permit which is not mine. I was forced to go there every day and telling them that the permit I was given is not mine ... I was taken another photo and I was told that they have lost my file and finally to accept to give my file I have bribed them.

Female, Burundi, 25

As mentioned above, a few people did have a good experience of the asylum seeking process.

It was very good and easy for me. When officers discovered my disability they took me in before even those who came before me. ... It was very good and easy for me but for other people it was difficult.

Male, Somalia, 30

This last comment is significant since it highlights the fact the refugee reception officers do occasionally recognize the special needs of torture survivors and are prepared to provide special assistance to such people. In this case of course the physical impact of torture was highly evident but it is conceivable that with appropriate training officers might be able to provide special assistance to torture survivors with less obvious needs.

Research participants were asked how much time passed between their crossing a South African boarder and their registration as asylum seekers. Only 22 participants gave clear answers to this question. Responses ranged from one day to two months. Of the people who answered this question, 59% said that they applied within one week of arrival. Only 9% replied that they had taken longer than two weeks to apply.

When asked for the reasons for delay in registration, a range of reasons were forthcoming. Most common was the fact of there always being long queues at home affairs offices (44% of respondents). Not knowing where home affairs offices are and not having the means to get to those offices was the reason given by a further 44% of people. One person said that she was afraid of being arrested and another said that she had gone to home affairs but had not been helped. She had not returned to the home affairs office thereafter.

Respondents were also asked how long it took for them to receive documentation recording their registration as asylum seekers. Only 27 participants answered this question and responses ranged from one day to one year. The majority of respondents (78% of those that answered this question) were able to register within one month of their arrival.

When asked about their difficulties registering as asylum seekers and then receiving a decision about refugee status, respondents provided 73 responses which are categorised and summarised in the following table.

Problem Area	Responses	Percentage
Long queues at Home Affairs offices	28	36.4
Being repeatedly sent away without documents	15	19.5
Refusing to pay or being unable to pay bribes	11	14.3
Faulty computers at Home Affairs offices	5	6.5
Lack on information on asylum seeking process	5	6.5
High cost of process (transport, bribes, etc.)	3	3.9
Language difficulties	2	2.6
Files disappearing	2	2.6
Poorly skilled Home Affairs personnel	2	2.6
Discrimination against people from some countries	1	1.3

Participants were asked whether or not they had told the home affairs officials about their torture experiences. Of the 35 respondents (45% of the sample) who gave a clear answer to this question, 20 respondents (57%) had described their torture experiences when applying for asylum. The 15 people (43%) who did not describe their torture experiences gave the following reasons for this: because the home affairs officials did not enquire about it (11 respondents),

because they were afraid that they would be deported (5 respondents), because they don't want people to know what happened (4 respondents), or because they are frightened to talk about what happened even in South Africa (1 respondent).

Twelve participants' responses revealed how the asylum seeking process is made even more difficult by torture experiences. There are several ways in which this might happen. For example, three respondents described how having to sleep out in the open for days at a time without sufficient food and water reminded them of past traumatic experiences.

The process was very bad because we have to sleep outside without food and water. You not moved. You have to stay in one place otherwise you lose your chance. We were so many. The mothers and children outside like the way.

Male, 25, Burundi

A woman who had been raped by her torturers made a similar point.

I was sleeping at home affairs for three days. It was very bad. ... I told them that with my problem I cannot sleep outside with the men. They told me we do not want you here.

Female, 22, Burundi

The asylum seekers and refugees participating in the project report on the fights that often break out while people are waiting outside the offices. Such incidents are particularly frightening for people who are traumatized by torture and war experiences.

... The Congolese come and they are fighting, shooting. You have to run away. When you run away you have to come back and keep your position again when the trouble cools down. Then after some minutes they fight again, you run, like that. So we are always running, fighting for the first position. But to get through to the morning still in that first position you have to fight hard. Me personally, a certain Ugandan guy who helped me. He could just hold me like this so that when they used to fight he could protect me. Those people can even die from there. Its so horrible!

Female, 23, Uganda

Four other people mentioned other torture related difficulties which made the asylum seeking process more difficult. One person reporting being too sick to go to the home affairs offices; another explained that the damage to his back prevented him from standing for long periods; a third mentioned that his stomach problems kept him from standing in line for days; and finally one said that he was too frightened to go to the offices because he was afraid that he would be required to talk about his torture experiences.

Impact of status determination on access to health services

Despite the fact that the large majority of those who had accessed health services in South Africa, including those that had had very positive experiences of such services, were in fact asylum seekers and not refugees, 84% of those who had made use of South Africa health services felt that their documentation was crucial to them getting the services that they did receive. They also felt that had they had confirmed refugee status things would have been easier.

I once went there and was refused treatment. That was before I got my status. They told me that I could not be treated because of my papers.

Male, Rwanda, 19

At least one person however stated her asylum seeker's permit had ensured access to medical attention from a government clinic.

At the clinic they have never refused me treatment because I have a simple paper [asylum seeking permit].

Female, Burundi, 25

While full refugee status is no doubt more recognizable by health service providers, people are getting assistance on the strength of asylum seeking permits.

CHAPTER 4 Discussion and Recommendations

Torture: An invisible crime

A clear theme emerging from the data is that in many cases torture remains a hidden aspect of refugee and asylum seekers' lives. This is clear both from the low proportion of asylum seekers who describe their torture histories when applying for asylum, and from the low proportion of participants who have sought medical care for torture related health problems.

