



# LIMPOPO

PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

## SECOND REPORT ON THE IMPACT OF MIGRATION ON - PUBLIC HOSPITALS IN LIMPOPO PROVINCE

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# THE IMPACT OF CROSS BORDER MIGRATION ON PUBLIC HOSPITALS IN LIMPOPO PROVINCE

## 1. Introduction and background

Towards the end of 2006, the Department of Health and Social Development embarked on a project that aimed at monitoring the impact of cross border migration on the services rendered by the provincial Government hospitals in Limpopo province. The monitoring process [an on-going process] is pursued through a pilot surveillance project that initially targeted hospitals in Vhembe and Mopani districts. Piloting the project in these two districts was prompted by the districts' situation which exposes them to cross border migration; they share borders with Zimbabwe and Mozambique respectively. The project has, to a great extent, been successful through the collaborative efforts between the management of hospitals and the Population and Development Directorate – the latter is in charge of the project's implementation.

The central objective of this project is to establish the impact of cross border (international) migration (CBM) on public hospitals in Limpopo Province through an evidence-based approach. The term "impact" in this instance is reflected through how frequent a public hospital uses its resources to address the needs of migrant patients. The perceived advantage of this approach, as opposed to conducting a cross section survey is that patterns in service needs, demographic aspects, and disease profiles of migrant patients (clients as conventionally referred to) can be identified. In response, focused interventions can be channeled to specific areas of need as identified through established patterns.



This is becoming critically important in the current era of globalization where international movements have become the norm rather than the exception. This report reflects on the outcome of the migration surveillance services project, based on the statistics collected during the 2007 calendar year.

The results of the project are presented by district mainly because the surveillance exercise commenced late in Mopani district (around April 2007). At any rate, hospitals were incorporated gradually which resulted into results coming in, in series. This implies that comparing the impact of cross border migration at district level is the ultimate goal (reflecting the provincial situation when all five districts are involved) when all hospitals in a district are able to provide the required information. At this moment the use of "District" within the context of the current results should be viewed in terms of particular hospitals in a district which provided information as opposed to all hospitals in the district. Added to this is the fact that Polokwane hospital (falling under Capricorn district) was incorporated into the surveillance exercise due to its proximity to the Department, and location (being in the provincial capital makes it easily accessible to patients in need of health care services). The intention is to incorporate all hospitals in Capricorn district but this could not be realised due to human capacity constraints. Before getting into the results of the project, a brief look at the methodology applied in the data collection process is provided hereafter.

## **2. Methodology, definitional issues and delimitations**

### **2.1 Definition**

Before getting into the results of this exercise, it is imperative to highlight the challenges involved in collecting statistics on migration at hospital level. The first challenge one has to grapple with is definitional; who is a migrant? This is important because migrants who acquire citizenship in South Africa could be perceived as migrants when they visit hospitals.



This has to be avoided because they are part of the South African population for which the health care system has to render services. Another challenge pertains to identifying migrant patients. While one's identity should be conceived from the identification documents (Identity documents and passport), patients may not have carried their identity documents when seeking health care services.

As a result, identifying migrant patients for migration surveillance purposes becomes quite challenging. It is even more challenging in situations where a migrant patient "deliberately" fails to provide his or her identity on the basis of documentation. This is not uncommon when it comes to undocumented migrants. Given these and other challenges, for purposes of this project, a migrant is defined as "*a foreign national who happens to be in South Africa for any reason, regardless of immigration status; who does not have a permanent residence status and; who is not a naturalised citizen of South Africa*".

In the introduction above, the use of the term "impact" was specified to refer to how frequent a public hospital uses its resources to address the needs of migrant patients. A contextual understanding and delimitation of "impact" is important given the various dimensions through which health services can be affected or affect migrant patients. In the first place, a potential migrant is in a certain health condition before making the migratory move. The health condition before the move is known to the migrant to - be and, this study places no interest in this particular issue but, it might be the very reason for the migratory move. Without getting into conventional definitional issues around "health" (one could stick to the one offered by the World Health Organisations), Roux and Van Tonder (2006, 121) put it that health can be a positive or a negative condition for migration. Labour migrants, for instance, need to be healthy to improve their probability of successfully selling their only commodity, their labour.



On the other hand, some individuals might elect to migrate in order to access health services that are not available at their home place. An individual's poor health can deter or prevent him or her from moving. In some instances migratory movements place both recipient populations and migrants themselves at risk of suffering setbacks – on the one hand because recipient populations might be exposed to unfamiliar infectious agents, while on the other because migrants themselves are affected by changes in environment (including modern lifestyles) and lack of knowledge of and access to unfamiliar healthcare systems (Roux & Van Tonder, 2006:121 – 122). While acknowledging these and other relationships between health and migration, this study will only provide a descriptive analysis of the impact of cross border migration within the context of the definition of “impact” provided in the background.

## **2.2 Data source and data collection**

The migration surveillance exercise focused on Government hospitals in Limpopo province. This implies that the data source is the hospital where migrant patients seek health care services. Records of patients [migrant and South African citizens] who make use of public hospitals are kept by hospitals. These served as the primary source of the [quantitative] data required for surveillance. Even though challenges exist in identifying international migrants, efforts are made in hospitals to record identified migrants.

### **2.2.1 The data collection instrument**

An instrument was developed by the Population and Development Directorate. It was discussed with the management of hospitals before the collection of statistics could commence. In most cases, statistics are collected by information officers based in hospitals.



Once collected, they are forwarded – on a monthly basis - to the provincial office (Population and Development Directorate) for compilation, analysis, interpretation and report writing. Issues addressed by the data collection tool include the following:

- Age and sex composition of migrant patients;
- Number of migrant patients visiting the out- patients Department;
- Number of migrant patients visiting the in - patients Department;
- Mortality among migrant patients;
- Number of migrants deaths that are unclaimed by relatives – paupers' funerals; and
- Profile of health services commonly required by migrant patients

Results emanating from the use of the data collection tool are indicated in the following section.

### **3. Results**

This section of the report provides a description of the results received from hospitals involved in the surveillance project. As indicated in the introduction, results will be provided on a district basis with results from Vhembe district being dealt with first in section 3.1 below.

