Viability of Peer to Peer Counselling amongst Refugees in Cape Town.

Independent Research Project

Cornerstone Institute

By

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Supervisor: Dr. Mario R. Smith
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ALL minutes from AMP strategizing and planning meetings regarding the peer counselling research and programme can be accessed on request from admin@adonismusatiproject.org
**List of Acronyms**

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<td>AMP</td>
<td>Adonis Musati Project</td>
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<td>CHW</td>
<td>Community Health Worker</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>MPH</td>
<td>Masters in Public Health</td>
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<td>MSF</td>
<td>Médecins Sans Frontiers</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>Non-Profit Organisation</td>
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<td>NYU</td>
<td>New York University</td>
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<td>WHO</td>
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Abstract

South Africa remains one of the highest destination countries for asylum seekers in the world. Many of these men, women and children have fled dire situations, such as war, genocide and starvation in their countries of origin, crossing borders into South Africa, sometimes illegally and at great risk, to try and access safety and survival. Instead they are faced with xenophobia, extreme hardships, an overburdened and ineffectual immigration system and a country struggling to support and feed its own population. Added to the overwhelming social and economic burdens of these cross-border migrants, is the psychological and emotional trauma of their experiences. The World Health Organisation estimates that over 50% of refugees have mental health problems ranging from post-traumatic stress disorder to chronic mental illness and that their functioning in society is greatly impaired if these problems are not addressed.

Although there are some NGO services and resources available in South Africa to assist this vulnerable population group there has been very little collective and strategic intervention addressing their mental health and psycho-social needs. One NPO that provides services to refugees and asylum seekers in Cape Town, The Adonis Musati Project (AMP), identified this need as crucial to the development and wellbeing of their clients and their ability to function optimally as well as integrate and contribute to South African communities.

Preliminary research was undertaken by AMP to assess the need for and viability of implementing a peer counselling programme to address the psycho-social needs of cross border migrants in Cape Town. Part of this research involved a focus group discussion (FGD) with 13 refugee and asylum seeker women living in Cape Town. The results of the research and FGD suggest that there is a great need for practical solutions to the worsening mental health problems experienced by cross border migrants in Cape Town. The concept of trained, resilient peers assisting their fellow refugees and asylum seekers was met with very positive results.
CHAPTER ONE

Introduction:

1.1 Background of the study

The United Nations High Commission for Refugees (UNHCR) identified South Africa as one of the highest destination countries in the world for asylum seekers as evidenced by the world wide record of applications for asylum lodged per country held by South Africa in 2010 (UNHCR, 2012). According to Sermand (2012), SA Stats (2009) and the SA Police Annual Report of 2011, there are between 3 and 6 million undocumented cross border migrants living in South Africa and approximately 500 000 asylum seekers arriving in South Africa each year. This estimate is greater than all 27 countries in Europe combined. Most of these cross border migrants enter South Africa to access safety and survival after fleeing conflict, torture and collapsing economies, as well as ethnic and political violence in their countries of origin (UNHCR, 2012).

Those who overcome the oftentimes dangerous journey from various African countries such as, the Democratic Republic of Congo, Somalia and Zimbabwe, then have to overcome the perils of trying to survive in South Africa (Médecins Sans Frontières (MSF), 2009). Sermand (2012) reported that

“25% percent of the entire Zimbabwean population has fled Zimbabwe to neighbouring countries, especially South Africa, as a matter of survival. They are raped, beaten, and robbed while crossing the border, they struggle to find basic shelter and other assistance in South Africa, and they are subjected to xenophobic violence, abuse, and neglect, even when trying to access healthcare” (p6)

This author further argues that “These vulnerable people are marginalized, stigmatized and victimized which worsens the public health risks they face because they are largely invisible and excluded from medical services (p3)”.

Refugees and asylum seekers are one of the most vulnerable population groups in South Africa. Most have suffered significant trauma in their countries of origin only to be faced with overwhelming obstacles when they cross the border seeking help. Apart from the stress of
trying to survive and access basic services, migrants face the constant threat of deportation, government red tape, corruption at immigration offices, xenophobia and lack of welfare and medical assistance (MSF, 2009). In addition they suffer many other human rights abuses including unwarranted arrests, exclusion from educational facilities and exploitation and discrimination in the workplace. Documents of limited validity compromise refugees’ efforts to become self-reliant by making it hard for them to hold long-term jobs or open bank accounts (UNHCR, 2012). The World Health Organization (WHO) reported that cross border migrants also have to overcome language and cultural barriers which in the case of women and children may lead to isolation and gender violence and for men underemployment and humiliation, all exacerbating the psychosocial dysfunction evident in so many (2012).

These asylum seekers and refugees, who make it into South Africa, have a number of critical needs including trauma counselling, food, clothing, shelter and medical assistance (MSF, 2009). Many also require assistance with advocacy, documentation, enrolling children in schools, learning local languages (especially English) and often training in order to acquire menial employment as soon as possible (The Agency for Refugee Education, Skills Training & Advocacy (ARESTA), 2012); (Scalabrini Centre of Cape Town, 2013); (WHO, 2012).

It is important to note that in South Africa there is a difference between a refugee, an economic migrant and an asylum seeker. According to the International Organization for Migration (IOM), an asylum seeker is an individual seeking safety from harm or persecution in a country other than their own and who then applies for refugee status in that host country. The decision to grant them status is determined by both international and national laws. A refugee is someone who has proven reasons for leaving their country of residence, including fear of persecution because of race, nationality, religion, or particular political or social membership. An economic migrant is an individual who leaves their country of residence or origin to settle in another country in order to improve their quality of life (International Organization for Migration, 2011). In order to simplify terminology, the population group that is represented in this study will henceforth be referred to as cross border migrants or simply migrants and will by definition include asylum seekers, refugees and economic migrants.

It is the aim of all asylum seekers to obtain refugee status which ensures similar rights to South African citizens. However, only a very small minority of cross border migrants ever obtain this status and the rights that accompany it. Most are caught in a system where it is necessary to renew their asylum papers every few weeks or months with no guarantees of

There are a number of non-profit organizations and service providers in Cape Town that attempt to address one or more of the needs of cross border migrants, including advocacy, training and welfare, but there are still significant gaps in service due to the large influx of asylum seekers, insufficient government resources and the complexity of the migrant’s situation (Scalabrini Centre of Cape Town, 2013), (The Adonis Musati Project, (AMP), 2013).

Recognition of the impact of their situation on the mental health of migrants is emerging but remains poorly addressed in terms of allocation of resources. Despite scientific evidence that conflict has a devastating impact on physical and mental health, the latter is not seen as a priority by many decision-makers (World Health Organization, 2012).

The Adonis Musati Project, a Non-profit Organization started in 2007 and named after a young Zimbabwean who died of starvation while waiting in the queue at the Refugee Reception center in Cape Town, sought to address some of the difficult issues faced by cross border migrants in Cape Town. Since its inception the project has been involved in a number of initiatives and activities including health and welfare, training, education and advocacy (AMP, 2013).

Due to a combination of natural growth in the agency along with shifts in demographics of clientele in part due to changes in the global/local political climate, The Adonis Musati Project (AMP) has adjusted its programs, location and services provided. While the mission of providing humanitarian assistance, advocacy and basic services remains the same, and successes are plentiful, it is evident from preliminary, semi-structured qualitative research, that due to the growing needs of this marginalized group AMP had to strategize to reach more clients in a more sustainable and effective manner. While AMP and other agencies assisting cross-border migrants are able to provide certain amenities, it has been observed by staff that nearly all foreigners assisted by AMP to date, are struggling with trauma and psycho-social problems.
This preliminary research conducted by AMP staff and volunteers indicates a great need in the refugee and asylum seeker community throughout Cape Town and surrounding areas for more culturally sensitive mental health interventions. This research included extensive literature reviews on the topic, interviews with key informants from various organizations that work with foreign migrants as well as interviews with AMP staff and clients. The results of this investigation indicate a large gap in sustainable, accessible and equitable mental health and/or psychosocial services, particularly in individual's current neighborhoods. One of the options to assist cross border migrants with this problem is the implementation of a community based intervention involving peer counsellors.

While it has been found that peer to peer programs currently exist in Cape Town, they are primarily focused on various types of health education, such as reproductive health or HIV/AIDS, e.g. the mother2mothers programme, or they are comprised of a series of workshops rather than ongoing support services. Furthermore, many existing ‘peer to peer’ programs are geared towards local South Africans in addition to migrants, rather than specifically for foreigners. This is of significance due to the magnified needs of migrants to have familiarity and safety, particularly with regards to language and culture, when engaging in psycho-therapeutic activities. Not only do they have to adjust to an unfamiliar culture, enormous psycho-social needs as well as xenophobia but they must deal with the aftermath of events that precipitated the need to migrate from their home countries in addition to trauma experienced crossing borders and trying to assimilate into their host country (www.m2m.org/fact-sheet.html), (WHO, 2012).

Many of the women who cross the border into South Africa from East Congo and Zimbabwe have suffered significant violence and often rape, pre-migration and post. United Nations agencies estimate that at least 200,000 women have been raped in the DRC since 1998, it has been described by one former senior UN official as the “rape capital of the world (The United Nations, 2013), (MSF, 2009).

MSF (2009):

  We have seen several cases where women are raped at the border crossing and later again in Musina. They have serious health needs and deep psychological scars (p 17)
Due to the difficulty in accessing services to meet these psycho-social needs, particularly trauma counselling, AMP plans to investigate initiating a peer to peer counselling program to supplement services currently offered by other stakeholders with regards to health and mental wellbeing for cross border migrants within South Africa. Though this would require expanding AMPs capacity and programs, the AMP staff and board is convinced that the holistic needs of cross-border migrants could be best met by people trained in counselling skills who had undergone similar experiences migrating and settling in Cape Town.

Apart from literature reviews on the subject, a needs assessment was conducted to determine the feasibility of such an initiative. This included: interviews with relevant stakeholders in the NGO community; AMP client and staff interviews and a focus group run by AMP on 6th July 2012, consisting of 13 cross border migrant women from different countries. There were difficulties in completing all the analyses and consolidating the themes due to a lack of focused planning regarding particular research and evaluation. Thus the need that existed was for a more thorough analysis to be done, aimed specifically at psycho-social needs. This thesis addresses that need by analyzing the focus group discussion.

1.2 Problem statement

At this stage in AMP’s research the need for alternative mental health interventions for refugees and asylum seekers had been indicated both through staff experience, preliminary research in the field as well as extensive literature reviews on the subject.

AMP would like to conduct qualitative research with regards to the following deductions made by staff and volunteers:

1. There is a great deal of mental distress in the cross-border migrant community in Cape Town
2. Mental health problems impair functionality and development
3. Positive mental health is fundamental to enhancing relationships, productivity and coping with adversity
4. Peer counseling would greatly help to address the mental health needs of the cross-border migrant community.
5. Peer counselling would be accessed by the cross-border community and viewed by them as a great asset.

The initial focus group run by AMP on the 6th July 2012 is an important component in
gathering evidence to substantiate other preliminary research and a thorough analysis of the focus group content is necessary to proceed with further plans. An empirically validated analysis of the focus group will thus form the basis of this thesis. **1.3 Rationale for the Study**

The focus group, conducted on the 6th July 2012, was initially created as one of several methods utilized in the preliminary research phase which was to assess the need and desire for a peer counselling programme for cross-border migrants. It is also a necessary step to create a valid proposal for the management committee’s approval before steps are taken to seek external funding. Prior to this, health questionnaires were distributed to clients for several months in addition to informal, individual interviews conducted with AMP staff and board, clients, and cross border migrants living in Capricorn. Staff from other agencies in Cape Town that work with cross border migrants were also interviewed. While it is hoped one can create programs for both men and women, this initial focus group was conducted with women only to ensure a sense of safety, confidentiality, and a space to discuss issues without family members present.

The purpose of the focus group analysis is to gain insight and direction for AMP by evaluating the responses of a sample of cross-border migrants to various topics and questions around mental health resources and needs (Cresswell, 2004).

This study will seek to analyze the data captured by the note takers as well as the recording and transcript.

Based on the organizations 5 years of experience, as well as other preliminary research, there is reason to assume that the participants in the focus group will corroborate many of AMP’s perceptions that there is indeed significant mental distress amongst cross border migrants and that participants will respond favourably to the idea of a peer counseling programme. However only thorough analysis of this initial focus group, in addition to future similar focus groups, could this assumption be validated.
CHAPTER TWO

Literature Review

2.1 Methods used

The methods used to assemble the necessary background literature pertaining to the thesis included extensive reading of articles, books and journals as well as reports regarding the current state of cross border migrants in South Africa and the subject of peer counselling. The literary research itself was directed, to a large extent, by the interviews already done with AMP staff, board, clients and relevant stakeholders and NGO’s regarding the subjects mentioned above. The data obtained by this preliminary in the field research formed the foundation for further investigation.