The reasons for this invisibility are complex but can be grouped into two main themes. On the one hand it is clear that home affairs officials often do not ask asylum seekers about their experiences of torture, and in some cases actively resist being told about those experiences. The reasons for this are multiple and include organisational problems such as the number of asylum seekers relative to the number of reception officers, the time taken to process asylum applications, and inadequate administrative and management systems. To these must be added problems of inadequate torture related education and skills training of reception officers. Finally, compassionate people find listening to stories of torture to be emotionally burdensome and so we should not be surprised that reception officers are unenthusiastic about listening to such stories from each person with whom they have dealings. In short it seems that most refugee reception officers do not have the time, the skill or the inclination to ask asylum seekers about possible experiences of torture.

On the other hand, the data also reveals that many torture survivors are reluctant to reveal details of these experiences, even when asked. The reasons for this are also several. For many torture survivors seeking asylum the memories of their torture remain powerful triggers for traumatic stress responses. When such a response is activated it is common for people to break down in humiliating tears and/or to become somewhat dissociated in which case they may be unable to respond consistently and accurately to difficult questions. Furthermore, many forms of torture such as rape of men and women as well as being forced to hurt other people, are experienced as deeply shameful by survivors and so once again are kept secret. Some asylum seekers also believe that admitting to being tortured might cast suspicion on them with the South African authorities or place them at risk from agents from their own countries. Finally, it should be remembered that for many asylum seekers their torture experiences are simply not a priority when they are seeking asylum. At that time, they are more concerned about the pressing needs to secure shelter, food and safety for themselves and their families and are unlikely to reveal their experiences of torture unless there is some clear benefit to be gained. Ironically, of course, a coherent account of torture is likely to contribute greatly to a decision to grant refugee status to asylum seekers.

The result of these "don't ask, don't tell" tendencies is that torture and its consequences remain largely hidden from the official and public eye. However, if the South African government is to meet its obligations with respect to UNCAT it is essential that torture cases are consistently identified and documented during the asylum seeking process. Similarly, if health care providers and social services are to adequately meet the needs of torture survivors, it is essential that torture histories are revealed and appropriately documented.

Recommendations to the Department of Human Affairs:

- Make it obligatory for Refugee Reception Officers to routinely and consistently enquire into possible torture histories at the time of the first application for an asylum seeker's permit.
- Refugee Reception Officers should be trained to ask about torture experiences respectfully. These officers need to be able to identify both the "flooding" and "dissociative" effects of re-exposure to traumatic stimuli. They should also be able to use such simple techniques as reassurance, distraction and grounding to assist torture survivors to recount the essence of their experiences without needing to unpack the associated and deeply distressing detail. Asylum seekers should receive the appropriate reassurances that such information will remain secret and will not jeopardise the applicant's chances of receiving refugee status.
- Refugee Reception Centres should maintain a short referral list of local mental health personnel to whom tortured asylum seekers may be referred should recounting their experiences prove too traumatic.
- Existing supervisory systems should ensure that such policies are rigorously and competently implemented.

Recommendations to civil society, human rights and faith-based organisations:

- Lobby DOHA for the policy changes to the initial stages of the asylum seeking process listed above.
- Monitor and support the implementation of such policies, specifically, the proportion of tortured asylum seekers' whose torture history is documented at the beginning of the asylum seeking process.
- Organisations offering emergency services and shelter to exiles should ensure that their staff are trained to recognize indicators of torture and to explore such experiences with their clients in an appropriate manner.
- Encourage asylum seekers to share their torture histories with refugee reception officers while ensuring that asylum seekers know that accounts of torture will be kept secret and will not jeopardize their chances of securing refugee status.
- Where appropriate, take referrals from Refugee Reception Centres for emergency mental health support services.

Recommendations to the Departments of Health and Social Services:

- Ensure that service providers (especially frontline personnel including nurses and social workers) are educated about the prevalence and consequences of torture among exiles. Service providers should be able to recognize possible indicators of torture and discuss the topic with their clients in an appropriate and reassuring manner.
- Provide emergency mental health support to local Refugee Reception Centres.

Recommendations to representatives of exile communities in South Africa:

- To run, in collaboration with the departments of home affairs, health and social services as well as civil society, human rights and faith-based organisations, an education campaign for exiles about the need to discuss torture experiences during the asylum seeking process. Most importantly asylum seekers need to know that their reports will remain secret and will not jeopardize their chances of receiving refugee status.

Experiences and impact of torture

In line with the study design all participants had been subjected to at least one kind of torture. However, the data reveals that the vast majority had in fact experienced a number of different kinds of abuses that can accurately be described as torture and/or organized violence. While the data does not reflect the frequency, duration or intensity of exposure, it is clear that many people were exposed many times over extensive periods.

Given this background we would expect a marked and lasting impact on health in a sizable portion of the sample and this is precisely what was found. Only 20% of the sample felt that they had recovered from their torture experiences. It is important to keep in mind at this point that the average time of residence in South Africa is 18 months, and that many have stayed much longer than that. This highlights the extent to which the health consequences of torture tend to be very enduring. Very often people learn to manage and live with health problems associated with torture but never actually recover from such experiences.

The most common problems reported were psychological in nature and focussed on trauma related disturbances and depression. Physical problems were largely more general in nature with only 20% of complaints being directly related to the particulars of the torture experienced. Social problems relate to general avoidance and distrust of other people which is a common psychological symptom following trauma. Problems with sexual functioning are also prevalent.

Recommendation to human rights and other civil society organisations:

- This data confirms other research (see chapter 1) which demonstrates that the impacts of torture on health tend to be both multi-faceted and lasting. Human rights activists should continue to use such data to influence policy makers and service providers to provide better and more appropriate services to asylum seekers and refugees. In particular this data highlights the needs for multi-disciplinary and holistic service provision.