#### **3.1 Results in respect of migration statistics from hospitals in Vhembe district**

Table1 shows the number of migrant patients who visited the hospitals in Vhembe district during the reference period (i.e. January – March and June – December 2007). For unclear reasons, statistics for April to June could not be obtained from hospitals.





Part of the explanation lies in the industrial action which disrupted the normal flow of activities in various institutions including Government hospitals. In fact it should be noted that the only statistics obtained for June came from Musina hospital. It should also be noted that besides the psychiatric hospitals, no information was received from Elim hospital as shown in Table1. This is due to a delay for the hospital in assigning a particular official to manage the collection and compilation of the required statistics.

**Table 1: Number of migrant patients by hospital and sex (Vhembe District)**

Hospital	Male	Female	Total
Musina	1496	1867	3363
Louis Trichardt	24	21	45
Tshildzini	06	00	06
Donald Frazer	180	46	226
Siloam	12	07	19
Malamulele	68	74	142
Elim	-	-	-
<b>Total</b>	<b>1786</b>	<b>2015</b>	<b>3801</b>

According to the information received, a total of 3801 migrant patients were received by hospitals in Vhembe district of whom 1786 (47%) are male. The majority of migrant patients (88.5%) sought health care services from Musina hospital followed by Donald Frazer hospital (6%). The impact of migration in this respect can be seen to be concentrated on Musina hospital.

It should be noted that a number of factors could be at play when it comes to the picture portrayed in Table1. For instance while the high incidence of migrant patients at Musina hospital could be due to its geographical proximity with Zimbabwe, this is hypothetical as the information collected so far, does not track the identity of migrant patients. Information on country of origin was left out in the inception stage of the data collection process to downplay a possibility of resentment





emanating from xenophobia. With time, this information will be included when the level of comprehending the project's objective is advanced.

Another possible factor influencing the scenario in Table 1 is the status of Government hospitals in relation to the policy issues surrounding hospital functionality. A regional hospital like Tshildizini could be receiving fewer migrant patients given its status as a regional hospital. Since such a hospital deals mainly with referrals, the incidence of migrant patients treated by such a hospital is likely to be low. This said though, the results from Tshildizini hospital reflect a smaller impact than the real situation. Part of the problem is attributed to software problems and changes in the systems used to collect data. Apparently, the changes in the systems resulted into delays to download data for admitted migrant patients.

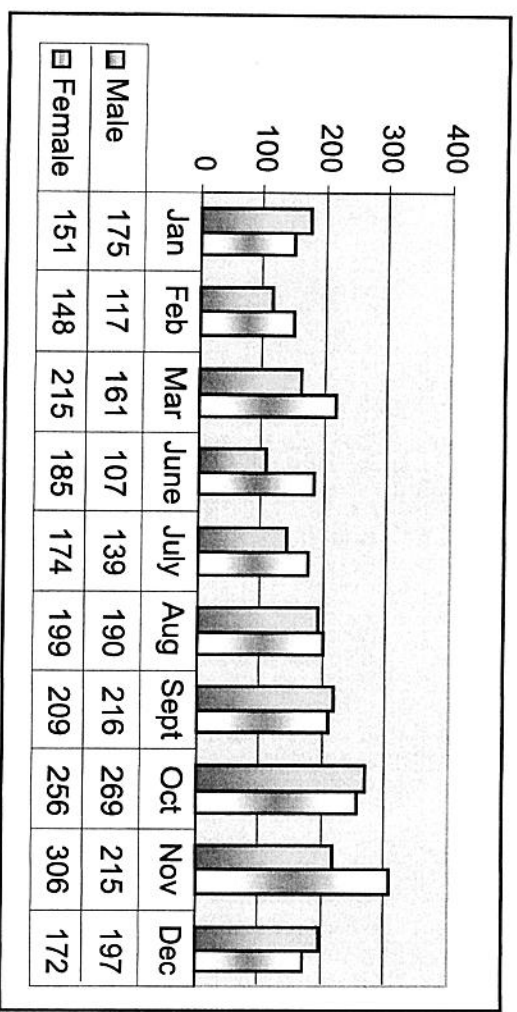
The third factor affecting the distribution of migrant patients by hospital could center around the prudence in collecting the information. This to a certain extent, is reflected by the lack of statistics received from some hospitals in certain months. This is not withstanding the fact that prudence could be partly underpinned by commitment or lack thereof for several factors. As far as the sex distribution of migrant patients is concerned, the female patients outnumber their male counterparts with the former constituting 53%. At this moment however, no conclusive statement can be made on the basis of these statistics given the reference period of around nine months which is considered to be rather short. The situation will become clearer as more time series statistics are collected more regularly.

Figure 1 shows the monthly distribution of migrant patients (by sex) that visited the hospitals in Vhembe district. Information herein depicts variations in the demand for health care services with the greatest demand occurring during October and November.



The distribution of the demand for health care services dips in February and June, the latter having been caused by statistics not coming through due to the industrial action. Once again, at this point in time, no explanatory factor can be given for the slump in February; any explanation attempted will be more of speculation than anything else. That said though, the monthly distribution of patients still provides some insights (and plausible hypotheses) into what might be expected especially when one looks at the months – like January and March – when the demand for health services rises substantially.

Figure 1 : Monthly distribution of migrant patients by gender – Vhembe district



One other observable feature from the distribution of patients in Figure 1 is that female patients do not consistently outnumber their male counterparts even though they [females] constitute the overall majority. The male patients substantially outnumber the females patients particularly in December, January and October.

