

# PERCEPTIONS OF MEDICAL DOCTORS ON REFUGEES' HEALTH SEEKING BEHAVIOURS IN DURBAN SOUTH AFRICA

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## Abstract

The available literature on refugees' health care seeking behaviours does not address the perceptions of medical doctors providing health services, yet doctors are likely to understand the refugees' health issues well. The aim of this study was to explore medical doctors' perceptions of health care seeking behaviours of refugees from the Democratic Republic of Congo (DRC) in Durban, South Africa. A qualitative approach was adopted consisting of in-depth interviews with four medical doctors practicing in the private sector. The results revealed that after failing to access health care services from public hospitals, refugees alternatively seek the same services from private practices, where they are compelled to pay a fee for these services. Refugees reported avoiding public hospitals due to mistrust, avoidance of stressors, miscommunication and non-possession of identity documents (which are a requirement in public health facilities), and their unmet cultural expectations. Findings suggest that refugees seek private health care services despite this being an additional financial burden to an already economically disempowered population group. This calls for cultural awareness, training and adoption of health care-communication facilitators, and building trust between health providers and patients in public hospitals.

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**Keywords:** Refugees, health seeking behaviours, Doctors' perceptions, South Africa

## Introduction

The 'health care for all in a democratic South Africa' was adopted after the country's first democratic election in 1994, and declared free and universal access that includes migrants and refugees as well as asylum seekers hosted by South Africa (Republic of South Africa, 1996; South African National Department of Health, 2014). As a party to the 1951 Convention on the Status of Refugees, which guarantees that refugees

exercise their fundamental rights and freedoms without discrimination and also be afforded the same treatment as nationals according to Article 20 (Greenburg and Polzer, 2008; Republic of South Africa, 1998; United Nations High Commission for Refugees, 2010), South Africa is also a signatory state to the International Covenant on Civil and Political Rights (ICCPR), which provides that all persons within the territory of a State Party have the inherent right to life and are entitled to equal protection of the law without discrimination (Articles 6 (1) and 26, respectively). Equally important, the right to access to health care services is also constitutionally guaranteed for everyone living in South Africa by the National Health Care Act as well as the refugee Act (Human Right Watch, 2015; Republic of South Africa, 1998).

Despite all these signatories, acts, policies and conventions, reports suggest that access to health care by refugees remains complicated and influences their health seeking behaviours (Crush & Tawodzera, 2014; Institute for Security Studies, 2014; Landau, 2012; Vearey, 2013). The 2015' Southern African Migration Project (SAMP) and the Africa Centre for Migration and Society (ACMS) reports reveal that health seeking behaviours of refugees and asylum seekers is shaped by myriad issues namely, the culture, trust, language and many other aspects that hinder access and utilization of public health care services (ACMS, 2015; HRW, 2015; SAMP, 2015). To this adds the complexities of refugee's definition, since some of the forced migrants are not documented, yet they call themselves 'a refugee'.

For the purpose of this study, a refugee is defined according to the 1951 convention on refugee status as "any person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country" (UNHCR, 2007). An asylum seeker is defined as a person who is seeking protection as a refugee and is still waiting to have his/her claim assessed (UNHCR, 2007). These two types of forced migrants as well as the undocumented ones were the people of concern in this study.

There are however, limited data on perceptions of medical doctors on refugee health seeking behaviours, especially in South Africa. Previous studies explored resettled refugees' health care seeking behaviours (Slewa-Younan et al, 2015), urban refugee health care seeking (Mohamed et al., 2014) and refugee's perceptions of their health (Elwell et al., 2014). None of these studies documented the perceptions of doctors on refugees' health seeking behaviours as the present study. This study aimed to explore factors shaping the refugees' health seeking behaviours and to find out why they seek private health care services despite their financial constraints.

Information generated by this study will be crucial to health policy makers, the South African government and the private sector to shape intervention measures that could assist refugees in seeking health care services in public hospitals.

