HEALTHCARE IN TRANSIT

MIGRANT JOURNEY PATHWAYS AND THE LINK WITH HEALTH OUTCOMES IN THE LIMPOPO REGION

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MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

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1. INTRODUCTION

Since 2000, Doctors Without Borders (MSF) has been a key health care provider to displaced populations in the Limpopo Region, especially in the vicinity of the Beitbridge border post between South Africa and Zimbabwe. A comprehensive and contemporary view of migrants' medical needs was lacking, however, and in 2019 a survey - The Limpopo Mobility Survey - was designed by the Brazil Medical Unit (BRAMU) of MSF, with the objective of providing reliable evidence on migrant journey pathways and how these journeys link with migrant health outcomes.

Specifically, the study team sought to highlight the gaps in medical care received by migrants, and to trace these to systemic exclusions on bureaucratic or other grounds.

Beginning in late 2019, MSF in partnership with the African Centre for Migration & Society (ACMS), University of the Witwatersrand (Wits) surveyed 1,375 people in Beitbridge (Zimbabwe) and Musina (South Africa), documenting the health challenges they faced.

The research focused on migrant populations located in five locations, namely

+ Zimbabwean deportees coming through Beitbridge Reception and Support Centre;
+ Migrants and asylum seekers of several nationalities staying in the border town of Musina;
+ Malawians using Beitbridge as a waiting area, specifically a shelter known as Magogo's House;
+ Cross-border population living in rural Beitbridge;
+ Different groups heading to South Africa via Beitbridge crossing points.

Map of survey locations in the Limpopo region

2. METHODOLOGY

In order to understand the interrelationships between migrants' health and their living conditions before, during and after the journey, MSF designed a data collection technique based on the Life History Calendar methodology (LHC) – the so-called Migration History Tool. It aimed to generate a thorough descriptive analysis of five key populations that had the Limpopo region as origin, transit and destination site. The software was designed with MSF funding. For matters deemed too sensitive, like sexually transmitted infections or sexual violence, audio questions were recorded so that migrants could answer without the assistance of the interviewer, thus avoiding disclosure and social desirability biases. The questionnaires have been previously translated to five languages: English, Venda, Shona, Ndebele and Swahili and the interviews were conducted in the language the respondent felt more comfortable with. Survey inclusion criteria included being 18 years or older; being an accompanied minor, between 15 and 17 years old; being fluent in one of the aforementioned languages; and not showing signs of cognitive impairment or drug abuse at the moment of the interview. Research ethics clearance was obtained from the Wits University Ethics Committee (non-medical), the Zimbabwean Medical Research Council and the MSF Ethics Review Board. Informed consent was obtained prior to starting the survey and participants had the opportunity to consult a MSF psychologist should they wish to.

Note on issues:

An important limitation of the study is that, due to language and cultural barriers, we have not been able to reach Somalis, Eritreans and Ethiopians – important subgroups that have Musina as transit point.

Credit: Tadeu Andre

3. FINDINGS OVERVIEW

The full survey report presents many important insights, but perhaps the most urgent finding to address is the fact that the significant waiting periods for asylum-seeker application outcomes in South Africa often exacerbate health challenges that migrants experience. While the report does not point to an acute health crisis at the border, it gives dimension to the negative impacts of current immigration processes, which often require migrants and asylum-seekers to travel from the rest of the country to Musina (as their office of first application) in order to renew their permits. Many of those whose papers expire before they are able to renew them must endure inhumane and often illegal conditions of arrest and detention prior to deportation, heightening the risks of contagion during the COVID-19 pandemic.

SELECT FINDINGS

Musina

+ The most urgent health needs are found in the border town of Musina. For all migrants, Musina is not merely a transit point but a place where displaced populations are getting trapped for lengthy periods of time, 9 months on average, with access to healthcare being a serious challenge for most. Our results show that Central Africans are particularly hampered from accessing medical care, primarily due to language barriers, and Burundian migrants and asylum seekers in particular reported poor mental health indicators. Sexual violence in Musina, particularly among male migrants, is at concerning levels.

Beitbridge

+ At the Reception Centre (in Zimbabwe), thanks to an extensive analysis of people's detention pathways, we have been able to show the average time deportees have spent in each type of detention facility in South Africa, be it Lindela Repatriation Centre in Krugersdorp, police stations or prisons. Our data has revealed that police stations, where migrants usually stay for protracted periods, feature the worst general living conditions and poorest access to health.

