

Continuity of Care for Migrant Populations in Southern Africa

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ABSTRACT

Providing assistance to mobile populations has long been a challenge for healthcare providers and humanitarian organisations. The challenge is even greater when these populations need long-term chronic care for diseases such as tuberculosis or HIV, which require adherence to treatment and regular follow-up. This article examines the implications of medical care in contexts of displacement, when human movement is a major obstacle to ensuring compliance with treatment regimes. It argues that patients' mobility can be integrated into health service provision through cross-border and regional referral systems, and examines how aid agencies can successfully work with other stakeholders, considering the impact of immigration policies, discrimination in health facilities, and xenophobia on the health of migrants in need of chronic care. It asks what the correct balance is to take in dealing with a medical crisis in a highly politicised environment. The experiences of Médecins Sans Frontières in Southern Africa are explained as an illustration of this dilemma.

KEYWORDS: medical care, cyclical migration, humanitarianism, Southern Africa

1. INTRODUCTION

Providing assistance to mobile populations has long been a challenge for healthcare providers and humanitarian organisations. The challenge is even greater when these populations need long-term chronic care for diseases such as tuberculosis (TB) or HIV, which require high adherence to treatment and regular medical follow-up. This is a challenge that Médecins sans Frontières (MSF) has been facing for some time while delivering assistance to nomadic and mobile pastoralist populations in Kenya, Ethiopia, and Mali.¹ In these contexts, the high mobility of patients has been a major obstacle to complying with treatment regimes, and in response, the organisation has

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1 G. Idukittaand & M. Bosman, "The Tuberculosis Manyatta Project for Kenyan Nomads", *Bulletin of the International Union of Tuberculosis and Lung Disease*, 64, 1989, 44–47.

developed adherence strategies such as TB villages and self-administered treatment, which have begun to be reported in the scholarly literature.²

In recent years, MSF teams in several Southern African countries have taken up the challenge to provide antiretroviral therapy (ART) in a context of high mobility and increasingly restrictive migration policies.³ Between 2007 and 2013, MSF provided medical and humanitarian assistance for migrants, asylum-seekers, and refugees through two projects in South Africa – one in Musina, along the border with Zimbabwe, and another in central Johannesburg.⁴ All MSF projects in the region – even if not specifically targeting migrant populations – offer medical services to significant numbers of internal and cross-border migrants, and ever since the organisation arrived in Southern Africa it has focused mainly on the delivery of HIV care. Drawing on MSF field experiences in the region, this article examines the impact of mobility and migration control on continuity of such care, discusses potential operational responses, and offers reflections on how human mobility more generally has an impact on medical humanitarianism.

The Southern African region has the highest prevalence of HIV and TB in the world.⁵ Countries such as Botswana, Lesotho, and Swaziland have HIV prevalence rates of above 20 per cent, whereas the other countries of the region have HIV prevalence between 10 per cent and 15 per cent. South Africa is facing the largest HIV epidemic of any country with 6.8 million people living with HIV and a prevalence of 17.9 per cent.⁶ Of the estimated 1.2 million deaths due to HIV worldwide in 2014, 790 thousand occurred in sub-Saharan Africa that same year. This means that almost two-thirds of the total deaths due to HIV occurred in the region. The region also faces unique mobility patterns, with migrant populations moving within and across countries. It is estimated that almost 10 million people are on the move across Southern Africa, a number that does not take into account the hundreds of thousands of undocumented migrants present in the region as well.

The combination of high prevalence of HIV and TB and high levels of mobility makes the Southern African region an area of great concern, especially for mobile populations' access to, and continuity of, HIV and TB care. Various studies have demonstrated that mobile populations (such as internal or cross-border migrants) are at a higher risk of HIV infection, and more likely to be engaged in HIV-related risky behaviours.⁷ Since 2009 mobile populations have been identified by the

2 K. Tayler-Smith, M. Khogali & K. Keiluhu, "The Experience of Implementing a 'TB Village' for a Pastoralist Population in Cherrati, Ethiopia", *International Journal of Tuberculosis and Lung Disease*, 15, 2011, 1367–1372; M. Khogali, "Self-Administered Treatment for Tuberculosis Among Pastoralists in Rural Ethiopia: How Well Does it Work?", *International Health*, 6(2), 2014, 112–117.

3 In this article, the Southern African region comprises Swaziland, Lesotho, Botswana, South Africa, Zimbabwe, Mozambique, Malawi, Zambia, Namibia, and Angola.

4 The project in Johannesburg closed in 2012.

5 TB being the main cause of death of people living with HIV.

6 UNAIDS, *Global AIDS Response Progress Reporting*, Geneva, WHO, and UNAIDS, Report, 2015, available at: http://www.unaids.org/sites/default/files/media_asset/JC2702_GARPR2015guidelines_en.pdf (last visited 11 Mar. 2016).