### **Methodology**

The study used qualitative methods. In-depth interviews were conducted with four medical doctors employed in the public health sector but who also work in the private sector after hours and on their off-duty days. The four medical doctors were selected through purposive sampling, as I knew that they dealt with migrants in their private practices. Three out of the four respondents were Congolese nationals and one was a Kenyan national. Interviews were conducted in Swahili. The in-depth interviews were audio-taped and transcribed verbatim in order to capture the participants' responses and to allow for a thorough examination of what participants said (Bryman, 2004). The transcripts were translated into English by and translated in English verbatim by the researcher. All the respondents were interviewed in their private practices in Durban. Appointments were booked with each doctor so that interviews are conducted at a convenient time when the doctors could focus and take part properly. Ethical clearance was obtained from the Social Science Ethics Committee of the University of KwaZulu-Natal (Protocol Ref No: HSS/0739/013D). Ethical principles were adhered to as data remained confidential. Participation was voluntary and participants did not receive any form of incentive or reimbursement.

The study was conducted in the city of Durban, which is the second largest city in South Africa, after the city of Johannesburg. Durban was selected because it is less researched on refugees' health yet it is one of the most overburdened by diseases and hosts a great number of refugees from the Democratic Republic of Congo (HRW, 2015; UNHCR 2015). A recent UNHCR (2015) country operations profile reports that South Africa hosts the highest number of DRC [23500 refugees and asylum seekers] who come second after Somalia refugees who are [24000]. According to the report, over 40% of these DRC refugees and asylum seekers are based in Durban, while the rest (60%) are spread across other provinces and cities in South Africa (UNHCR, 2015).

### ***Data Analysis***

Data was analysed using framework analysis (Buse, Mays & Walt, 2005; Exworthy, 2007; Gale, Heath, Cameron, Rashid, & Redwood, 2013). The in-depth interviews were audio-taped and transcribed verbatim in order to capture the interviewee's discussions and to also allow for a thorough examination of what participants said (Bryman, 2004). The transcripts were

translated into English. After transcription, familiarization with data was obtained by reading and re-reading the transcripts to gain detailed insights into their experiences. A data coding system was developed that linked the codes or units of data to form themes that informed the model presented in this paper as suggested by (Morse & Richards, 2002).

## Findings

The respondents differed in age, specialization, nationality and time spent in practices (Table 1). The private practices of the doctors interviewed were frequently visited by refugees and asylum seekers. Patients pay an amount of approximately 250 South Africa Rand, (translated into 22 American dollars), as a consultation fee and spend additional money buying prescribed medication.

Table 1. Demographic characteristic of participants

Names	Dr 1	Dr2	Dr3	Dr4
Age	49 yrs	36 yrs	54 yrs	57 yrs
Gender	Male	Male	Male	Male
Location	Durban	Durban	Durban	Durban
Formal Employer	National department of health			
Specialization	Family Medicine	Gynecology	Paediatrics	Dentist
Nationality	DRC	Kenyan	DRC	DRC
Period of work	21 yrs	5 yrs	11 yrs	28 yrs
Own Private practice	yes	yes	yes	yes

Doctors in table 1 above provided information through which a number of themes emerged including, failure in communication, avoidance of stressors, mistrust of health care service providers, lack of documentation and dissatisfaction with public health services as well as the unmet refugees' cultural expectations. These were perceived by medical doctors as the main issues influencing the health seeking behaviours of refugees in the city of Durban, South Africa.

## Avoiding stressors

According to private medical doctors, refugees encounter stressful events at public hospitals. They are not only stressed by the communication challenges, but by the health systems as a whole, the health care professionals and also lay health workers such as security guards. One doctor reports that:

*“Refugees are stressed by the public health system which according to them lacks respect for patient’s values, attention to patient preferences and expressed needs (Dr2).*

*“Refugees report being stressed due to the lack of integration of care, information, communication and education, the physical comfort and emotional support, tough transition and continuity of care as well as the follow up on patients’ adherence to treatment at public hospitals” (Dr 4).*

In addition to what is described in the above quote, a lot more issues were reported by the respondents as their perceived reasons for refugees seeking private health care services. One respondent pointed out the fact that his practice charges ZAR 250 per consultation but refugees will always pay less than half the amount claiming that they cannot afford. The respondent further indicated that for his eleven years experiences in private practice, refugees have been coming with similar stories. The most common he noted were their negative experiences with public hospitals and the challenges they face in attempting to access health care services.

*“Some refugees cite language, xenophobia, discrimination, missed appointments, insults and negative attitudes of the health care workers as their reasons of not to continue seeking public health care services” (Dr 3).*

In line with the quote above and while this might be true, the doctors perceptions did not take into consideration challenges that citizens also face. The doctors described the situation as refugee failure to adapt and adjust to the receiving state. The doctors perceptions were that, upon their arrival in the country, refugees are told different stories regarding the public health care systems. The beliefs of refugees may be without verification but because they trust their fellow refugees, who tell them that public hospitals do not treat them well and that they do not even trust doctors and nurses at public hospitals.