  An estimated 36% of single female Malawian migrants residing at Magogo's House in Beitbridge had gone through an episode of sexual violence very recently. The survey is suggestive of a connection between the area's known smuggling and human trafficking activities and the sexual and reproductive health needs of respondents, as well as the concerning levels of sexual abuse that were identified.

Cross border communities

+ Almost half (43.36%) of the households we analysed received some sort of financial support from migrants residing abroad. Residences that had children left behind were much more likely than others to receive this kind of aid, and the children of these households were not necessarily more vulnerable in terms of access to health care or food insecurity.

Musina	Crossing Points	Magogo's	Villages	Reception Centre
Low diagnosis and treatment of Chronic Diseases				
Higher percentage of people with unspecified signs and symptoms	Higher percentage of people with unspecified signs and symptoms			
Higher percentage of people with Signs of STIs		Higher percentage of people with Signs of STIs, especially women		
Low knowledge of HIV		Misconceptions about HIV		
Low HIV testing				
			Highest HIV Prevalence among men	Highest HIV Prevalence among women
Low family planning uptake				
Low use of mid/long term contraceptive methods		Low use of mid/long term contraceptive methods	High use of traditional methods	
High rates of sexual violence (especially men)	High rates of sexual violence (men and women)	High rates of sexual violence (especially women, but also men)		High rates of sexual violence (men and women)
High rates of harmful consumption of Alcohol (Zimbabwean men)	High rates of harmful consumption of Alcohol (Zimbabwean men)		High rates of harmful consumption of Alcohol (Zimbabwean men)	High rates of harmful consumption of Alcohol (Zimbabwean men)
High rates of Depression and Suicide Ideation among Central African men; low sense of social support for all populations				High rates of anxiety and depression among women

Brief Summary of Main Health Needs, by Study Site, Musina and Beitbridge, 2020

SITE SPECIFIC FINDINGS

Musina

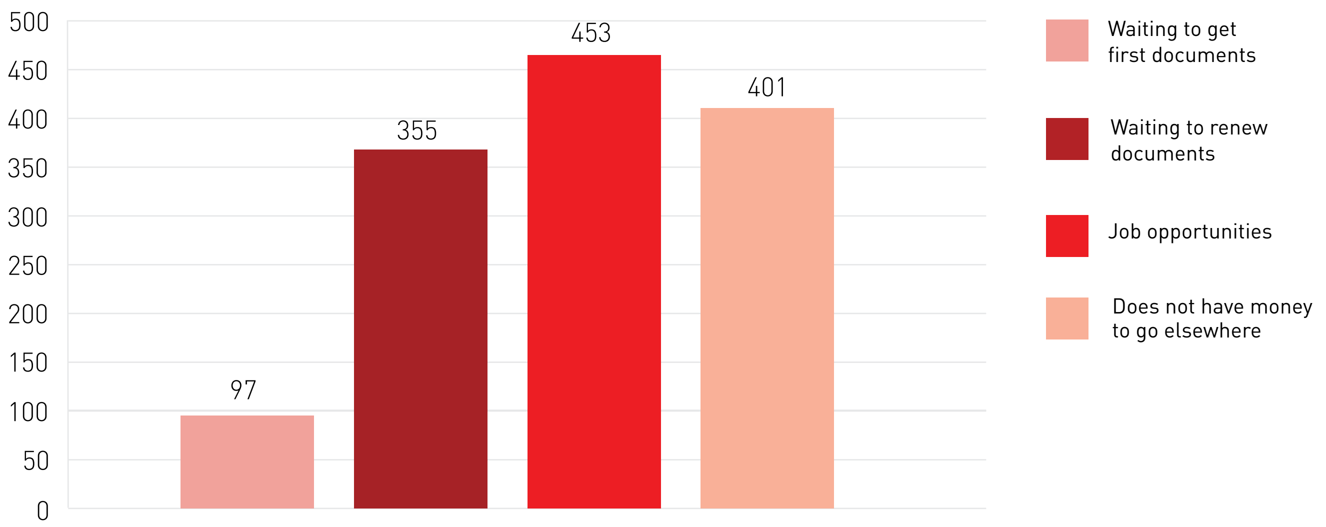
In Musina, the South African town closest to the Beitbridge border crossing with Zimbabwe, migrants are living for extended periods - 9 months, on average. This is longer than what would be common for a transit point, reinforcing the notion that migrants and asylum seekers are becoming trapped in the city for increased periods of time. Conversely, the infrastructure of support to mobile populations in Musina, including shelters and health facilities, are not coherent with the extended periods of time they remain in the site.

