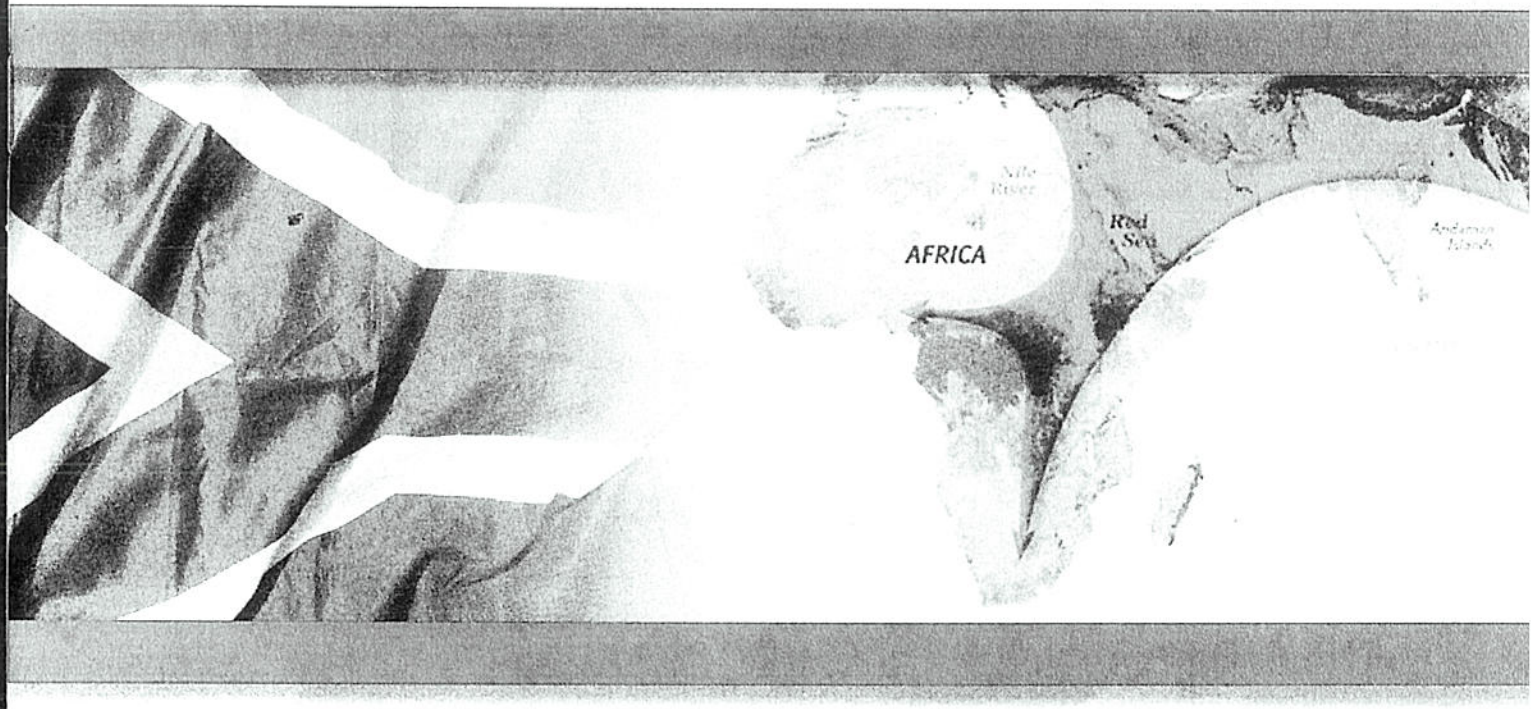
LIMPOPO

PROVINCIAL GOVERNMENT

REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF SOCIAL DEVELOPMENT



Cross-Border Migration and, Access and Utilisation of Health and Social Services in Limpopo Province

IOM • OIM

Well cared for, socially empowered and self-reliant people of Limpopo

ACKNOWLEDGEMENT

The Limpopo Department of Social Development expresses thanks to all who participated in the survey. Its thank go to the Limpopo Department of Health for participating in the study by granting access to hospitals. Th Department wishes to acknowledge the collaborative effort between itself, the United Nations Population Fun (UNFPA), the International Organisation for Migration (IOM), National Department of Social Development (Chie Directorate Population and Development), and the University of Witwatersrand. It was this collaborative effort tha provided leverage for successfully completing the study.

FORWARD BY THE MEC

Migration is one the historical phenomena that have shaped human settlement. South Africa and, Limpopo province in particular is privy to this phenomenon. Historically immigration to South Africa was dominated by labour migration from neighboring states of the SADC region. The current era of globalisation has not only changed the geographic scope but also the causes of international migration.

In 2010, The Limpopo Department of Social Development commissioned a study titled "Cross-Border Migration, Access and Utilization of Health and Social Services in Limpopo Province". The central objective of the study was to explore the provision, access and utilization of health and social services by cross-border migrants in the Province of Limpopo.

Findings from this study indicate a difference in perspective regarding the degree of satisfaction by service recipients, and the views held by service providers. This is particularly cited at the primary health care [PHC] level of service delivery which has presented major infrastructural and financial constraints on hospitals in the respective areas.

The study recommends that the attitude of staff [particularly at clinics] towards the migrant clientele needs to be changed for the better if access to services and utilization thereof are to be improved.

I sincerely hope that addressing the issues raised in this report will go a long way in aligning the set outcomes of the ruling party with the international protocols to which the Government of the Republic of South Africa is a signatory. I therefore urge all stakeholders to make use of this report.

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Mme Dikeledi Magadzi

2011/08/23

Date

MEC: DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

FOREWORD BY THE HOD

The research report on "Cross-Border Migration, Access and Utilization of Health and Social Services in Limpo Province" 'has been produced. The report focuses on dynamic aspects of migration and its impact on health ar social services. It provides an insight into the experiences of the recipients of the services while in the sar breath, the perspective of officials – who render services on behalf of the Department – is systematically put scrutiny.

The central objective of the study revolves around establishing the extent to which the services rendered by th Department reach out to the migrant clientele in the process of rendering services to the local population Limpopo province. A qualitative approach to the study was deemed ideal given the complexities that Migratic portrays from a research and administrative perspective.

The study unearths issues that require policy consideration around international migration and service delive within the context of globalisation. It also sheds light on alternative approaches to conducting migration researc in order to address the study's findings.

In light of the above, the department urges all stakeholders to take note of the study's findings and, desig interventions aimed at improving service delivery in Limpopo province.

Dr. A Morake

Date

HEAD OF THE DEPARTMENT

STRUCTURE OF THE REPORT

List of Acronyms

CDE	Centre of Development and Enterprise
DRC	Democratic Republic of Congo
FGD	Focus Group Discussion
HSRC	Human and Sciences Research Council
ICU	Intensive Care Unit
ID	Identity Document
IDI	
IOM	International Organisation of Migration
PHC	Primary Health Care
PPU	Provincial Population Unit
RDP	Reconstruction and Development Programme
SADC	Southern African Development Community
SAMHS	South African Migration and Health Survey
Stats SA	Statistics South Africa
TB	Tuberculosis
TOR	Terms Of reference
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organisation

EXECUTIVE SUMMARY

Migration research has tended to focus on its dynamics encompassing causes, consequences and drivers of this important demographic event. Current research interests focus on health consequences of migration in both local and international contexts. Because of migration volume, its impact on infrastructural facilities and social services has tended to attractive negative reactions from the citizens of a particular country. Xenophobic violence in various parts of the country (Republic of South Africa) is ascribed to migrants' use of social services meant for the citizens. In response to this, the Population Unit of the Province of Limpopo initiated this project to examine the impact of cross-border migration on the access and utilisation of health and social services in three Districts of the Province which share international borders with the Republics of Botswana, Mozambique, and Zimbabwe. The overall objective of this project was to explore the provision, access and utilisation of health and social services by cross-border migrants in the Province of Limpopo. The need for services by migrant clients and the frequency thereof could exert pressure on the services rendered by the Department of Health and Social Development in the Province.

The study was a cross-sectional rapid appraisal of the impact of cross-border migration on access and utilisation of health and social services in three districts of Limpopo. In-depth interviews with cross-border migrants, key informant interviews with selected staff of health and social service points, as well as focus group discussions with migrants provided data for this study. These were implemented between April and May 2011 in the three Districts of Limpopo Province, namely Mopani, Vhembe and Waterberg Districts.

In all, there were 69 key informant interviews with heads of health and social development units. Also there were 24 in-depth interviews with migrants who were selected from the focus group discussion participants. There were 12 focus group discussions from the three selected districts. The recruitment of respondents was largely purposive. Analysis of data was done on the basis of consensus opinions of the selected respondents around the various themes of the research.

Findings:

1. Migrants access services related to minor ailments including flue, HIV/AIDS, TB, delivery, contraception, abortion etc.
2. According to the heads of various health and social development units interviewed, the increasing volume of migrants who access and use these services tend to put pressure on budgetary allocations of the department. However, various strategies used to identify the quantum of this impact did not yield any result. For instance, key informants were not able to provide convincing evidence in terms of figures and amount on how the utilisation of health and social services causes pressure of budget resources.
3. There is reported pressure on health and social development facilities as the number of cross-border migrants admitted in the various units tend to put pressure on the number of people expected to use certain facilities. Instances of overcrowded morgue were given as evidence. Pressure on doctors and nurses time was also included.
4. Both migrants and, health and social service providers have differing views on migrants' satisfaction of services delivered to them. While migrants reported that they received and do receive raw deal in the hands of health and social development sectors, the service providers claimed that they are not aware of

any dissatisfaction about the services received by migrants .