### **Mistrust of public sector’s health care services providers**

Medical doctors in private reported that the refugees reportedly trust them more than they trust doctors in public hospitals.

*“My views with regard to refugees seeking health care services from our private post are: firstly they trust us more than the other doctors in public hospitals” (Dr1).*

Not only refugees are failing to trust the public health care services providers, but they reportedly believe that only medical doctors trained in their country of origin would address the illness appropriately.

*“They believe that some of the illnesses from home are not known by medical doctors trained in South Africa so they cannot be well addressed except by a fellow country doctor” (Dr1).*

*“The refugees do not trust the medication they get from the public hospitals. They sometimes come with them unused and claiming that they are fake and they go to purchase other treatments over the counter” (Dr3).*

*“Refugees are referred by others to us because they trust our working and the way we treat them. Some of them do get reference even from home to here in South Africa” (Dr4).*

Building trust requires a lengthy time spent together and a sharing of some social and cultural values and understanding. Ultimately, this study proves that refugees find it hard to trust some health care workers who are not able to communicate in a language that they will understand. Furthermore, refugees reported to private doctors that they do not trust doctors in public hospitals due to the inefficiency and carelessness with which they are treated. As one doctor reported:

*“Refugees come to my private practice because there is efficiency in diagnosis and test results, and they know I am from their home” (Dr3).*

The challenges with refugees’ health seeking behaviours are that they trust doctors from their home country more than other South African based-doctors. They have thus created a medium through which they communicate regarding the quality of services that they receive from doctors from their home countries and the same messages are filtered through those who are still in their native country. Upon their arrival, the refugees are already aware of the ‘negative’ treatment from public health facilities and the favourable treatment from private ones.

However, although the refugees do not trust the medication received from the public hospitals, and prefer buying medicine from their home over the counter; their private medical doctors indicated the opposite. One respondent indicated that he did not instead trust the medication from his native country and believed that the ones received in the South African public hospitals were genuine. This factor implies the cultural influence on health seeking behaviours of the refugees and their failed social integration. Instead of adapting to the way things are done in the host country, the Congolese refugees expect to receive the very same type of services and treatment as they were receiving from their country of origin

### **Lack of documentation**

Identity documents are requested at the very first encounter in public health care in South Africa. Failure to produce one can lead to lack of access to health care services, although this should not be the case according to the 2014 national department of health’s policy. To avoid these hurdles, undocumented migrants and refugees seek health care services from private practices where identity documents are not necessarily requested. Medical doctors at private practices reported that communicating with the client in the same language alone gives them a rite of passage to be issued treatment without having to produce any identity documents. The only thing that the

private practitioners reportedly ask is a consultation fee. One doctor reported that:

*“We don’t ask refugees for Identification Documents. We only need them to pay for our consultation fees and to tell us their illness history”* (Dr1).

*“Many of the refugees who come to my practice have no identification document. Knowing that it is their reasons of not being treated from public hospitals; we try not to ask them”* (Dr3).

Identifying an individual to whom services are being provided is crucial. However, saving life weighs more than anything and is a priority to private doctors. The respondents indicated that there have been many cases where refugees were denied treatments because they could not provide identity documents. Some of those denied treatment had stayed home, or sought traditional medication while others purchased over-the-counter treatments. This becomes one of the major reasons why they directly consult with private doctors to avoid documentation challenges.

### **Dissatisfaction with public health systems**

Refugees reported lower level of satisfaction with the public health care in Durban. To this their specific point about being ignored, ill-treated and misdiagnosed. While it is worth noting that the health sector of South Africa has been struggling to satisfy its own people, refugees are likely to be unaware of such situations and consider their own needs first. One of the doctors perceived the refugee to be too ambitious and self-centered. He argued that refugees claim that their needs are not met and they do not consider if the same needs are met for citizens of the host country. The respondent stated that:

*“When we ask refugees to go to public where they could be assisted free of charge they report that they are not satisfied with the quality of services at public hospitals”* (Dr4).