Zimbabweans, and especially Zimbabwean women, stay for longer periods in the city - 16 months on average, compared with 9 months for Burundians and 6 months for Congolese. Awaiting documentation is the main reason given.

"It is taking longer and longer for Asylum Seeker Permits to be processed, especially for central africans, and as a result individuals are staying longer in shelters, and we have the problem of overcrowding"

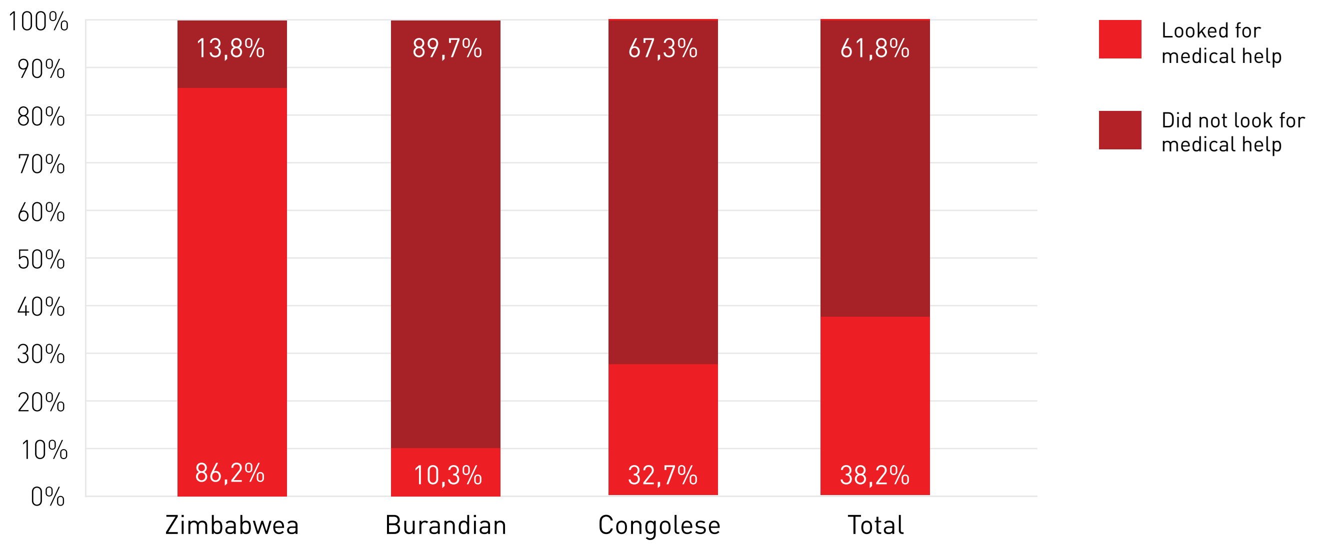
Social worker, Musina

Credit: Tadeu Andre



Average Number of Days in Musina, by Reason to be in the City, Musina, 2020

28.25% of our respondents had experience a health issue in Musina, but 61.29% did not report for care, with language barriers the likely reason for this. Health seeking behaviour seems to be highly dependent on nationality, with Zimbabweans much more likely to access healthcare than their Central African counterparts.



Health Seeking Behaviour following a Health Problem, by Nationality, Musina 2020

When asked why they did look for specialized assistance, responses differed significantly. Burundians and Congolese reported being particularly affected by discrimination, xenophobia and language barriers. The same pattern was observed when we asked respondents about health seeking behaviour in South Africa, not Musina specifically. For Zimbabweans, risk of deportation was a bigger barrier to care.

"I didn't choose this country, but I'm now in Musina in South Africa and I can't go anywhere. Sometimes it's cold. And, you know, I can't permit or allow myself to see my brother sleep outside and get sick, so I invite them into this shelter, even though conditions are not good."