7 S. Weine & A. Kashuba, "Labor Migration and HIV Risk: A Systematic Review of the Literature", *AIDS and Behaviour*, 16(6), 2012, 1605–1621.

South African Development Community (SADC) Policy Framework for Population Mobility and Communicable Diseases as having higher than average HIV risk and burden compared to the general population – due to a combination of individual, behavioural, social, and structural factors, which will be described later in this article.⁸

In this article, the first three sections offer some context to the issue of healthcare for mobile populations in Southern Africa. Section 2 looks at mobility and migration in the region historically, sketching the outlines of a lengthy and fascinating story of human movement since colonial times. Section 3 summarises the main health risks connected with mobile populations, which are then expanded in section 4, which looks at how mobility poses a challenge to healthcare systems across the region. Section 5 of this article contains the main bulk of research, explaining and analysing two recent MSF programmes for migrants in the region: the Musina farms project on the South Africa–Zimbabwe border, and the more regional “corridor project” looking at healthcare for populations on the move. Finally, Section 6 of this article concludes by summarising the central arguments, reflecting on the main challenges human migration and related state policies poses for contemporary humanitarian actors across the world.

2. MIGRATION AND SOUTHERN AFRICA IN CONTEXT

Southern Africa has always been a region of high and diverse population movements.⁹ Since the mid-19th century, migrant workers have sought employment in the mines and commercial farms of the region, which has contributed a great deal to the industrial development of countries such as South Africa and Botswana. Migrants working in mining and farming were mainly male, and have been subjected to extremely poor living conditions and family separation, and – apart from the mining industry, which was the most regulated in terms of foreign employment – migrants have had to resort to irregular or informal migration channels to find employment.¹⁰

At independence, tensions arose between sending and recipient countries, and Malawi, Zambia, and Tanzania tried unsuccessfully to prevent their nationals from migrating abroad. National migration policies at this time were influenced by broader projects of “nation-building” and “Africanisation”, which were seen as contradictory to open immigration policies. As a result, immigration policies in the immediate post-colonial era focused on control, enforcement, and exclusion rather than facilitating cross-border migration.¹¹ Such restrictionism has been challenged in the past few

8 SADC, *Policy Framework for Population Mobility and Communicable Diseases in the SADC Region*, Gaborone, Directorate for Social and Human Development and Special Programs, Final Draft, 2009, available at: http://www.arasa.info/files/6613/7574/3254/SADC_Policy_Framework_FINAL.pdf (last visited 11 Mar. 2016).

9 J. Crush, V. Williams & S. Peberdy, “Migration in Southern Africa”, Geneva, Global Commission on International Migration (GCIM), paper prepared for the Policy Analysis and Research Programme of the Global Commission on International Migration, 2005, 1–39.

10 *Ibid.*

11 *Ibid.*

decades by developmental ambitions at regional level, and one of the long-term objectives of both the African Union and SADC is to realise freedom of movement for its peoples across the continent – an objective that cannot be realised if cross-border migration continues to be seen as a threat by governments. Nevertheless, the main destination countries, particularly South Africa and Botswana, have implemented increasingly restrictive immigration and refugee policies in the last few years. These policies mainly target “unauthorised migrants” and include sweeping operations, mass arrests, and deportation campaigns, often in total disrespect of human rights and international norms.¹² The rise of nationalist and xenophobic sentiments in the region has influenced this change of policy, especially in recipient countries, leading to a number of humanitarian crises in recent years.

Nowadays, there is region-wide registration of important population movements each year. We now know, for instance, that millions of people continue to travel from Zimbabwe, Malawi, Mozambique, and Lesotho to South Africa, Zambia, and Botswana. We also know that different categories of people are on the move for diverse reasons, presenting different patterns of mobility within and across regional borders. This diversity has led to complex debates on classification and terminology, since a person can easily fulfil more than one definition and pass from one category to another throughout their journey. The debates surrounding terminology also involve the definitions of mobility and migration: there is, indeed, no standardised definition of these terms, but rather a lack of consistency in the terminology used by different agencies involved in supporting people on the move.