Sources of support

For most people family and community provide the first, most important and lasting source of support during times of adversity and illness. Service providers should serve as a safety net for when family and community are not able to respond effectively to the problems that individuals are facing. However, in the case of many asylum seekers and refugees the most important family and community support systems are absent. Approximately one in every five people in this sample feel that they have no reliable support whatsoever. Many other listed service provider organisations as their only source of support. This data speaks strongly to how important it is to have service providers who cater specifically for the population of tortured exiles.

For many, other exiles and leaders of their own expatriate group provide the most important sources of support. For this reason it is imperative that the refugee community becomes increasingly organised around supporting and facilitating service delivery to its members.

The asylum seeking process and secondary victimization

Over and over again, tortured exiles describe the hardships and frustration of the asylum seeking process. They speak of lack of information, queuing for days and nights on end without adequate protection and food, violence breaking out among waiting asylum seekers, and rude, corrupt and incompetent officials. These findings have been documented repeatedly by various organisations and the enormous backlog of unprocessed applications speaks for itself.

However, one very disturbing finding to emerge from this study is the high proportion of asylum seekers in the sample. In the CASE (2003) study of exiles in South Africa (including people with and without a torture history) 60% were asylum seekers and 40% had managed to secure refugee status. In this analysis, comprised of exiles all of whom have a history of torture, 80% are asylum seekers while only 20% have been able to secure refugee status. Given that a person who has been tortured in their country of origin is much more likely to meet the criteria for refugee status, this is surprising and very worrying. Could it be that for a history of torture makes it more difficult for people to get refugee status?

There are three possible answers to this question. The first is that this sample is not a random sample and it is indeed possible that the low proportion of refugees is a result of the sampling procedure. This however is unlikely since a snowball sample is more likely to pick up people who are better known and established within their communities. Such people are also more likely to have refugee status than new arrivals. The second possible answer is that the current study took place two years after the CASE study and that during this time the backlog in applications has grown even further. In this case the disparities between the two samples might reflect the changing proportions of refugees and asylum seekers in the country due to the fact that applications are being processed at a rate much slower than that at which exiles are entering the country.

It is however, the third possible answer that should be of great concern to human rights activists and policy makers, namely that the hardships involved in the application process disproportionately disadvantage tortured exiles as compared with their countrymen and women who have not been tortured. This is not in fact the first study to produce this surprising finding. Montgomery and Foldspang (2005), working in Denmark with a sample of refugees and asylum seekers from middle eastern countries found that status determination was not predicted by exposure to torture, despite what would be expected under international conventions. The authors conclude that this result emerges from torture-related psychological barriers that prevent survivors from talking about their experiences.

The data in this and other studies shows us that the physical consequences of torture often involve such symptoms as muscular and skeletal pain that is exacerbated by long periods of standing, and of nausea that is exacerbated by poor diet and dehydration. The psychological consequences include depression which makes it very difficult to find the energy for prolonged and frustrating enterprises, and anxiety disorders which leave people hypersensitive to triggers associated with violence and danger. When one looks at the realities of the current asylum seeking process through the eyes of a person with some of this group of symptoms one sees a process that is disproportionately terrifying and arduous. It seems likely that many torture survivors are severely disadvantaged in the struggle for refugee status because of the way it is

currently administered. Ironically, the people who are most clearly deserving of refugee status end up being least likely to receive it, a cruel secondary victimization.

Importantly, this study also reveals the relative ease with which the burdens associated with the asylum seeking process may be eased for people who are physically or emotionally incapacitated as a result of torture experiences. There are a couple of examples in which personnel at refugee reception centres have recognized and responded to the special needs of torture survivors. There is very little reason why such responses could not become the norm while processing the applications of all asylum seekers.

Regardless of the effects of the asylum seeking process, the high number of people with undetermined status is of great concern. Refugees are commonly referred to as among the most marginalized and disempowered people in a society. Asylum seekers are without even the security and access to services that refugees enjoy. The implications of such insecurity for people struggling to come to terms with the psychological impact of torture may be profound and are not as yet well understood.

Recommendations to the Department of Home Affairs:

- It is essential that the DOHA's programme to reduce the backlog of unprocessed applications for asylum be given the highest priority and be well managed to ensure its effective implementation.
- The DOHA should adjust existing procedures for the processing of applications to reduce the amount of time that asylum seekers are forced to spend waiting to be seen. Such adjustments should include the provision of more, well trained and better equipped Refugee Reception Officers.
- Because some waiting is inevitable, the DOHA should provide better facilities for the comfort and protection of those waiting. Such facilities should include shelter from the elements, somewhere to sit, effective security, as well as access to clean water, affordable food and toilet facilities.
- The DOHA should fast-track the asylum seeking process for exiles who report having been tortured. Since members of this group are more likely to meet the criteria for refugee status, such processes will assist in the reduction of the current backlog and will prevent tortured exiles from having to repeat the arduous process repeatedly when their temporary status expires.

Recommendations to civil society, human rights and faith-based organisations:

- Human rights organisations and representatives of the various refugee communities should continue to monitor the conditions of the asylum seeking process and where appropriate bring cases of secondary victimization to the attention of the relevant authorities as well as the general public.

Recommendations to researchers:

- Future research should investigate and compare the psychosocial position and needs of tortured asylum seekers with those of tortured refugees. While social researchers understand something of the situation and needs of tortured refugees, relatively little is known about how those needs are exacerbated by the precariousness of the asylum seekers' situation. Findings from such work may have important implications for service provision to this group.

Access to health and social services

This study allows for a very rough estimate of the size of the tortured exile population currently in need of health care. In chapter one it was argued that there are currently between 8,400 and 21,000 tortured exiles living in the metropolitan areas of South Africa. Of these, 65% reported a current need for health services (see table 14). This suggests that there is currently a population of between 5,500 and 13,500 tortured exiles in need of assistance and in the main not receiving it. This is a significantly large group of people but certainly not an insurmountable challenge to existing health services.