5. Health and social development services providers are not aware of any international conventions and protocol on the treatment of migrants and their families, and hence are not aware of how these are applicable to their units. They are also not aware of any government policy on how migrants should be treated in terms of access and utilisation of services.
6. Health and social services providers do not provide differential services to migrants and citizens. It is reported that both have equal access to treatment in the Province.
7. According to migrants, the major inhibitor to their access and utilisation of a full range of services in the Province is the lack of South African identity documents. This is also supported by the service providers.
8. It is a consensus that the problems of provision of services to cross-border migrants is not the fault of the Provincial government but those of the individual service providers like nurses, doctors, and social workers.
9. Hence a suggestion was made on the need for training and retraining of health and social service providers to understand issues around services provision to migrants including the South African government commitment to international obligations in respect of migration.
10. A suggestion was also made for the expansion of infrastructural facilities and human capacity to provide these services – more medical personnel and more facilities.
11. Most health and social service development units do not have records of the number of migrants who use their services – an indication of poor record keeping, which impedes the study's ability to quantify the impact.
12. Thus, the major limitation of this study is the inability to quantify the impact of migrants' access to and utilisation of health and social services in the Province. This can only be achieved by the use of quantitative survey tools.
13. There is also the problem of identifying who is the real cross-border migrants as most of the migrants interviewed in this study have been in the country since 1985.

Recommendations

- Cross-border health and development programmes and projects in South Africa and neighbouring countries should be created in order to relieve the pull factor of better employment, education and health services in the country.
- Translators or at least people with basic knowledge of the language of origin of the migrants could facilitate service provision and utilisation.
- Vocational and basic education programmes should be extended to migrants who could be absorbed into the labour market – both in South Africa as well as in their area of origin.
- Migrants who have been in South Africa for a certain amount of time and who have shown to consistently work and / or contribute to the economy should be provided amnesty to allow them to apply for South African citizenship, or at least permanent residency.
- It is critical that social service providers do a compulsory sensitisation and anti-xenophobia course.
- Provincial and district government departments should make provision for supplementary funding to

health and social service facilities.

- Provincial health information data systems need to be re-designed to be able to capture data in respect o migrant clients.
- There is a need for Health systems in the districts to be strengthened in order to meet the challenges of the increasing volume of migrant users. Infrastructure and human resources development ought to be intensified.
- Both national and provincial governments should strengthen coherence to policies and protocols tha promote equal access to health and social services for migrants.
- This study is explanatory. In order to quantify of impact of cross-border migration on health and socia services, a further objective study with a clear conceptualisation of "migration" will be needed.

CHAPTER ONE: INTRODUCTION AND BACKGROUND

Migration is the crossing of the boundary of a predefined spatial unit by persons involved in a change of residence (Kok & Collinson 2006: 6). However, beyond the fact that migration is seen as a change in usual place of residence, there is not much consensus on the definition of migration. Whatever the definition of migration, however, it includes both a spatial and temporal dimension – although these, too, differ between countries and time periods. Also, migration may be a repeatable event. Further, Collinson, who refers to Lee (1966) notes that the likelihood of migration is mediated by intervening obstacles including distance, immigration laws and other factors such as a person's skills and health status (Collinson 2009). Migration has many dimensions, and cannot be properly analysed without taking into account the spatial, economic and social factors. Causes of migration are theoretically complex, multilevel in nature, difficult to determine, and cannot be easily generalised (Kok & Collinson 2006: 10).

Even though migration involves people who move from one place to another it is far more than simply the mobility of people – it is the "force that deeply changes the conditions of life, reshaping social and economic structures of individuals, families, communities and nations". In relation to health and social services, "(m) migration ...may have the potential to increase access to health care and ameliorate poverty related health vulnerabilities." On the other hand, migration also often leads to the separation and fragmentation of families, and to social marginalization – this may isolate migrants from social support structures and health care services (Collinson, Lurie, et al. 2006: 308). As such, migration is often central to households' livelihoods.

The advent of democracy in South Africa in 1995 was followed by substantial international migration both globally and within the Southern African Development Community (SADC) region, for reasons that vary from education and skilled labor to trade, tourism and business reasons.

This tendency has revealed itself in Limpopo province with several migrants seeking health services from the province's public health care facilities. The impact is equally felt by other social services - particularly social work services – as unaccompanied minors need to be reunited with families and, the next of kin has to be traced in cases where migrant patients are deceased. Failure to trace the next of kin to the deceased will ultimately end in a pauper's funeral.

It is against this backdrop that the Limpopo Department of Health and Social Development identified a need to establish the impact of international [cross-border] migration on health and social services rendered by the Province. It is hoped that the study's findings will provide insights into approaches to improve service delivery in general, as well as meeting the needs of migrant clients in the era of globalisation.

1.2 Problem statement

There are a number of definitions used to describe migrants that are in a country without the necessary documents. An "illegal immigrant" is one definition which refers to someone with unauthorized entry into the country, and is a term that is used by those that view this [immigration] simply as a criminal offence.

Although "undocumented migrants" means the same thing, this term is often employed by those who conceiv migration issues from a human rights perspective. This term, however, can be misleading as m "undocumented migrants" have forged or corruptly acquired legal documents. Finally, the term "unauthori immigrants" is increasingly being used in favor of the previous two due to its neutral tone. On the other ha economic migrants are those who have been attracted by economic opportunities that don't exist in their countr origin. These migrants either remain unauthorized or seek asylum to gain refugee status. In fact, South Afric 2007 was second only to the United States in the numbers of migrants granted asylum.

By 2008, however, the number of applications increased by 400%, making South Africa the most heavily us country for asylum in the world (Johnston, Altbeker & Bernstein 2010).

Based on a workshop hosted by the Centre of Development and Enterprise (CDE) on the 13th of November 20 Leslie (2008) wrote a report on migrant numbers, needs and the policy options available – although both workshop and the report focus specifically on Zimbabwean migrants. One key point that emerged from workshop, and which has been noted by a number of authors, is that "under the best of circumstances, data migration is notoriously difficult to collect and understand when borders are porous, officials are corrupt, reco keeping is poor, and migrants come and go between countries, figures are even more unreliable" (Leslie 200 However, from media and research reports on current migration trends and patterns in South Africa, thr conclusions are evident:

1. Cross-border migration is increasing and unlikely to slacken again in the foreseeable future. This h important implications for sending and receiving countries.
2. Current policy still makes it difficult for skilled people to enter the country legally – procedures are mark by complicated and demanding permits and quota systems.
3. Migration increases pressures on already strained and overloaded policy and system for migrati management that are seemingly unable to cope with undocumented entrants from the region.

Policy reform addressing all migrant classes is only possible if citizens have confidence in the capacity government agencies to manage migration effectively. This requires clear leadership with regard to migrati policy by assuring citizens that their interests will always come first, and emphasizing the positive contribution th many migrants make to South Africa's growth and development (Johnston, Altbeker, and Bernstein 2010).

In recent times there has been a sharp increase in the number of documented and undocumented migrar entering the country. However, at the CDE sponsored workshop in 2007 local government officials noted that t Department of local government has no jurisdiction to deal with the problem of illegal migrants that t responsibility rests with the Department of Home Affairs. Therefore, although it is the department of loc government that is impacted upon most in terms of budgetary and capacity constraints; it lacks the capacity a facilities to deal with immigrants who are not declared refugees (Leslie 2008).

An initial assessment of the use of health facilities in Vhembe and Mopani by international migrants [document and undocumented] revealed that 3801 and 1801 migrant patients were treated in selected hospitals in Vhem and Mopani districts respectively during the 2006/7 fiscal year. Little information is available regarding the impa of migrants on health and social services in the Province over the past few years. It is assumed that prop

planning and allocation of resources may be skewed or extremely difficult due to lack of information.

Little or no information is available on the number of migrant patients utilizing health and social services or inde what services they utilize. Although much of the information is available at various health units and social servic points, there is no systematic collection of the information, which makes it more difficult to gather, analyze a report.

1.3 Study Aims

The aim of the study was to explore the provision, access and utilisation of health and social services by cros border migrants in the Province of Limpopo. The need for services by migrant clients and the frequency there could exert pressure on the services rendered by the two departments.

1.5 Specific Objectives include:

- To examine the provincial department's responses to the health and social services needs of tl migrant populations
- To assess the access and utilisation of health and social services by migrant populations
- To identify gaps and challenges in the provision of these services to cross-border migrants.
- To propose policy and practice recommendations for effective health and social services delive to migrant populations.

1.4 Research Questions

This study attempted to answer the following questions:

- What are the patterns of health and social service utilisation by Cross-Border Migrants in the Province?
- How accessible are the provincial health and social services to Cross-Border Migrants?
- What are the barriers and challenges for effective health and social service delivery to Cross-Bord Migrants?
- What are the barriers to the utilisation of provincial health and social services in Limpopo?
- What are the common health and social service needs of Cross-Border Migrants and how is the provinci government responding to these?
- What are the existing policy provisions for Cross-Border Migration and how are they being applied?