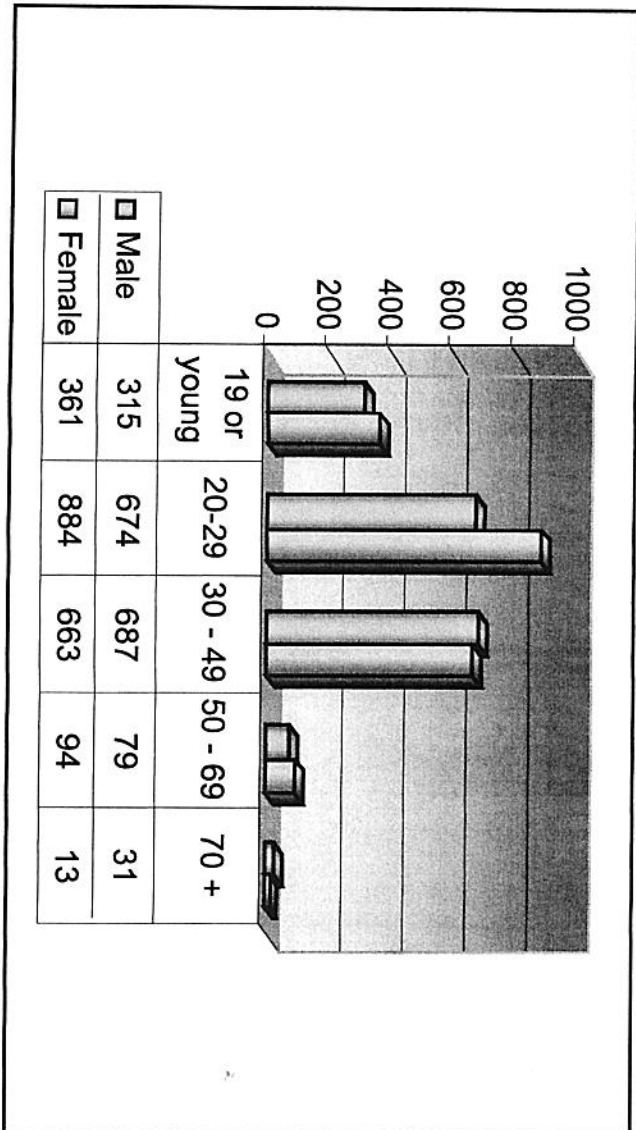


In the process of collecting data for migration surveillance, age and sex of migrant patients are reflected. At the current stage of piloting the project, age is grouped until a clear system for capturing migrant patient data is in place. It needs to be reiterated that providing detailed statistics broadens the framework within which in-depth analysis can be done to enrich the resultant information.

Figure 2 shows the distribution of migrant patients (by age group and sex) who visited the hospitals in Vhembe district during the period under review. These results show that at least four in every ten patients (41%) were aged 20-29 while 35.5% were aged between 30 and 49 years. The migrant patients aged 19 or younger constitute 17.8%. This portrays a picture of generally young people involved in migration (a feature that is not unexpected) even though inferences cannot be made on the entire migrant population in the province. When it comes to the sex distribution, females almost outnumber the males in all age groups.



Figure 2; Migrant patients by age and sex (six Hospitals involved in analysis: January –March; Jun- Dec. 2007)



### 3.2 Migration impact by hospital section/department- Vhembe district

The number of patients seeking health care services constitute the demand for health care services in a hospital. In a situation where the demand is quite high, the quality of care can be negatively impacted upon as the hospital staff gets overwhelmed. The impact of the demand for health services is deemed to differ on account of which department (Out-patient versus In-patient) most patients visit. Besides the impact in terms of absolute number of patients visiting a particular hospital section/department, the cost implications for the Out-patient Department differ from the cost implications for the In-patient Department.

Figure 3 shows the distribution of patients who sought health care services by department (out-patient and in-patient) for the six hospitals in Vhembe district which participated in the pilot project. A detailed scenario of the information in Figure 3 is provided in Table 2.

These results show that at least three quarters of the migrant patients (2870 or 75.5%) received health care services from the out-patient departments. The number of male patients differs slightly from that of female patients who visited the out-patient Department. The situation is different when it comes to the In-patient Department. While close to 25% of all migrant patients were admitted, 63% of the admitted patients are female. One generally known cause for female admission is the demand for maternity services as reflected by the recorded number of migrant births (280 in Table 3). When the maternity factor is eliminated (assuming that each mother gave birth to one baby, for simplicity's sake), male admissions outnumber the female admissions by a figure of 31.

Discussions around the statistical significance of the difference between male and female admissions (after eliminating maternity cases) should not be entertained - at least for now - for a number of reasons. Firstly a lot of data pertaining to babies born by migrant mothers were not adequately provided by most hospitals. This puts the credibility of the data under scrutiny on the basis of incompleteness. Secondly the assumption around the number of babies born to each mother may be unrealistic particularly if several mothers had twins or triplets. Such a situation reduces the number of women admitted for maternity purposes and by implication, it increases the number of women admitted for other reasons hence reducing the figure of (31). All in all it is a point that may deserve further analysis as more robust data becomes available.



Figure 3: Distribution of patients by sex and hospital section visited (all six Hospitals involved in analysis)