The data also reveals that only a small proportion of tortured exiles who feel the need for health care are actually seeking services. This is particularly true around treatment that is directly related to experiences of torture. Ironically this low usage can become a self-perpetuating problem. Few tortured exiles approach health service providers and so their concerns are viewed as insignificant against the broader picture of health in South Africa. As a result little is done to improve service provision and so tortured exiles continue not to ask for help.

While health services are limited for all South Africans unable to afford private care, there is a clear problem around access for tortured exiles living in the country. Access to services depends upon many inter-related factors, including: target populations having knowledge of the available services; the geographic placement of services; a legal and policy framework that provides access to asylum seekers and refugees; cost; the capacity to communicate effectively; the actual and perceived security surrounding services; and the willingness of personnel to assist foreigners.

Tortured refugees' and asylum seekers' reports of access to health and social services vary widely. While some exiles reported relatively easy access to services, excellent service and effective and compassionate care, many more report being turned away, being required to pay large amounts for treatment, and being insulted and rejected. On the whole, tortured refugees and asylum seekers believe that they are unlikely to receive effective assistance or find relief. It is important to understand why they hold this belief. Given that 80% of the sample rate South African health services highly it seems unlikely that refugees believe that South African health service providers are *unable* to provide the assistance that they need. However, it is likely that the 80% of the sample who find providers rude, dismissive and unhelpful are afraid that they won't be helped, or that they will be badly treated and shamed by health service providers. The stories of good service provision are important because they demonstrate that it is possible to provide greatly improved health services to tortured exiles. The negative stories are important because they show just how much more work needs to be done.

These findings suggest that departmental policies around services to asylum seekers and refugees are unclear or have not been adequately communicated to all relevant service providers. Furthermore the unpredictability of access to services suggests that the implementation of existing policies is not being adequately managed, resulting in different sites responding in

different ways to asylum seekers and refugees in need. As a result these people often find themselves in the uncertain and sometimes humiliating position of asking for assistance never knowing when they are likely to be helped and when they are likely to be turned away, at times very offensively. Asylum seekers in particular noted that without refugee status it is much more difficult to access services. Given this situation, it is not surprising that so many people, especially those suffering the negative psychological effects of torture, prefer to ignore their health problems rather than face unsympathetic health service providers. This in turn makes it that much more difficult and expensive to assist them when then the problems become too serious to ignore further.

The question of the cost of services is also an important one. While it is true that some refugees and asylum seekers received better service because they were able to pay for it, many received services for extremely low fees. Of course this is exactly the same position in which South African citizens find themselves. Private institutions are generally believed to provide higher quality services but they are expensive. However, the problems arise when asylum seekers and refugees are told that because they are not South African citizens they must pay relatively high fees for services at public hospitals. Intake personnel are either unaware of South African law and the policies of the department and institution under which they are employed, or they are using a bureaucratic manoeuvre to give expression to their prejudice against foreigners or to avoid having to work with someone that they have difficulty understanding. Clearly such behaviour is intolerable and must be addressed.

The issues of asylum seekers being less able to access services than refugees does not seem to be as important as one would expect. Although many asylum seekers believe that getting refugee status will increase their access to services and other opportunities this many not in fact be the case. In this sample, asylum seekers were as likely to get assistance as refugees, with several asylum seekers reporting very good services.

Ultimately (as discussed in previous chapter) it is the responsibility of the relevant state departments to provide appropriate health and social services to refugees and asylum seekers in a manner that is geographically, economically and social accessible.

Recommendations to the Departments of Health and Social Services:

- Departmental policies regarding service provision to asylum seekers and refugees must be clarified. Specifically the policies need to clearly articulate which services are available to asylum seekers and refugees, at which sites, and at what cost. Naturally such polices need to be in line with the relevant international conventions, the constitution and laws of South Africa, as well as recent court rulings. Policies should also clearly specify who is responsible for the provision of various services.
- Supervisors and managers in the relevant institutions should take responsibility for ensuring that these policies are consistently implemented.
- Personnel induction processes at all sites must deal explicitly with the policies and practicalities relating to the provision of general and emergency services to refugees and asylum seekers.
- Managers and supervisors need to recognize that such policies run contrary to the beliefs and values of many service providers. As such it is important to ensure that policies are clearly

and repeatedly discussed with service providers so that ignorance of policies cannot be used as an excuse for the exercise of xenophobia.

- Managers and supervisors need to act decisively to prevent unfair discrimination and xenophobia and to appropriately discipline employees who discriminate against asylum seekers and refugees.

Recommendations to the Department of Home Affairs:

- At the time of first application for refugee status, refugee reception officers should refer tortured asylum seekers directly to local health care services where appropriate.

Recommendations to civil society, human rights and faith-based organisations:

- Ensure that cases in which refugees and asylum seekers are denied access to services are carefully documented and reported to the relevant authorities.

Models of service delivery to tortured exiles

The narratives discussed in this study reveal that asylum seekers' and refugees' recent life stories tend to be filled with traumatic experiences, physical violence, sexual violence, hardship and significant losses. Sometimes, the actual torture experiences represent a small and often neglected part of the overall story. Similarly, the urgency of recent traumas and current crises prevent service providers from recognizing or responding to torture related problems. This may significantly compromise the service provider's ability to adequately address their client's concerns. For example, a patient who constantly complains of severe muscular pain for which no clear cause can be found may be dismissed by an inexperienced medical practitioner as malingering. This practitioner would have failed to recognize that such pain is commonly associated with some kinds of torture, and/or a somatized response to complex PTSD.

As such, the provision of services to torture survivors does require specialist training. Most importantly personnel should recognize that it is often difficult for survivors to discuss their torture experiences and that it may be necessary for the provider to enquire about such experiences in an appropriate manner in order to be able to provide the necessary assistance or referral.