The literature review is organized into three main sections and each will examine core aspects pertaining to the proposed study. First, I will unpack the concept of peer to peer counseling, its theoretical framework, the various applications and models and their effectiveness, particularly with regards to refugees and trauma. Second we will look at the relevance of a community based intervention such as peer counseling amongst cross border migrants within the context of South Africa and Cape Town in particular. Third, a brief summary of the goals, operations and data collected from AMP that initiated this research. Fourth a summary of areas requiring further exploration or gaps in the literature will be outlined.

2.2 Relevant Literature

2.1.1 The Concept of Peer Counselling

According to Mead, Hilton and Ross (2001)

Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another’s situation empathically through the shared experience of emotional and psychological pain. (p134)

Peer support or peer counselling transpires when individuals provide emotional, social or practical help to one another, including the sharing of knowledge and experience, and often encompasses an enterprise which entails trained supporters leading and facilitating the initiative. It has been used very successfully in a number of contexts including mental health,
addiction and education and encapsulates the concept that people with similar life experiences can offer better support, practical advice and genuine empathy to their peers than professionals in many instances (Mead and MacNeil, 2006). The very fact that it is community based and not dependent on professionals is what makes it most effective (Mead and MacNeil, 2006).

According to Mead and MacNeil (2006), there are several “critical ingredients” that constitute peer support and these include the fact that the groups are voluntary, consumer run, flexible, non-medical and non-hierarchical and they often preside in an informal setting. They promote the peer and helper principles, empowerment, advocacy, community, self-awareness and skills development (Mead and MacNeil, 2006).

2.1.2 Theoretical Support of Peer Counselling

According to Salzer (2002) and Solomon (2004), the effectiveness of peer to peer support as a therapeutic model, has a strong theoretical basis. These include Social Comparison Theory, Social Learning Theory, Social Support theories, Experiential Knowledge theory as well as the Helper-Therapy Principle or Helper Theory.

Social Comparison Theory formulated by Festinger in the 1950’s essentially looks at the positive outcomes, of both upward and downward comparisons, that people acquire as they seek contact and interface with others who have had similar experiences to them.

Bandura’s Social learning Theory indicates that people are more likely to change their behaviour positively, when modelling is imparted by peers rather than non-peers and that peers who have undergone and successfully overcome or managed relevant experiences hold more credibility and set an example as role models for others (Salzer, M., & Shear, S. L., 2002).

Social Support Theories suggest that consumer driven support in its various forms including, emotional; instrumental; informational; companionship and validation, increases and enhances positive behaviour modification amongst participants and shields against stressors and hardships (Young, 2006; Solomon, 2004).

Experiential knowledge pertains to the particular perspectives and knowledge individuals acquire because of their unique life experiences which may include substance abuse, violent or sexual abuse, physical or mental illness or surviving traumatic events such as wars or
natural disasters. This sharing of life experiences contributes to problem solving and improves quality of life (Shubert, M., & Borkman, T., 1994).

The Helper –Therapy Principle proposes that helping others within a self-help or mutual assistance support group is beneficial to both the helper and the helped. It is a model first described by Frank Riessman in 1965 when he discovered positive psychological benefits and a greater sense of well-being and worth amongst helpers as a result of making an impact on someone else’s life. This is turn has a positive effect on the helped and proved to be mutually beneficial (Riessman, 1965), (Salzer, M., & Shear, S. L., 2002).

2.1.3 Peer support and Refugees

Power struggles throughout the world over the last few decades have led to the suffering and displacement of millions of human beings. With this suffering comes huge trauma and psychological scarring. There has been much concern by professional not only on the impact this has but on how to apply effective strategies to cope with the enormity of the problem. This has led to the formation of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007).

The IASC main principles stress the need to protect the universal human rights and special needs of all members of affected communities without discrimination and to provide access to social support and services for everybody. They also emphasise building on local resources and capacities and the need to develop multi-layered responses that strengthen existing community and family support systems as well as offering focused, non-specialized support structures. According to Salem-Pickartz (2008) training peer counsellors is a response to this call and to the fact that there will never be enough trained professionals to deal with the impact of global displacement.

Macauley (2011), states that peer to peer support is becoming a significant strategy in helping survivors of conflict and war. It can occur in community settings, be adapted to suit certain environments and emphasizes peoples strengths all while being culturally sensitive since it is delivered by members of the same community.

Most trauma specialists acknowledge that in an understanding and supportive social setting, long-term psychological dysfunction may be prevented (Macauley, 2011).
One of the difficulties facing refugees and victims of trauma is that mental-health services in post conflict settings as well as countries they have fled to are often thinly stretched and not always culturally appropriate (Macauley, 2011).

Evidence of this problem is re-iterated in research. Salem-Pickartz (2008) emphasizes that psychotherapy in and of itself is not adequate in dealing with the enormous magnitude of psychological distress suffered by refugees. She emphasizes that community-based interventions amongst refugees extend the reach of mental health support significantly and can complement more traditional mental health services where available (Salem-Pickartz, 2008). Miller (1999) also emphasises the importance of complementing traditional clinical approaches with community based interventions thus creating a more comprehensive approach to refugee mental health (Miller, 1999).

The World Health Organization recognizes that many of the mental health theories, projects and intervention methodology have been developed in Western countries and many times implemented without the necessary cultural adaptations. Many of these models are not sustainable and increase the dependency of the populations they are trying to assist. They thus hinder local capacity building and would be more meaningful if they adopted a more holistic and multi-sectoral approach (World Health Organization, 2012).

Although studies conducted by the WHO and other leading global organizations have a general consensus that government fragmentation, lack of on-going funding, and poor programme development contributes to on-going sustainability, it is also agreed that CHWs (peer counsellors) provide a critical link between their communities and service providers (Bhutta et al, 2010) and should continue to be utilized. The WHO (2010) recommends that strict recruitment criteria, training content, certification process, on-going and refresher training, supervision, and incentives be considered in the development phase (Bhutta et al, 2010).

2.1.4 Peer counseling for Refugees/ Cross border Migrants in South Africa

Asylum seekers that cross the border into South Africa often face enormous health risks because of their irregular legal status. As such many avoid healthcare at hospitals and clinics and so place themselves and others at great risk (Sermand, 2012).
Many of the cross border migrants that enter South Africa have endured conflict and massive human rights violations leading to enormous cognitive and emotional affliction. According to WHO (2012) it has been determined that more than (50%) of refugees suffer from mental health problems including trauma and stress, as well as chronic mental disorders. Due to the enormous scale of the problem, extensive psychiatric help for each individual is not possible. It is recommended that community-based psycho-social care becomes an essential component towards addressing this problem. It has been found that the psychosocial functioning of this affected population is greatly improved when the community is involved (World Health Organization, 2012).

While the situation in Cape Town is not that of an emergency context, many of the foreigners have relocated due to some type of conflict or emergency, carrying different degrees of resilience and/or mental health outcomes. In light of the wide scope of personal (and political) responses, to promote sustained success the UNHCR also recommends programs such as peer counselling to ensure cultural and linguistic appropriateness, and social mobilization (UNHCR, 2012).

As many of the clients served at AMP are also struggling with HIV/AIDS related issues, a peer counselling programme would also need to specifically address this. Medley et al. (2009) reported that peer education and counselling programmes in developing countries are effective in increasing knowledge amongst clients regarding HIV, improved condom use and improved behavioural outcomes.

2.1.5 The Adonis Musati Project: Goals, Operations and Preliminary Research data

The mission of the organization is to “provide humanitarian assistance and support to vulnerable and disenfranchised refugees and asylum seekers, in order to facilitate a transition to self-reliance”, (AMP, 2013). This transition to self-reliance is accomplished by trying to address physical, as well as psychosocial needs using a variety of programmes.

There are three main programmes addressing these needs:

1. The Independent Living Programme – this is a long term project that provides board, lodging, education, mentorship and social work services to refugee youth found living on the streets in Cape Town
2. The Refugee Outreach Programme – both short and long term assistance provided to clients in the form of:
Research Report: Peer Counselling Focus Group

- Assistance with advocacy regarding legal rights pertaining to documentation, education and medical care
- Assistance with access to food, clothing, shelter, education, medical care and safety
- Assessment of needs and then providing information and referrals to resources and service providers assisting refugees and asylum seekers in Cape Town
- Assistance with starting small businesses or attending skills training (funds-permitting).
- Provision of limited psycho-social lay counselling

3. Support Group Programme:
   Running 12-week support groups for both male and female clients in order to:
   - Create a safe space for participants to share their stories
   - Teach basic psycho-social life skills to participants
   - Provide information about relevant resources and service providers
   - Assist participants to set at least one measurable goal for their lives
   - Provide basic welfare to participants while on the programme

2.1.6 Preliminary Research data

During 2012 the AMP staff and board realized there were limitations with some aspects of the programmes and that in order to reach more clients in a way that lends itself to long term sustainability, methodology would need to be reviewed (AMP, 2012). Seeing clients on a one-on-one basis was not sustainable and made the monitoring and evaluation of progress difficult. Intake interview data collected over a three year period was evaluated and emerging trends and patterns identified. Several themes emerged including the need for further counselling, psycho-education regarding health (both physical and mental) and life-skills. Although some of these issues were dealt with to some extent during support groups, these programmes were unregulated with vaguely formulated outcomes and facilitated by untrained staff. It was decided to do additional preliminary research into alternative ways of rendering services to clients using a more holistic, community-based model. From this was birthed the idea of a peer counselling programme involving training and supervision of experienced, resilient members of the refugee community to assist fellow refugees. Literature research was undertaken and interviews held with project leaders and directors of several relevant service providers in Cape Town to assess the possibility and need for such a programme. This data was documented and complemented the psycho-social needs

2.3. Summary of findings
In summary, literature substantiates the fact that peer-to-peer support is a viable and workable model in many contexts. There is substantial evidence that many refugees, including those crossing the border into South Africa, have significant mental health problems, as well as psycho-social difficulties. Organizations such as MSF, UNHCR and WHO, highly recommend community-based mental health interventions such as peer-to-peer counselling as a means of addressing these difficulties. There is consensus that peer counselling amongst refugees and asylum seekers would be beneficial.

2.4 Limitations of research

Much of the literature is applicable to victims of trauma and migration, but there have been very few studies done on cross-border migrants living in Cape Town as opposed to the rest of South Africa. There also appears to be no documented or published evidence of research regarding peer counselling initiatives or interventions with refugees in Cape Town and insufficient research and evaluation of similar programmes implemented elsewhere in South Africa. This is research that needs to be undertaken. AMP, on the ground preliminary research, confirms the need for additional investigation and research regarding the feasibility of a peer counselling programme amongst cross border migrants in Cape Town and further carefully evaluated research such as focus groups are necessary to develop this. Thus AMP attempted to test the perceptions of cross-border refugees about a peer-led support group. However, staff shortages and expertise hindered the analysis of the focus group feasibility discussion and preparation of a formal report. The researcher was given permission to transcribe and analyse the focus group discussion and write it up in partial fulfilment of her thesis requirement (AMP, 2012).
CHAPTER THREE

Methodology

3.1 Aims of the study

It is AMP’s intention to include focus groups as part of the preliminary research into the viability of implementing a peer counseling programme. Theory and rationale supporting this particular research methodology to compliment other preliminary research, is very important and will be discussed further in this chapter.

3.1.1 Research design

Qualitative methodology is important to use in this particular type of research as it examines a specific research problem through the eyes of the local population involved. In addition information about opinions, values and behaviours is culturally distinctive and socially contextualized (Mack et al, 2005).

It is particularly useful in exploratory research as the use of probing and open ended questions allows participants to respond in their own words unlike quantitative methods which force them to choose from a fixed response.

Open ended questions allow for culturally salient and meaningful responses that are often unanticipated by researchers. According to Mack et al (2005), they usually have richness to them and invite further exploration. Another benefit of using qualitative research is the element of probing. Researchers have flexibility to engage with each participant in a unique way according the individuals personality. This allows for researchers to probe further by asking how or why after participants’ initial responses, thus adding to the value of the narrative (Mack et al, 2005).

Compared to individual interviews, focus groups may shed more light on participant’s perspectives through robust discussion and debate around certain ideas or experiences, in this case the needs and difficulties surrounding migration in Cape Town. Focus groups are also well suited to investigating how ideas and knowledge are cultivated and function within a particular cultural context (Kitzinger, 1995). This is particularly pertinent due to the multicultural element of this particular focus group and is reiterated by Gibbs (1997) when he states that focus groups are particularly useful when researchers want to take into account the
everyday use of language or culture of a particular group and when exploring consensus on a specific topic. Although the methodology is qualitative, it is vital that there is good design, planning and implementation of the focus group study, including methodology and analysis. Apart from careful planning and preparation; sampling; ethical considerations; moderation and note taking need to be taken into account (Breakwell, 1995).