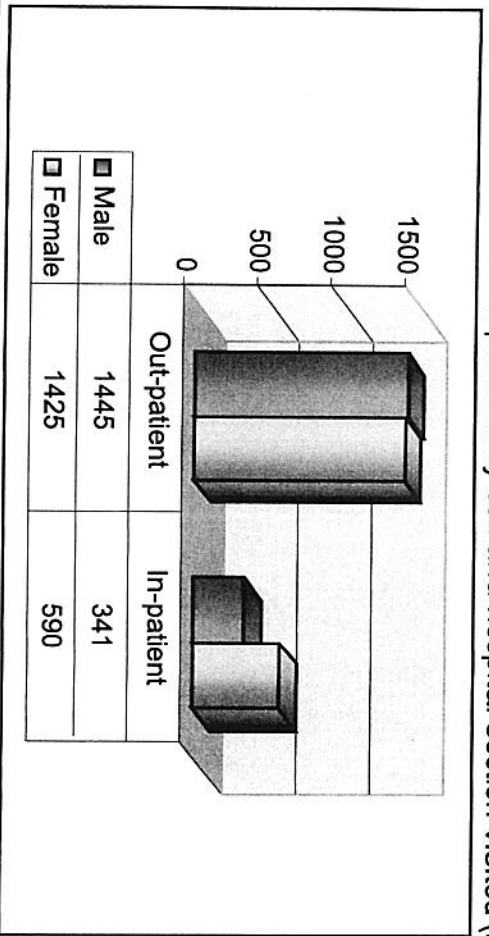


Table 2 Monthly distribution of migrant patients by department – Vhembe district

Department	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Out-patient	Male	148	95	124	90	90	117	155	178	225	177	136	1445
	Female	108	90	154	140	140	116	182	168	167	194	106	1425
	<b>Total</b>	<b>256</b>	<b>185</b>	<b>278</b>	<b>230</b>	<b>230</b>	<b>233</b>	<b>337</b>	<b>346</b>	<b>392</b>	<b>371</b>	<b>242</b>	<b>2870</b>
In-patient	Male	27	22	37	17	17	22	35	38	44	38	61	341
	Female	43	58	61	45	45	58	17	41	89	112	66	590
	<b>Total</b>	<b>70</b>	<b>80</b>	<b>98</b>	<b>62</b>	<b>62</b>	<b>80</b>	<b>52</b>	<b>79</b>	<b>133</b>	<b>150</b>	<b>127</b>	<b>931</b>
<b>Total: Both Departments</b>	<b>326</b>	<b>265</b>	<b>376</b>	<b>292</b>	<b>292</b>	<b>313</b>	<b>389</b>	<b>425</b>	<b>525</b>	<b>521</b>	<b>369</b>	<b>3801</b>	

**NB. The data for June came from Musina Hospital only. Most hospitals did not address migration related data in June and two months prior to June, partly due to the industrial strike.**

### **3.3 Migrant births - Vhembe district**

Births as vital events are recorded by maternity wards in hospitals where babies are born. Records of babies born by migrant mothers are similarly kept by the hospitals where such births occur. Table 3 shows the monthly distribution of babies born by migrant mothers during the reference period. It is clear from Table 3 that most hospitals did not provide information pertaining to babies born to migrant mothers; not that there were absolutely no such events. The situation for Malamulele hospital can be understood as it was the last to be incorporated into the surveillance project. All in all one can make do with the available information as steps to improve data quality are put in place.

Information in Table 3 shows that migrant births vary substantially on a monthly basis. Most births occurred in September, October and December (45, 42 and 38 respectively). The lowest number of births (3) was recorded in August. The results in Table 3 need to be analysed in conjunction with the In-patient information (for females) in Table 2. The number of migrant babies born in a particular month would be expected to at most, equal the number of female admissions. This carries the assumption that in a situation of parity between births and female admissions, the latter solely occurred for maternity reasons.



Table 3. Monthly distribution of babies born to migrant mothers by Hospital – Vhembe district

	Jan	Feb	March	June	July	Aug	Sept	Oct	Nov	Dec	Total
Musina	21	32	21	31	32	-	37	29	-	21	224
Louis Trichardt	-	-	-	-	-	-	-	-	-	-	-
Tshildzini	-	-	-	-	-	-	-	-	-	-	-
Donald Frazer	-	-	-	-	-	03	02	02	-	-	7
Siloam	-	-	-	-	-	-	-	-	-	-	0
Malamulele	-	-	-	-	-	-	06	11	15	17	49
<b>Total</b>	21	32	21	31	32	03	45	42	15	38	280

***Food for thought: Is the distribution of migrant births similar to that of the local population? What proportion of the total births does the migrant babies constitute?***

Results pertaining to September show the total number of recorded migrant births (45) being bigger than the number of female admissions (41). This is contrary to the expectation referred to above although mothers could give birth to twins and triplets. Before it could be declared an anomaly (though it is highly likely in spite of the assumption regarding parity), this finding calls for a need to simultaneously strengthen the data collecting mechanisms, and a broadening of the scope of data analysis. On a separate note, the variation in the monthly occurrence of migrant births is noted but the possible causes thereof are deemed to be beyond the scope of the current project.

### **3.4 Migrant deaths - Vhembe district**

One dimension in which cross border migration impacts on health services in Limpopo province is through migrant deaths. Migrant deaths put a strain on hospital resources in a number of ways but the two main causes of strain on hospital

resources centre around the storage of dead bodies (i.e. mortuary services) and burial of unclaimed bodies, termed “paupers’ funerals”. The latter is a last resort when the deceased cannot be buried by their relatives.

Table 4 shows the monthly distribution of deaths, and paupers’ funerals conducted by three hospitals in Vhembe district during the period under review. These results show that in most cases migrant deaths end up translating into paupers’ funerals. This is reflected by the fact of the 27 deaths registered by the three hospitals, 18 of them (i.e. two thirds or 66.7%) were buried by the hospitals concerned. At hospital level, results show that 11 out of the 16 migrant deaths registered in Musina hospital (i.e. close to 70%) had to be buried by the hospital. A similar situation is depicted by the other two hospitals although the incidences are lower. In the case of Donald Frazer hospital, all migrant death cases (5) ended up turning into paupers’ funerals.

Table 4: Distribution of migrant deaths and paupers’ funerals (hospitals in Vhembe district)

Deaths	Jan	Feb	Mar	August	Sept	Oct	Nov	Dec	Total
D. Frazer	-	-	-	1	1	2	1	-	5
Musina						5	6	5	16
Malamulele					3	3			6
<b>Total Deaths</b>				1	4	10	7	5	27
<b>Funerals</b>									
D. Frazer	1		1			1	2		5
Musina	6	5							11
Malamulele						1	1		2
<b>Total Funerals</b>	7	5	1	-	-	2	3		18

A point worthy noting evolves around the monthly recording of migrant deaths in relation to the paupers' funerals conducted by hospitals. Paupers' funerals are conducted after exhaustive attempts to track the next of kin have been made. This involves time (a couple of months ranging from three to six). As a result of this task of tracing the next of kin, paupers' funerals are conducted months after the death itself has occurred. It is in this respect that Donald Frazer hospital conducted a pauper's funeral in January even though no migrant death case was registered during the same month.

### **3.5 Summary**

This report has so far provided an introduction and the rationale for the migration surveillance project. The methodology employed has been described. Section three provided the results pertaining to the impact of cross border migration (CBM) to hospitals in Vhembe district. A detailed analysis of the impact of CBM has been offered on the basis of gender and age of migrant patients. The impact of CBM has also been analysed in terms of which hospital section/ Department (In-patient/ Out-patient) receives most migrant patients. Finally, a description of the impact of migrant deaths on hospital resources has been provided.