Lulila Musimbo, DRC

Credit: Tadeu Andre

In total, 21.4% of our sample reported having recently experienced a form of physical abuse. Notably, more men than women reported an experience of sexual violence. Those staying in a men's shelter in Musina were most affected - 30% of men living at the shelter for 1 year or longer said they had suffered sexual violence in the last year. Following an incident of sexual violence, most (75.3%) did not seek medical help. No women who suffered sexual violence reported for healthcare. The data reveals that not only are migrants highly exposed to sexual violence, but also that access to health following assault is extremely troublesome.

In regard to mental health, Burundian migrants and asylum seekers reported particularly poor mental health indicators, with 9.5% displaying moderate to severe depression scores. This group was more likely to have lived in transit countries; to have fled from armed violence; and to be experiencing poor living conditions in Musina, including physical assault; and to face discrimination when accessing health care.

23.74% of all migrants surveyed reported having suicidal or self-hurting thoughts on at least some days. The percentage rises to 37.66% among Burundian respondents.

Credit: Luca Sola

Reception Centre

Beitbridge is the town where Zimbabweans migrants deported from South Africa are handed over to Zimbabwe immigration authorities after being detained in prison in South Africa, and in order to offer comprehensive humanitarian assistance to this group The Beitbridge Reception and Support Centre was established in 2006 by the International Organization for Migration. Since 2019 MSF has run a migrant health project in Beitbridge, and the organization has been operational in the town and surrounds since the early 2000s.

The survey confirmed health needs that are well documented, including a very high prevalence of HIV among women, but respondents also reported that access to healthcare was generally good, and in fact many respondents were clients of MSF. The interviews are perhaps most valuable for the picture they present of the migrant experience in South Africa, particularly the experience of different forms of detention, and relative access to healthcare, with respondents having spent more than five years in South Africa on average.

47.1% of respondents said that accessing healthcare in South Africa was very easy, although some reported having to pay for healthcare, with a third of the interviewees who looked for medical care after being physically assaulted reporting that they had to pay in order to be treated, and the average price for the service was US$78. The perception of difficulty in accessing medical assistance varied across cities. For instance, a greater number of people reported experiencing barriers to care in Pretoria and Johannesburg, where 25% and 16.6% of migrants respectively said that medical assistance was either difficult or almost impossible to get.

Credit: Luca Sola

Detention

There are three main facilities where international migrants in South Africa are sent to following arrest police stations, prisons and the Lindela Repatriation Centre. 22% of the interviewees said they were asked to bribe police officers, whereas 4.2% were not informed about the reasons of detention and less than half were offered legal aid. The results indicate serious violation of migrants' rights at the moment of arrest. Many were still subject to physical violence by police officers - 21.1% of the male interviewees, and 5.4% of female respondents.

Following detention, migrants go through a number of different facilities before being deported. Our respondents had been to 2.6 facilities on average, with some passing through 6 different institutions. In general, migrants had spent 136 days in detention, although 25% had spent more than three and a half years incarcerated before being deported. The average number of days spent in each detention facility varies depending on the facility type, and whether the migrant went to prison or not.

Police stations are the institution where 51% of our respondents had been detained for longest time, followed by prison (44%), and Lindela (5%). Living conditions in police stations were reported as being poorer than in Lindela, or most prisons. In police stations, fewer than half of respondents had their own bed, and they were also considered the dirtiest of the three types of facilities. Sheshego and the Lephalale Police Stations were named as the worst facilities. When it comes to access to health, only 26% of the interviewees had been tested for HIV and 9.4%, for Tuberculosis, most in Lindela or prison. In police stations, the rates are much lower.

Medical Service Availability	Medical Assistance Available	No Medical Assistance Available	Total
Type of Facility		**Percentage (%)**	
Detention Centre	100.00	0.00	100.00
Police Station	36.36	63.64	100.00
Prisons	61.11	38.89	100.00
Total (%)	**54.84**	**45.16**	**100.00**
Total (N)	**17**	**14**	**31**

Medical assistance available by Type of Facility

Being a migrant was seen as an impediment to accessing medical care in the three types of facilities. The reason why most people did not look for medical care, or did not find an available service, was related to their migratory status.

Our findings show that irregular migrants end up de facto staying lengthy periods of time in detention facilities before being sent back to Zimbabwe. In the meantime, 50% cannot access medical services when needed.