3.1.2 FCD as a compliment to other research

Breakwell et al (1995) explains that focus group studies can enhance other methods of study and investigation on the same topic. This is very relevant to AMP as they have already conducted other preliminary research such as interviews. Billson (2006) confirms that focus groups are most successful when they complement or supplement other methodology and researchers place significance on triangulation (i.e. looking at the topic through a different lens).

3.1.2 Research setting

As AMP operates from Cape Town it is relevant to get responses and feedback from clients within the greater Cape Town area, as the proposed programme will be implemented in this locality. The focus group discussion took place at the offices of The Adonis Musati Project in Observatory, Cape Town. The premises are comfortable and easily accessed by public transport.

AMP understood that in order for participants to open up and share honestly they needed to feel both safe and relaxed and from the feedback received from participants this goal seems to have been achieved. The fact that they all shared their experiences so willingly corroborates the findings of Gibbs (1997) related to safe environments for FGD’s.

3.1.5 Ethical considerations:

AMP took great care to follow the necessary ethical guidelines. The purpose of the study was made very clear on the flyer and in person (using translators where necessary). The women who agreed to participate in the focus group gave informed consent for AMP to use the research for the benefit of refugees and asylum seekers. This is in concordance with the FHI (2011) guidelines indicating consent forms must be written in a language the participant understands and if participants are not literate each phrase or section should be read to them slowly and carefully ensuring they understand.
According to FHI (2011), recruiting participants from vulnerable people groups can be challenging and may elicit concerns regarding confidentiality, fear or misinformation about the study. That is why during the focus group itself participants were assured of their anonymity and given the option of sharing only what they felt comfortable disclosing. Gibbs (1997) reiterates how important it is that the facilitator does not pressurized participants into talking and that right from the outset confidentiality must be addressed. Gibbs goes on to emphasize participants must agree to keep confidential anything they hear from each other and they must be assured that researchers will respect anonymity.

The intentions of the research were explained in more detail to participants when they arrived for the focus group and it was made clear that their responses would be recorded for research purposes as suggested by Fritz (2008). In addition at the start of the focus group all participants agreed to keep confidential any sensitive information shared within the group. This corroborates the recommendation by Fritz (2008) that participants of focus groups need to be well informed regarding the purpose of the research they are being asked to participate in and the risks they may face as a result. They also need to be made aware of the possible benefits of the research and informed consent processes need to be established and followed.

Fritz, (2008) goes on to say that it is vital that risk be reduced and confidentiality be maximized and that all members of the research team should receive adequate ethics training. Although the research team was well aware of ethical conduct, no standard training, which included researchers and the translator, was undertaken prior to the FGD and this should be considered when planning future focus group discussions at AMP.

Fritz (2008) reminds researchers that sensitive topics may evoke emotions amongst participants, thus it is vital to plan ahead and have adequate referral services available should this be necessary. The AMP team was prepared for this possibility with an appropriate referral system beforehand should any of the more sensitive topics evoke uncontained emotions amongst participants.

3.2 Method of data collection

3.2.1 Population /target group

The section of the population that is being targeted for this particular research is cross-border migrant women in the greater Cape Town area, including refugees, asylum seekers and economic migrants.
3.2.2 Sample

The study participants, a sample of 13 asylum-seeking women, were chosen using snowball sampling through word of mouth and a multi-lingual flyer. The flyer which was translated into several African languages was distributed to potential participants explaining to them the nature of the focus group.

According to Breakwell et al, (1995), Sampling and recruitment of subjects should be employed using methods that would provide the most significant information with regards to the purpose of the study. As such group members should have something to offer with regards to the topic at hand. Although a cross section of participants could be beneficial, they should all have some common characteristics. This is true of the sample chosen as they are the target group AMP offers services to.

The women who chose to participate came from various cultural backgrounds but were all refugees or asylum seekers, all single mothers and all living within the greater Cape Town area. The reason for this was to assess the needs of the most vulnerable portion of the population group AMP serves. As a small incentive to participate, the women were all offered lunch, a small food hamper and transport money to and from the group.

The sample comprised of 13 foreign women including 1 from Burundi, 4 from Rwanda, 6 from Democratic Republic of Congo, 1 from Congo, and 1 from Zimbabwe. The women came from 5 different surrounding areas (3 from Retreat, 2 from Lavender Hill, 6 from Capricorn, 1 from Steenberg, and 1 from Khayalitsha.). According to studies, effective focus groups should have approximately 10 participants or less and length of sessions should be about two hours (Breakwell et al, 1995) and the fact that this group consists of 13 must be taken into account. The larger group was thought to off-set the sensitive nature of the group and the linguistic challenges potentially faced by the participants. Also a longer time period was allowed to ensure that there was sufficient time for all to contribute.

Their ages ranged from 21 years to 49 years and though all had asylum papers, none had refugee status. Their length of stay in South Africa was between one and nine years. 10 of the women could communicate in English but 3 of them needed the assistance of a translator to understand what was being asked and to respond.

According to Kitzinger (1995), most researchers would recommend homogeneity within the group so as to make the most of people’s shared experiences, however there are also
advantages in bringing together a diverse group in order to thoroughly explore different perspectives within a group setting. The researcher must also be aware of how hierarchy within the group may affect data (Kitzinger, 1995). The researchers were cognizant of the fact that the participants were of different ages, from diverse cultures and had varied economic and educational backgrounds and that this may or may not affect participation. Their occupations in countries of origin included: Social work, Nursing, Law, Lab Technician, Hairdressing, Business, Teaching and studying.

According to Gibbs (1997) it is important that participants feel comfortable with each other and it may be more appealing to meet with others they think possess similar qualities, circumstances or levels of understanding regarding certain issues as opposed to meeting with others they perceive as being very different. However, although the participants were from different backgrounds and countries, they all had the common experiences of migration and the difficulties of past and present trauma as commonalities.

3.2.3 Method of data collection

The method of data collection employed in the study was a focus group discussion. This included the collation of dialogue and responses to questions posed during the focus group discussion. The discussion was recorded manually by two note takers. This is in line with the recommendations of Family Health International (2011), which state moderators and note takers should take notes strategically, record both question and response using key words and phrases and cover a wide variety of observations including body language, moods and attitudes.

According to Kitzinger (1995), there are several aims one can hope to achieve when examining participants’ responses within a focus group. These include bringing to light respondent’s points of view, their language and what is important to them.

This was all taken into account and the focus group methodology included relevant questions to gain information from women living in communities in and around Cape Town. The series of questions was created to elicit information regarding services in Cape Town, pertinent demographic/historical information as well as their opinions regarding counselling, peer counselling and mental health assistance. The questions served as a guideline, allowing for appropriate adjustments to be made throughout, and allowing participants to come up with questions of their own where appropriate. This corresponds with what Kitzinger (1995) says
about researchers encouraging respondents to create and discover their own questions and manner of analyzing their common experience. He goes on to emphasize how focus groups should help identify cultural values and group norms, encourage participants to talk openly about difficult or embarrassing issues and allow participants freedom to express criticism. However when conducting cross cultural focus groups a number of issues need to be accounted for. Researchers must take into account language differences and be aware that some concepts cannot be adequately translated in some languages. Different cultures may also have different ideas regarding body language and eye contact and may also not feel comfortable sharing sensitive or private information and researchers would do well to investigate certain customs prior to the group meeting (Billson, 2006). As the facilitators, note takers and translators have all had many years of working with cross-border migrants in South Africa, these cultural nuances were respected and understood.

Gibbs (1997) emphasized how focus groups enable researchers to gain large amounts of information in shorter periods of time compared to other methods such as interviews or surveys. This is significant for AMP as resources are limited and extensive data needs to be collected in as short a time as possible.

Once the focus group was wrapped up, the research team should have taken a short break before participating in a debriefing session held by the note-taker. This would have been to clarify notes taken and gather any additional information while it is still fresh in the researcher’s minds (Family Health International: FHI 360, 2011).

All notes and the recording were collated after the FGD and a date set aside to analyze the data collected.

3.2.4. Process

Those women willing to participate were requested to volunteer their time for the focus group conducted on the afternoon of 6th July 2012. Expecting a 20% drop out rate, more women were asked than the initial 12 that AMP hoped would make up the group. However none of the women dropped out and all 13 in addition to the translator, facilitator and two note takers, attended. This is not the ideal number of participants suggested by experts such as Breakwell et al (1995) which identify the ideal number of participants as between four and eight. (This may or may not have affected the data as some participants were more confident at speaking than others and a smaller group may have been more comfortable for some women.)
It is very pertinent that all those conducting the focus group are also very familiar with the project and its ethos according to Breakwell et al (1995). All those that were involved, including facilitator, note takers and translator were very knowledgeable about cross border migrants and the work of AMP in particular. This may have allowed for a more free flowing discussion and the ability for moderators to see participants contextually, both adding value to the process and the evaluation.

Once the participants were assembled in a comfortable, neutral and safe environment at the AMP offices in Observatory, the facilitator, translator and note takers introduced themselves. The purpose of the focus group was made clear to everyone and participants agreed to keep all sensitive and private information shared amongst them confidential. In addition the research team agreed to protect participant’s anonymity.

As recommended by both FHI (2011) and Billson (2006) researchers were well aware of respecting cultural differences in the way they conducted themselves. Body language, dress code and the use of eye contact (which may be problematic in some cultures) were all taken into consideration. As suggested by Kitzinger (1997), participants were helped to understand that it was a discussion amongst the whole group and not between them and the facilitator alone, and that there would be no judgement about anything they shared. They were also reminded that they were not obliged to share anything they did not feel comfortable sharing, emphasizing that the research team were not the experts—they were and that the team wanted to learn from them.

The research team was aware that participants came from different countries and circumstances and that there may be tensions within the group, as well as language and cultural barriers to participation. Difficulties with interpretation and language were addressed with care by moderators, with the assistance of a translator as recommended by Billson (2006).

The focus group methodology consisted of questions to gain information from women living in communities in and around Cape Town. The series of questions was created to elicit information regarding services in Cape Town and relevant demographic/historical information as well as their opinions regarding counselling, peer counselling and mental health assistance.

The questions that were designed by AMP were very applicable to the lives of the participants. They served as a guideline, allowing for appropriate adjustments to be made.
throughout, allowing participants to come up with questions of their own where suitable and encouraging debate and freedom of expression as recommended by Kitzinger (1995).

It was not AMP’s original intention to ask questions related to prostitution and HIV/AIDS, but it became obvious the discussion was moving in that direction and those issues were very much a part of their daily struggle.

The questions devised by AMP covered the themes mentioned including, but not limited to: known services; if the services are considered to be accessible and if not, what the barriers are; what types of services are sought out; and why some may seek out services while others may not. Once the initial round of questions was completed questions and discussion revolved around the potential benefits of a peer counselling programme and whether or not it might be a viable option. Explanations of the concepts of counselling, psychology and support groups were explained to individuals in their mother tongue. As recommended by FHI (2011) and Kitzinger (1995), robust discussion and debate were encouraged by the moderators. Although some participants were more outspoken than others, the facilitator did encourage all participants to respond, even if the response was brief, and to talk to each other and not just the researchers. Billson (2006) reiterates the fact that moderators should not allow a small percentage of the group to dominate the conversation as this will negate the research.

There was one facilitator, one translator and two note takers. The facilitator was the founder of The Adonis Musati Project, the translator was a current staff member at AMP and refugee herself, and the note takers are both affiliated with New York University- one a current MPH student that conducted some of the preliminary research for AMP’s investigation into peer counselling and the other the director of NYU’s MPH program who has been involved with AMP since 2009. Even though the skills of the moderator are essential if the focus group is to be successful, literature supports the idea that the facilitator/ moderator be someone directly involved in the project and who understands the relevance of the research even if their group skills are not perfect (Breakwell et al, 1995).

In keeping with recommendations by Billson (2006) the research team was aware that participants came from different countries and circumstances and that there may be tensions within the group, as well as language and cultural barriers to participation. Having a translator as part of the team allowed for participants to express themselves freely in their mother tongue. It is not certain if all the back translation to the moderators was completely accurate but there were others in the group that spoke several languages including English and they
often corroborated the words translated.

In addition to note taking, the focus group discussion was recorded to further enhance the reliability of the data analysis.

The session lasted for 2 hours which is in accordance with the timeframe suggested by Kitzinger (1995) and Breakwell et al (1995). However many of the women were present beforehand for an informal gathering over tea and food provided by AMP.

It appears that the women still had plenty to say after the two hours was finished and the FGD could easily have gone on for longer. Once the discussion was wrapped up, participants were thanked and reimbursed according the initial agreement.

3.3 Method of analysis:

It was decided to use classical content analysis to examine the data. According to Cresswell (2004) and Zhang and Wildemuth (2009), when working in an interpretive paradigm, qualitative content analysis is invaluable.