Section four will provided the results pertaining to the impact of CBM on hospitals in Mopani district. Since the analytical format is similar to the one in section 3 (dealing with the results for Vhembe district), no details will be provided hereafter except in particular instances where such an explanation is deemed warrant.



#### Section 4: Results from Mopani district

As indicated in the summary above, this section provides information in respect of the impact of CBM on hospitals in Mopani district. It should be noted that the surveillance project was implemented in phases due to human capacity constraints. As a result hospitals in Mopani district were gradually incorporated from June 2007 and, statistics started being received from August. Table 5 shows the results obtained from Maphutha Malajije and Nkhensani hospitals during the five month period. A total of 1801 migrant patients received health care services between the two hospitals with the majority (89%) visiting Nkhensani hospital.

Table 5: Number of migrant patients by hospital and sex (Mopani District)

Hospital	Male	Female	Total
Dr CN Phatudi	X	X	X
Letaba	X	X	X
Maphutha Malajije	122	78	200
Nkhensani	785	816	1601
Sekororo	X	X	X
Van Velden	X	X	X
<b>Total</b>	<b>907</b>	<b>894</b>	<b>1801</b>

**NB. X indicates that no data was received from a particular hospital for one reason or another. Sekororo hospital was only incorporated in December 2007. As such it does not feature in the analysis**

Figure 4: Monthly distribution of migrant patients by sex – Mopani district

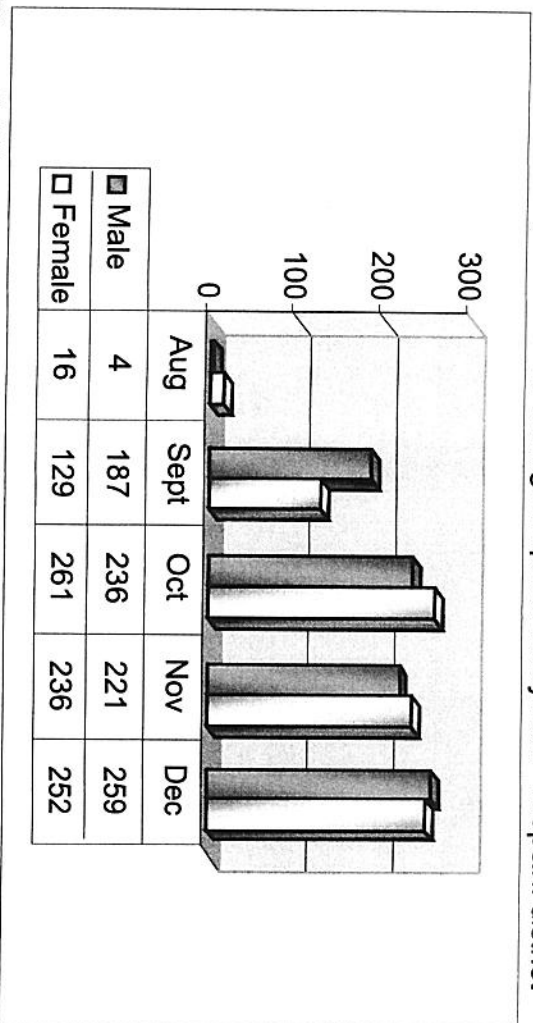
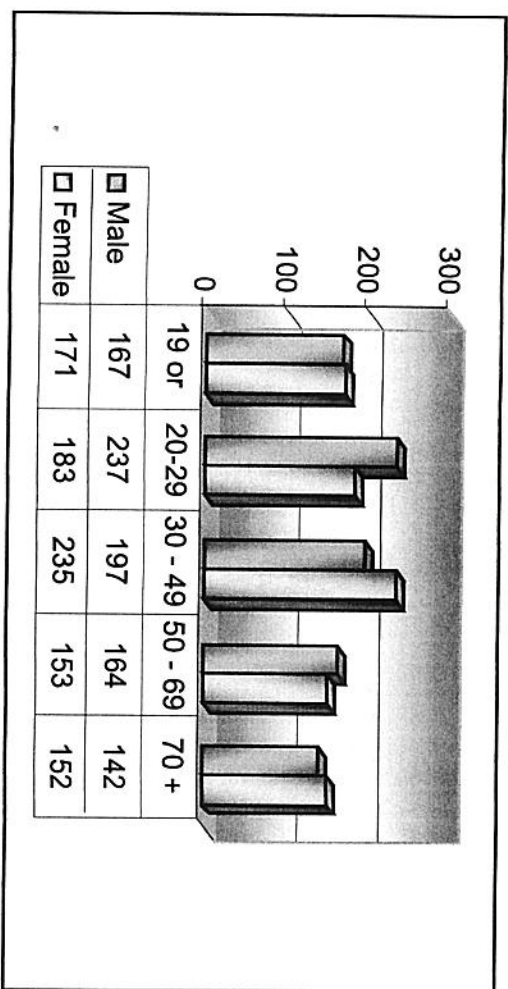