Migrants in search of livelihood and economic improvements constitute a significant percentage of the flow in the region. Defined as economic migrants, this category includes workers in a wide range of sectors such as farm labourers, miners, construction workers, domestic workers, mobile workers, and traders who are very mobile. They are crossing international borders and also moving widely within the borders of their own country from rural to urban centres or between urban centres. The feminisation of migration, as experienced at a global level, is also a growing regional phenomenon.¹³ Although cross-border movements are still dominated by men in Southern Africa, it is estimated that women have been increasingly migrating in the last 20 years, especially to South Africa.¹⁴ Women are more likely to be informal workers (cross-border sellers for instance), and are more likely to be in an

12 S. Snyman, *Monitoring Immigration Detention in South Africa*, Lawyers for Human Rights Immigration Detention Report, 2010, available at: <http://www.lhr.org.za/publications/immigration-detention-report> (last visited 11 Mar. 2016); R. Amit, *Lost in the Vortex: Irregularities in the Detention and Deportation of Non-Nationals in South Africa*, Johannesburg, African Centre for Migration and Society, FMSP Research Report, 2010, available at: <http://www.migration.org.za/uploads/docs/report-21.pdf> (last visited 11 Mar. 2016); Global Detention Project, *Botswana Detention Profile*, Geneva, Global Detention Project, Global Detention Profile, 2009, available at: http://www.globaldetentionproject.org/fileadmin/docs/Botswana_Detention_Profile_2009_01.pdf (last visited 11 Mar. 2016).

13 International Organization for Migration (IOM), *World Migration Report*, Geneva, IOM, Report, 2013, available at: <http://publications.iom.int/books/world-migration-report-2013> (last visited 11 Mar. 2016).

14 B. Doodson & H. Simelane, *Gender, Migration and Remittances in Southern Africa*, Cape Town, Southern Africa Migration Project, Migration Policies Series No. 49, 2008, available at: <http://www.queensu.ca/samp/sampresources/samppublications/policyseries/Acrobat49.pdf> (last visited 11 Mar. 2016).

irregular situation than male migrants.¹⁵ These factors increase the risk of abusive working conditions and sexual exploitation.¹⁶

Besides economic motivations, there is a myriad of other reasons that influences people's mobility in the region. Family reasons play an important role in the movement of people: some people may migrate or return home to be reunited with family members. Seasonal and temporary return to a country or region of origin is also a significant characteristic of migration in this region – as it has been for many years.¹⁷ The lack of access to basic healthcare in border regions has also influenced the development of the so-called “medical tourism” as observed in several MSF projects in Southern Africa. Across the region, and facilitated by informal borders, people enter neighbouring countries every day to access healthcare. This phenomenon is influenced by different factors, such as the quality of services, availability of drugs, the distance to the nearest clinic, or a common language spoken in the health facilities. In Nsanje, Malawi, for instance, the border to Mozambique is only demarcated by a river; people on either side share the same cultural heritage and speak the same language. For people on the Mozambican side, the health facilities in Nsanje are much closer than the nearest health centre in Mozambique, which leads to a large amount of cross-border migration.

3. MOBILE POPULATIONS AND MEDICAL RISKS

Today, the region continues to feel the effects of mixed movements of forced migrants from East Africa (Ethiopia and Somalia), the Democratic Republic of Congo, and Burundi. Migrants are usually en route to South Africa, which offers better integration and economic opportunities.¹⁸ The International Organization for Migration (IOM) estimates that at least 20,000 forced migrants from East Africa and the Horn of Africa transit through the region per year.¹⁹ Their irregular status while in transit makes them vulnerable to abuse, arrest, and deportations as well as to various health and psychosocial risks (rape, loss of chronic medication, physical abuse, and drowning to name a few). They are less likely to access healthcare en route because they tend to remain hidden until their final destination. This population, therefore, has a high susceptibility to HIV and TB. It is a risk that stems from social, economic, and political factors in both their home and receiving countries, and includes separation

15 Crush, Williams & Peberdy, “Migration in Southern Africa”, 14.

16 C. Rogerson, *Cross-Border Migrants and the South African Construction Industry*, Cape Town, Southern African Migration Project, Policy Series No. 11, 1999, available at: <http://www.queensu.ca/samp/sampresources/samppublications/policyseries/Acrobat11.pdf> (last visited 11 Mar. 2016); J. Crush et al., *Borderline Farming: Foreign Migrants in South African Commercial Agriculture*, Cape Town, Southern African Migration Project, Policy Series No. 16, 2000, available at: <http://www.queensu.ca/samp/sampresources/samppublications/policyseries/Acrobat16.pdf> (last visited 11 Mar. 2016).

17 F. Cooper (ed.), *Struggle for the City: Migrant Labor, Capital, and the State in Urban Africa*, Beverly Hills, Sage, 1983.

18 IOM, *Health Vulnerabilities Study of Mixed Migration Flows from the East and Horn of Africa and the Great Lakes Region to Southern Africa*, Geneva, IOM, Executive Summary Findings from the Formative Stage, 2013, available at: <https://publications.iom.int/books/health-vulnerabilities-mixed-migrants-east-and-horn-africa-and-great-lakes-southern-africa?language=en> (last visited 11 Mar. 2016).