"We've noticed that there are a greater number of people that have psychological or psychiatric problems, serious problems, I think maybe because of the traumatic situations that they're coming from. Those who come from DRC and Burundi, they come very traumatised."

Sister Francis Groban, social worker, Musina.

Credit: Tadeu Andre

We have also asked participants if they had access to condoms while detained, and how easy was it to access them upon request or by default. Although rates are low for all facilities analysed, our results show that Lindela is the place where the protective method was least accessible. The lack of access to condoms is Lindela is concerning, especially given the high rates of transactional and forced sex found in the facility. At the Repatriation Centre, 8.3% of interviewees reported they have had sex in exchange for money or other goods, and 16.7% admitted to have had sexual relationships against their will:

Good access to healthcare services was reported at the Reception Centre itself, but a higher ratio of women here than at any other site surveyed reported experiencing anxiety, depression and suicidal ideation at the Reception Center than for any other group studied. 21% of all female deportees interviewed displayed moderate or severe symptoms of anxiety disorder, and 7.1% of women reported having had self-hurting thoughts more than half of the days during the past weeks. The results could be correlated to higher HIV prevalence among women (22.64%, compared to the 12.8% average for the general adult population in the country) and to factors such as family separation following detention.

"Client came with acute psychosis secondary to harsh conditions experienced in detention in South Africa."

Notes from deportee database, Beitbridge Reception Centre

Credit: Tadeu Andre

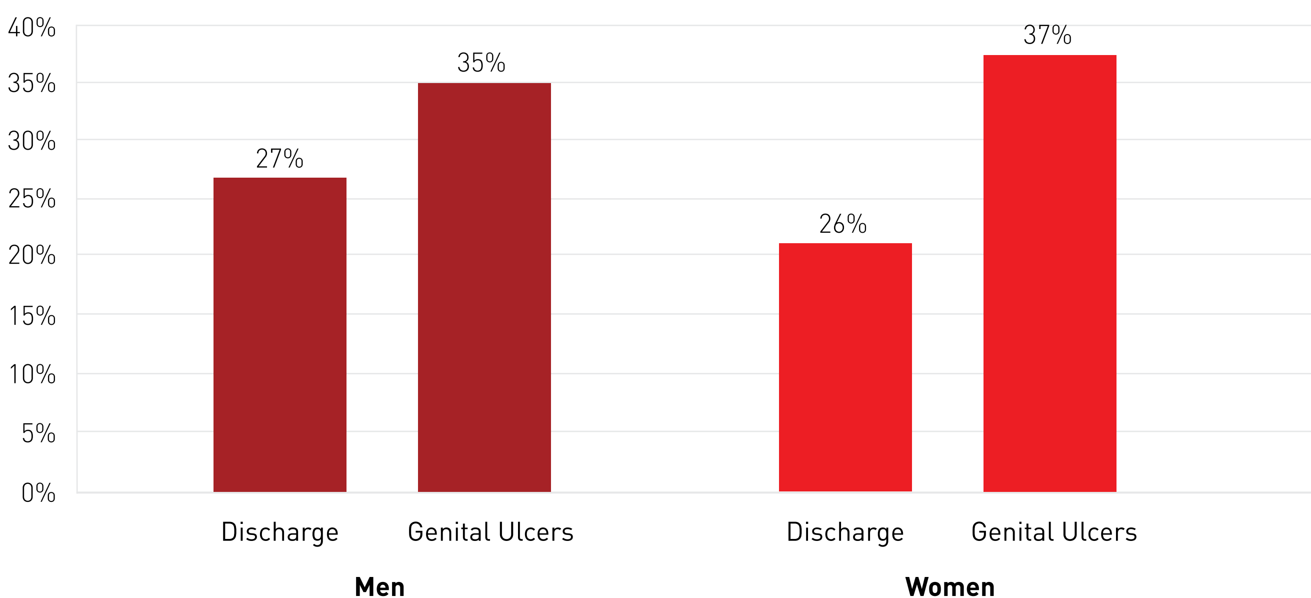
Magogo's House, Beitbridge

Among the different nationalities passing through Beitbridge, Malawians follow a unique path, in which they wait a couple of days or even weeks before crossing to South Africa at the so-called 'Magogo's house', or surrounds. Magogo's house is an informal shelter run by a Malawian traditional leader. The site is used as a location of reunion of migrants and smugglers. There, people wait for others to send in resources that can be used to bribe authorities at the South African border. During the survey, 178 migrants were interviewed at Magogo's house, all Malawian nationals.