Figure 5: Migrant patients by age and sex – Mopani district

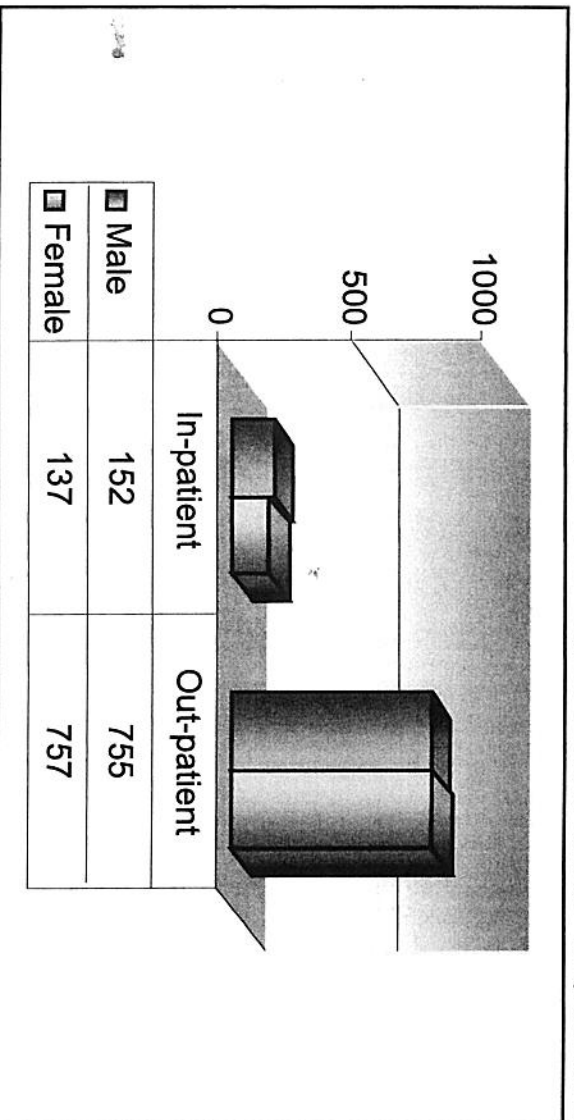


#### 4.1 Migration impact by hospital section/department

Table 6 Monthly distribution of migrant patients by department – Mopani district

Department	Aug		Sept		Oct		Nov		Dec		Total
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Out-patient	0	0	86	75	217	221	212	220	240	241	755
	<b>Total</b>	<b>0</b>	<b>161</b>	<b>161</b>	<b>438</b>	<b>438</b>	<b>432</b>	<b>432</b>	<b>481</b>	<b>481</b>	<b>1512</b>
In-patient	4	0	101	54	19	40	9	16	19	11	152
	<b>Total</b>	<b>4</b>	<b>155</b>	<b>155</b>	<b>59</b>	<b>59</b>	<b>25</b>	<b>25</b>	<b>30</b>	<b>30</b>	<b>289</b>
<b>Total- both departments</b>	<b>20</b>	<b>20</b>	<b>316</b>	<b>316</b>	<b>497</b>	<b>497</b>	<b>457</b>	<b>457</b>	<b>511</b>	<b>511</b>	<b>1801</b>

Figure 6: Distribution of patients by sex and hospital section visited – Mopani district



## 4.2 Migrant births

Table 7 Monthly distribution of babies born to migrant mothers by Hospital – Mopani district

	Aug	Sept	Oct	Nov	Dec	Total
Dr CN Phatudi	-	-	-	-	-	-
Letaba	-	-	-	-	-	-
Maphutha Malatjje	-	9	-	-	-	9
Nkhensani	14	11	10	-	10	45
Sekororo	-	-	-	-	-	-
Van Velden	-	-	-	-	-	-
<b>Total</b>	14	20	10	-	10	54

## 4.3 Migrant deaths

Table 8: Distribution of migrant deaths and paupers' funerals (hospitals in Mopani district)

Deaths	August	September	October	November	December	Total
Letaba	01					01
Maphutha Malatjje						
Nkhensani			01		01	02
Total deaths	01		01		01	03
<b>Funerals</b>						
Letaba						
Maphutha Malatjje		01				01
Nkhensani						
Total funerals		01				01

**NB. Hospitals without data are excluded. No paupers' funeral was conducted among the reported migrant deaths for the five month period. Maphutha Malatjje hospital conducted a pauper's funeral for a death that occurred prior to August.**



#### **4.4 Summary**

Section four provided the results pertaining to the impact of cross border migration on some Government hospitals in Mopani district. No detailed analysis in this respect has been offered as indicated at the inception of section four. Even though a detailed description is not provided, the information put across elucidates the impact of CBM on the basis of gender, age and the key service areas selected for consideration.

Section five will provided the results pertaining to the impact of CBM on Polokwane hospital. Once again no details will be provided unless it is deemed necessary on account of clarity.

#### **Section 5: Results from Polokwane hospital**

This section will look at the situation at Polokwane hospital with regard to the impact of CBM on the hospital services. As will be shown in the results, Polokwane hospital was only approached (for surveillance purposes) somewhere around mid-May 2007. Statistics started coming through in July 2007. Before looking at the information provided by the hospital itself, there is a need to contextualise the choice of Polokwane hospital rather than talking of CBM in relation to Capricorn district as whole. Part of the explanation lies in the hospital's proximity with the Provincial Department's offices which enabled the latter to easily establish contact with the hospital's management for migration surveillance purposes. One other explanatory factor is the geographical location of Polokwane hospital. Being in the provincial capital and, taking the geographical location of Polokwane city into consideration, Polokwane hospital's services are likely to be highly susceptible to cross border migration (with specific reference to Zimbabwe).

It should also be taken into consideration that Polokwane hospital is a referral hospital with some specialised services that are not found in other hospitals in Limpopo province. This last consideration needs to be born in mind as referred migrant patient cases might result into double counting. As indicated in the introduction it should be kept in mind that the impact of cross border migration is likely to differ at district level. Therefore a district – level analysis is imperative and this will only be achieved when all hospitals in Capricorn district (together with the remaining districts in Limpopo province) have been involved in the surveillance exercise. With this contextual explanation born in mind, one can venture into the results emanating from Polokwane hospital as indicated hereafter. Table 9 shows that Polokwane hospital received 209 migrant patients during the July – December period of 2007, with males slightly outnumbering the female patients.