19 IOM, *In Pursuit of the Southern Dream: Victims of Necessity*, Geneva, IOM, Report, 2009, available at: <http://publications.iom.int/system/files/pdf/iomresearchassessment.pdf> (last visited 11 Mar. 2016).

from spouses, families, and social support networks; language barriers; discrimination; substandard living conditions; and exploitative working conditions, including sexual violence.

The higher risk is also due to the fact that mobile populations in the region often move from areas of lower to higher risk and prevalence of HIV, thereby increasing the risk of infection. As an example, people from central and Northern provinces in Mozambique move to the south of the country, where its capital Maputo is situated, and which is close to the border with South Africa. Maputo province has an HIV prevalence of approximately 18 per cent, about 7 per cent higher than the national average, and a TB incident rate that is more than double that of other regions in Mozambique.²⁰ In South Africa's Limpopo and Mpumalanga provinces, a study by IOM found HIV prevalence rates of 39.5 per cent among migrant farm workers.²¹ This is more than twice the Joint United Nations program on HIV/AIDS (UNAIDS) estimated national prevalence. The same study recorded a TB case-notification rate of 6 per cent per annum – about nine times the national average. Among this study population, about 60 per cent of TB patients were co-infected with HIV, reflecting broader regional trends.

Data from Swaziland and South Africa suggest that about 60–70 per cent of all TB patients in the region are co-infected with HIV.²² Although the correlation between TB transmission and mobility is less documented than in the case of HIV, existing literature does document the relationship in Southern Africa and links it largely to South Africa's mining industry.²³ Factors such as silica dust exposure underground and overcrowded living conditions are responsible for new infections and reactivation of latent infections amongst miners. The South African Department of Health, in its TB Strategic Plan for South Africa 2007–2011, estimated that the country's gold mining industry has the highest TB incidence in the world at up to 7,000 cases per 100,000 individuals per year compared with a global incidence of 128 per 100,000.²⁴

The relation between TB and migration in the region is not only related to the higher risk of co-infection with HIV, but also to the lack of capacity in health systems to respond to the needs of infected returning migrants. There is a tendency for migrants to come back home only when they are already very sick.²⁵ Serious and complicated cases, often co-infected with HIV, require treatment, medical equipment, and facilities not always available in the migrants' home countries, especially in

20 R. Bennett, "Oscillating Migration Driving HIV and TB in Sub-Saharan Africa", *Sacema Quarterly*, 18, 2013, 1–3.

21 IOM, *Integrated Biological and Behavioural Surveillance Survey (IBBSS)*, Geneva, IOM, Report, 2010, available at: <http://reliefweb.int/report/south-africa/integrated-biological-and-behavioural-surveillance-survey-ibbss-commercial> (last visited 11 Mar. 2016).

22 UNAIDS, *Global AIDS Response Progress Reporting*.

23 D. Stuckler et al., "Introduction: 'Dying for Gold': The Effects of Mineral Mining on HIV, Tuberculosis, Silicosis, and Occupational Diseases in Southern Africa", *International Journal of Health Services*, 43(4), 2013, 639–649.

24 Department of Health, South Africa, *Tuberculosis Strategic Plan for South Africa, 2007–2011*, on file with the author.

25 S. Clark et al., "Returning Home to Die: Circular Labour Migration and Mortality in South Africa", *Scandinavian Journal of Public Health Supplement*, 69, 2007, 35–44.

remote rural areas. In addition, the management of cases of multi-drug resistant TB (MDR-TB) is complicated in these locations, where the capacity and availability of human resources together with access to adequate drugs is extremely limited. The lack of a proper multi-country strategy and the shortage of resources for regional TB programmes in recent years have had a significant impact on the lives of millions of people including in the communities where migrants come from.²⁶ For this reason, tensions have been building between sending and receiving countries about the cost of healthcare of migrant patients. In the context of historic migrant labour movements across the region to South African mines, neighbouring countries have accused South Africa of exporting TB, and leaving their health systems to bear the brunt.²⁷

4. MOBILITY AS A CHALLENGE FOR HEALTH SYSTEMS

Various socio-economic factors have increased the risk of mobile populations. Both internal and cross-border migrants often live in overcrowded conditions without proper ventilation or access to basic water and sanitation.²⁸ In the context of mines and farms, workers may be forced to live in single-sex hostels that preclude partners or families travelling with them. Previous research has found that in the face of limited accommodation, some farm workers are forced to resort to transactional sex to secure access to housing.²⁹ Internal and cross-border migrants may also live away from partners, families, and communities for weeks or months, leading to multiple concurrent partnerships and relations with sex workers. Away from familiar social support networks and communities, migrants may experience social disinhibition leading to increased risk taking and alcohol abuse, fuelled by inactivity.