CHAPTER TWO: REVIEW OF THE RELATED LITERATURE

2.1 Migration and policy issues

Health and social policy are not identical in the various African countries, and choices made by governments influence the speed of mortality decline, rural and urban differentials, and therefore people's choice to move (Garenne 2006: 273). Access to social services and social protection has become an important issue for both migrants and receiving countries (UN 2002: 33). Though protected by UN conventions, extending social protection regimes to non-citizens is viewed by many as undermining the economic benefits of migration for receiving countries. In most African countries this is a contentious issue. Some of the attacks on foreign nationals in South Africa were reportedly fueled by speculations over unequal access to social services, including health services.

In a foreword to a World Health Organisation (WHO) report (2003: 4) Paul Hunt and Gabriela Rodriguez Pizarro, two United Nations special rapporteurs on rights to health and human rights of migrants, argue that:
"All human rights – including the right to health – apply to all people: migrants, refugees and other non-nationals. The International Convention on Economic, Social and Cultural Rights recognizes the right of everyone to the enjoyment of the highest attainable standard of mental and physical health."

While the United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families is now international law, the human rights perspective has raised questions that have fueled much debate. First, to what extent are member states able to enforce and observe the law when most o these states are faced with more pressing domestic challenges such as poor service delivery which has implications on public health? Second, how can member states protect the rights of immigrants when they canno protect the rights of their own citizens? And finally, are contestations around access to health and social services not likely to create conflict between native host populations and migrants?

2.2 Reasons For People to Migrate

There are different reasons why migration is initiated and then perpetuated. In South Africa's case immigratio from neighboring countries has been happening for almost a century – even though there has been a dramati surge in numbers (Bosman et al. 2000b). Theories of the perpetuation of migration, in general, state tha individuals are influenced to migrate by the socio-economic situation they find themselves in. According to Myrda (1957) [and later Taylor, Massey and Stark] the act of migration also affects the socio-economic structure at famil and community level, increasing the probability that other individuals will also decide to migrate. This theory c circular and cumulative causation of migration provides a way of understanding the causes and impacts c migration as any decision to migrate is seen as a basic decision motivated by social (sociological), economic, a well as individual (psychological) factors (Bosman et al. 2000b).

Viljoen and Wentzel (2007), in a study of migration from Lesotho to South Africa, found that poverty is the main (c push) factor for migration to South Africa – motivating people to seek employment in South Africa (Viljoen Wentzel 2007).

However, this is not only true of migration from Lesotho to South Africa, but from other neighboring countries as well – such as Zimbabwe and Mozambique (Johnston & Bernstein 2007; Johnston 2008; Bosman et al. 2000b). On the other hand the study conducted by Viljoen and Wentzel (2007) found that four percent of Basotho migrants came for medical reasons, and three percent for education. The relatively low access to social services in Lesotho also provides a massive incentive for people to access South African services, specifically the free medical care for pregnant women and children.

Bosman *et. al.* (2000b), amongst others, report the findings of two studies conducted with migrants. The first study was conducted at the Lindela Repatriation Centre in 1997 with migrants living in urban areas (mainly in and around Johannesburg), while the other was with migrants and farmers from rural farms on South Africa's borders with Zimbabwe and Mozambique. Both studies were conducted only with migrants from Mozambique and Zimbabwe. When comparing the results of the two studies however, there were key characteristics of the migrants that ended up in urban areas and those who had located themselves in rural areas while other factors were more or less uniform irrespective of where the migrant had settled.

All migrants, in both rural and urban areas, had sited poverty, poor economic conditions, and unemployment in their areas of origin as key push factors that led to their decision to migrate. Fewer, but still a considerable number of Mozambicans stated that they had come to South Africa during the civil war in the 1970s and 1980s and some Zimbabweans had come to South Africa due to ethnic and political discrimination in their country. Key pull factors cited by both urban and rural migrants in the two studies was the job opportunities in South Africa; higher wages compared to wages in their home countries; food, housing and medical care; as well as a lack of confidence in the future of their home countries. Another key pull factor that many migrants mentioned, and which had facilitated their move, was the importance of networking – the influence of families and friends, the reinforcement of the positive perception of South African job opportunities; and their help in facilitating adaptation into society and finding accommodation for them before their arrival. However, although most migrants were unauthorized, many of them viewed their stay in South Africa as non-permanent.

The key difference between the rural and urban migrants in the two studies was that those in the urban areas mostly had some formal education (and some even had tertiary education) and popular skilled trades – such as plastering, bricklaying, and plumbing for the men; and domestic work, informal trade and sales experience for the women.

Furthermore, most of the women and men in the urban areas were youth in their twenties. On the other hand, the rural migrants were less educated – most had very little or no formal education. Females in the rural areas were also in their twenties, but the ages of the men varied much widely than those in the urban areas – from the early twenties to late forties (Bosman et al. 2000b).

2.3 Migrants: Contributions and Costs

In a study on immigrants in Johannesburg it was found that immigrants were generally employed – those that were not employed had come to South Africa a fairly short while before the study. Almost half that stated that they were employed were self-employed, and had hired workers – many of whom were South Africans.

This is compared to around 12-15 percent of South Africans in Gauteng who state that they are self-employe (Johnston 2008). When officials in the same study were asked why they thought migrants were employed ove South Africans, the response offered was that it was because migrants provided cheap and exploitable labo labor laws and union protection was circumvented, and often migrants were prepared to do work that Sout Africans preferred to avoid. Furthermore, due to fears of repercussions and deportation, migrants were viewed a passive and cooperative.

However, two-thirds of the government officials did acknowledge that migrants are hard-working, determinec productive, and had good skills and a good work ethic. Foreigners interviewed concurred with some of these view – specifically that they were prepared to do work that South Africans did not want to (even when unemployed) an were prepared to accept lower pay. Thus, officials are aware that immigrants do make a significant contribution t small-business activity and investment (however small). However, government officials also believe that service and facilities are overloaded and that the economic costs are higher than the economic benefits that migrant bring (Johnston 2008).

Johnston and Bernstein (2007), and Johnston, Altbeker and Bernstein (2010), argue that migration policy (implemented effectively) could dampen South Africa's severe skills shortage. However, until now (according to th authors) the South African approach to skills has been too narrow. Skills in terms of qualification and certificatio are only one part of the more holistic "human capital'. Human capital itself encompasses knowledge, abilities values, habits, and attitudes that are not measureable the same way as actual qualifications and certificates. Th over-emphasis on formal education and certification conceals a number of issues that are required for a broad an deep endowment of human capital to function well. This includes entrepreneurship, experience, cross-over an generic skills, quality of work, and people's ability toward career and professional mobility. According to studie reviewed by the authors, South Africa does indeed require capital of all sorts and not simply elite priority skills Thus, South Africa should be looking for skills, experience, and capital to create (and not just fill) jobs.

In order to do this, immigration policy can be used for growth and employment. However, this would require determined effort of political leadership to go beyond "isolated statements about the desirability of acquirin migrant skills to a systematic campaign of persuasion". Such a campaign would need to include the understandin that immigration skills are a form of investment that South Africa urgently needs. A further understanding is that th managed importation of skilled people from abroad won't threaten black South Africans – instead it'll improve th education and training system, manage development projects that will improve the lives of South Africans, an create business that in turn will expand opportunities for employment (Johnston, Altbeker, & Bernstein 2010).

Skilled immigrants can help South Africa achieve its economic goals, especially due to endemic skills shortages i South Africa – which has been identified as one of the key constraints to South Africa's growth.
This situation has been exacerbated by the mass emigration of skilled South Africans (Johnston, Altbeker, Bernstein 2010).

Challenges in coping with large numbers of unauthorized migrants are heightened by uncertainty over th numbers themselves. Whatever the numbers, however, migrants can (and often do) make important contribution to the economy.

International evidence and research done by the CDE strongly suggests that immigrants play an important role in the economy. Immigrants are less likely to be out of work than locals, and immigrants possess some informal skills and other aptitudes for which there's unmet demand and / or have the skills and energy needed for self-employment. This does not mean that immigrants are simply contributors to the economy – they do impose costs on the receiving country. These costs include competition for jobs, service provision, social tensions that feed xenophobia, and increased opportunities for corruption (Johnston et al 2010).

2.4 The Relationship between Migration and, Health and Social Services

The relationship between health and migration is very complex. At the micro-level the migrant's social, economic, cultural and demographic characteristics influence meanings of health and determine health outcomes of the individual. At the meso-scale, social and symbolic ties among migrants and non-migrants define how groups negotiate for health and other social services. Ultimately, at the macro-level, nation-states provide the political, economic and legislative environment that not only protects native populations but also foreign nationals. Therefore, cultural and socio-economic background, the nature and quality of health care prior to migration are important determinants of health and well-being of migrants in destination areas.

The heterogeneous nature of migrant populations, especially their demographics – age, sex, education, cultural practices and nationality - mean the health needs and social services they demand in destination areas are complex. The notion of health among migrants is just as diverse as the immigrants themselves. WHO (1990) defines health as the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. A multilevel analysis by Collinson (2009) found that migration mediates constraints (underdevelopment, disease, limited labour markets, gender roles, and cultural norms) and enablers (health care, housing quality, educational level and prior migration), which changes household and individual risks and resources for health.