Furthermore, service providers in both the government and non-government sectors should treat torture survivors in an holistic manner. There are two dimensions to such an holistic response. Firstly, it is important that the torture experiences are given their appropriate place in the overall picture of the clients' needs. While torture experiences may underlie many other problems, it may be necessary to focus on more urgent needs first while not ignoring the impact of torture. Secondly, as discussed in previous chapters torture tends to impact upon multiple spheres of a person's life. This requires that various service providers (such as psychologist, social worker, psychiatrist, physiotherapist and medical practitioner) collaborate effectively and efficiently. In short, torture survivors' needs are complex and demand thoughtful, comprehensive and organised response.

The challenge facing the departments of health and social services is to provide accessible services which are relatively specialist in nature in the most cost effective manner possible. A core question is the extent to which services to torture survivors (both exiles and South Africans) should be specialist add-ons to existing more general services or whether such treatment should

be integrated into general service provision. The creation of special services for tortured people reduces accessibility since it necessitates fewer sites offering the appropriate services. Integration into existing services creates much greater accessibility but involves awareness raising and training of a much larger group of service providers.

Several different models are conceivable for the provision of services to tortured exiles in South Africa. Some of these are listed and compared below.

General “upskilling” of state health and social service providers:

Perhaps the ideal for torture treatment activists is the possibility that exiled torture survivors would be able to approach any government health facility in the country and receive affordable, high quality and specialist services, in a secure environment, offered by skilled and sympathetic personnel. For this ideal to become a reality will require (a) that policies related to service provision to exiles are clarified and communicated, (b) that the implementation of these policies is better managed, (c) that prejudice against foreigners is challenged and prevented from impacting upon service provision, and (d) that all service providers become more knowledgeable and skilled in responding to the special health and psychosocial consequences of torture.

Components (a) and (b) have been discussed previously. Components (c) and (d) could be achieved through a combination of various training platforms including basic health training in Universities and Colleges, induction training, in-service training, and continuing professional development. Nevertheless, this must be seen as a long-term goal since attitude change tends to happen slowly and training the huge numbers of people responsible for the provision of health and social services will be a costly and time consuming exercise.

Specialized clinics within certain state hospitals:

Much more achievable in the short term is the creation of specialist clinics for torture survivors within certain existing hospitals located in the geographical areas in which exiles are most likely to be found. Four such clinics in central government hospitals in Johannesburg, Cape Town, Durban and Pretoria would be an excellent start. These clinics would need to be staffed by multidisciplinary teams (nurse, doctor, psychologist, and physiotherapist) with special interest and competence in assisting torture survivors. Such clinics would need support services for administration, interpretation and security, and would need to be able to bring in social work, psychiatric, and surgical expertise where necessary.

The advantages of such a model is that it makes relatively specialist services accessible to the majority of tortured exiles in South Africa in a relatively affordable manner. It also allows for much stronger data capture and management which will enable medical researchers and health administrators to better understand the health needs of torture survivors and the most effective strategies for meeting those needs. The disadvantages are that not all tortured exiles live in the major metropolitan areas and they would need to travel to get specialist care. Finally, because care is only available at particular institutions an information campaign would be required to inform the various exile communities of where specialist care is to be found. This activity should be undertaken in cooperation with representatives of exile communities as well as the relevant human rights and religious organisations.

One stop torture treatment centres:

One stop centres have also been proposed as a way of offering coordinated services to marginalized and disempowered groups within the general population. Such services have had some success in the provision of care to abused children, rape victims and women who have been victims of domestic violence. Certainly the possibility of having refugee reception centres, access to short-term shelter, medical and psychological care, a social welfare office, and other related services all under the same roof and supported by a common administrative structure is very exciting. The advantages with respect to ease of referral, reduced travel costs and time for exiles, and efficient case management are obvious. However, in this case, the cost of establishing such centres needs to be measured against the size of the population in question. Is it worth establishing four such centres (since one would be needed in each of the metropolitans mentioned above) for a population of 42,000 people, or are there more cost effective ways of meeting the needs of a smaller group like this.

Networks of specialists consultants on torture related care:

Currently a significant portion of services offered to tortured exiles happens through an informal system of referrals between individual medical and psychological practitioners who may or may not be associated with organisations concerned with the wellbeing of torture survivors and exiles. In some cases these services are paid for, and in some they are offered at no charge. Such networks have ensured that a significant number of tortured exiles receive care that they would otherwise not have had access too. There are of course many disadvantages. Firstly, exiles need to find their way into such networks by constantly asking for assistance from many different people until they find someone knows someone else who is able and willing to assist with a particular problem. The greater the physical, psychological or social impact of the torture has been, the less likely it is that a torture survivors will be able to persist in searching out assistance. Secondly, when a helpful professional has been located the logistical and financial problems of travelling to that person in order to receive the care must be negotiated. Thirdly, such networks rapidly become overwhelmed because providers are typically assisting tortured exiles outside of their full-time employment. Finally, the informality of the current networks mean that ultimately this model of service provision is extremely inefficient. Torture survivors and service providers spend a great deal of time and effort trying to identify someone who might be able to help with a particular problem.

By formalizing and expending the existing networks many of these disadvantages are ameliorated. A comprehensive and continually updated reference list organised around both geographical location and the kind of services offered would greatly increase the efficiency and effectiveness of these referral networks.

Refugee advice desk:

While a central venue offering multiple services (one stop centre) may not be feasible, a national refugee advice desk certainly is. Such a desk could be staffed with trained people, speaking a wide range of different languages, from the refugee community and be available nationally on a telephonic basis. This advice desk would be able to put people in touch with appropriate services within their area.