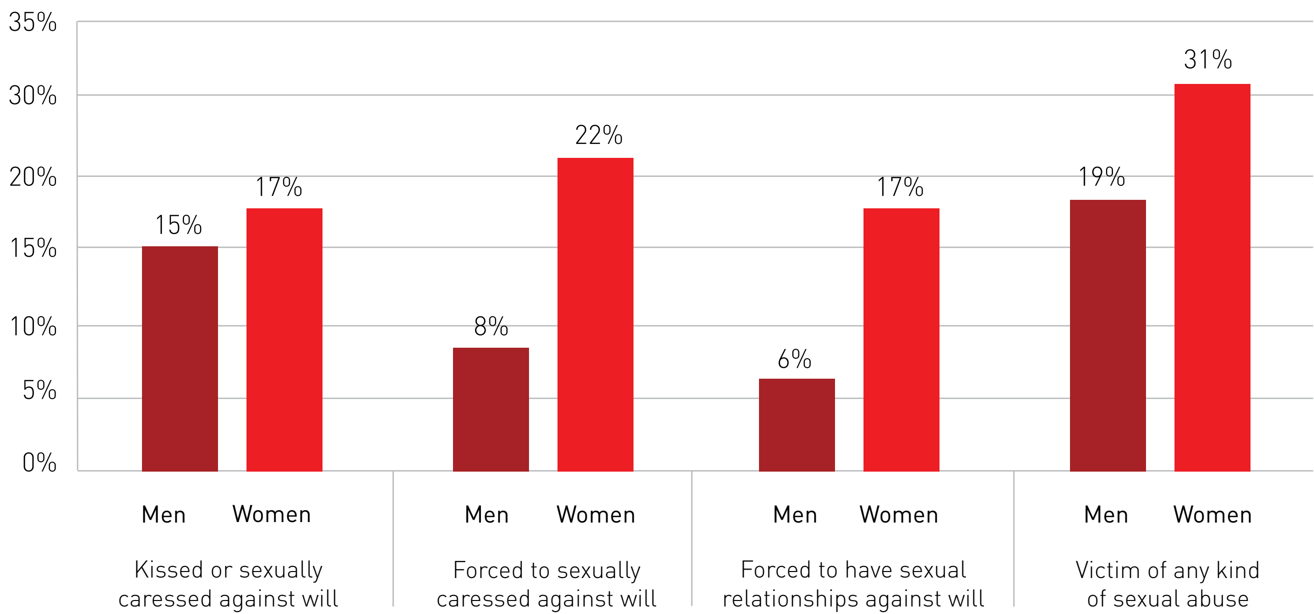
The percentage of people reporting any chronic condition or recent infectious illness at this site is very low, which could be the result of either real low incidence and prevalence rates of such diseases, or poor testing and diagnose. Of all conditions analysed, Malaria is the only one that stands out, with 37.6% of Malawian migrants reporting to have had it since January 2019.

The percentage of respondents reporting genital ulcer at Magogo's place is the highest of all groups interviewed, as are the levels of sexual abuse. Marital status is related to sexual abuse, and female single migrants are particularly vulnerable: 35.7% had gone through an episode of sexual violence very recently.

Marital status correlated with sexual abuse, and female single migrants are particularly vulnerable: 35.7% had gone through an episode of sexual violence very recently. The survey is suggestive of a connection between the area's known smuggling and human trafficking activities and the sexual and reproductive health needs of respondents, as well as the concerning levels of sexual abuse that were identified.



Percentage of People who Reported Discharge or Genital Ulcer, by Sex, Malawian Migrants, Magogo's House, Beitbridge, 2020



Percentage of Respondents who have been Sexually Abused in the last year, by Type of Abuse and Sex, Malawian Migrants, Magogo's House, Beitbridge, 2020

Credit: Luca Sola

Cross border villages

In order to understand not only the plight of migrants but of their families left behind, we ran the mobility survey in the so-called cross border villages along the Limpopo river, specifically the villages of Dite, Chikwarakwara and Shashe, and we also applied the same questionnaire to the cross-border population we interviewed at the crossing points, namely Pounden, Gate 2 and Mike. Even though the importance of international remittances on the wellbeing of families is widely recognized, migration scholars have been extensively debating the impact of transnational living arrangements on children left behind. In order to understand the impact of international migration on children living in the cross-border villages, we asked questions about all children (0-15) living in the households analyzed. Data comprised of information on vaccination, infectious diseases' signs and symptoms and access to health care. We also collected figures on parents' migratory status, as well as details about caretakers. One important limitation of our survey, however, was that we did not collect data on children's mental health, as these would have to be self-reported through a specifically designed methodology.