As such, the linkages between health and migration result in both positive and negative influences, operating in both directions – between health and migration, as well as in the versa. In this way, the effects of health can induce either, or both, push and pull factors. The health status of migrants is determined both by characteristics of their destination (health environment and infrastructure) and by the migrants' individual characteristics (income, education, health information and personal behaviors) (Garenne 2006: 252-255). Thus, migration is fundamentally linked to changes in the socio-economic status of individuals and households, and therefore migration is seen as a livelihood strategy (Collinson 2009: 7; and Findley 2009: 33-35).

Poverty is a major force shaping migration and the strongest relations between poverty and migration are seen in the higher rates of migration in the communities with lower livelihoods. Household health maintenance, therefore, is influenced by a number of community factors – such as access to primary health, water and sanitation, and educational opportunities (Findley 2009: 44-45).

A research conducted by the School of Public Health and Health Services at The George Washington University (2002: 2) concluded that "culture affected how people label and communicate distress... Cultural meanings influence whether people are motivated to seek treatment, how they cope with their symptoms..."

Different categories of migrants, whether forced or voluntary, documented or undocumented have unique health needs which create a complex matrix in the provision of health and related social services.

According to Roux and van Tonder (2006) and Nhacolo et al. (2009) when a migrant's health status in the receiving area is compared with that in their area of origin, it is essential to take into account the health parameters (socioeconomic and cultural environment) that existed before the move, possible risks and exposures during the journey, and exposure to risk in the place of destination. However, in general, migrants are often healthier than non-migrants in the area of destination – due, mainly to positive selection in terms of their age, physical abilities and power, and education. However, in the area of origin, the health status of in-migrants has been found to generally be lower than that of the general population. It is inconclusive, but this could be due to migrant's poor access to health and social services.

In fact, it is unclear what role access to health care facilities in the proposed area of destination plays in attracting migrants, or indeed, what role health information plays in the decision to migrate. Results from the South African Migration and Health Survey (SAMHS), conducted by the HSRC, showed that less than 60% of migrants obtained information before moving regarding health and public services – although the likelihood of acquiring this information increased with educational level (Roux and van Tonder, 2006: 141-143).

2.5. Health and Access to Social Services in South Africa

The stock of immigrants as a share of total population in South Africa declined between 1960 and 2005, from 5.4 percent to 2.3 percent respectively (Shaw 2007: 5). While "there is often a degree of imprecision and statistics used in analyzing migration" (Bach 2003: 2) recent studies suggest that a significant proportion of immigrants now reside in South Africa, which has become a major migrant destination country. Within the Southern African Development Community (SADC) Zimbabwe is one of the main sources of immigrants. Other notable migrant sending countries include the Democratic Republic of Congo (DRC); Mozambique; Somalia; Kenya; Nigeria and Zambia (Stats SA 2001 Census).

The advent of democracy in South Africa in 1995 was followed by a sharp increase in the number of travelers from neighboring countries in the Southern African Development Community and beyond for reasons that vary from education and skilled labor to trade, tourism and business reasons. Entries into the country from main sending countries in the region more than doubled between 1991 and 1994, and again doubled by 2005.

In a study conducted on cross-border migration to Mpumalanga, Bosman et al. (2000a) found that there's a high amount of uncertainty amongst government officials and business people on how to deal with migrants specifically, in terms of social service provision due to unclear policy guidelines. This is exacerbated by the fact that no one really knows for certain the exact numbers of migrants in South Africa due to the difficulties in controlling and monitoring influxes in migrants' movement. However, in Mpumalanga – where the study was conducted – government officials reported that the presence of migrants, especially those close to the border, had negative impacts on the provision of services and infrastructure. This is specifically true for housing, education and health as well as municipal services because such services (and their budgets) are planned for based on official population numbers – which excludes significant numbers of migrants (Bosman et al. 2000a).

Although it is difficult, if not impossible to calculate a reliable estimate of the number of undocumented immigrar in South Africa, deportation figures suggest a steep rise in the number of undocumented migrants entering tl country. Between 2002 and 2007, the number of deportations grew by a lofty 12.8 percent per annum according the Department of Home Affairs. Migrants from Mozambique and Zimbabwe have comprised more than 80% of annual deportations since 1990.

As in many other countries, "the health risks faced by migrants are compounded by discrimination and restricte access to health information, health promotion services and health insurance" (United Nations 2001:34). In Sou Africa, "health care is provided for the bulk of the population by limited public measures in terms of free prima health care, as well as hospital care for women with young children and the aged" (Nyenti et al 2007: 5). F immigrants, access to health care is covered by private schemes. The law obligates employers to provide medic cover for all employees, irrespective of whether they are migrants or not.

In the Lesotho study it was found that although a South African identity document is required to access fre primary health care (PHC), patients from Lesotho were still treated without presenting the necessary documen in South African facilities. Only in the provincial hospital did patients have to pay a small fee at the second ar subsequent visits if they did not have the required documents. Reasons provided by Basotho for accessing Sou African services included the fact that some South African clinics are closer to them than their own, Lesotho heal services are perceived to be of lower quality, and many Basotho reside permanently in South Africa and therefo access services in the country (Viljoen & Wentzel 2007).

The only policy that exists regarding the provision of health services is the National Health Act of 1994, whic simply states that public health services are to be provided for free to all people who cannot afford primary healt care or who are not on a medical aid scheme. The act does not specify how migrants are to be treated. As a resu they also benefit as the act entitles them to free access if they cannot pay. However, like the 2007 study c Basotho migrants, health officials interviewed in the Mpumalanga study fear that undocumented migrants ar putting pressure on already insufficient health budgets of provincial and local health services. Furthermor although migrant children in Mpumalanga (whether parents are legal or illegal) attend free schools in the regio whether this places pressures on the school system and budget has not been sufficiently researched (Bosman e al. 2000a). However, in the study on migration from Lesotho to South Africa it was found that although Basoth children migrate to go to school in South Africa, this is only true for those that belong to middle and upper-incom families. South African schools are seen to be progressive and "in tune with international trends". On the othe hand, Basotho children that permanently reside in South Africa access education the same way as do loc children. This, and the inability of poorer Basotho households living in South Africa to pay for basic services, ha put a strain on local municipality budgets (Viljoen & Wentzel 2007).

The South African Constitution (Section 27(1) (c)) guarantees everyone the right to have access to social securit Such a right of access is not absolute but is limited by available resources and intrinsically linked to other right enunciated in the Bill of Rights of the Constitution. As a member of the United Nations, South Africa accedes t international covenants, which include protecting the rights of immigrants. Immigrants are generally exclude from social security protection, except for legal migrants with permanent residence status and two categories c migrants; refugees and asylum seekers who enjoy a modicum of benefits.

Refugees have access to all social grants which include old age, child support, disability, care dependency, foster child, war veterans, grant-in-aid and social relief (Nyenti et al 2007:3). Like permanent residents, refugees can negotiate for loans from financial service providers and have access to bursaries in public schools. Children of refugees have access to free basic primary health care. Refugees who contribute to unemployment benefit may access the fund in the event of unemployment. They have unrestricted movement in the country.

Unlike refugees, asylum seekers have no access to social grants. Access may be authorised once the refugee status is conferred by the responsible authority – Department of Home Affairs. Legally, South Africa does not provide services for undocumented migrants. The reality is that many of the undocumented immigrants have access to social services provided by local authorities. Some of the local authorities have blamed migrants for contributing to the "service delivery burden" that resulted in many protests in the last few years, beginning in 1998. Students in tertiary institutions, such as universities and technical colleges (technikons), are issued with temporary residence permits. They are not covered by public sector health care schemes. Private medical schemes regulated by the Medical Schemes Act provide health care for all foreign students who must be members of a local medical aid scheme before they can register.

However, a report released by the CDE that analysed South African migration policy found that the government's response to migration was "ad hoc and confused". South Africa's migration policy is based on strict entry criteria for foreigners, especially those seeking work and study permits – contradicting both the South African constitution and South Africa's SADC position. According to the report, what South Africa requires is open borders to skilled migrants, as South Africa is experiencing a net brain drain, in order to achieve its development goals (CDE 1997).

With regard to unskilled migrants, the current "get tough" policy in South Africa takes in the wrong assumptions about the nature, consequences and causes of migration and further goes against the South African macro-economic policy. In general, and not just in relation to unskilled migrants, one of the major problems in dealing with the migration issue in South Africa is the absence of accurate information. The result is policy decisions are taken in the absence of solid empirical information about numbers and trends (CDE 1997).

Evidence of studies from the developed countries in the 1980s shows that, unlike what is commonly believed, immigrants are not burdens upon natives because of the welfare services they use. In fact, natives actually benefit from immigrants who pay in more than they take out and are there net contributors - mainly due to their age composition (Simon 1989: 124-132). Another study, conducted by the Urban Institute of the United States on economic consequences of high levels of migration to California (by predominantly low-skilled and uneducated Mexicans) came to the same conclusions (Kok and Collinson 2006: 2). However, whether this is the case in Africa, and specifically South Africa, has been widely debated.