The bi-directionality of migration and communicable diseases (including TB/HIV infections) cannot be emphasised enough. It is not only those who migrate who experience an increased vulnerability to HIV as a result of the migration process, but also the communities they originate from. This risk is becoming ever more significant due to the increased frequency of circular movements, with mobile workers returning home more often and thus increasing the probability of disease transmission.³⁰ Increased health risks are also related to working conditions. Migrant workers may not be given time off of work to seek health services off site and may fear loss of employment should they be diagnosed with either HIV or TB. Some categories of migrant workers such as miners or construction workers may also deprioritise the threat of TB or HIV in the face of more immediate threats such as physical injury or

26 *Ibid.*

27 A. Baleta, "Southern Africa Declaration Targets TB in Mining Sector", *Lancet*, 380, 2012, 1217–1218. In an attempt to clarify roles and responsibility and increase collaboration between countries for migrant health, the SADC has recently been working on development of the Declaration on TB in the Mines, which represents the only example of a regional initiative for TB and MDR-TB.

28 MSF, *Nowhere to Go: Survival Migrants in South Africa Caught between Evictions and Policy Vacuum*, Geneva, MSF, Report, 2011, available at: <http://www.msf.org/article/nowhere-else-go-survival-migrants-south-africa-caught-between-evictions-and-policy-vacuum> (last visited 11 Mar. 2016).

29 IOM, *Integrated Biological and Behavioural Surveillance Survey (IBBSS)*.

30 J. Veary, B. Wheeler & S. Jurgens-Bleeker, *Migration and Health in the SADC Region: A Review of the Literature*, IOM, Report, 2011, available at: http://reliefweb.int/sites/reliefweb.int/files/resources/E3AEF43DCC2CFA1F492577E70021F885-Full_Report.pdf (last visited 11 Mar. 2016).

death as part of already dangerous professions. Pre-existing occupational diseases, such as silicosis, may further increase the risk of contracting active TB as they weaken the lung function.

Most importantly for medical humanitarianism, chronic health conditions such as HIV and TB require patients to remain adherent to treatment. Interruption of treatments can significantly increase risks for disease transmission and can facilitate drug resistance, resulting in medical complications, illness, and ultimately death. For this reason, access to and continuity of care for mobile population has been often cited as a serious concern, specifically for HIV and TB given the regional burden of these diseases. However, while policy-makers acknowledge that patients, particularly in border communities, may be engaging in “medical tourism” or accessing services across borders due to factors explained above, the issue has not been systematically addressed.

This lack of response is driven by many reasons, including complex questions regarding financing, the lack of multi-country data on migrant flows, mobile populations’ access to services, the use of different terminology, and structural discrimination.³¹ As a consequence, national health systems in the region have failed to create or integrate a proper cross-border referral system. For instance, cross-border migrants already on HIV treatment in their home countries may be re-started on HIV treatment in neighbouring countries with a new regimen, or they may fail to receive treatment, because without medical record they do not meet the treatment initiation criteria of their host country.³² Conversely, health workers often do not know how to refer or receive cross-border patients. Sometimes they are unable to explain treatment in the patient’s home language, do not know how to complete a referral/transfer letter, or are simply already overloaded with work.

If access and continuity of care are not guaranteed in the region, the interruption of treatment represents a serious threat, exposing mobile populations to the risk of developing drug-resistance for both TB and HIV. This is particularly alarming for any health system in a context of limited resources and high prevalence, with a devastating impact on the fight against the HIV/TB epidemic. Moreover, migrant sickness (and death) has multiple effects. It adds to the burden of care in the health system and households back home.³³ Return migration patterns “to die at home” have been well documented and are a direct consequence of this phenomenon.³⁴ The situation also disrupts livelihood systems as it affects their ability to generate income, interrupting the provision of remittances to families and communities.

31 There is no universally accepted definition of migration and no consistency in the use of terminology across SADC countries or between SADC and international organisations.

32 If ART regimens are being increasingly harmonised in the region, different treatment regimens and protocols continue to exist between countries.

33 M. Collinson, “Striving Against Adversity: The Dynamics of Migration, Health and Poverty in Rural South Africa”, *Global Health Action*, 3(3), 2010, available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2882287/> (last visited on 29 Mar. 2016).

34 S. Clark et al., “Returning Home to Die: Circular Labour Migration and Mortality in South Africa”, *Scandinavian Journal of Public Health Supplement*, 69, 2007, 35–44.