Table 9: Number of migrant patients who visited Polokwane hospital by sex

Hospital	Male	Female	Total
Polokwane	108	101	209

Figure 8: Monthly distribution of migrant patients by sex – Polokwane hospital

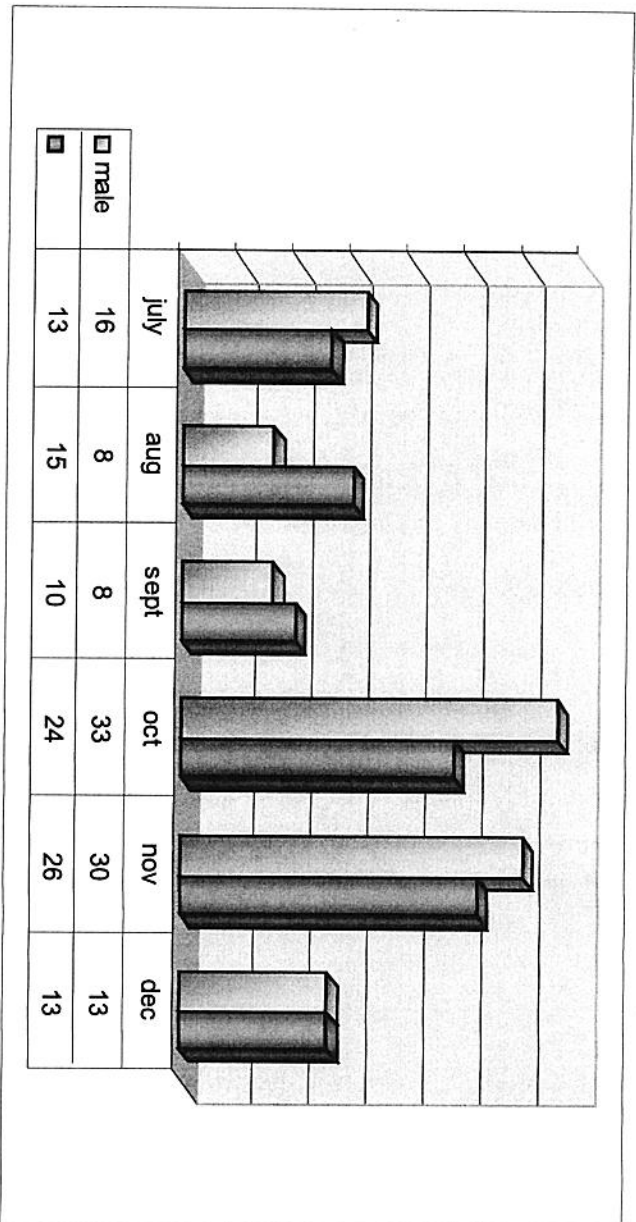


Figure 9: Migrant patients by age and sex— Polokwane hospital

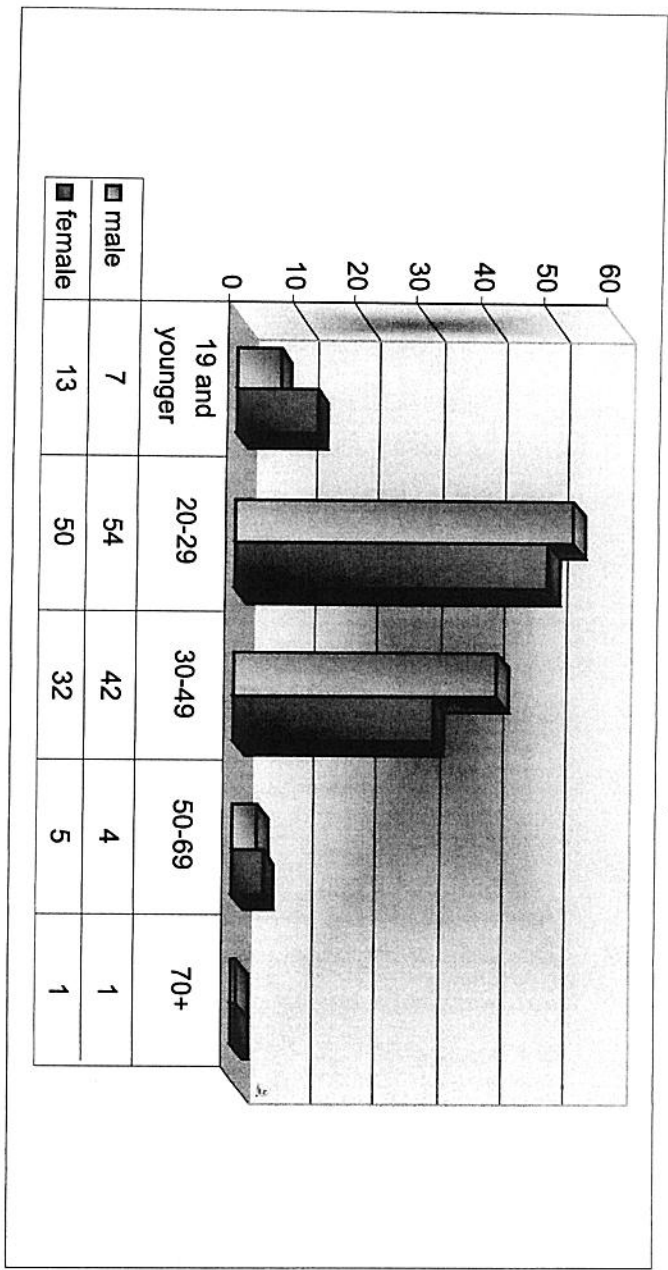
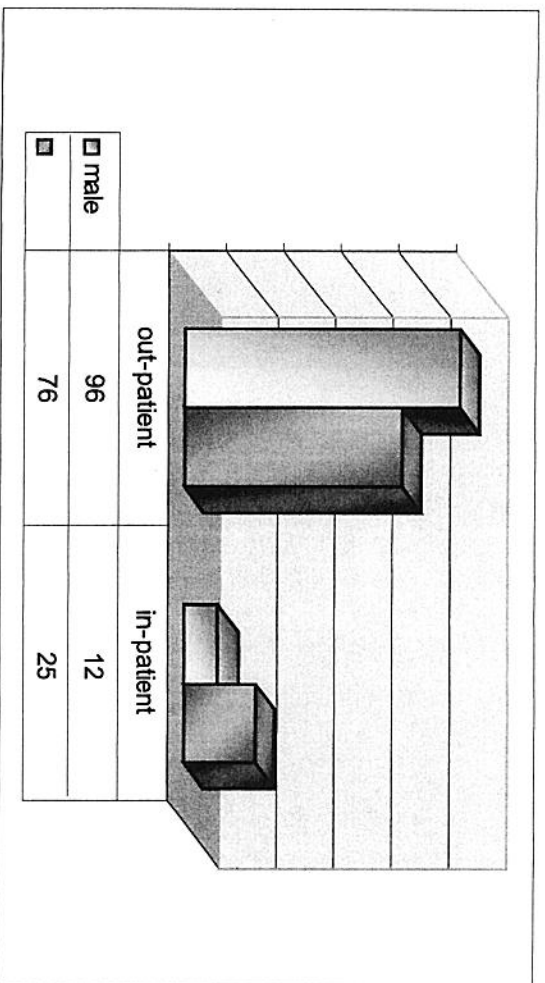


Figure 10: Distribution of migrant patients by sex and hospital section visited – Polokwane hospital



### 5.2 Migrant births

Available statistics indicate that one migrant mother gave birth in Polokwane hospital during December 2007.