There were a number of quantitative methods AMP could have applied to this FGD but as Zhang and Wildemuth (2009) state identifying important themes and categories within the content that can in turn provide researchers with valuable descriptions of specific settings or experiences, may support development of new theories or validate existing ones. This is very valuable to AMP as the intervention they are planning is based on theory yet is pioneering in its context, i.e. Cape Town. In addition content analysis was chosen over other forms of qualitative analysis such as discourse analysis as the results need to be more around the issues at hand rather than meanings behind participants discourse with one another (Onwuegbuzie, Dickinson, Leech & Zoran, 2009). When analyzing content it is important to take into consideration both the physical organizing and categorizing of data, as well as the interpretative component which determines meaningfulness in relation to key questions. Both elements are important in development of data analysis. As qualitative content analysis is reasonably subjective, the emphasis is on meaning as opposed to quantification (Breakwell et al, 1995). This is very relevant to the understanding AMP hopes to achieve from this research.

However focus groups should be analyzed for group dynamics and behavior, as well as content in order to get a more holistic view of participant’s opinions (Breakwell et al, 1995) and so discourse and nuances of the participants of the FGD were not totally disregarded.
3.3.1 Techniques

Similar to analyzing other qualitative studies, focus group analysis involves drawing together and discussing related themes and how they correlate to the variable within the sample group (Zhang & Wildemuth, 2009). With regards to the AMP focus group, once all the notes and the recording had been assembled by the AMP research team, as suggested should be done by Kitzinger (1995), a very short debriefing session, recommended by Family Health International (2011), was held with the facilitator and one of the note takers preparing the way forward for qualitative content analysis. However, although the implementation of debriefing amongst moderators straight after a FGD is an important element according to experts, it was not done as thoroughly as it should have been after the AMP focus group and did not involve sufficient discussion with the additional note taker due to time constraints.

Although the session was recorded and the recording listened to after the session by one of the note takers in order to corroborate their notes, it was not transcribed, also due to time constraints. However Zhang and Wildemuth (2009), agree that while a complete transcript may be the most useful, it may be just as useful to extract only information relevant to the questions at hand and the additional value of having the whole recording transcribed may not justify the additional time required to create it.

The starting place of the analysis was to look at the questions that were asked during the focus group and the topics that were addressed.

The notes were then coded and categorized in relation to the underlying themes presented by the questions, as recommended by Zhang and Wildemuth (2009). Allowance was made for the inclusion of any other potentially beneficial information that emerged but did not necessarily fall under any of the question subheadings. For example, it was not AMP’s original intention to ask questions related to prostitution and HIV/AIDS, but it became obvious the discussion was moving in that direction and that those issues were very much a part of many participants’ daily struggles.

The coded segments arranged into themes and categories were also analyzed in light of the key assumptions made by AMP regarding the state of mental distress amongst cross border migrants and the need for peer counselling, as well as literature reviews and preliminary research. Patterns were identified between categories, such as mental health and peer counselling and themes and codes related to those topics were compiled.
There are a number of ways to analyze content qualitatively by essentially summarizing raw data into themes or categories based on valid deduction and interpretation. Both inductive and deductive reasoning can be applied to analysis. With deductive analysis researchers can generate concepts or ideas taking into account or starting with theory or previous studies and not merely coding categories from raw data alone. This approach is often used to validate a theoretical framework (Zhang & Wildemuth, 2009). In the case of this FGD, previous research was taken into account and formed a foundation for the concepts and ideas.

Once data is coded, researchers need to make sense of the themes or categories they have identified. This would include revealing patterns, examining relationships between categories and testing those categories against the entire range of data. This step is very dependent on researchers reasoning ability (Zhang & Wildemuth, 2009).

Kitzinger (1995), suggests data should include examples of dialogue between participants and not merely quotations in isolation and taken out of context. However this was not adequately recorded in the notes taken at the AMP focus group and unfortunately cannot be followed up as there is no transcript. Although the recording was listened to by one of the note takers it was taken to the United States before transcription could occur and can no longer be accessed. As qualitative content analysis is reasonably subjective, according to Breakwell et al (1995), with emphasis on meaning as opposed to quantification, there is concern that by not having the transcript, data analysis may be incomplete.

3.4 Reflexivity

Although the emphasis of the analysis is based on the responses by the refugee women, as the founder of The Adonis Musati Project, it is difficult to extract myself completely from the process. I have a special interest in this research for a number of reasons.

Having worked with and counselled hundreds of refugees and asylum seekers over the last six years and I have witnessed firsthand the psychological distress experienced by most of the clients at AMP. Past and present trauma, as well as the stress of relentless insecurity regarding documentation leaves many psychologically immobilized. Although I realize there may be concerns of bias around the research I feel that my experience and connectivity with this population group allowed me some advantage when facilitating the focus group discussion. Although I am a white, middle aged, South African woman, I am also a mother and a wife, a sister and a daughter. I have learned to understand and deeply respect the
resilience and courage I witness in cross border migrants. By the responses and openness of the sharing it appears the women felt safe and valued. I feel my age and my experience with this population group, engendered trust amongst the participants.
CHAPTER FOUR

Results

When reporting methods and results, researchers should endeavour to find harmony between description and interpretation. Description acknowledges background within context while interpretation represents researcher’s personal and theoretical understanding of the study (Zhang & Wildemuth, 2009).

The results of the focus group were drawn from the notes taken during the session, as well as some debriefing subsequently. Although it was not possible to transcribe the recording, one note taker did listen to the recording and elicit the main themes and codes from the data relevant to the issues in question which were then compared to the notes taken by the facilitator and other note taker.

Most of the women participated throughout the session, with only a few who required encouragement from other members to offer input. There were several women that were more outspoken than others, yet overall most of the women had a chance to participate equally, ensuring a safe environment to share personal histories and pertinent information in response to questions being asked. There appeared to be mutual respect and understanding amongst the women. For the purpose of this study, the answers will be summarized, leaving names and any identifying information absent to ensure confidentiality and safety for these women.

The questions served as a guideline and allowed for relevant adjustments to be made throughout, covering the categories Mental Distress and Peer Counselling and looking at themes including, but not limited to: Reasons for migration; Known refugee services in Cape Town; Experiences of service providers in Cape Town; Barriers to service; Known counselling services; Origins of trauma; Present situation struggles; Means of survival; Need for counselling services; Ideal counselor determinants; Support group determinants.

The following table looks at some of the responses in relation to the categories and themes mentioned:
### Reasons for Migration

<table>
<thead>
<tr>
<th>THEME</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>more assistance in Cape Town…… papers.</td>
</tr>
<tr>
<td>Family</td>
<td>Could be arrested if stayed in Johannesburg</td>
</tr>
<tr>
<td>Jobs</td>
<td>came to find family</td>
</tr>
<tr>
<td>Education</td>
<td>reunite with husband</td>
</tr>
<tr>
<td>Documentation</td>
<td>“life in Cape Town”.</td>
</tr>
</tbody>
</table>

The women came to Cape Town for a number of reasons which included: finding family members and reuniting with husbands; to find employment; a better life; to learn English; to gain easier access to documentation and because they thought Cape Town would be safer compared to their countries of origin.

### Known services offered to refugees in Cape Town

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cape Town Refugee Center, Wynberg: Welfare &amp; Education</td>
<td>“They have never helped”</td>
</tr>
<tr>
<td>UCT Law Clinic: Legal</td>
<td>“You are given an appointment but then you are never called”</td>
</tr>
<tr>
<td></td>
<td>“Once they gave me food”</td>
</tr>
<tr>
<td></td>
<td>“Since 2010 they have never paid school fees. They give you a choice between paying school fees or transport when you need both”</td>
</tr>
<tr>
<td></td>
<td>“We don’t get the report for our child’s school if we don’t pay</td>
</tr>
</tbody>
</table>

When asked if any of the women had any positive experiences from services available in Cape Town, the group collectively continued to discuss negative occurrences. Only 4 women attempted to access legal help at UCT, 3 received some assistance and 1 did not receive the help she sought.

Some of the refugee services were acknowledged as being helpful but in a very limited way e.g. they will pay a month’s rent or food but not both, school fees or transport but not both. Several other who went to the same service provider (Cape Town Refugee Centre) to receive help, after a number of unsuccessful visits were continuously told to keep coming back in future without being offered money for transportation, food or any other assistance as is specified in their outline of services. This was similar with the clinics, ambulance service and in occurrences of rape or attack. One woman said she went to a clinic every day in Retreat for 3 days in a row but was still not helped. Several said they suffered from high blood pressure. They were often left to find their own solutions.

Several women cited language and cultural differences as reasons for bad or no
Research Report: Peer Counselling Focus Group

<table>
<thead>
<tr>
<th>Ambulance Service: <strong>Medical</strong></th>
<th>Ambulance will not come</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinics / Hospitals: <strong>Medical</strong></td>
<td>may have to pay and can’t afford</td>
</tr>
<tr>
<td></td>
<td>went to clinic in Retreat every day for 3 days but not seen and not given back her folder</td>
</tr>
<tr>
<td></td>
<td>high blood pressure</td>
</tr>
<tr>
<td></td>
<td>discrimination, especially for HIV</td>
</tr>
<tr>
<td></td>
<td>xenophobia</td>
</tr>
<tr>
<td></td>
<td>don’t understand culture /language</td>
</tr>
<tr>
<td></td>
<td>can’t explain</td>
</tr>
<tr>
<td></td>
<td>they don’t understand</td>
</tr>
<tr>
<td></td>
<td>found out about services- from other refugees, other NGO’s, churches or if sick;</td>
</tr>
<tr>
<td></td>
<td>Some places they can’t get to because they can’t afford the transport;</td>
</tr>
<tr>
<td></td>
<td>Fear of expired legal status;</td>
</tr>
<tr>
<td></td>
<td>Don’t know rights</td>
</tr>
<tr>
<td></td>
<td>in clinics women are required to find their own solution, get very little medical assistance,</td>
</tr>
<tr>
<td>Trauma Centre and Rape Crisis Centre: <strong>Counselling</strong></td>
<td>most places did not offer appropriate follow through while ‘they do whatever they want with the money they have’.</td>
</tr>
</tbody>
</table>

Most women cited discrimination, lack of cultural sensitivity and xenophobia as problems they often experience when seeking medical help, particularly if it involves HIV. The specific area of Capricorn was mentioned, however women from other areas agreed, inferring that this was common throughout the township communities.

One woman, a social worker in her country of origin, acknowledged that she did not just want to speak poorly about the services available, or 'accuse' anyone, however her need or desire to talk about her experiences was important. The identified services (Trauma Centre and Rape Crisis Centre) were of no help due to the same reasons mentioned above, and that most places did not offer appropriate follow through while 'they do whatever they want with the money they have'. This seemed to create a sense of general mistrust by all of the women.

Several of the women also mentioned getting to service providers outside their neighborhoods was unaffordable and so they were not able to access all help available. Fear of expired legal status also prevented them from accessing public services like hospitals or police for fear they would be arrested or deported.
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| 1. Mental Distress | Barriers to service | When specific facilities for other services were sought out (legal help, information about education for their children, hospitals, welfare, etc.), there was an overall sense of not being helped appropriately. One of the barriers to the women receiving service included Xenophobia. Some women stated that at certain facilities and clinics, local South Africans were often helped first regardless of order of arrival.

Another barrier encompassed discrimination where women had negative experiences at clinics with HIV testing and receiving medication due to them being foreigners. Language and culture also made some services difficult to access and receive assistance. One woman mentioned that when she sought help for her own depression and for the rape of her daughter she received no assistance after being sent to several locations. Ultimately, the professionals noted language barriers as a reason for not being able to treat. Women mentioned that in clinics they are required to find their own solution, receive very little medical assistance, and encounter few individuals that understand their experience.

Fear with regards to xenophobia, expired documentation and possible arrest may also stop foreigners from approaching government service providers. In addition there is fear involved in not knowing their rights as well as fear not being able to communicate in a South African language, which also stop foreigners from trying to access services.

Another common barrier to access, particularly to service providers outside of their neighborhoods, includes the inability to pay transport there and back. |
| 2. Peer Counselling | o Xenophobia  
| o Discrimination  
| o Language  
| o Culture  
| o Fear  
| o Financial-transport | not being helped appropriately, local South Africans often helped first regardless of order of arrival.

feel rejected.

sought help for depression and for the rape of my daughter but received no assistance after being sent to several locations.

Told language/translation was reason for not being helped encounter few individuals that understand their experience.

“they need someone to do counselling (and) to understand – if marriage is broken”, “their xenophobia”… “not being able to integrate”. traumatized from experiences here yet never found counselling for this.