Suggested integrated model of service provision:

Ultimately it remains the responsibility of the State to make appropriate health and social welfare services accessible to asylum seekers and refugees across the country. This will take time but the departments of health and social development should be taking practical steps to (1) increase awareness of torture and its consequences, (2) develop capacity for assisting torture survivors at all institutions, and (3) fight xenophobia among service providers.

As a step towards this the departments of health and social development should establish small clinics within one central hospital in each of the major centres. These clinics will have the dual responsibility of offering accessible specialist services to torture survivors in that geographical area and of building capacity more generally in the health and social welfare systems for the care of tortured exiles. These clinics should have a small core staff and draw in expert assistance from specialist external medical and psychological personnel who should be paid at an appropriate rate for their services.

A national refugee advice desk should be established through cooperation between relevant state departments, human rights and faith based organisations already assisting tortured exiles, and international agencies concerned about torture (for example, UNHCR and RCT). A priority project for this advice desk is to formalize and document the existing informal referral networks that are employed in the provision of health and psychosocial services to exiles. This database should be available to service providers online and to tortured exiles through the advice desk itself.

Recommendations to tertiary training institutions and professional associations:

- Ensure that the training of all medical, social and psychological personnel includes significant input relating to the indicators and impact of torture as relevant to their chosen field.
- Explicitly explore the ethical issues relating to prejudice and xenophobia in the provision of health services.
- Create opportunities for health professionals to develop and share their expertise in service provision to torture survivors through local conferences, journals, and continuing professional development programmes.

Recommendations to Departments of Health and Social Development:

- Establish small multi-disciplinary clinics within general hospitals in all major centres.
- Establish referral lists of local expert service providers who can be contracted in to assist individual torture survivors.
- Provide specialist, accessible and holistic services to tortured exiles through clinic staff and other local providers.
- Use these clinic structures to develop awareness of torture among all service providers in the institution, and to combat xenophobia among health service providers.

Recommendations to local and international agencies concerned about torture as well as representative structures of refugee communities in South Africa:

- Collaborate in the establishment of a national refugee advice desk to provide information to exiles from all countries.
- Establish through this advice desk a national referral database of organisations (government and non-government) and individuals who provide services (including care for torture survivors) to refugees and asylum seekers. Continually maintain and develop the national referral database.

Research on services for tortured exiles

Reflections on the current study:

The current study has provided a snapshot of the lives of tortured exiles living in South Africa. The data speaks broadly to past experiences including torture history, current challenges and problems, medical and psychosocial needs, and experiences of South African health systems. The sample, while not random and therefore not statistically representative of the population of tortured exiles, is of a significant size and includes a broad demographic diversity. If anything, the data is likely to under-represent the most severe torture cases since these people will find it particularly difficult to engage with researchers and talk about their torture experiences. Collecting data from tortured exiles is an extremely difficult enterprise and much has been learned in this study.

It is clear that snowball sampling is an effective technique for drawing a sample but that it takes a great deal of time due to the general invisibility of torture to service providers and representatives of refugee communities alike.

While it is ethically important to compensate participants for their time offering payment up front to very poor people compromises voluntary participation. At the same time giving people a surprise payment after the interview sets up perverse incentives for participation as interviewees discuss their payments with others within their circle of friends and family. A surprise payment to all participants at the conclusion of the data collection phase of the research solves this problem.

Interviewing people about torture experiences and life in exile is also fraught with difficulties. Torture survivors find it extremely difficult to talk about their experiences, while at the same time many are hoping to maximize their chances of receiving refugee status and gain access to other services. All of these dynamics impact upon the way tortured exiles present themselves to researchers. Furthermore, tortured exiles have long and complex life stories and very often telling those stories is extremely tiring. All of these factors need to be considered in the development of data collection instruments.

Finally, the management of interviewers, interpreters and transcribers all working in different language presents enormous logistical problems, especially since the project manager is unlikely to be able to work in more than one or two of the languages. This too must be carefully managed.

Future research on tortured exiles living in South Africa:

The development of more accessible and comprehensive health services for refugees and asylum seekers who have survived torture depends upon two complementary types of information. In the first place it is essential that health service planners and managers understand the size, location, and movement of this population. Such epidemiological data allows for targeted interventions in particular institutions where they are likely to have the greatest benefit.

For example, reliable information of this kind would enable the Department of Health to:

- (1) equip senior medical personnel in specific institutions with specialist skills relating to treatment of torture survivors;
- (2) ensure that intake personnel fully understand and properly implement laws and policies that affect the refugee population; and to,
- (3) take reasonable measures to ensure some common language between foreign clients and South African medical personnel.

While this kind of information is essential to planners, it is of little use to the doctors, nurses, psychologists, physiotherapists and social workers whose responsibility it is to assist individual refugees who have been tortured. For this level of work to be improved much greater understanding is needed of the ways in which refugees and asylum seekers who have been tortured function in South African society. Such an understanding depends upon knowledge of the early lives of clients, the events leading up to their exile, their experiences of torture, the experiences of journeying to South Africa, and their lives on the streets of South Africa's cities today. Such information will assist practitioners to better understand this populations' complex medical and psychosocial needs as well as the barriers that prevent torture survivors from accessing and engaging effectively with treatment.

Two very different kinds of information are required and these demand very different kinds of research methodology. The epidemiological data described above must depend upon the data already being collected from asylum seekers at the point of initial registration and through the process of status determination.

Methodologies for collecting, analyzing and distributing the second kind of information are much more challenging. In order to answer more subtle questions about torture survivors' experiences it is necessary that researchers collect much more detailed and sensitive information. This immediately presents many challenges to research design, data collection, data management, analysis and ethics. Much can be learned from the procedures employed and lessons learned in this study.