CHAPTER THREE: METHODOLOGY

3.1 Study Methodology

The study is primed for rapid appraisal; hence a purely qualitative approach has been used to gain in-depth information about access and utilisation of health and social services by cross-border migrants in the Limpopo Province, South Africa. In-depth interviews with cross-border migrants, key informant interviews with selected staff of health and social service points provided data for this study. These were implemented between April and May 2011 in the three Districts of Limpopo Province, namely Mopani, Vhembe and Waterberg Districts.

In Mopani District, the Units selected are Letaba Hospital, Holy Children's Home, Maphutha Malatjie Hospital Nkhensani Hospital; and Giyani Community of migrants (Hlophekani). In Vhembe District, the institutions selected are Malamulele Hospital, Malamulele migrants village (Xiporapora and Rholani), Thohoyandou Children's Home Musina Hospital, Louis Trichardt Memorial Hospital, and Takalani Children's Home. In Waterberg District, the units andareas selected are Ellisrus Hospital, Thabazimbi Hospital, Smasher Block and Bela Bela Hospital and Okakavanjo areas of Waterberg District.

In each district, health and social service points were purposively selected based on existing knowledge of migration dynamics in the area. In each area selected, there were four focus group discussions with cross-border migrants – two per gender, four in-depth interviews and 6-8 key informant interviews were conducted. In all, there were 69 key informant interviews with heads of health and social development units. Furthermore there were 24 in-depth interviews with migrants who were selected from the focus group discussion participants. All in all there were 12 focus group discussions from the three selected districts.

3.2 Study Sites: This study was done in three Districts of the Province of Limpopo, namely Mopani, Vhembe and Waterberg.

Mopani District has its headquarters in Giyani. The main language of the district is Tsonga or Northern Sotho (StatsSA 2001). Mopani is surrounded by the Republic of Zimbabwe to the North and the Republic of Mozambique to the East as indicated in figure one below.

Figure 1: Map of Limpopo Province showing the location of Mopani District

Vhembe district is the northernmost district of the country and shares its northern border with Beitbridge district in Matabeleland South, Zimbabwe. The capital town of Vhembe district is Thohoyandou. Tshivenda is the dominant language in the area. Vhembe is surrounded by the Republic of Zimbabwe to the north as indicated in figure two.

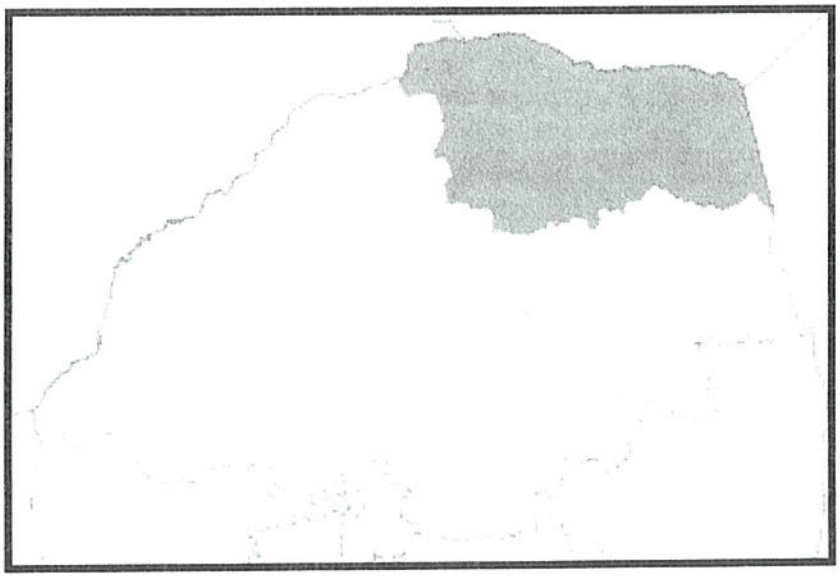

Figure 2: Map of Limpopo Province showing the location of Vhembe District

Waterberg district has its headquarters in Modimolle (formerly known as Nylstroom). The majority of its 614 139 people speak Northern Sotho (2001 Census). Waterberg is surrounded (clockwise) by the Republic of Botswana to the West (see figure three).

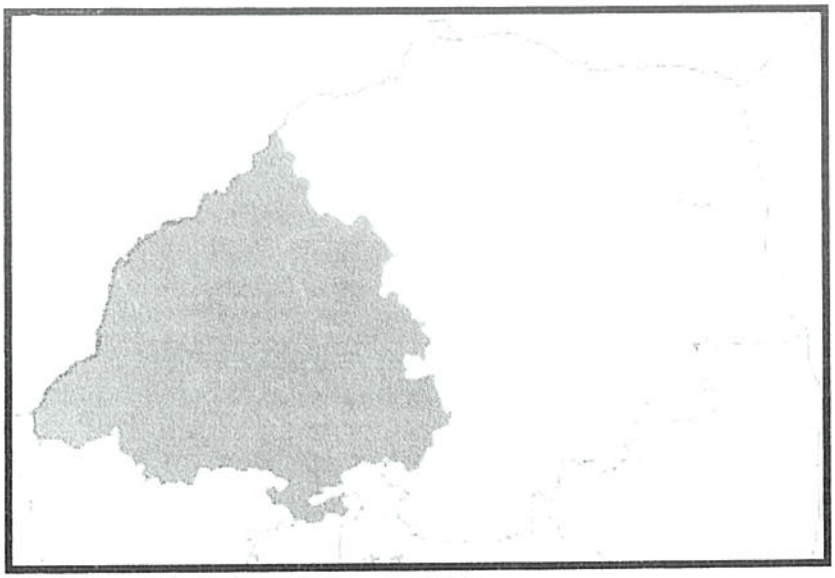

Figure 3: Map of Limpopo Province showing the location of Waterberg District

3.3 Recruitment Procedures and Sampling

The recruitment of respondents was largely purposive. The recruitment was done with the aid of staff of the Department of Health and Social Development. Key informants were selected based on the fact that they are directly involved in providing services to the migrant communities. These key informants included heads of nursing services, outpatient departments, general wards, casualty wards, mortuary units, medical social workers and community liaison officers. Respondents for in-depth interviews, who are migrants, were drawn from the focus group participants. In-depth interviews sought to investigate issues already addressed at the FGD sessions and to specifically gather more information relating to personal experiences which may not have surfaced at the group level discussions. Interviews were conducted mainly in the local dialects of the respondents by the male and female field workers who were trained to be able to promptly establish rapport and to elicit interviews without causing embarrassment and resentment among the respondents.

3.4 Ethical considerations

The study was not subjected to extensive ethical processes because it is a rapid assessment survey heavily drawing on qualitative approaches. Never the less, all participants verbally consented to the audio recording of their responses and were guaranteed anonymity and confidentiality of their responses. An informed consent statement was read out to the selected participants, approved and countersigned.

3.5 Training of Field Workers

Nine postgraduate students of the School of Social Sciences, University of Limpopo were recruited for the field work

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There was an intensive training on the following topics (1) the context and objectives of the project, (2) project methodology – areas of research, focus group discussion, in-depth interviews and key informant interviews, role playing, (3) visit to the selected districts, (4) logistics and (5) implementation time line. Generally the training covered research questions, objectives and methodology.

After the training, the field workers were divided into two groups to cover each of the districts. Thus a group of 4 research assistants conducted the interviews in Vhembe while another group covered the same in Mopani. The criterion for this division was ability and proficiency in the languages spoken in each of the districts.

In each of the selected service points, appropriate heads of units involved in the delivery of services to migrants were identified. The units identified include maternity, out patients, general ward, casualty, Mobile Clinic and Mortuary Units. Migrant communities were also identified through the assistance of Community Liaison Officers of the Health service points.

3.6 Limitations

As this study is purely qualitative, results cannot be generalised to the larger population, although it does provide a descriptive analysis of the situation of cross-border migrants in Limpopo Province, in terms of access to and utilisation of health and social services.

Another limitation is that few key informant interviews were conducted at the local clinic level; the majority of interviews were conducted at hospital level. No key informant interviews were conducted with service providers from other social service areas such as the department of Home Affairs or Education.

One major limitation of the study is its heavy reliance on qualitative research methodology. The consequence of this situation is the inability to to quantify the impact of cross-border migration on available health and social services in these areas.

The self-selection of the service points included in the study, and the key informants in these units to be interviewed, could also bias the results, as most of the key informants could not provide reasonable responses to some of the questions.

Another limitation pertains to the lack of clarity regarding the definition of who a cross-border migrant is. It was difficult to identify cross-border migrants as most of the migrants interviewed could not classify where they belong. Again most of the migrants have similar family names as their neighbours. Besides, most of them have stayed in the country for a long time, even though, without legal documentation.

have helped us to be registered." Another of the Mozambican respondents noted that she worked for a nurse, and the nurse had helped her gain legal status; while another was given legal status after receiving a recommendation letter from a social worker. The Malawian and Batswana FGD participants were both legally in the country, whereas the Zambian participant was in the country illegally. Most Zimbabwean immigrants stated that they did not have either passports or identification documents.

The two Mozambican in-depth interviewees that had settled in Humulani and Malamulele noted that South Africa had become their home, and although they would like to visit Mozambique, they were unsure whether family and friends would still be alive. Furthermore, they were scared to go back as they are in South Africa illegally without passports or identification documents. Zimbabwean immigrants also noted that although they would like to visit their country, they were not able too either because the current situation did not allow it, or due to financial constraints or lack of identification documents or passports.