5. THE MSF EXPERIENCE: RESTRICTIVE IMMIGRATION POLICIES AND CONTINUITY OF CARE

This examination of MSF's work in southern Africa focuses on the last 10 years, during which time migration has become a serious political and humanitarian issue. Between 2000 and 2012 South Africa was faced with a large influx of around 1.5 million Zimbabweans fleeing the consequences of economic and political crisis in their country – some fleeing from persecution, others fleeing for economic reasons, but most finding themselves unable to access adequate protection in South Africa as they fitted neither into the categories of refugees nor regular economic migrants.³⁵ As a result of these movements and ambivalent government policies, South Africa has been faced with outbreaks of xenophobic violence, and in May 2008 this xenophobia notoriously reached a peak. Over just 10 days, 62 people were killed and 500 injured, countless foreigners' shelters were destroyed and between 80,000 and 200,000 people were forcibly displaced.³⁶ A survey conducted in 2010 by the Southern African Migration Programme on South African attitudes towards foreigners showed persistent xenophobic sentiments remained, and in April 2015 another peak of xenophobic violence spread from KwaZulu Natal to other parts of the country following anti-immigrants comments from Zulu King Goodwill. This led to the deaths of at least seven people and the displacement of 7,000 foreign nationals. Many further thousands of Zimbabweans, Malawians, Mozambicans, and Nigerians were repatriated by their governments as a result.³⁷ In the hastily erected camps where foreigners had taken refuge in Durban, MSF medical and psycho-social teams treated dozens of people for physical injuries, diarrhoea, or body aches. Hundreds, including children of all ages, demonstrated signs of post-traumatic stress disorder. Despite calls for reconciliation, the most emblematic response of the South African government has been to portray the violence as the result of criminality and to launch "Operation fiela" ("sweep out the dirt") an intervention led by the police and the army to "reclaim the streets" and crack down on crime. The way the operation was conducted has been highly criticised by human rights organisations.³⁸ Initially designed as a response to xenophobic violence, "Operation fiela" turned out to be mainly targeting foreigners, the very victims of these attacks, and led to the arrest and deportation of hundreds of undocumented migrants. It is feared that the lessons from these peaks of xenophobic attacks are still to be learnt by the South African authorities that have failed to prevent this second escalation of violence and continue to ignore the low

35 A. Ponthieu & K. Derderian, "Humanitarian Interventions in the Protection Gap", *Forced Migration Review*, 43, 2013, 37–40.

36 V. Igglesden, *Xenophobic Violence in South Africa in May 2008: The Humanitarian Response in Gauteng and the Western Cape (A Narrative Account)*, Forced Migration Studies Programme Working Paper, Western Cape, Forced Migration Studies Programme, University of Witwatersrand, Working Paper, Dec. 2008, available at: <http://cormsa.org.za/wp-content/uploads/Research/Disaster/NarrativeHumanitarianResponse.pdf> (last visited 11 Mar. 2016).

37 "Tough Homecoming for Zimbabweans Migrants Fleeing Xenophobia", *IRIN News*, 27 Apr. 2015, available at: <http://www.irinnews.org/report/101410/tough-homecoming-for-zimbabwean-migrants-fleeing-xenophobia> (last visited 11 Mar. 2016).

38 Lawyers for Human Rights (LHR), "LHR Wants Operation Fiela Declared Unconstitutional", *LHR Press Release*, 2015, available at: <http://www.lhr.org.za/media/2015/lhr-want-operation-fiela-declared-unconstitutional> (last visited 11 Mar. 2016).

scale but very real xenophobic attacks happening on daily basis on South African soil.

Access to basic healthcare should be available to everyone under the 1996 South African Constitution – nationals as well as foreigners. However, restrictive immigration and asylum policies over the last three years have created new health risks for already vulnerable migrant populations. The country was home to 112,233 registered refugees and around 463,000 asylum-seekers in 2014.³⁹ It is one of the largest recipient countries in the world of asylum applications and the main destination for people of mixed migration flows southwards from the Horn of Africa, the Great Lakes, and other countries in the region such as Zimbabwe. Faced with the lack of legal immigration channels, thousands of people have applied for asylum to regularise their stay, overwhelming the national asylum system. Initially, South Africa tried to respond to this reality with specific immigration measures, such as the Moratorium on Deportations of undocumented Zimbabweans (in place since April 2009) and the Zimbabwean Documentation Process. However, these measures were interrupted in late 2011.

Over the last few years, South African authorities have adopted a much more restrictive approach to immigration affecting both migrant and refugee populations. This approach has aimed to withdraw certain rights from refugees and asylum-seekers and limit their access to livelihood opportunities and protection. Foreigners' universal access to healthcare has also regularly been questioned in political debates. Refugee Reception Offices have been closed and not reopened despite court orders; the right of refugees to work has been challenged and foreigner-owned "spaza" shops have been violently forced to close by police across the country. South Africa has been increasingly resorting to policies and practices based on deterrence and control, presenting migrants and refugees as a security threat and restricting their access to asylum procedures.⁴⁰ As a consequence, vulnerable populations have been subjected to legally questionable practices by state security forces such as arbitrary arrest, detention, and forced return.