Recommendations for future research:

- Such analysis, reporting and distribution might be best achieved through collaboration between DOHA and Statistics South Africa (StatsSA) whose responsibility it is to analyze and distribute such information. Given that such information is not currently being released by DOHA is it important that this remain a core item of advocacy and public pressure within the sector.

- Further, the DOHA should record in a systematic and comprehensive manner the full details of asylum seekers' histories and current situation. In this way, a growing data base will be available which will enable more effective and efficient service provision to this group.
- South African research providers together with human rights organisations, representatives of refugee communities and service providers should continue to collaborate on detailed and applied studies of the population of tortured refugee and asylum seekers in order to better understand the changing health seeking behaviours and other dynamics of this important group of people. In particular researchers should conduct similar studies in different centres within South Africa and look at the outcome of different treatment modalities.

Conclusions:

The stories that asylum seekers and refugees tell often demonstrate the poor treatment that many exiles receive at the hands of ordinary South Africans. A great deal of this xenophobia and prejudice is supported by false beliefs. These beliefs relate to refugees' perceived reasons for leaving their countries of origin and coming to South Africa. This data demonstrates that the majority of refugees hold fond memories of their previous lives and would gladly return home if this were possible.

Services to refugees and asylum seekers in South Africa are far less accessible and reliable than they could be. Such shortcomings in service begin with the asylum seeking process but continue on into both health and social services. While it is true that a small minority of refugees and asylum seekers have received relatively positive treatment by service providers in South Africa, the majority report a picture of intolerance, incompetence, fragmentation, corruption and exploitation.

The provision of appropriate health and social services to tortured refugees and asylum seekers does not require an enormous budget allocation. The beneficiary population is relatively small and concentrated in the major centres. Also, a great deal can be achieved through more effective management and coordination of existing services. Nevertheless, South Africa has ratified UNCAT and if this country is to meet its obligation and take its place as one of the world's countries that contributes significantly to the well-being of torture victims, some dedicated financial resources must be made available in the overall budgeting of the appropriate departments.

If South Africa is to continue to deserve its international reputation as a country in which human rights are valued and protected, it is essential that services to asylum seekers and refugees are urgently improved. It is hoped that this report offers some starting points for how these services might be more effectively provided in the near future.

References and Bibliography

American Psychiatric Association, 2000. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – Text Revision(DSM IV-TR)*, American Psychiatric Association: Washington, DC.

Artz, L. and Themba Lesizwe (2005). *Ethics relating to social science research with victims of violence and other vulnerable groups*, Themba Lesizwe: Pretoria.

Başoğlu, M. 1993. Prevention of torture and care of survivors: An integrated approach, *Journal of the American Medical Association*, 270, 606-611.

Başoğlu, M.; Paker, M.; Paker, Ö.; Özmen, E.; Marks, I.; Incesu, C.; Şahin, D. and Sarimurat, N. 1994. Psychological effects of torture: A comparison of tortured with nontortured political activists in Turkey, *American Journal of Psychiatry*, 151, 76-81.

Başoğlu, M. and Aker, T. 1996. Cognitive-behavioural treatment of torture survivors: a case study, *Torture*: 6, 61-65.

Başoğlu, M.; Paker, M.; Özmen, E.; Taşdemir, Ö.; and Şahin, D. 1994. Factors related to long-term traumatic stress responses in Survivors of Torture in Turkey, *Journal of the American Medical Association*, 272, 357-363.

Başoğlu, M.; Paker, M. 1995. Severity of trauma as predictor of long-term psychological status in survivors of torture, *Journal of Anxiety Disorders*, 9, 339-350.

Başoğlu, M.; Paker, M.; Özmen, E.; Taşdemir, Ö.; Şahin, D.; Ceyhanli, A.; Incesu, C. and Sarimurat, N. 1996. Appraisal of self, social environment, and state authority as a possible mediator of posttraumatic stress disorder in tortured political activists, *Journal of Abnormal Psychology*, 105, 232-236.

Belvedere, F.; Mogodi, E. and Kimmie, Z. 2003. *National Refugee Baseline Survey: Final Report*, Community Agency for Social Enquiry (CASE): Johannesburg.

Beneduce, R.; Jourdan, L.; Raeymaekers, T. and Vlassenroot, K. 2006. Violence with a purpose: exploring the functions and meaning of violence in the Democratic Republic of Congo, *Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*, 4(1), 32-46.

Coker, E. M. 2004. "Travelling pains": embodied metaphors of suffering among Southern Sudanese refugees in Cairo, *Culture, Medicine and Psychiatry*, 28, 15-39.

Cross, C.; Gelderblom, D.; Roux, N. and Mafukidze, J. 2006. *View on Migration in Sub-Saharan Africa: Proceedings of an African Migration Alliance Workshop*, HSRC Press: Pretoria.

Dada, M.A.; Olumbe K.A.; McQuiod-Mason, D.J. and Kalebi, A.Y. 2005. *Concise text and Manual of Forensic Medicine, Medical Law and Ethics in East Africa*, Independent Medical and Legal Unit: Nairobi.

Department of Home Affairs (2006). Press release on Refugee Backlog Project, downloaded from http://home-affairs.pwv.gov.za/refugee_affairs.asp#1 on 15 August 2006.

DePrince, A.P. and Freyd, J.J. 2002. The harm of trauma: pathological fear, shattered assumptions or betrayal? In Kauffman, J. (Ed.) *Loss of the assumptive world: A theory of traumatic loss*, New York, Brunner-Routledge, 71-82.

Genevke, I. 1999. Achievement after more than 20 years of health professionals' work against government sanctioned torture and future aims. Paper presented at the *XI World Congress of Psychiatry*: Hamburg.

Gerrity, E.; Keane, T.M. and Tuma, F. (Eds.) 2001. *The Mental Health Consequences of Torture*, Kluwer Academic/Plenum Publishers: New York.