### 5.3 Migrant deaths and paupers' funerals

According to the information received from Polokwane/ Pietersburg hospital, no migrant patient died in the hospital and subsequently, no pauper's funerals were conducted.

## 6. Conclusion

The central objective of this project was to establish the impact of cross border (international) migration on public hospitals in Limpopo Province through an evidence-based approach. This has been accomplished through a migration surveillance project piloted in hospitals of Vhembe and Mopani districts. The collaborative project has to a great extent unearthed the interface between resource issues on the side of hospitals and the demographic and vital aspects of the migrant patients. While the goal of reflecting the impact of CBM at district level is partially achieved, the project's findings albeit the limited scope in terms of time, offer meaningful insights for decision making on the side of the Department of Health and Social Development. The following observations are made on the basis of the project's findings.

1. Migrant deaths impact substantially on hospital budgets of relatively small (District) hospitals. The impact needs to be viewed mainly in respect of having to accommodate dead bodies in private mortuaries before paupers' funerals could be conducted. The impact needs to be looked at holistically, taking other resources (like social work services, contacting the next of kin which might require making international telephone calls, etc.) into consideration.
2. Musina hospital in Vhembe district and Nkhensan hospital in Mopani district experience a distinctively high impact of cross border migration. In the case of Vhembe district 88.5% of the migrant patients sought health services from Musina hospital. This figure does not differ much from the situation in Mopani district where 88.9% of the patients sought health services from Nkhensani hospital. The cause(s) for the status quo are not known at this juncture but, they should be a cause for concern especially if they are not random.



3. Available results indicate that in general, Out-patient departments receive most of the migrant patients as compared with In-patient departments. On average 80% of the migrant patients who visited the hospitals involved in the project received health care services from Out-patient Departments/sections. While the cost implications (Out-patient versus In-patient) are different, this finding needs to be seriously considered particularly from a human resource point of view when it comes to the Out-patient departments. This is because the impact of cross border migration is not factored into the hospitals' plans; it is an "add on".
4. As far as age is concerned, the majority of migrant patients are generally young aged 20 – 49 with a median age of 28.9 for males and 28.1 for females. This is not unexpected from a demographic point of view when it comes to migration propensity on account of age (Oosthuizen, M. & Naidoo, P., 2004: 9-11; Xu-Doeve, L.J.W., 2007: 19). The demographic implication of such a young migrant population reflects itself in other demographic factors particularly fertility. Results of the surveillance project show that most of the admissions involving migrant patients are female. A corresponding finding (though not statistically tested) to female admission relates to the number of babies born to migrant mothers. This indirectly shows that giving birth accounts for most of migrant female admissions and, the attendant resource requirements need to be considered.

## **7. Recommendations**

With limited information on cross border migration in respect of its [CBM] impact on health services, this project emphasised only two aspects of the problem. The first was to establish, through the collection of empirical data whether CBM substantially impacts on the health services of Government hospitals in Limpopo province. Secondly, through analysis of collected data, the project/study has managed to establish some of the ways through which CBM impacts on the services rendered by the provincial Government's hospitals.





This study/project has only attempted to highlight some of the dynamics at play when migrant patients seek health care services. In the endeavor to maintain a high standard of health care services rendered by the Limpopo provincial Government hospitals in the era of global migration, two specific recommendations are made.

#### **Recommendation 1**

The Department of Health and Social Development should consider incorporating migration data in its data collection systems. This will enhance the realisation of the goal which seeks to establish the impact of cross border migration at hospital level for all hospitals in Limpopo province. Currently data addressing some attributes which pertain to migrant patients is collected during migrant patient visits (e.g. age, sex and nationality). Although this is happening in some hospitals, no uniformity exists with regard to the content and/ format of the collected data. In some cases data pertaining to migrant patients is collected only in cases involving admissions; Out-patient migrant data is not collected. This could possibly be an opportune time to briefly refer to the case of Tshilidzini hospital.

The results reflected for Tshilidzini hospital are far from the real situation on the ground. Part of the problem is attributed to software problems and changes in the systems used to collect data. The changes in the systems resulted into delays to download data for admitted migrant patients. This problem was highlighted by a number of hospitals and it definitely impacted on the results of the study. That put aside it is hoped that if data collection is standardised, salient attributes related to patients' needs (like the services required by migrant patients or the type of treatment they need), together with the demographic profile of migrant patients, would go a long way in reflecting the impact of CBM and enhance planning accordingly. The importance of identifying migrant patient needs is underpinned by the fact that migrants are not a single

homogeneous group. They [migrants] vary significantly in terms of their origins, destinations, social and economic backgrounds as well as in their health characteristics (Gushulak, 2001a: 259).

## **Recommendation 2**

The Department of Health and Social Development should consider collecting data that addresses the impact of CBM on health care personnel (i.e. nurses and doctors). This is particularly crucial given the observed volume of migrant patients seeking health services in the out-patient departments of hospitals. Data addressing indicators like nurse–patient ratio, and Doctor-patient ratio could assist in avoiding an overload of existing health personnel in hospitals with high volumes of migrant patients. As far as In-patient departments are concerned, data that assists to ascertain bed occupancy (with and without migrant patients), and related indicators, could enhance planning for the infrastructure needs of hospitals which are overwhelmed by the demand for admissions.

Having made the concluding remarks and recommendations on the basis of the collected empirical data, the reader is cautioned that the data used in this project is not representative of the migrant population. As a result no inference in that respect should be made. Secondly, caution is made against interpreting empirical migration reality on the basis of observed data. The report ends with Xu-Doeve's reminder that "*taking observed data on migrants as valid and true can lead to a serious misrepresentation and misinterpretation of actual empirical reality*" (Xu-Doeve, 2007:51).

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