Refugees like any other human being prefer to seek health care services from a place where they feel their total human rights are respected and recognized. The quote above, paints a clear picture of the main reasons or factors that attract them to private clinics/hospitals where the treatment is very expensive. The refugees’ health seeking behavior is not strange but unique in a sense that an economically disadvantaged individual should be given priority but the health system does not provide that. Although many of the refugees cannot afford the payment for the services they still strive to pay based on the care and treatment received from their doctors from their countries.

*“Although there are many other traditional and cultural related reasons for their choice of seeking treatment with us, but dissatisfaction with public hospitals is why they come to private”*(DR1).

Many refugees feel like their rights to health care services are being violated in the public sector. During the interviews, one respondent reported that refugees cite some other elements related to the quality of health care received from the public hospital which according to them hinders their access and utilization of the health care services. The doctors also mentioned that refugees from the DRC culturally wait until they become seriously ill to start seeking health care services.

### **Unmet cultural expectations**

Refugees' health needs are diverse and complex. Cultural and traditional beliefs from their home country strongly influence their health seeking behaviours. One doctor indicated that refugees are too demanding and some of them impose on the health care workers a specific way to be treated. This alone may result in rejection by the public health care system. The respondent indicated that when refugees come to the private practices, the private doctors are all aware that the refugee will want to be treated as they would be in their country of origin. He stated the following:

*“Some patients were told at public hospital that their illness is not treatable in South Africa as they called it a ‘Congo fever’, another one was called ‘ukushaya’ so they came to us and both were diagnosed with malaria and typhoid fever respectively”* (Dr 1).

The medical doctor, who has been treating the refugees for the past 20 years, perceived them to be more demanding and asserts that it is hard for the public sector to satisfy their health needs unless they are allocated their own doctors who understand them and their culture better.

*“The queues at public hospital are very long, yet Congolese love to explain their illness history and of course there is a need for them to explain what the problem is about. Unfortunately at public the doctor has not much time to share with the refugee patient because he/she must attend to as many patients as possible during the day”* (Dr3).

There is however a need to note that there is a huge discrepancy between the culture, tradition, socio-economic, political and religious and traditional lifestyle between South African and Congolese. Nonetheless, of the many differences between the two countries, those between the two health systems are critical ones. Having an increased awareness of the refugee historical and cultural heritage can aid the health care workers in understanding the situation of the latter within South African health system. In many situations, a combination of therapies from both cultures can easily be used if the patient so desires. Based on the findings in this research, this

partnership of methods should be used and encouraged and the usage should not be only in exceptional cases. Sensitivity to other cultures and their traditional value system is critical in health care. If one can bypass one's own ethnocentricity, caring for anyone who is culturally different can be a positive experience. This implies that the understanding and acceptance of the cultural values and traditions of a population is crucial in effectively caring for that patient holistically. The opposite of the above-proposed application has been reported by respondents with regard to their treatment by the South African health system.

The quote above brings up the experiences of the doctor and his perceptions of the refugees' health seeking behaviours with regard to health systems. Regardless of the many elements raised by the refugees when they present at private practice; they are still perceived by the doctors as too demanding and ambitious, wanting to be treated the way they could be treated back in their countries. The doctors' perceptions are therefore: lack of understanding of the South African health system by refugees, their health seeking behaviour, culture, health education and expecting more than the health system can deliver.

### **Easy communication**

All the doctors interviewed in this study pointed to the issue of communication as one serious problem that refugees face when seeking health care services. The doctors encounter refugees at both public and private hospitals, as they also serve in private hospitals after public working hours and on weekends. Two respondents reported the following:

*“Refugees run from public hospital to private, simply because they can easily communicate well with us”* (Dr1).

*“When they come here we communicate in their mother tongue which allows them to explain themselves easily in Swahili, French, and Lingala”* (Dr3).

The failure of communication between health care service providers and their clients has negative implications on the health of the latter. As reported in this study, many refugees are not able to communicate with health care workers in public hospitals. Moreover, the South African health care system has not implemented the interpretation programme at its facilities. The language problem therefore compels refugees to seek help from private practices owned by Swahili and French speaking medical doctors. They do this for ease of communication.