Gerrity, E.; Keane, T.M. and Tuma, F. and Ortiz, D. 2001. Future Directions, in Gerrity, E.; Keane, T.M. and Tuma, F. (Eds.) 2001. *The Mental Health Consequences of Torture*, Kluwer Academic/Plenum Publishers: New York.

Goldfield, A.E.; Mollica, R.F.; Pesavento, B.H. and Faraone, S.V. 1988. The physical and psychological sequelae of torture: Symptomatology and diagnosis, *Journal of the American Medical Association*, 259, 2725-2729.

Gorlick, B. 2000. Human rights and refugees: Enhancing protection through international human rights law, *New Issues in Refugee Research, Working Paper 30*, United Nations High Commission for Refugees: Stockholm.

Harris, B. 2002. Xenophobia: A new pathology for a new South Africa? in Hook, D. and Eagle, G. (Eds.) *Psychopathology and Social Prejudice*, University of Cape Town: Cape Town, pp169-184.

Higson-Smith, C. 2002. *Supporting communities affected by violence: A casebook from South Africa*, Oxfam Publishing: Oxford.

Hudnall Stamm, B.; Stamm, H.E.; Hudnall, A.C. and Higson-Smith, C. 2004. Considering a theory of cultural trauma and loss, *Journal of Loss and Trauma*, 9, 89-111.

Human Rights Watch, 1998. *"Prohibited Persons": Abuse of undocumented migrants, asylum-seekers, and refugees in South Africa*, Human Rights Watch: New York.

Human Rights Watch, 2005. Living on the Margins: Inadequate protection for refugees and asylum seekers in Johannesburg, *Human Rights Watch*, vol. 17, pp1 - 64.

Jaranson, J.M. 1995. Government-Sanctioned Torture: Status of the Rehabilitation Movement, *Transcultural Psychiatric Research Review*, 32, 253-285.

Juhler, M. 1993. Medical Diagnosis and Treatment of Torture Survivors, in Wilson, J.P. and Raphael, B., *International Handbook of Traumatic Stress Syndromes*, Plenum Press: New York, 763 – 766.

Kollapen, J.; Klaaren, J.; Rens, A. and Schneider, J. 1999. *Report into the Arrest and Detention of Suspected Undocumented Migrants*, South African Human Rights Commission: Johannesburg.

Landau, L.B. 2006. Myth and rationality in Southern African responses to migration, displacement and humanitarianism, in Cross, C.; Gelderblom, D.; Roux, N. and Mafukidze, J. (Eds.) *View on Migration in Sub-Saharan Africa: Proceedings of an African Migration Alliance Workshop*, HSRC Press: Pretoria.

Ley, K. 2006. Bread and roses: Supporting refugee women in a multicultural group, *Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*, 4(1), 47-52.

McQuoid-Mason, D.J. and Dada, M.A. 1999. *Guide to Forensic Medicine and Medical Law*, Independent Medical and Legal Unit, South Africa.

Meredith, M. 2005. *The State of Africa: A History of Fifty Years of Independence*, Jonathan Ball Publishers: Johannesburg.

Montgomery, E. and Foldspang, A. 2005. Predictors of the authorities' decision to grant asylum in Denmark, *Journal of Refugee Studies*, vol 18 (4), 454-467.

Nugent in *Watchenuka and Another vs Minister of Home Affairs*, 2003, para 24 and 25, downloaded from

http://www.supremecourtofappeal.gov.za/judgments/sca_judg/sca_2003/10_03.htm

Palmay, I. 2002. Refugees, Safety and Xenophobia in South African Cities: The role of local government, Centre for the Study of Violence and Reconciliation: Johannesburg. Downloaded from <http://www.wits.ac.za/csvr/papers/papalm4.htm>.

Rasmussen, O.V. 1990. Medical aspects of torture: Torture types and their relation to symptoms and lesions in 200 victims, followed by a description of the medical profession in relation to torture, *Danish Medical Bulletin*, vol. 37, supplement 1, 1-88.

South African Human Rights Commission, 1999. *Report into the Arrest and Detention of Suspected Undocumented Migrants*, South African Human Rights Commission (SAHRC): Johannesburg.

Summerfield, D. 1999. A critique of seven assumptions behind psychological trauma programmes in war-affected areas, *Social Science and Medicine*, 48, 1449-1462.

Turner, S. and Gorst-Unsworth, C. 1993. Psychological Sequelae of Torture, in Wilson, J.P. and Raphael, B., *International Handbook of Traumatic Stress Syndromes*, Plenum Press: New York, 703-713.

United Nations, 1989. Convention against torture and other cruel, inhuman, and degrading treatment or punishment, in United Nations (Ed.), *Methods of combating torture*, United Nations Centre for Human Rights: Geneva.

United Nations, 2002. *World Population Prospects: 2002 Revision*, New York: Department of International Social and Economic Policy Analysis.

United Nations High Commission for Refugees (UNHCR), 2006. *2005 Global Refugee Trends*, United Nations: Geneva.

Valji, N. 2003. *Creating the Nation: The Rise of violence Xenophobia in the New South Africa*, unpublished Masters thesis, downloaded from <http://www.wits.ac.za/csvr/papers/papnv1.html>.

Williams, V. 2000. In need of protection: Good policy versus harsh reality for refugees in South Africa, *Track Two*, 9 (3), downloaded from <http://ccrweb.ccr.uct.ac.za/archive/two.index.html>.

Zungu-Dirwayi, N; Kaminer, D.; Mbaqa, I. and Stein, D. 2004. The psychiatric sequelae of human rights violations: a challenge for primary health care, *Journal of Nervous and Mental Disease*, 192, 255-259.