5.1. Musina and the Zimbabwean–South African border

In this context, MSF have been providing essential medical services to mobile populations, and one illustrative example is the programme in Musina. Here, MSF had to respond to emerging medical and humanitarian needs of migrant populations who had been directly affected by repressive state practices, presenting particular challenges for continuity of care. Traditionally, the majority of asylum-seekers and refugees seeking protection in South Africa from persecution or generalised violence have travelled from Zimbabwe, Ethiopia, Somalia, or the Great Lakes region, and since January 2011, individuals without passports or documentation have been systematically denied access into the country at the official border post and turned

39 United Nations High Commissioner for Refugees, *2015 UNHCR Country Operations Profile – South Africa*, undated, available at: <http://www.unhcr.org/pages/49e485aa6.html> (last visited 11 Mar. 2016).

40 LHR, *Refoulement of Undocumented Asylum-Seekers at South African Ports of Entry with a Particular Focus on the Situation of Zimbabweans at Beitbridge*, LHR, Situation Report, Sep. 2011 (on file with the authors).

away.⁴¹ In some cases, asylum-seekers have been driven back to the Zimbabwean side of the border, in violation of both national and international laws, leading to increasingly desperate attempts to enter the country, with many people forced to cross the Limpopo River, exposing themselves to the threat of drowning or falling prey to wild animals or criminal gangs known as “guma gumas”.

Between 2008 and 2013, MSF teams in Musina treated hundreds of people who were victims of this kind of violence on their journey to and from Zimbabwe. Some had been raped or forced to rape while crossing the border, many others have been subjected to further violence including beating, abduction, or witnessing others being violated. Sexual violence had grave health and mental consequences on these people, including physical and psychological trauma, the risk of contracting HIV and/or sexually transmitted infections, and unwanted pregnancy. In Musina, MSF offered primary healthcare services in a clinic in front of the Department of Home Affairs (DHA) office, where asylum-seekers register their asylum claims.

Musina in the Limpopo province is a dynamic border town of 40,000 inhabitants. It is one of the South African communities with the highest number of immigrants and the main entry gate from Zimbabwe. Through its border, scores of migrants have crossed into South Africa in search of better livelihoods or seasonal work on a belt of farms along the border. MSF started to provide assistance to migrant farm workers in 2009, after HIV testing in the Musina farms had revealed positivity rates of 40 to 46 per cent – much higher than the district average of 14 per cent. The initial assessment showed that three quarters of these farm labourers were not accessing HIV treatment even though it was freely available in town. Several obstacles to accessing care were identified: the 50 kilometre distance between the farms and Musina’s health facilities; the cost of transportation to Musina town; the absence of days off or sick leave to go to the health centre; the long waiting time at health facilities; and the necessity for patients to complete five appointments before ART initiation. From November 2010 to December 2013, therefore, MSF organised primary healthcare mobile clinics to 10 farms around Musina. The services provided included integrated HIV and TB screening and care, and HIV testing, diagnosis, treatment, and drug initiation.

As we have seen, access to treatment for chronic illnesses, including HIV and TB is particularly challenging for mobile populations. A patient reporting to a public health facility in South Africa without transfer documentation from another health facility often had to start the process from the beginning, requiring a HIV test, a CD4 count and preparation counselling. This resulted in a long interruption of treatment. The threat of being arrested before reaching the DHA office was an additional constraint, as migrants’ priority tended to be to regularise their status rather than seek healthcare. Moreover, the majority of patients who crossed the river reported the theft of their belongings, including medication and medical records.

In October 2011, with the ending of the Moratorium on deportation of undocumented Zimbabwean migrants, arrest and deportation campaigns restarted in Musina, affecting undocumented migrants of all origins. Following the closure of the

41 The main reason given to these individuals is that they should apply for asylum in another country or that South Africa is not accepting asylum-seekers any more.

only immigration detention centre in Musina in December 2011, immigration authorities started to use police stations to detain undocumented migrants. People were rounded up in the town itself and on outlying farms and placed in detention with the intention to deport them. During this period, MSF carried out weekly medical visits to police cells. The main focus of these visits was to ensure access to basic healthcare and chronic medication for those detained, but MSF teams also witnessed the extreme vulnerability of migrants in detention, which had adverse consequences on their health and constituted a total lack of respect for human dignity.