“no one understand”. negative experiences at clinics with HIV testing and receiving medication

language and cultural barriers confusion about medical rights if undocumented transport difficulties discrimination;

Can’t afford transport;

Could get arrested and no money to pay;

Don’t know what rights are; |
<table>
<thead>
<tr>
<th>1. Mental Distress</th>
<th>Awareness of counselling services</th>
<th>Origins of trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At church can talk to others about problems sometimes</td>
<td>experienced trauma all locations –countries of origin and in South Africa.</td>
</tr>
<tr>
<td></td>
<td>Rape crisis Centre and the Trauma Centre</td>
<td>gender based crimes, such as rape or being attacked in either location,</td>
</tr>
<tr>
<td></td>
<td>“I went to the rape crisis center with my daughter when she was raped but the people there were not qualified to do counselling.”</td>
<td>did not know where to go for help or who would listen.</td>
</tr>
<tr>
<td></td>
<td>“I went to the Trauma Centre and the person that I spoke to said that she doubted that there was xenophobia in Cape Town”</td>
<td>did not feel safe going to the police, to their husbands, or others in their community.</td>
</tr>
<tr>
<td></td>
<td>“There was not help with translation.”</td>
<td>fear, stigma and rejection</td>
</tr>
</tbody>
</table>

When asked about awareness of counselling and current counselling services, only a few of the women knew what counselling was and where to access it. After the facilitator defined counselling within various cultural contexts, they all stated that they would seek them out if available. Rape crisis center and the Trauma Center were mentioned. Church was also mentioned as a resource by a couple of the women as safe locations to talk to others. Those that had already utilized counselling services were not satisfied, stating that cultural differences, language barriers, and judgment were some reasons for not continuing to seek out these services.

“I went to the rape crisis center with my daughter when she was raped but the people there were not qualified to do counselling.”

“I went to the trauma center and the person that I spoke to said that she doubted that there was xenophobia in Cape Town”

“There was not help with translation.”

When asked if they experienced trauma from the past (their home countries), the transition, or while here, they all stated that it included all locations and experiences. Many reported gender based crimes, such as rape or being attacked in either location, yet did not know where to go for help or who would listen. Many reported that they did not feel safe going to the police, to their husbands, or others in their community. There was an overall feeling of fear, stigma and/or rejection.

“Our children are depressed but we can’t get help for them”

“xenophobia is a problem”

“nobody understands the things we went through. We are not like normal people.”
### Research Report: Peer Counselling Focus Group

#### 1. Mental Distress

<table>
<thead>
<tr>
<th>Present situation struggles</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Unemployment</td>
</tr>
<tr>
<td>o Documentation</td>
</tr>
<tr>
<td>o Non recognition of skills and competencies acquired in home countries</td>
</tr>
<tr>
<td>o Poverty</td>
</tr>
<tr>
<td>o Safety</td>
</tr>
<tr>
<td>o Rape</td>
</tr>
<tr>
<td>o Depression</td>
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<td>o Physical problems</td>
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<td>o Trauma</td>
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<td>o Hopelessness</td>
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<td>o Lack of empathy from service providers/officials/policemen</td>
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<td>o Lack of resources</td>
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<td>o Prostitution</td>
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<tr>
<td>o HIV/AIDS</td>
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<tr>
<td>o Language barriers</td>
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<td>o Isolation</td>
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#### 2. Peer Counselling

- jobless, having no money, dependent on others, 'because of their situation'.
- previous jobs were not honored- "What do papers actually represent- nothing".
- Discrimination never receive status, only continued renewals of temporary papers for asylum or refugee seekers
- high blood pressure, stomach problems, 'trauma' and 'feeling lost'.
- often have to choose between school fees and rent, and if school fees not paid then term marks could not be picked up by the parent.
- don’t feel safe in CPT.
- feel the pain from what happened to them in their home country and also from what happened to them in RSA.
- "We have a lot of problems here but no answers."
- "Some people attack us here but we can’t go to the police."
- "We need someone to listen to us."
- "We have no choice where we live because we have no jobs or money"
- "The papers that we have from our home country don’t count here."
- "Home affairs says that you can work or study but jobs are not honoring your papers even if you have refugee status."
- "We can’t open a bank account. No green ID book. We are very stressed."
- "The Xhosa are very racist."

Xenophobia

Isolation;

Many of the women stated that they had to continue to live where they were and endure these struggles for several reasons- jobless, having no money, dependent on others, 'because of their situation'. Many came to South Africa with competencies in other areas, yet were unable to utilize their past skills, official documents or certificates. They stated that their previous jobs were not honored- "What do papers actually represent- nothing". This led the women to feel further discriminated against. It was also noted that they felt as if they would never receive status, only continued renewals of temporary papers for asylum or refugee seekers. Some of the previous jobs held by the women included- two teachers; two nurses; one dress maker; three businesswomen; one social worker; two students; one hairdresser and one lawyer.

One woman mentioned that they often have to choose between school fees and rent, and if school fees were not paid then term marks could not be picked up by the parent. Many women stated having high blood pressure, stomach problems, 'trauma' and 'feeling lost'.

The range of struggles included mental distress (depression, hopelessness, suicidal thoughts) as well as physical distress such as illness, hunger and the multiple stresses related to rape, prostitution and marital strife.

Not being able to understand English or other local languages was also cited as a major struggle. When asked if they would ever go back to their home countries, all emphatically stated 'no'. However all agreed that they don’t feel safe in CPT.

They feel the pain from what happened to them in their home country and also from what has happened to them in RSA.

"We have a lot of problems here but no answers."
"Some people attack us here but we can’t go to the police."
"We need someone to listen to us."
"We have no choice where we live because we have no jobs or money"
"The papers that we have from our home country don’t count here."
Research Report: Peer Counselling Focus Group

<table>
<thead>
<tr>
<th>Mental Distress</th>
<th>Means of survival</th>
<th>Counselling beneficial – would help in many ways</th>
<th>Need for counselling services</th>
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<tr>
<td></td>
<td>1. Prostitution</td>
<td>Many women rely on prostitution to survive. It had to be done in order 'to provide food'; 'to survive'; and everyone was exposed to HIV, rape and STD's.</td>
<td>All refugees would benefit from mental health services; I need to talk;</td>
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<td>2. Difficulty finding employment</td>
<td>Causes stress, reminding them of the past experiences. When one was able to find a job, often experienced xenophobia in the workplace. “We have limited options except for prostitution. Everyone knows someone who has had to take this option. If you have no job you must still pay rent and buy food. You must do something to survive so everyone gets exposed to HIV/AIDS.”</td>
<td>Most acknowledged that counselling would be beneficial, and help them in a variety of ways. However location, language and cultural understanding were expressed as very important features of a counselling service.</td>
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Difficult to get welfare and help
I have no one to talk to;
Nobody cares we are suffering;
Hunger;
Problems getting children into schools;
Rape;
Violence against women;
Difficulties in marriage;
Stress; Depression; Hopelessness;
Prostitution;
Suicidal thoughts;
Don’t speak or understand English or other local languages

When asked if the women knew anyone that relied on prostitution as a means to survive, everyone said yes. It was eluded that some of these women engaged in sex work as well, yet although they did not state that outright about themselves, it was talked about in reference to all women in their communities. It was stated that it had to be done in order 'to provide food'; 'to survive'; and that everyone was exposed to HIV, rape and STD's. Some said that women would rather work but it was very hard to find a job. These experiences produced further stress, furthering possible damaging effects from their past experiences. When one was able to find a job, several women expressed experiencing xenophobia in the workplace. “We have limited options except for prostitution. Everyone knows someone who has had to take this option. If you have no job you must still pay rent and buy food. You must do something to survive so everyone gets exposed to HIV/AIDS.”
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<tr>
<th>2. Peer Counselling</th>
<th>Ideal counsellor determinants</th>
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<tr>
<td></td>
<td>o Common understanding</td>
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<td>o Common language</td>
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<td>o Culturally sensitive</td>
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<td>o Listening skills</td>
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<td>o Impartial</td>
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<td>o Wise</td>
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- someone who understands their situation
- 'someone with a heart';
- 'someone with similar experiences';
- 'someone who understands';
- 'someone with similar language';
- someone that would not judge them.
- these features mentioned were more important than only if from the same country.
- but cultures don't always mix e.g. Hutus and Tutsis or East and West Congo
- having someone that cared and understood their experiences, as well as language were most important
- someone that could help find solutions to problems, not just listen.
- confidentiality was important, impartial and 'having wisdom'.
- to be spiritual or to 'know god'.
- understanding humans on a deeper level was pertinent.
- “Someone who can find solutions to our problems”
- Better to have someone who understands Refugees;
- Understand our problem why we came to South Africa;
- Similar culture;
- Similar experiences;
- One woman mentioned the need for someone who understands their situation to do the counselling, and all of the women further agreed. When the women were asked who might best help them, the main factors were 'someone with a heart';
- 'someone with similar experiences';
- 'someone who understands';
- 'someone with similar language';
- One woman mentioned the need for someone who understands their situation to do the counselling, and all of the women further agreed. When the women were asked who might best help them, the main factors were 'someone with a heart';
- 'someone with similar experiences';
- 'someone who understands';
- 'someone with similar language';
- someone that would not judge them. When asked if this person needed to be from the same country or region, most agreed that although this would be helpful, these features mentioned were more important than only if from the same country.
- However, others stated that cultures don't always mix. Not all spoke up at this point. The general feeling was that having someone that cared and understood their experiences, as well as removing language barriers (either through a common language or translator), were the most important aspects. One woman stated that she wanted someone that could help her find solutions to her problems, not just listen. All stated that confidentiality was important, in addition to being impartial and 'having wisdom'. The women spoke about the need to be spiritual or to 'know god'. When this was probed for further understanding, it was explained that this did not necessarily mean only in the religious sense, but that understanding humans on a deeper level was pertinent.
- “Someone who can find solutions to our problems”
- It was mentioned the counselor should understand refugee trauma e.g. rapes at border crossing into RSA and that many women refugees from east Congo have been raped and abused and that one should not have Hutu and Tutsi from Rwanda counsel each other.
| 2. Peer Counselling | Support group determinants | All women stated that individual counselling would be important to begin prior to group counselling, and that peer counselling seemed to be an appropriate avenue. The majority of women stated that it may be easier to share their experiences with others once they felt ‘healed’. They shared the following:

Sometimes it matters e.g. if all group members are from east Congo they may open up more – but if mixed may hold back because of shame; However mixed groups can work if discuss things women and refugees have in common: Health; Families; Refugee experiences; They suggest they would work better in the area that people live so they don’t have to travel far. Counsellors and support group leaders must be trustworthy.

“Our solutions come from each other”

“Must keep it confidential” |
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<td>Individual counselling</td>
<td>individual counselling important before group counselling, peer counsellors can do this it may be easier to share experiences with others once they felt ‘healed’. Sometimes it matters e.g. if all from east Congo may open up more – but if mixed may hold back because of shame; Can work if discuss things women have in common: Health; Families; Refugee experiences; They must work in the area that people live so they don’t have to travel far; Trustworthy counsellors. “Our solutions come from each other” “Must keep it confidential”</td>
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<td>Shared experiences</td>
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<td>Shared culture</td>
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<td>Proximity to home</td>
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<td>Must listen well; Must understand trauma e.g. that many women refugees from east Congo have been raped and abused maybe in Kinshasa they don’t understand; cannot have Hutu and Tsutsi from Rwanda counsel each other; Many women have been raped crossing borders.</td>
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CHAPTER FIVE

Discussion

Analysis of the data needs to be seen in light of both the methodology used, that is the focus group, as well as literature reviews on cross border migrants and the concept of peer counselling.

5.1 Methodology discussion

Careful consideration was taken when devising a suitable method of acquiring additional data for the preliminary research undertaken by the Adonis Musati Project. Individual interviews had already been conducted with clients, staff and relevant stakeholders and NGO’s working with cross border migrants. With all of this research, in addition to literature reviews, as a foundation, AMP realised there was a need to consolidate and expand their findings by using alternative research methods. The focus group in this case was used as a supplement to other methods of data collection which according to Breakwell et al (1995) and Billson (2006), is recommended.

The focus group held at AMP on 6th July 2012 was the first held by the organisation on both the mental health needs of cross border migrants in Cape Town and possible community driven interventions to address those needs. As Kitzinger (1995) suggests, surveys may identify gaps between knowledge and behavior but only qualitative methods, such as focus groups, can actually fill these gaps and explain why these occur which essentially is what this focus group has begun to uncover.

The sample group that AMP chose to participate in the FGD was typical of the clients AMP serves. Although participants came from different cultural backgrounds, they were chosen because of certain commonalities such as all being asylum seeker or refugee women and single mothers. This method of choosing participants is supported by Breakwell et al (1995) and Kitzinger (1995). As the potential beneficiaries of the planned peer counselling intervention are from a similar context to the focus group participants the discussion and data is very relevant.
**5.2 Discussion**

Zhang and Wildemuth (2009) recommend that when analyzing content it is important to take into consideration both the physical organizing and categorizing of data as well as the interpretative component which determines meaningfulness in relation to key questions. When the AMP focus group notes were categorised meaning and understanding with regards to the classified themes was foremost in the minds of the researchers.

The results showed a number of interrelated themes dealing with mental health problems, as well as the need for more sustainable assistance with regards to a number of facets including welfare, employment, safety, documentation, education and health. Xenophobia and discrimination appear to have exacerbated many of the women’s already stressful and traumatized lives.