We found a surprisingly high percentage of children with international migrant parents (mother, father or both) – almost 40.5% of the 274 children surveyed.

For most children with absent fathers, the mother is the one who takes up the main caregiving responsibilities. On the other hand, once the mother leaves or dies, the caretaker usually becomes a significantly older woman (16.2 years older than the average caretaker), who is most probably the grandmother. Children with international migrant mothers tend live in extended arrangements, i.e. those with other relatives besides of siblings and parents, whereas children with international migrant fathers are more likely to reside in extended or single parented households.

Guided by the international literature on the matter, one of our questions was: "does the migration or absence of the mother – and the consequent

Credit: Tadeu Andre

transference of caregiving roles to an older person – have a negative impact on children's health"? We do not have all the necessary elements to answer this question unequivocally, but our results suggest that having a migrant or absent mother does not diminish the prospects for 0-5-year-old child to be vaccinated, or increase the risk of infectious diseases in 0-15-year, or indeed limit the access that these children have to medical care.

Migrant has Left Children Behind		Migrant Sends Remittances
Percentage (%)		
Yes	41.10	63.64
No	58.90	36.36
Total (%)	**100.00**	**100.00**
Total (N)	**200**	**200**

International Migrant, by Children Left Behind and Remittances, Cross-Border Population, Rural Beitbridge, 2020

In total, almost half (43.36%) of the households we analysed received some sort of financial support from migrants residing abroad. Interestingly, residences that had children left behind, were much more likely than others to receive this kind of aid: among households with left behind children, 85% receive remittances, compared to only 26.45% of households with no left behind children at all. This result is important because it could help explaining why children who have parents abroad were not necessarily more vulnerable – in terms of access to health care or food insecurity – than others, as it will be later outlined. In fact, having a migrant parent could even have a protective effect on Zimbabwean children living along the border.

Credit: Luca Sola

4. RECOMMENDATIONS

In light of the finding that vulnerable migrants are waiting nine months on average at Musina for application outcomes, a place of precarious access to social and health services, Doctors Without Borders calls on the government to allow migrants to renew their documentation status online or at their nearest refugee reception office, rather than at their office of first application, as the policy currently requires.

In the context of the COVID-19 pandemic, the increased mobility across long distances, often in crowded transport, results in significant risks for governments own COVID-19 prevention strategies.

SITE SPECIFIC RECOMMENDATIONS

Beitbridge

+ Increased availability of mental health, family planning and HIV testing services at the Beitbridge Reception Centre, and advertise services in all vernacular languages;
+ Health promotion campaigns needed to increase awareness of STI signs and symptoms among deportees and emphasise the importance of looking for early medical attention in those cases;
+ Provide more options of mid and long-term family planning methods, informing especially unmarried women about its benefits;
+ Increase rapid screening of diabetes and tuberculosis at the reception centre in Beitbridge

Musina

+ Increased access to malaria testing;
+ Improve sanitation at male and female shelters within Musina;
+ Provide legal and mental health services particularly for unaccompanied minors;
+ Clinic signage and health promotion materials in other African languages; translation services at clinics

South African Detention Centres

+ Increase condom availability at Lindela Repatriation Centre;
+ Increase the provision of health assistance to undocumented migrants who are staying in prisons and who should not be denied healthcare on the basis of nationality;
+ Working with authorities as well as other partners, develop a health promotion strategy responding to the high rates of sexual abuse in Lindela to target survivors to receive post-assault care either at Lindela or at the reception centre in Zimbabwe;
+ Something on police stations?

"Client stays in Soweto where she was denied access to HIV services. She visited 3 hospitals and turned away as a passport, ID and asylum was demanded."

Notes from deportee database, Beitbridge Reception Centre

Credit: Tadeu Andre

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