4.2 Place of Residence

All immigrants that participated in the focus group discussions, as well as those that informed the in-depth interviews, had not specifically chosen their area of destination. Those that stated the reason for choosing the area in which they lived said that it had initially been a resting place, and then together with other migrants from their countries of origin had decided to stay in the area and build permanent housing. All migrants had since stayed in the areas in which they settled.

4.3 Skill Level and Occupation

None of the interviewees from the in-depth interviews had any formal education or training, and most were unemployed at the time of interview. Those that were employed stated that they were vendors, car washers or worked in gardens to earn extra money. Some of the respondents named the skills that they possess and use to supplement their income, and as livelihood strategies. These included ploughing and growing vegetables, knitting and sewing, locksmith, construction, and the one Mozambican male respondent stated that he was a "herbalist" that worked with herbs for medicinal purposes. The Mozambican female respondent from Humulani had no formal education, but did state that "... I do have papers and a certificate that shows my ability to work."

4.4 Access and Utilisation of Health and Social Services

This sub-section on access and utilisation of health and social services in South Africa is sub-divided into three (3) thematic areas, namely the services that are required and used by migrants; the level of satisfaction of migrants who use these services as well as the difficulties and barriers that migrants encounter in accessing and using health and social services; and finally recommendations by the respondents themselves to these difficulties and barriers that they have encountered.

i. Services Required and Accessed by Migrants

Migrants require a number of health and social services. Most require health services for minor ailments, such as colds and flu's, as well as treatments for arthritis, high blood pressure and diabetes. Almost all the Mozambican migrants stated that they require health services for feet and waist problems – although it is not known what is meant by this, and why there was such a large number of Mozambican migrants that complained about having problems with their feet and "waists". Treatment and services related to malaria, tuberculosis (TB), HIV / AIDS and general medication were also noted as key areas that are required by migrants. General check-ups as well as emergency services were also named as services accessed and required by migrants in the area – emergencies that had occurred included road accidents, being attacked by a crocodile, and being burnt with boiling water while cooking.

"We access services to test for TB, flue, diabetes, high blood pressure, measles and general checkup" Males, aged 35+ years, Mozambican migrants in Malamulele and Males, aged 35+ years, Humulani, Mozambican.

From Humulani, the services utilised are diabetes treatment, flu, chest problems, feet pains, waist pains, coughs, and malaria. Family planning and birth assistance, as well as general Sexual and Reproductive Health for both men and women, were in demand by cross-border migrants. Some of the men complained about what they call "drop disease" associated with weak erections. One Mozambican man in one of the focus groups noted that he had gone to the health facility when he realised that his "private parts weren't fully functioning".

Health services for children included immunisation and weighing – which would require having the Road to Health card, which many were unable to get due to their illegal status with a consequent inability to get a birth certificate for their children.

Key informant interviews with staff at the health facilities concurred that these were services that had been accessed by migrants. However, two services that migrants had not spoken about during the focus group discussion and in-depth interviews were those provided by the mortuary at the hospitals, and social workers – namely "pauper burials" and food parcels. One hospital stated that they gave mothers old clothes and blankets for their children when they delivered at the hospital. Overall, in the three Districts, migrants reported that they access and use general health services.

ii Level of Satisfaction with, and Difficulties and Barriers to Accessing and Using Health and Social Services

The level of satisfaction with health and social services was one area that had widely disparate views. Most migrants complained about the services they received, yet most key informants (mainly key health staffs interviewed) stated that migrants seemed satisfied with the services they rendered.

The biggest complaint from migrants was ill-treatment by nurses at the local clinic. Many stated that nurses were unfriendly and arrogant. They said that nurses often refused to help migrants.

The opposite, however, was said about the nursing staff at the hospital – all migrants that participated in the study complimented the nursing staff at the hospital and noted the difference in attitude between the nurses that worked at the local clinic and those that worked at the hospital, as indicated by the following extracts:

> *"Nurses at the hospital treat me with care and love but nurses at the local clinic treat me very badly, they have no spirit of Ubuntu"*
>
> (Female Respondent, 35 years or more, Humulani)

Another respondent, with reference to the hospital specifically:

> *"I went to the hospital to give birth. They were very helpful and they even gave me gifts for my child."*
>
> (Female FGD Participant, 35 years or more, Musina)

A female participant in the female focus group of women aged between 15 and 35 years in Malamulele complained similarly that "local clinics treat us very badly; they treat us like dirt and unlike people."

Besides the arrogance, unfriendliness and complaints of ill-treatment three of the women migrants stated that nurses at the local clinic mocked and called them names (such as "komvers"), two of these women also complained that during the delivery of their children nurses would laugh at them and say that they "give birth like pigs" and are generally discriminated against. Two (2) FGD participants (one male and one female) from different groups told the story of a woman in their area:

> *"A pregnant women was in labour pains but they told her to go back home and she delivered on the road and when she came back to get a birth card they told her that she can't get it because she didn't give birth at the clinic."*
>
> (Male Respondent, 15-35 years, Humulani)

Furthermore, many made the observation that often when they go to the local clinic, nurses tell them that they are on lunch or are on their tea break and refuse to help them.

> *"...nurses say that they are on tea-breaks and lunch at all times when they have to help us."*
>
> (Female FGD Participant, 15-35 years, Malamulele)

Another participant stated:

> *"My neighbour's child wasn't attended to because the nurses said they were on their tea time and it's their time to rest."*
>
> (Male FGD Participant, 35 years or more, Humulani)

Specifically, a number of respondents from Humulani said that the situation was made worse when the matron was at the local clinic, and that the situation had been better when the matron had gone away for a month. As one FGD participant noted:

> *"...there was a time that she (the matron) was not around and the clinic was better."*
>
> (Male FGD Participant, 15-35 years, Humulani)

The result is that most migrants no longer go to the local clinic, and simply go to the hospital instead. As a female interviewee noted:

> *"I don't go there anymore because the nurses hit us and shout at me, so this becomes for me as a migrant not to go to the clinics and receive help."*
>
> (Female Interviewee, 35 years or more, Humulani)

And another respondent:

> *"Nurses take advantage of us because we are migrants; they do as they please with us."*
>
> (Female FGD Participant, 35 years or more, Musina)

iii. Migrants Perspectives:

According to migrants in Malamulele, *"whether or not you have an ID and are legal or not, immigrants are badly treated in the Province. The ones treated well are those that are either friends with the nurses [nepotism] or who give the gifts (bribery). The situation is worse if the head matron of the clinic is there."* Males, +35 years

The overall complaint is that nurses are generally rude and arrogant, and do not want to help migrants. Most of the participants did not feel that the Province helped migrants, although others stated that the province has put services in place but the people that render the services are the problem. Migrants from Malamulele area also felt that the Batho Pele Principles are not fully being practiced, and that there is a lot of discrimination against migrants.

Similarly migrants based in Humulani noted that (1) irrespective of legal status of migrants, they are treated worse than locals because they know that migrants can't complain to anyone. (2) Hospitals treat migrants well but the local clinics treat them badly. (3). Difficulties experienced by the respondents included stubbornness and arrogance from the nurses and being told outright that they won't help foreigners.

"They say we smell; we must clean up when we want them to help us ... My neighbor's child wasn't attended to because the nurses say that they were on tea break and it is time to rest", Males, 35+ years, Humulani

Mozambican migrants in the Districts of Mopani and Vhembe reported not being treated well at the health facilities. They indicated being denied treatment because they do not have ID's. Even if you have an ID, the treatment and care received is poor, and often when they are treated, it is 'painful'. They are treated well at the hospitals but very badly at the local clinic – especially by the matron.

"A pregnant woman was in labor pains but they told her to go back and she delivered on the road and when she came back to get a birth card they told her that she cannot get it because she did not give birth at the clinic…. They say we love having children and getting money for them …; there was a time that she (the matron) was not around and the clinic was better", Females, 15-35, Humulani.

Although migrants apply for legal status, the process is backlogged and no one can ever tell them what the status of their application is. Recently people came to the village saying they wanted to register the migrants and requested for R5 for the form.

They took the money and said it was to go and make photocopies but when they asked the Department of Home Affairs about it, they denied knowledge of such a team.

There is divided opinion about the role of Limpopo Provincial government. According to female migrants aged 15-35, the Province has not done much for the migrants. The RDP housing is only found in the areas where the councilor comes from. Although many have applied for RDP houses, they are told they are Mozambicans and will not get one. Others acknowledge that the province is supplying medicine and that they are trying to help them to receive treatment, but that they should help more in terms of trying to register migrants. Musina and Waterberg migrants acknowledged that the Province has provided the amenities, but it is the people at the clinics who do not provide good services.

"..We do not have problem with the Province, we have a problem with the nurses....; Province does not do anything because they do not know of the problems we encounter", Males, 35+, Musina.

For Musina migrants, they claimed that young migrants are treated badly, and it does not matter if you have an ID or not they still treat you badly, although one respondent did state that it depended on the nurse attending to a particular migrant patient. Here again, it came out clearly that nurses at clinics maltreat the migrants.