When analyzing the results there is substantial evidence that there is a great deal of mental distress in the cross-border migrant community due to: past and ongoing trauma, which include war, rape, gender violence and xenophobia; present day struggles, including poverty, unemployment, expired legal status, HIV/AIDS and lack of adequate services and resources. There is also evidence that women are struggling to function optimally because of stress and strong indications to suggest that peer counseling could greatly help to address some of their mental health needs.

**5.2.1 Reasons for Migration**

The reasons given by the participants for their migration to Cape Town are corroborated by the latest reports by the UNHCR (2012) which lists conflict, torture, collapsing economies in their countries of origin, as well as ethnic and political violence to name but a few of the reasons for migrants desperation to try and access safety and survival in South Africa. Trends in the past, according to the AMP database of clients since 2007, have often seen one or more of the breadwinners entering South Africa and once employed, attempting to send money back to their families still in countries of origin. However because it is so difficult for them to survive and send money home, families remain in dire situations. In the last two to three years more and more families are crossing the border to find parents and spouses due to the unbearable conditions both economically and socially in their homelands and this may account for some of the participants responses about families and finding their husbands.
Although the reasons may vary as to why different individuals or people groups apply for asylum in South Africa, the common thread is that they have either little or no choice if they and their families wish to survive. Very few people would choose to relocate to a country that was hostile to them and their circumstances if they had another more viable option.

5.2.2 Known services offered to refugees in Cape Town

From discussion around this question it is evident that through some means, the participants were aware of basic service providers pertinent to them and the areas they lived in, but did not have information about all the service providers that could be beneficial to them. The dissemination of important information like this which includes all the possible locations they could access for assistance could be a very useful tool provided to them by a peer counsellor.

5.2.3 Experiences of Refugee service providers in Cape Town

From the feedback elicited from the women it is clear that many of them have had negative experiences of refugee service providers in Cape Town for a number of reasons and it would appear they need someone to advocate on their behalf and hold service providers accountable.

5.2.4 Barriers to Service

In summary there were a number of significant barriers mentioned when trying to access services and help. These included language and cultural barriers, ignorance about their rights, xenophobia and a general feeling of hopelessness and negativity. This correlates with findings by Sermand (2012) and reports by Médecins Sans Frontières (2009; 2012).

5.2.5 Awareness of counselling services

When asked about counselling services, only a few of the women knew what they were and where to access them. After the facilitator defined counselling within various cultural contexts, they all stated that they would seek them out if available. Church was also mentioned as a resource by a couple of the women as safe locations to talk to others. Those that utilized counselling services were not satisfied, stating that cultural differences, language barriers, and judgment were some reasons for not continuing to seek out these services.

The issue of where to access counselling services dealing with specific issues like marital conflict, rape and trauma is once again information that needs to be distributed amongst the asylum seeker /refugee population. In addition those service providers need to be held
accountable if they are not assisting clients as they publicize they are.

5.2.6 Origins of Trauma

When asked if the women experienced trauma from the past (their home countries), the transition, or while here, they all stated that it included all locations and experiences. Many reported gender based crimes, such as rape or being attacked in either location, yet did not know where to go for help or who would listen. Many reported that they did not feel safe going to the police, to their husbands, or others in their community. There was an overall feeling of fear, stigma and/or rejection. This type of trauma so prevalent amongst asylum seeker women is confirmed by several reports written by medical personnel and researchers from Médecins Sans Frontières (2009; 2012). The responses from these women about their rape and trauma can have an enormous impact on the family and the community and need to be dealt with in a very culturally sensitive way. It is evident that the women need advocacy as well as confidential, solution-focused counselling in order to free them from the cycle of abuse.

5.2.7 Present situation struggles

Some of the issues that were mentioned by the women included Xenophobia and bad experiences because of it, feeling unsafe as a refugee and as a woman. Apart from lack of resources, unemployment, hunger and difficulty in finding welfare help, many of the women mentioned rape, gender violence and marital conflict. Some spoke of not having anyone to listen to them, having depression and feeling suicidal.

Many of these struggles women discussed are reported by other non-profit organizations such as Médecins Sans Frontières (2009) and Sermand (2012), as well as WHO (2012) and UNHCR (2012) and they are particularly aware of the psychosocial strain these difficulties place on individuals and families.

There appears to be a general sense of frustration amongst the women with regards to their present struggles. Some of the most prevalent issues revolved around not being helped, not being heard and not being respected in their host country for the skills they did have to offer. In addition not feeling safe in their families or locations as well as presenting with a number of physical and psychological concerns was also mentioned by most of the respondents. Due to the nature of the experiences mentioned it is very important that potential peer counsellors either identify with or fully understand the different struggles faced in order to help clients
find solutions.

5.2.8 Means of survival

When asked if the women knew anyone that relied on prostitution as a means to survive, everyone said yes. It was eluded that some of these women engaged in sex work as well, yet although they did not state that outright about themselves, it was talked about in reference to all women in their communities. It was stated that it had to be done in order 'to provide food'; 'to survive'; and that “everyone was exposed to HIV, rape and STD's”. Some said that women would rather work but it was very hard to find a job. These experiences produced further stress, furthering possible damaging effects from their past experiences. When one was able to find a job, several women expressed experiencing xenophobia in the workplace.

As many of the clients served at AMP are also struggling with HIV/AIDS related issues a peer counselling programme would also need to address this. Medley et al. (2009) suggest that peer education and counselling programmes in developing countries are effective in increasing knowledge amongst clients regarding HIV, improved condom use and improved behavioural outcomes. However the unique experiences of cross border migrants including rape, violence and the need to use prostitution to survive, need to be taken into account when developing the intervention.

From the research and discussion amongst the women it is evident that prostitution, HIV/AIDS, STD’s, rape, gender violence need to be addressed both in the training and implementation of any kind of peer counselling or mental health programme. In addition xenophobic fears around those issues, either experienced through service providers or in trying to access employment as an alternative to high risk behaviour in order to survive, also needs to be attended to and dealt with.

5.2.9 Need for counselling services

Most acknowledged that counselling would be beneficial, and help them in a variety of ways and that all refugees would benefit from mental health services. Several participants mentioned that location, language and childcare would make counselling more accessible for them.
According to reports done by WHO (2012), it has been determined that more than 50 per cent of refugees suffer from mental health problems including trauma, stress and chronic mental disorders in light of having endured conflict and massive human rights violations. As such WHO (2012) recommends that community-based psychosocial care becomes an essential component towards addressing this problem. It has been found that the psychosocial functioning of this affected population is greatly improved when community is involved.

In summary there seems to be consensus both through research and the responses by the focus group women that a mental health intervention, such as counselling was needed and would be very beneficial to cross-border migrants in Cape Town. However bearing in mind what was said throughout the discussion with regards to barriers and problems with service providers and in response to this question, location, language and assistance with childcare would make attendance at counselling sessions much more accessible.

### 5.2.10 Ideal counsellor determinants

One woman mentioned the need for someone who understands their situation to do the counselling, and all of the women further agreed. When we asked all of the women who might best help them, the main factors were ‘someone with a heart'; ‘someone with similar experiences'; ‘someone who understands'; ‘someone with similar language'; and someone that would not judge them. According to WHO (2010; 2012) the basic premise of a peer counsellor entails trained individuals helping others with similar backgrounds, experiences and understanding of particular needs which reiterates what the women saw as important characteristics of a peer counsellor.

When asked if this person needed to be from the same country or region, most agreed that although that would be helpful, the features mentioned above were more important than only if from the same country.

However, some women stated that cultures don’t always mix and mention was made of the different experiences of women from Kinshasa compared to East Congo and the potential tension between Hutus and Tutsi from Rwanda. In addition not all may understand that many women while crossing the border from Zimbabwe have been gang raped. Not all spoke up at this point. These responses or lack of responses are very important and not taking them into account when implementing peer counsellor training or starting support groups can possibly
cause damage and mistrust.

One woman stated that she wanted someone that could help her find solutions to her problems, not just listen. Bhutta et al (2010), maintain that peer counsellors provide very valuable links between communities and service providers and this may be where clients such as this are assisted in a more sustainable and solution focused way by drawing on and linking with already available service providers and monitoring the services they say they offer.

All stated that confidentiality was important, in addition to being impartial and 'having wisdom'. The women spoke about the need to be spiritual or to 'know god'. When this was probed for further understanding, it was explained that this did not necessarily mean only in the religious sense, but that understanding humans on a deeper level was pertinent.

The World Health Organization (2012) recognizes that many of the mental health theories, projects and intervention methodology have been developed in Western countries and many times implemented without the necessary cultural adaptations. When the women talk about needing someone “spiritual” it is very important that those designing a programme and training of peer counsellors bear in mind that spirituality is a common African cultural characteristic and understanding and respect of this aspect should be taken into account. Many of these models created by western academics are often not sustainable according to WHO (2012) and increase the dependency of the populations they are trying to assist thus hindering local capacity building. They suggest it and would be more meaningful if interventions adopted a more holistic and culturally viable approach which is what AMP hopes to achieve.

Kenneth Miller (1999), reiterates this and in his report suggests that community-based interventions may be more effective than clinic-based treatments alone as does Solomon (2004) who outlines the benefits of peer support and services in a psycho-social setting.

In light of the difficulties experienced by cross-border migrants in South Africa, the UNHCR (2012) also recommends more sustainable community-based interventions, such as peer counselling or peer education in order to ensure cultural and linguistic appropriateness. This is very much in line with what was requested by the women in the focus group when listing sensitivity to culture and ability to speak their language as selection criteria for peer counsellors.

In summary the general feeling amongst the women was that having someone trustworthy and “spiritual”, that cared and understood their experiences, as well as removing language barriers
(either through a common language or translator), were the most important aspects of a potential peer counsellor.

5.2.11 Support group determinants

All women stated that individual counselling would be important to begin prior to group counselling, and that peer counselling seemed to be an appropriate avenue. The majority of women stated that it may be easier to share their experiences with others once they felt 'healed'. Studies by WHO (2012) and Médecins Sans Frontières (2009; 2012) suggest that if one on one psychiatric or psychological intervention is not possible due to the enormous scope of the problem, other community based interventions would be beneficial. Support groups in easy to access and safe locations (due to transport difficulties and fears of safety mentioned earlier in the FGD) with a culturally sensitive, trained peer counsellor/ facilitators would be one aspect of the intervention plan. However AMP must note that individual counselling as requested by some participants is something that would benefit them before attending a support group and as such should be considered in planning.

According to the Inter Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007) there are several do’s and don’ts when researching the possibility of a community-based mental health intervention. Before an intervention, such as a peer counseling programme, which would include support groups, researchers need to collect and analyze information to determine what kind of response, if any is required and assessment tools should be tailored to cultural context and questions asked in the local language in a safe environment that respects confidentiality. AMP has attempted to follow these IASC guidelines with the focus group as well as the other preliminary research in order to tailor the programme to the needs of the recipients as much as possible.

Some of the women suggested that if the support group facilitator could really identify with the person and be trusted, participants may open up more otherwise with someone with experiences of rape from East Congo for example may not expose their thoughts or feelings because of shame. Due to the pioneering aspect of the mental health intervention AMP is planning, responses such as the one above need to be taken into account.

In summary according to the discussion in the focus group, support groups need to be in a safe, accessible location, preferably after some one on one counselling with a trusted, culturally sensitive peer counsellor.
CHAPTER SIX

Conclusion

6.1 Significance of the study

The focus group was very useful in allowing the research team to acquire additional necessary information using a unique and more dynamic approach. It is important to gather as much information about the concept and need for a mental health intervention such as peer counselling from a variety of cultural viewpoints. Due to time constraints, focus group discussions have been identified as valuable tools for acquiring as much information in as short a space as possible (Breakwell et al 1995). The value of the cross cultural group was that it gave researchers an opportunity to see how women from different cultural backgrounds could interact in a very supportive and understanding way towards each other. The many commonalities of the group became obvious.

The results confirmed many of the issues brought up by other preliminary research done by AMP. They highlighted the struggles and trauma of this population group and the necessity of culturally sensitive mental health interventions for cross-border migrants in South Africa. The significant concerns that emerged from the discussion included access and barriers to existing services, trauma and difficulties experienced, psychosocial needs of participants and possible solutions with advocacy and counselling.

The data from the focus group supported the initial thoughts of AMP that generated interest in the development of a peer-led counsellor programme. That foreign cross-border migrant women living in Cape Town experienced an abundance of fear, ‘xenophobia’, gender violent acts, lack of experienced safety, and a lack of cultural understanding from service providers. These factors and the combination of them, exasperate many of the traumatic experiences felt at home and through their relocation. A program that focused on counselling from trustworthy women with similar experiences, language and cultural sensitivity would be welcomed, let alone needed for the psychosocial betterment of these women and communities.
Information from the focus group conducted indicated that individual counselling is needed for some women prior to entering group sessions.

The significance of this initial focus group is that it can also be analysed in relation to the other preliminary research in order to find common threads, as well as subsequent focus groups with different participants, including one consisting of men.