### **Discussion**

During the search of literature for this study, no research has been found that has been conducted in South Africa documenting doctors'

perceptions of the health seeking behaviours of refugees. This study has revealed that refugees in South Africa avoid public health care services due to many challenges they face and the latter shape their health seeking behaviours. Some studies done in South Africa (Crush & Tawodzera, 2014; CoRMSA, 2014; SAMP, 2015) confirm that refugees adopt alternative health seeking behaviours due to the way they are treated at public hospitals in the host country. These negative treatments are however against the Batho Pele Principle (Independent Police Investigative Directorate, 2014) which suggests that people should be treated equally in every sphere of the government, and services are to be accessible by every individual living in South Africa.

Findings in this study are consistent with Morris, Popper, Rodwell, Brodine & Brauwer, (2009). They conducted a qualitative pilot study in San Diego County, California USA amongst refugees to explore their health care access issues. The health care providers interviewed in their study reported similar perceptions of refugees' health seeking behaviours citing acculturation and cultural beliefs regarding health care in the host countries. In line with Morris et al., (2009), refugees wait and only seek care when they are very sick, many do not consider health care services for prevention and the difference in economic and health systems in the host countries and a refugee's native country are perceived by medical doctors as aspects that shape the latter's health seeking behaviour.

In addition to cultural expectations, respondents in this study pointed out dissatisfaction with public hospitals as another aspect that shapes the refugees health seeking behaviours. Similar to this study, Morales et al, (1999) studied English- and Spanish-speaking Latinos in a cross-sectional study in America. They reported that Latinos who responded in Spanish were significantly more dissatisfied than Latinos who spoke in English. Dissatisfaction was measured by five observations about medical staff: (1) they listen to what patients say; (2) they give answers to questions; (3) they explain about prescribed medications; (4) they explain about medical procedures and test results; and (5) they give reassurance and support. It is important to note that dissatisfaction indicates the poor quality of communication but this may or may not be related to language and communication barriers.

Consistent with this study's finding, Morris et al., (2009) found that language and communication were major reasons why refugees avoided public hospitals in host countries and sought health services from doctors from their home country who own private practices. Further studies have shown that language barriers are associated with lack of awareness about health care benefits (such as Medical aid eligibility) (Feinberg et al., 2002), less insured status (Hampers et al., 1999), longer visit time per clinic visit

(Kravitz et al., 2000), less frequent clinic visits (Derose and Baker, 2000), less understanding of the physician's explanations (David and Rhee, 1998; Gerrish, 2001), more lab tests (Hampers et al., 1999), more emergency room visits (Hampers et al., 1999), less follow-ups (Kravitz et al., 2000), and less satisfaction with health services (Meredith et al., 2001; Morale, et al., 1999). All these elements were reported by respondents in this study as key forces driving refugees away from public hospitals.

Other studies suggest that trauma and stresses endured by the refugees in their countries of origin influence their health seeking behaviours in many ways (Lee, Robin & Friensen 2010; Mabaya & Ray, 2014). These findings are similar to those reported in this study, on the basis that all the respondents and their clients have experienced trauma and stress following war, political instability and violence from their country of origin.

Similar to the findings of Oucho & Ama (2009), they conducted a study amongst refugees and migrants in Botswana, in which participants reported that after they were diagnosed with particular illness, follow-ups did not happen. Doctors interviewed in this study reported that their clients pointed out issues of delayed tests results, lack of follow ups for those who are diagnosed positive with any disease. This practice demotivates them not only from seeking health care services but drives them out of the public hospitals to seek care from private practices.

### **Limitation**

This study has some limitations. The small sample size and the purposive sampling mean that interpretation of the results may not be subject to bias. Also, because this was part of a self-sponsored postgraduate research study, it was constrained by time and financial resources. Nonetheless, the use of probing questions subsequent to each interview question appears to have absorbed the apparently limited sample size. Additionally, the nature of the topic under study might have influenced the outcome, as some doctors were not available for interviews due to their busy schedules. Despite these shortfalls, this study contributes significantly to the literature documenting refugees' health seeking behaviours from the perspective of doctors to inform health policy-makers.

### **Conclusion**

Results from this research suggest that refugees' health seeking behaviours are complex and hard to comprehend. Interviews with their home-country doctors who own private practices have provided details on the way refugees deal with their health issues. The perceptions of private doctors suggested that mistrust, avoiding stressors, lack of documentation and failure to communicate are the main issues pushing refugees away from

public hospitals. Refugees were also reported to seek health care services only when they become very ill. Findings in this study indicate a need for interventions targeting refugee populations, particularly improving access to health care services, while promoting health belief and encourage the use of preventive treatment and care.

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