"... nurses say they give birth like pigs...., Nurses send us back home without helping us; ....We do not go there because nurses say that they are on tea-breaks and lunch at all times when they have to help us..." Males, +35 years, Musina.

"... nurses call us names ..; some nurses say we give birth like pigs ...; even if you have papers, if you are a Mozambican, you will be treated badly...; Local clinics treat us badly, they treat us like dirt and unlike people ...., when we go to the clinics, the nurses are always on tea breaks....". Females, aged 15-35, Malamulele.

On the attitude of health personnel, responses from female participants noted as follows:

"It depends on the attitude of the nurse. If she does not want to help you, she will not. You will stay the whole day without any help". Females, 35+, Humulani.

One FGD participant noted that *"my husband died in my hands because the nurses were standing around asking for a South African ID which we did not have".* Also there was a woman who was in labor pain and was told to go back home and she delivered on the road and the baby died.

Participants in general noted that documented and undocumented migrants had differential access to services, although some respondents observed that depending on a situation, documented and undocumented migrants do access the same services. Some of the respondents in Humulani were unsure whether district and provincial health service providers were helpful, although others noted that sometimes they were.

The greatest problems encountered by the migrants evolve around the ill-treatment they receive from the nurses at the local clinic because the nurses say they do not have an ID.There was consensus that there was no difference in the way that documented and undocumented migrants are treated when accessing services. Irrespective of their status, all migrants felt ill-treated (refer to the extract below).

"Nurses take advantage of us because we are migrants; they do as they please with us. .....we stand for long hours and we do not receive help; .... We go for family planning; they give us wrong injections instead of the ones we want... We do no longer go to the local clinics; ....we now prefer to do home deliveries because nurses do not want to help us because we do not have identify documents.....", Females, aged 15-35, Musina.

In Giyani area, all participants agreed that they were well-treated by service providers at the hospitals. The migrants said that the only problem they have encountered with the PROVINCE is that they have not been provided with any help in being registered for ID's. In general, they were pleased that the Province had provided them with the medication and facilities to access services.

In Musina, one participant aged 15-35, male, noted that documented and undocumented migrants are treated differently. Another participant complained that he was often given wrong medication.

In fact, one (1) of the key informants from Malamulele Hospital observed that a big problem was that migrants for some reason did not go to the local clinics, but instead came to the hospital which put immense budgetary pressures and impacted on the availability of space and beds. The key informant recommended that ways to encourage migrants to go to the local clinic must be found. It is clear that respondents' failure to access and use health services in the clinics is because of bad attitude exhibited by the clinic nurses and matrons.

Due to the ill-treatment of migrants by the nurses, those that cannot afford to go to the hospital have turned to traditional healers or home remedies when they or their family fall ill. Key informants noted that this had become one of the difficulties they have had to deal with, as many times the medication provided by healers or the home remedies used counteract the effects of medication and migrants arrive at the clinic severely ill, and this also presents a problem for adherence to medication received at the hospitals. Often migrants do not come back for follow-up consultations.

Key informants, however, were under the impression that migrants are happy with the services they receive mainly because the services were for free and because none of them had ever written a complaint or complained to any of the nurses. However, focus group participants had stated that the migrants often did not complain because they felt they did not have the right to – unlike South African citizens.

The low level of satisfaction, mainly due to the ill-treatment and discrimination of the migrants at the local clinic, is a barrier to the use and access of health services in the area. The only time that migrants were well attended to, according to the participants of the focus groups, was if the migrants befriended the nurses and gave them "gifts" – one participant openly spoke about bribery. It should be noted that the migrants that are legal stated that although legality increased the possibility to access services, they were still ill-treated and discriminated against.

However, there are a number of other bottlenecks that have an impact on access and utilisation of these services for migrants who live in the Limpopo Province. The main barrier to access and use of health and social services is the legal status of migrants. Without the required identification documents and registration at the department of home affairs, access to social services is limited. This barrier was observed by both the migrants themselves as well as the key informants.

There have been incidents where migrants were taken advantage of. One focus group participant told of a recei event whereby people came to the village saying that they were there to help the migrants register at th Department of Home Affairs. Migrants were charged five rand for the registration form, and were requested to pa more money so that copies of the form could be made. When the people did not return, the migrants approache the Department of Home Affairs who said that they knew nothing of this initiative. Furthermore, migra participants noted that even when they did apply for identification documents, their application was delayed – or migrant had applied for legal status in both 1996 and 2003 unsuccessfully.

Most of the respondents spoke of access to health services; however one focus group raised the issue of acce to clean water. According to them Humulani and Malamulele villages do not have proper and clean water, and th pipes that are supposed to carry water to these villages have dried up.

Another social service that was briefly mentioned by some of the participants was education. None of th respondents complained about a lack of access to education, those who did have children all stated that they we attending school. The Mozambican male interviewee, however, was concerned that without proper identificati documents his children would not be able to further their studies after they had matriculated. This was al mentioned by one of the Zimbabwean interviewees as well.

iv. Health and Social Development Staff Perspectives:

Interviews were held by key informants that strategically form part of Senior Management of various health a social development units. According to these key informants, the commonest ailments that brought cross-bord migrants to the clinics and hospitals are minor ailments, common colds and flu's, and HIV related services. Th indicated that the common problems encountered in the provision of health and social services to the cross-bord migrants are budgetary pressures, space issues, and non- adherence to treatment regime. They noted th adherence to treatment regimen is weak and difficult to follow-up. This is mainly because migrants don't have fix addresses and they always move in search of jobs. They argued that immigrants' health care costs are r included in the budget but must be attended to. They suggested that it is advisable to know the numbers migrants so that they can be budgeted for adequately.

Number of beds and space was also highlighted as a problem, especially in the mortuary where migrants' bodi remain for lengthy periods of time as either no one comes to claim them (as family and friends cannot be traced) no one wishes to assume responsibility for the body due to the costs involved. This has been made worse sin the municipalities no longer provide funds for "paupers' burials", and therefore the bodies remain in the mortuar sometimes for more than two years.

The social workers that were interviewed concurred that lack of funds for paupers' funerals presented a ma financial constraint. Furthermore, mortuary managers that were interviewed stated that this also became occupational health hazard and that often, because bodies had to be stacked one on top of the other due to a la of space, the bodies began to "stink".

From the Key informants' point of view, the biggest problems in dealing with migrants relate to incomplete information, unidentified bodies, and funds for burial.

According to some of the key informants from Waterberg, "providing services to migrants "cripples" the available resources. Bela-Bela sits along the N1 highway which has a lot of road accidents, especially involving Zimbabwean migrants, and Bela-Bela is the only hospital along a long stretch of the N1 that has an ICU – therefore the hospital is flooded with Zimbabweans. The hospital is very small and cannot take so many migrants during car accidents, so we're forced to take more than we can carry – because we cannot turn them back". Another problem is communication with migrants as is tracing the next of kin when people die. Another problem is that migrants try hiding their identity for fear of being deported, so they give the incorrect information. Most health and social development staff are not aware of protocol or conventions governing the treatment of migrants.

In terms of perception of service delivery, most of the health personnel claimed that they have not heard of complaints from the migrants about the quality of their service delivery. While some claim they have not received any complaints from the migrants, others noted that most migrants do have issues with the nurses and matrons.

The services provided for migrants (even if illegal) and citizens are the same – mainly autopsy, freezing, forensic photographs. However, if the body isn't identified, the hospital will liaise with the social workers who do the necessary documentation. If the body doesn't get identified within 30 days it goes to the freezer where it stays for two years and then the body is buried.

Both migrants and health staff have conflicting views on the quality of health and social service delivery.

v. Respondent Recommendations

As noted above, the greatest barrier, according to both migrants and the key informants is the lack of identification documents. All participants recommended that migrants be given legal status – this would help in migrants being able to access services, but would also help hospitals and other social service providers to budget properly for those accessing the services.

All key informants stated that although there were policies and guidelines for the general delivery of services, no policy or guideline specific to migrants exists. Policy that can inform the way that services are delivered to migrants in the area was one recommendation from many of the key informants interviewed.

When migrants were asked whether the province provided assistance, the responses were divided. Some of the migrants said that the province did not provide any assistance and that their pleas were often ignored, whereas a large number of the migrants acknowledged that the province had provided the amenities and environment for them to access the services and that the problem rested on those that provided the services to them. Some of the respondents recommended that the province must "come see how (they) live" and the difficulties they encounter in order to ameliorate migrants' situation in the Limpopo Province.

As one of the participants noted:

> "*The province has given us the health care units…but the people who have to provide the service are nc doing anything…the province knows nothing about the way we are being treated by the nurses.*"
>
> (Female FGD Participant, 35 years or more, Musina

CHAPTER FIVE: DISCUSSION AND CONCLUSION

Overall, the goal of this study was to explore the provision, access and utilisation of health and social services by cross-border migrants in the three districts of Limpopo Province. It is speculated that massive use of health and social services by cross-border migrants has tended to put budgetary pressure on available resources.

Generally, most of the migrants or those who claimed to be migrants and residing in the districts come from neighbouring countries, either to find employment or because they were fleeing the war in the 1980's (Mozambicans) and or political repression as in Zimbabwe. According to key informants from the migrants' side, there are few migrants that access services, , who are from countries such as Somalia, Ethiopia, India, Pakistan, Ghana, Malawi, Nigeria and the DRC. Most of these respondent-migrants said they were not properly documented, which presents a problem for them to access and use social services in the area.