6.2 Limitations of the study

What has been recommended by most experts including Family Health International (2011), Breakwell et al. (1995) and Billson (2006) is that researchers focus on other forms of communication, such as body language and group interactions in addition to the content of the discussion. Although interactions were noted briefly by moderators, such as the mutual respect and understanding participants displayed towards one another, particularly when sensitive material was discussed or declared, this area of data capture and analysis was not thoroughly explored and taken note of in this particular group which may have added value to the study.

Kitzinger (1995) suggests data should include examples of dialogue between participants and not merely quotations in isolation and taken out of context. However this was not adequately recorded in the notes taken at the AMP focus group and cannot be followed up as there is no transcript. Unfortunately subsequent to the initial listening of the recording and the hard copy was taken to the United States by the note taker and cannot be accessed in South Africa due to technological problems. As qualitative content analysis is reasonably subjective, according to Breakwell et al (1995), with emphasis on meaning as opposed to quantification, there is concern with that not having the transcript, the recording and some of the additional notes from the second note taker, data analysis may be incomplete.

It would have been ideal to have the transcript of the recording and to have analyzed the results closer to the time that the focus group was held but these are perhaps learning curves for the researchers to take into account in subsequent focus group discussions.

One of the limitations may have been the size of the group which included the thirteen foreign women, the facilitator, translator and two note takers. Although experts recommend less than ten participants per group it is not clear how the size of the group affected the content of the data.
Not all the participants were from the same ethnic or educational background, although they all share the experience of migrating to South Africa. There were very few economic migrants in the group and most had fled war or conflict. This could slant the outcome of research as their trauma may be different.

The note takers and facilitator were all of western descent and some of the nuances or content may be seen through those expectations and lenses typical of westernised culture. This could lead to bias particularly with analysis of data.

A final limitation of the study is that the results were not compared to other FGD’s on the topic taking into account variables like age, country of origin and sex. It would have been interesting to compare these results with an all-male FGD as the prospective peer counselling training and implementation will include men.

6.3 Recommendations

The women of this focus group were obtained through snowball sampling, and it would be helpful to continue to generate a large enough sample to avoid any possible selection bias.

Due to the limitations of this initial focus group discussion, it is highly recommended that AMP follow this research up with a number of subsequent similar focus groups including one made up of men. These future focus groups are also necessary to validate findings and compare data.

However the FGD results do correspond to the other preliminary research and provide some evidence that the initial assumptions made by AMP were substantiated. According to this sample group of women, there is a great deal of mental distress in the cross-border migrant community in Cape Town. Their feelings of negativity and hopelessness impair their functioning and development, and as literature corroborates positive mental health is fundamental to enhancing relationships, productivity and coping with adversity. A well planned peer counselling programme could greatly help to address the mental health needs of the cross-border migrant community and according to the participants such a programme would be welcomed by them and utilized.

Although further investigation is needed, at least with one other focus group, from all the preliminary research and with the dire need for a strategic and sustainable intervention, it is recommended that the development of a peer counselling programme is feasible. This needs
to be executed with on-going input from refugee and asylum seeker clients and staff.

If AMP decides to proceed with a peer counselling programme, it is recommended that AMP seek out either support from a non-profit such as Salus World, Hope House and/or a local University’s Public Health Department to ensure that this project occurs in a sustainable and achievable manner. It could also be possible to partner with other organizations that have similar interests and or experience, such as Sonke Gender Justice, Trauma Centre or Scalabrini. In addition if peer counsellors are selected and trained, the curriculum and on-going supervision need to be tailored to meet the needs of refugees and asylum seekers in South Africa. It is not only necessary to ensure that counselling interactions are being conducted appropriately, but to assure that individuals doing to the counselling are being supported. This is a particularly important aspect to the programme, as it is necessary to avoid counter-transference and/or secondary trauma, particularly in individuals that have been through similar situations.

IASC Guidelines on Mental Health and Psychosocial Support (2007), suggest that

Humanitarian actors should promote the human rights of all affected persons and protect individuals and groups who are at heightened risk of human rights violations. Humanitarian actors should also promote equity and non-discrimination. That is, they should aim to maximize fairness in the availability and accessibility of mental health and psychosocial supports among affected populations, across gender, age groups, language groups, ethnic groups and localities, according to identified needs. (Page 9)

It is recommended that AMP adhere to the principles outlined above.
References:


Inter-Agency Standing Committee (IASC). (2007). Introduction: Mental health and


www.m2m.org/fact-sheet.html. (n.d.). Retrieved 2012, from mothers2mothers:
http://www.m2m.org/fact-sheet.html


Appendix 1

English flyer

**Adonis Musati Project** Needs your Advice to help Refugee Women to Cope Better

**When**: July 6\(^{th}\), 9:30-13:00  
**Where**: Adonis Musati Project  
13 Bedford Road, Observatory

AMP wants to understand what types of counselling services are available to refugee women. We want to understand your experiences to help us develop a **peer to peer counselling** program.

Receive lunch, transport money
Appendix 2

Focus Group Questions:

**General Information:**
Name
Ethnic origin
Family Status
Time in SA; Time in Cape Town
Reasons for migration
Status-

I- **Services**-

1- **What type of problems have you found in settling here?**

Xenophobia
Unsafe
Discrimination
Isolation
No one to talk to
Not able to find a job
Not able to work in area qualified for
Difficulty in accessing welfare /help
Indifference
Lack of resources
Hunger
Problems getting children into schools
Children ostracized at school
Rape
Gender violence
Marital conflict
Depression
Prostitution
Suicidal thoughts
Hopelessness
Don’t speak or understand English or other local languages

**What types of services are you aware of?**

Aware of major refugee NGO’s and clinics etc.
Churches in the area

**Do they require travel? local? language Barriers?**

Problems getting there –no transport money
Some are local –others far away
Local sometimes show discrimination
Difficulties with language especially at clinics, schools etc.
Don’t understand culture

How found out about services-
Word of mouth
From other service providers
When sick

Are you able to utilize these services?
are able to utilize most of the services

Why or why not?
are able to utilize most of the services
Some they can’t get to because they can’t afford the transport
Others they fear to go to clinics/hospitals in case they don’t have correct documentation-could get arrested or fear they may have to pay and can’t afford
we don’t know all our rights especially if only have temporary or expired legal status

How do you experience these services?
Some of the refugee services are helpful but in a very limited way e.g. they will pay a month’s rent or food but not both, school fees or transport but not both
Trauma center offered limited help –cultural and language barriers
Rape crisis the same

Staff? Other refugees?
Staff at refugee NGO’s sometimes helpful but help very limited
Staff seem to ask “rehearsed questions” –same every time especially if raped
Clinics –sometimes very rude, felt judged, felt like an outsider

What sort of problems have you encountered?
Not being helped
Feeling alone and stigmatized
Daughter raped and not getting correct help from police or counselling centers
Problems with understanding or expressing themselves especially at clinics
Language and cultural barriers
Unable to work because of language and lack of documentation
No one to listen
Previous experience as nurse or teacher invalid in South Africa
Xenophobia
Don’t trust authorities

What worked best for you?
Asking other refugees for help
Asking church for help
Trying to learn English
Isolating
Sometimes prostitution to survive
Some NGO’s some of the time

Were you able to overcome your problems, and if so, how?
Not able to overcome most problems
Feel stuck
Isolated
No one cares
Scared as asylum seekers
Scared as women

2- Do you understand what counselling means?
Not an African concept
Understood being listened to
Need someone to help us find solutions

3- Are you aware of counselling services?
Not aware of where they are
I have been for counselling
Trauma center and rape crisis
 Didn’t know there were services for asylum seekers

In town or in your local communities??
Not aware of any counselling services /support groups in community only in town or Woodstock

Are there problems accessing these services?
There are problems accessing
Lack of transport money
Not sure of way around cape town
Stay in their community because fear
Also fear of not being able to speak English
Not understood
They don’t speak our language
No one would understand

Do you try to access these services?
Have been for counselling
To rape crisis for my daughter
They just asked the same questions each time
Trauma counseling not enough
Research Report: Peer Counselling Focus Group

They don’t understand

Do you yourself- or do you know anyone- that may benefit from mental health services?

All refugees would benefit from mental health services
I need to talk
Suffering
alone

Would location determine if you would use these services?
Location very important because transport costs
also asking someone to look after children is difficult

Would language determine if you would use these services?
Language very important
Counsellors need to understand language /dialect
Can’t express freely or accurately in a foreign language

Would it matter if just anyone provided counselling or do you think that having another refugee/foreigner provide the counselling would make a difference?
Better to have someone who understands
Refugee better

What would make an ideal counsellor?
Similar culture
Similar experiences
Same language
Must be caring from the heart
Must be spiritual
Must listen well
Must understand culture
Must understand trauma e.g. that many women refugees from east Congo have been raped and abused
Many women from Zimbabwe have been gang raped crossing borders

If a group was formed, do you think that having women from the same country of origin matters?
Sometimes it matters e.g. if all from east Congo may open up more –but if mixed may hold back because of shame
Can work if discuss things women have in common
Health
Families
Refugee experiences

In your opinion, what would make this type of peer counselling most accessible?
They must work in the area that people live so they don’t have to travel far
Trustworthy counsellors
Appendix 3

Focus group with Migrants at AMP July 6 2012

Notes by Professor Sally Guttmacher

13 women

Country of origin

DRC = 7

Zimbabwe = 1

Ruanda = 4

Burundi = 1

Where they live in CPT

Retreat (3)

Lavender Hill (2)

Capricorn (6)

Khayalitsha (1)

Steenburg (1) “It’s not safe”

Knowledge of services in their area

Hospital services are good or bad depending on who serves you.

Legal help: “I got help”

“I didn’t get help”

One went to retreat because of high BP. She went for 3 days but was not seen and was not given back her folder

Most did not know about the law clinic
Knowledge of a place for Counselling?

One said the church

All agreed that they would really like this

They feel the rejection (related to xenophobia)

“Our children are depressed but we can’t get help for them”

xenophobia is a problem

“nobody understands the things we went through. We are not like normal people.”

They feel the pain from what happened to them in their home country and also from has happened to them in RSA.

We have a lot of problems here but no answers.

Some people attack us here but we can’t go to the police.

We need someone to listen to us.

All agreed that they don’t feel safe in CPT.

Work

We have no choice where we live because we have no jobs or money

The papers that we have from our home country don’t count here

Home affairs says that you can work or study but jobs are not honouring your papers even if you have refugee status.

We can’t open a bank account. No green card. We are very stressed.

The Xhosa are very racist.

We have limited options except for prostitution. Everyone knows someone who has had to take this option. If you have no job you must still pay rent and buy food. You must do something to survive so everyone gets exposed to HIV/AIDS
**Have you been to an organization in CPT that has helped you and what did they do for you.**

CTRC: They have never helped

It’s not safe in Capricorn (?)

You are given an appointment but then you are never called

Once they gave me food

Since 2010 they have never paid school fees. They give you a choice between paying school fees or transport when you need both

We don’t get the report for our child’s school if we don’t pay the school fees.

In Wynberg they did not help me or my child

Said that money was there to help us find work but all the money went to the CTRC which said they had no money.

A woman from the East Congo said that she left her children there to come to RSA. Now she is very confused because she has no food or money to get back to her kids in the Congo.

**Do you know anyone who has been raped here or attacked? and do you know where you can go for help here if that happens?**

Rape crisis centre

Trauma Centre

“I went to the rape crisis centre with my daughter when she was raped but the people there were not qualified to do counselling.”

“I went to the trauma centre and the person that I spoke to said that she doubted that there was xenophobia in Cape Town”

The was not help with translation

**What kind of work did you do before coming here?**

Hotel in Burundi
Student of hotel work

Social work in Ruanda

Hairdresser/housewife; Zimbabwe

Nurses: 2 from Congo

Lab Tech: Congo

Business: 3 people

Teacher: 2 people

Lawyer: 1, Congo

Dressmaker: 1

Student: 1

**Why did you come to Cape Town?**

Family member here

Told that you could get more assistance in CPT

Many were told that they would be arrested if they stayed in J’BURG

Were told there were jobs

Knew someone

Came to find her husband but he disappeared

The life in CPT

Came to be with a cousin but couldn’t find him

For the safety but no jobs

1st I went to Mozambique but came here because I wanted a school with English

**Would they like counselling and or a support group led by someone from their own country**
Yes to both

Someone who has been in a similar situation. The country doesn’t matter so much. Someone who understands your situation

Someone who can find solutions to our problems

Our solutions come from each other

Must keep it confidential
Appendix 4

Focus Group Questions:

General Information:
Name
Ethnic origin
Family Status
Time in SA; Time in Cape Town
Reasons for migration
Status-

1- Services-

1- What type of problems have you found in settling here?

   What types of services are you aware of?
   Do they require travel? local? language Barriers?
   How found out about services-

   Are you able to utilize these services?
   Why or why not?