Migrants reported that they had access to available health and social services in the area. However their greatest barrier still remains the discrimination and ill-treatment they endure from those who provide the health services – specifically at the local clinics. They singled out nurses and matrons as the service providers who frustrate, ridicule and demoralise them before they could get services. Many of the migrants have, thus, either stopped accessing these services choosing to either visit a traditional healer or use home remedies; or they simply go to the hospitals instead of the clinics. This has presented major infrastructural and financial constraints on the hospitals in the area as the unexpected increase in number of cross-border migrants is not budgeted for due to lack of data on migrant clients accessing services on a daily basis.

In terms of service quality, both migrants and health and social service providers reported differing views. Migrants perceive service delivery to be of high quality, and accessible. They nevertheless complain of the attitude of the service providers. On the other side service providers claimed that they are not aware of any complaints from migrants who received the services.

One other important finding is that service providers at the coalface lack knowledge of existing policy and protocols on the treatment of migrants with regard to the services under review. Most of the study's key informants who are mainly heads of different health units reported lack of knowledge and application of policy provisions for cross-border migrants. The result of this situation is that each health and social service unit designed its policy and protocol to attend to migrants' health and social needs.

Although giving migrants legal status would firstly allow for better budgetary planning, and by implication increase access to services, However, unless other bottlenecks such as the issue of discrimination and ill-treatment of migrants are dealt with, utilisation rates will remain low.

Recommendations

i. Recommendations from Respondents

As noted above, the greatest barrier, according to both migrants and key informants is the lack of identification documents. All participants recommended that migrants be given legal status – this would enhance their ability to access health and social services. This would also help hospitals and other social service providers to budget properly for migrants who seek to access these services.

Key informants all stated that although there were policies and guidelines for the general delivery of services, no policy or guideline specific to migrants/cross-border migrants exists. About 50 percent of heads of health units claimed lack of knowledge of any policy and protocol (national and international) on the treatment of cross-border migrants. Policy that can inform the way that services are delivered to migrants.

When migrants were asked whether the province provided assistance, the responses were divided. Some of the migrants said that the province did not provide any assistance and that their pleas were often ignored, whereas a large number of migrants acknowledged that the province had provided amenities and environment for them to access the services. They claim that the problem rested on those that provided the services to migrants. Some of the respondents recommended that the province must "come see how (they) live" and the difficulties they encounter in order to ameliorate the migrants' situation in the Limpopo Province.

As one of the participants noted:
"The province has given us the health care units…but the people who have to provide the service are not doing anything…the province knows nothing about the way we are being treated by the nurses."
(Female FGD Participant, 35 years or more, Messina)

ii. Recommendations from Findings

- Cross-border health and development programmes in South Africa and neighbouring countries should be created in order to relieve the pull factor of better employment, education and health services in the country. Many migrants stated that decisions to migrate to South Africa were motivated by better employment opportunities and social services. By increasing employment, development and ameliorating social services in countries of origin, the likelihood of cross-border migration into South Africa would be substantially decreased.

- Migrants from certain countries live in communities with which they share common cultural background. This situation enables migrants to access the services. In situations where there are substantial cultural differences, both migrants as well as social service providers stated that the language barrier was an obstacle to better service provision. Translators or at least people with basic knowledge of the language of origin of the migrants could facilitate service provision and utilisation.

- In situations involving unskilled and / or semi-skilled migrants, vocational and basic education programmes should be extended to migrants who could be absorbed into the labour market – both in South Africa as well as in their area of origin. This would have a regional developmental benefit, and could be done in collaboration with other organisations and departments in the country of origin.

- Migrants who have been in South Africa for a certain amount of time and who have shown to consistently work and / or contribute to the economy should be provided amnesty to allow for them to apply for South African citizenship, or at least permanent residence. This will also help migrants' children to pursue post-secondary school education, which may have long-term developmental and socio-economic benefits.

- It is critical that social service providers, at least those in areas where a large proportion of the population are known to be immigrants, do a compulsory sensitization and anti-xenophobia course. Many migrants (both documented and undocumented) stated that ill-treatment - especially at clinic level - by staff is one of the greatest barriers of social service utilisation by immigrants.

- There are major budgetary constraints at hospitals and clinics where a large proportion of the population is undocumented migrants. Provincial and district government departments ought to make provision for supplementary funding to health facilities to ease the burden on service delivery. Included in this is a higher budgetary allocation to mortuaries at health facilities where the bodies of undocumented migrants are often kept for months – funding is required for pauper's burials (in case of unclaimed bodies) after a certain period of time as this becomes a health hazard.

- Since it is not possible to quantify the impact of cross-border migration on health and social services, mainly because of lack of data on the number of cross-border migrants and the types of services they use, it is recommended that the Provincial health information data systems be re-designed to capture the migration status of patients. It is also recommended that a set of common data collection tools be used to collect and compare data on migration impact on health and social services across the districts .

- There is a need to train the health care providers in the knowledge and application of national and international protocols on the treatment of cross-border migrants. This would include amongst others (i) intensifying the distribution of various directives that address health access; (ii) disseminating information to the general population including migrants and health care providers on how to access the health care and social services in different languages; (iii) making national health policy on health access rights understandable by lay persons; (iv) clarifying protocols on national medical referrals; and9 (v) ensuring that role players are aware of the health rights of migrants(IOM: 2010).

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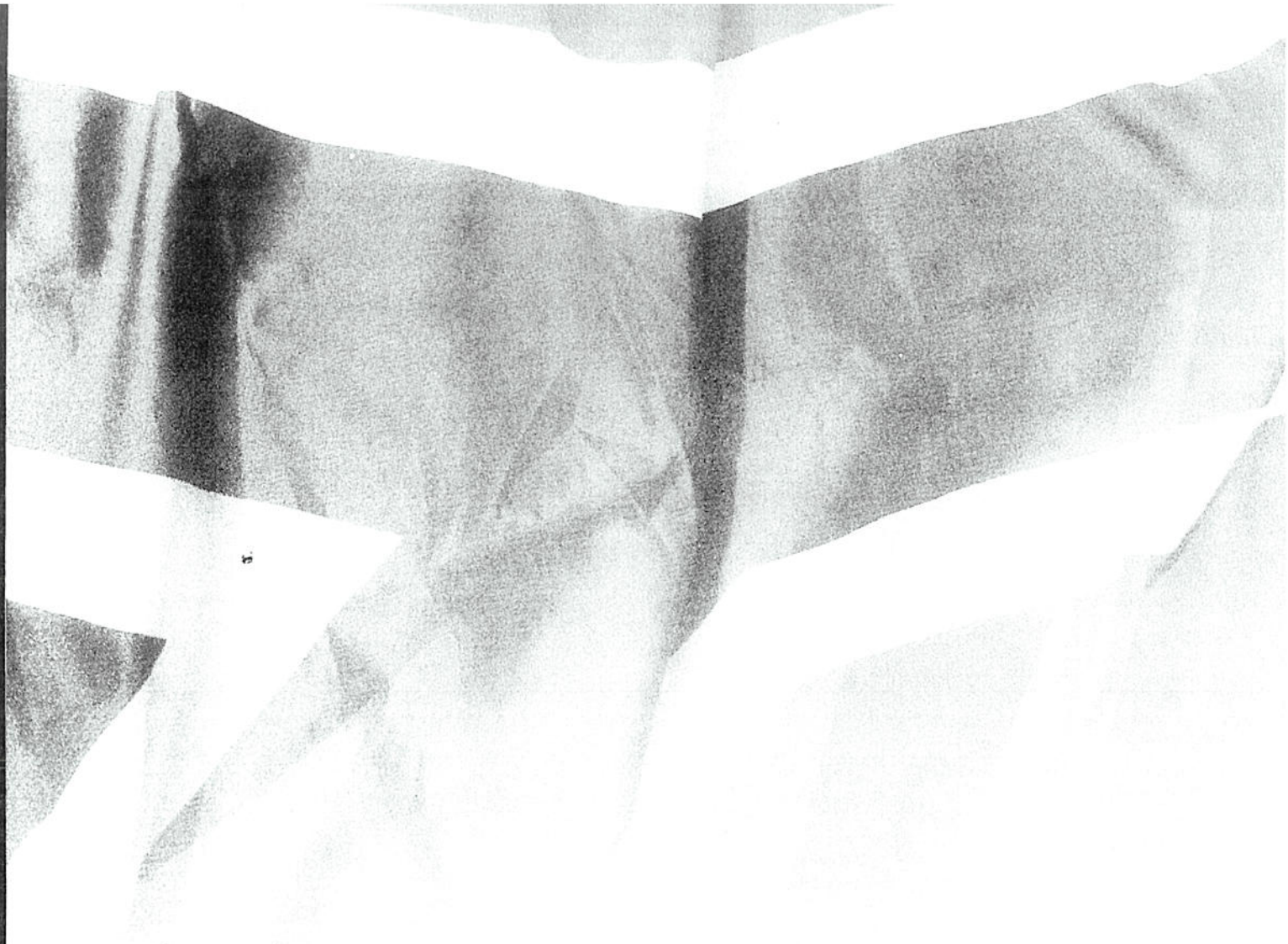

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