   How do you experience these services?
   Staff? Other refugees?
   What sort of problems have you encountered? What worked best for you?
   Were you able to overcome them, and if so, how?

2- Are you aware of counselling services? In town or in your local communities??

   Are there problems accessing these services?

   Do you try to access these services?

   Do you yourself- or do you know anyone- that may benefit from mental health services?

   Would location determine if you would use these services?

   Would language determine if you would use these services?

   Would it matter if anyone provided counselling or do you think that having another refugee/foreigner provide the counselling would make a difference?

   If a group was formed, do you think that having women from the same area matters?

   In your opinion, what would make this type of peer counselling most accessible?

Appendix 5
International Organization for Migration: GLOSSARY OF TERMS

Asylum seeker - A person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds.

Country of origin - The country that is a source of migratory flows (regular or irregular).

Economic migrant - A person leaving his or her habitual place of residence to settle outside his or her country of origin in order to improve his or her quality of life. This term is often loosely used to distinguish from refugees fleeing persecution, and is also similarly used to refer to persons attempting to enter a country without legal permission and/or by using asylum procedures without bona fide cause. It may equally be applied to persons leaving their country of origin for the purpose of employment.

Irregular migrant - A person who, owing to unauthorized entry, breach of a condition of entry, or the expiry of his or her visa, lacks legal status in a transit or host country. The definition covers inter alia those persons who have entered a transit or host country lawfully but have stayed for a longer period than authorized or subsequently taken up unauthorized employment (also called clandestine/undocumented migrant or migrant in an irregular situation). The term "irregular" is preferable to "illegal" because the latter carries a criminal connotation and is seen as denying migrants' humanity.

Refugee - A person who, "owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country. (Art. 1(A)(2), Convention relating to the Status of Refugees, Art. 1A(2), 1951 as modified by the 1967 Protocol). In addition to the refugee definition in the 1951 Refugee Convention, Art. 1(2), 1969 Organization of African Unity (OAU) Convention defines a refugee as any person compelled to leave his or her country "owing to external aggression, occupation, foreign domination or events seriously disturbing
public order in either part or the whole of his country or origin or nationality." Similarly, the 1984 Cartagena Declaration states that refugees also include persons who flee their country "because their lives, security or freedom have been threatened by generalised violence, foreign aggression, internal conflicts, massive violations of human rights or other circumstances which have seriously disturbed public order."

**Xenophobia** - At the international level, no universally accepted definition of xenophobia exists, though it can be described as attitudes, prejudices and behaviour that reject, exclude and often vilify persons, based on the perception that they are outsiders or foreigners to the community, society or national identity. There is a close link between racism and xenophobia, two terms that can be hard to differentiate from each other.

(INTERNATIONAL ORGANIZATION FOR MIGRATION, 2011)
Appendix 6: Some preliminary interviews with stakeholders and staff

Appendix 6:A

Adonis Musati Project and Sonke Gender Justice

Summary of meeting, 25/6/2012

In Attendance:

Micheline M Muzaneza- Staff, Sonke; TCBCM

Gahlia Brogneri - Management team, founder Adonis Musati Project

Lauri Benblatt, MA, LPC- Public Health Intern, Adonis Musati Project

Content:

Meeting took place on June 25, 2012 under the context of building community relations and building capacity. AMP staff was interested in learning about Sonke's current program's involving training, peer counseling and relations/workshops in the townships as part of preliminary research for their own development of a peer to peer counseling program. M Muzaneza was willing to share information with us, while it was made clear that our intentions would not cover the same need, but cover areas in services to refugees that are not being covered by most agencies.

Potential collaboration and ongoing relationships was discussed in order to best serve the community. While Sonke has a wider scope of service, this will be welcomed and appreciated by AMP when the time comes to administer surveys and begin the peer to peer counseling program. In addition, AMP will continue to refer clients to Sonke as the need arises.

Future Contact:

Upon leaving the meeting, we discussed the availability of Sonke to help with distribution of surveys when available, as well as continued referrals between the two agencies. The meeting was successful in that both agencies will be able to have their mission met, while continuing to benefit the betterment of refugees and asylum seekers.

Appendix 6:B
**Scalabrini and Adonis Musati Project, 2/7/2012**

**In attendance:** Daniele, Welfare Co-ordinator; Lauri Benblatt, intern- Adonis Musati Project

**Summary of Meeting:**

**Outreach:** Lauri was interested to see if clients that have been referred to Scalabrini from AMP have actually followed through and utilized their services. Daniele was uncertain of this, and was going to follow up with a colleague to find out.

If there has not been adequate follow up, it is important to understand the reasons contributing to this, as well as how to create a better system to ensure follow through. Daniele mentioned that AMP may not be aware of their updated services, including changes in fees for services, which may or may not be a contributing factor. He also mentioned that he would forward an updated flyer to AMP, but that in the future is is best to call or outreach to Scalabrini to receive updated information.

**Support group:** Both organizations discussed past experiences and future goals with support groups, and the potential for possible collaboration. Daniele informed of their past effort with an number of groups that clients had to participate in, including acupuncture, an income generating project, and support services. However, due to several factors this was a time limited session, and they are interested in beginning support services again. Daniele pointed out that a support group should have another name other than 'support', as it is often associated with economics and income.

Although Scalabrini has contacted other organizations for potential partnership and/or collaboration, Daniele seemed interested in continuing a dialogue for potential collaboration with AMP as well. He had several ideas regarding the details and logistics of the group- such as having it for approximately 10 women, possibly including art therapy or some sort of creative process, as well as offering acupuncture. Having facilitators that are properly trained is important for both organizations.

**Peer to Peer Counseling:** While Daniele had some great ideas and suggestions for the Peer to
Peer Counseling program that is currently being researched by AMP, due to the nature of their capacity, Daniele noted that Scalabrini would not be interested in collaborating on this project. He did ensure that we would not be covering the same population, nor offering the same services. This is a good assurance, as AMP wants to make sure that we are covering gaps in services offered to refugees.

**Recommendations:** I referred him to Janice, as she would be the ongoing contact person for Adonis Musati Project. I also referred him to as Salus World from the US in regards to training, particularly due to the nature of their organization as well as the contact already made with AMP.

**Appendix 6:C**

**SWEAT- Community Outreach, 18/6/2012**

19 Anson Place, Observatory

In Attendance:

Janice Sparg- Social Worker, Adonis Musati Project

Lauri Benblatt, LPC, MA, MPH intern, Adonis Musati Project

Dr. Gordon Isaacs, Psycho-social manager: Outreach and Development

Adonis Musati Project met with SWEAT to discuss the possibility of co-referrals. SWEAT’s primary mission is to provide community outreach, advocacy, and legal services. They also provide peer education, counseling, HIV/AIDS education and human rights support. The majority of their services are for sex workers, yet they do serve a percentage of individuals that have been trafficked as well. It seems as if this service may be expanding. 70% of their 'staff' are in the trade, and are either peer educators or management positions. Dedicated foreign peer educators are mostly from Kenya, Zimbabwe and Uganda.

As SWEAT provides outreach to foreigners as well, cross referrals seems like a viable option between the two organizations. In addition, as AMP looks ahead with preliminary research into starting a peer to peer counseling pilot program, SWEAT was informed that there would not be an overlap in services, but that AMP is looking to serve a different population of foreigners and refer as necessary.
Appendix 6: D

19/6/2012

Interview: Barbara Zhungu- Adonis Musati Interviewer and staff; refugee from Zimbabwe that’s been in South Africa for 5 years (Johannesburg for 1 year, Cape Town for 4 years). Barbara was one of the first people to work with AMP, originally in the Salt River offices as well as the shelter. She is currently receiving assistance from AMP to attend a counselling program.

I- Explanation of Peer to Peer Counselling proposal:

Barbara believes that a peer to peer counselling program would benefit the refugee and asylum seeker community under specific conditions. She suggests that individuals need to be referred, at least for the pilot program, to ensure women are contacted in hard to reach areas.

II- Experience as interviewer:

Barbara is aware from a professional and personal standpoint that women do not have a platform such as this type of program to talk about their experiences and difficulties, and offering one in a consistent way would be helpful. She believes that this is particularly needed for women, as they are the most vulnerable due to home care, child care, and gender inequalities. Barbara does feel that men need to be addressed as well, and does not have any suggestions or thoughts on how to address both. However, she does believe that in order to avoid social repercussions that may arise from women’s programs that encourage counselling, education and empowerment of women, men should be included at some point in the framework of education or counselling.

Barbara suggested the area of Capricorn to begin this type of program, and did not have any thoughts either way on whether the pilot program should include women from a specific country or if it should have a broader context.

Issues: Barbara feels that the biggest gap found in refugee services are those for mental health, psycho-education and psychosocial counselling. She suggested that Rwandan /Burundian women are in great need, however also stated that other refugee women are in
need of these services as well (Congolese and Zimbabwean were mentioned).

**IV- Concerns:**

Barbara addressed language as a main barrier that would need to be addressed. Once the definition of ‘peer to peer’ was re-explained, she further understood that this concern may be minimized. As mentioned, the awareness of gender roles would be very important, including how to overcome male resistance and any potential ramifications.

**APPENDIX6:E**

18/6/2012

**Interview:** Augustine Muyambo- Adonis Musati Project, Congolese refugee- Interviewer

Nurse in Congo; living in Cape Town for 5 years. Documents and passport are all up to date. Currently working part time at AMP, and is studying at the University to be a counsellor.

Explanation of Peer to Peer Counselling proposal:

Although Augustine was able to repeat back her understanding of what a ‘peer to peer’ counselling program may look like, it was unclear to me if she had a full understanding of the scope of the picture. We discussed that it may take several meetings and attempts. She expressed interest in being trained as one of the Peer Counsellors

**II- Experience as interviewer:**

Augustine talked about her experience as an interviewer, relating personal stories and her ability to overcome her initial difficulty with being in the role to eventual comfort. She agrees that being able to understand and emotionally relate to the clients experience is very useful, and has helped in the process. Augustine feels that at times AMP is not able to provide enough resources. While this is most likely due to financial constraints and time limitations, it is also possible that the full extent of the client’s needs may not be understood, and that a program that provided longer term services as well as one in which was serviced by other refugees that understands their circumstances on a personal level could be useful.

**Issues:** Augustine reports that some of the major issues she sees are: HIV/AIDS education not being translated or transferred to partners/family members for a variety of reasons
(embarrassment, fear, lack of clear understanding); Reproductive health and family planning—lack of education and/or resources; psychosocial counselling

**III- Interviews, Focus Group:**

Augustine feels that having individuals from several countries would be more beneficial that focusing on just one area. In her experience—both personally as well as what she sees in the community and as an interviewer—it is helpful for women to learn from each other’s experience, and that seeing that they are not alone in their experience benefits them.

While she does work with some of the Zimbabwean community, she has more contact with the Congolese, Rwandan, and Burundian refugee communities here at AMP.

**IV- Concerns:**

Unfortunately we were not able to cover concerns that she may have due to time limitations. This will have to be addressed in a follow up conversation.

APPENDIC 6:F

19/6/2012

**Interview:** Janice Sparg- Adonis Musati Project, Social Worker and Project Manager

Janice is from Cape Town, South Africa, and has been with AMP since December 2009 where she worked at the old shelter for boys and then transferred to the office with AMP’s expansion. Janice is in charge of the Stage 2 clients, conducts interviews regularly, works with the Independent Living Program, and volunteers with clients at an Equine Therapy program.

Explanation of Peer to Peer Counselling proposal:

Janice was aware of the proposed program, and although had some concerns (see below), she was overall encouraging and feels like this is well needed and has the potential to be beneficial particularly for those in hard to reach areas.

**II- Experience as interviewer:**

Although Janice is in charge of the Stage 2 cases—clients that require time limited, in depth assistance and case work counselling—she is also aware of and partakes in Stage 1 interviews
as needed. While her main task is outreach and referral services, it is apparent from the client’s stories and biographies that more in-depth services from those with similar experiences could only benefit their mental health. As she works with the stage 2 clients, she feels like addressing psychosocial needs may help them utilize the referral and resources that AMP provides in a more efficient and effective way.

**Issues:** Janice feels like mental health stemming from traumatic experiences, including the refugee experience, is an affected area of client’s well-being that is not being properly or thoroughly addressed by current services offered in Cape Town. Not only are they not being addressed, but to her knowledge the refugee communities from different countries have different awareness or access to the services that are there.

**III- Interviews, Focus Group:**

Janice feels that a focus group would be beneficial to gather more information on community needs as well as gaps in the area. She identified the refugee community of Rwandans and perhaps Burundians as those in particular need (or that are unaware or not connected with current services), as well as those from DRC. She recommended Capricorn as an area to do the pilot program.

**IV- Concerns:**

Janice’s biggest concern is administrative, funding, and language barriers. After explaining the concept of community health workers (peer to peer), it was further understood that language barriers would be addressed by the nature and definition of the program.