One of the problems was the absence of medical screening prior to detention and the limited provision of basic medical care. Deportees on chronic treatment for TB or HIV could not access their medication while in detention. Many were arrested without their medication and were not given access to healthcare professionals. This resulted in people being deported without receiving the necessary medical care and in interruption of treatment with potentially fatal consequences. In this context, the detention and deportation procedures were the main reason why people in need of chronic care interrupted their treatment. Another aggravating factor was the lack of infection control in the detention premises: cells were constantly overcrowded and hygiene conditions were extremely poor, presenting further risk for the transmission of infectious diseases.

5.2. Wider lessons from the region

Over the past decade or so, MSF has been supporting HIV and TB programmes in settings with large migrant populations and/or population mobility in several countries in Southern Africa. The organisation has, however, often had very limited information regarding the mobility patterns of patients. One source of information in the projects is the reporting of the main reason for defaulting/lost-to-follow-up (LTFU) of patients, and analysis of this data has highlighted several patterns. One of these patterns concerns the reason for missing HIV patients: across different countries, mobility is the most common reason reported for HIV patients missing an MSF health visit, with figures ranging from 23 per cent in Mozambique, 28 per cent in Malawi, and 32 per cent in Zimbabwe.⁴² In light of this information, MSF has recently been trying to address the problem of mobility, focusing research and interventions on the migrant population. Some examples can help illustrate both the problem and the solutions tested within MSF.

In Lesotho, one of the most migration-dependent economies in the region, the HIV prevalence is the third highest in the world. MSF has supported antiretroviral (ARV) treatment and care in two districts since 2006 where 12 per cent of the patients were migrant workers, mostly to South Africa. The provision of ARV treatment to this highly mobile population was identified by the government as one of the main challenges in the scaling up of HIV/AIDS treatment and care to the population of Lesotho. MSF documented the trends in “lost to follow-up” among migrant workers in the programme in 2010, finding that while there was no statistically significant correlation between migrants status and lost to follow-up in the first three

42 MSF internal quarterly programme reporting 2013 from Malawi, Mozambique, and Zimbabwe (on file with the authors).

months of the treatment, the defaulting rates increased significantly among the migrant patients with time. The report found that:

[...] between three and six months after initiating antiretroviral therapy, migrants had a 2.78-fold increased rate of defaulting (95% CI 1.15–6.73); between six and 12 months the rate was 2.36 times greater (95% CI 1.18–4.73), whereas after one year the rate was 6.69 times greater (95% CI 3.18–14.09).⁴³

One of the limitations of this study was the lack of available data on reasons why patients defaulted on treatment, but programme health workers considered one reason for the high default rate in the migrant population: that people returned to work in South Africa once they felt less sick. Whether the patients from Lesotho accessed and continued treatment in South Africa was unknown to the MSF team.

The analysis did, however, demonstrate the importance of routine tracing of defaulters in HIV programmes, as well as the development of adapted models of care for mobile populations to ensure continuity of chronic treatment. Some practical recommendations emerged from the Lesotho research as well, which matched previous MSF experience with displaced populations in conflict-settings.⁴⁴ For instance, the report included the following recommendations for ensuring greater continuity of care:

[...] providing drug supplies of up to three months for stable patients; adapting adherence counseling to ensure patients are aware of the importance of uninterrupted treatment; developing links with treatment providers in South Africa; and issuing patient-held clinical cards summarizing the most important treatment history in case of unplanned self-transfer.⁴⁵

Following these recommendations from the Lesotho study a specific model of care was implemented in the MSF project in the Musina farms between 2010 and 2013.⁴⁶ The high mobility of the population was one of the main challenges in their access and adherence to treatment: looking for work from one farm to the next, or periodically returning to Zimbabwe for family reasons, made it difficult for HIV positive migrants to continue – or sometimes even start – their ART treatment. To make matters worse, undocumented migrants were afraid of being arrested and deported, so they tended to stay underground, avoiding interaction with government officials – including medical staff in public hospitals and clinics, even if in theory they had access to free healthcare and ART.

43 H. Bygrave, K. Kranzer & K. Hildrebrand, “Trends in Loss to Follow-up among Migrant Workers on Antiretroviral Therapy in a Community Cohort in Lesotho”, *PLoS One*, 5(10), 2010, 1–5.

44 H. Culbert et al., “HIV Treatment in a Conflict Setting: Outcomes and Experiences from Bukavu, Democratic Republic of Congo”, *PLoS Med*, 4, 2007, 794–798.

45 Bygrave, Kranzer & Hildrebrand, “Trends in Loss to Follow-up among Migrant Workers on Antiretroviral Therapy in a Community Cohort in Lesotho”, *PLoS One*, 5(10), 2010, 1–5.

46 MSF, *Providing Antiretroviral Therapy for Mobile Populations: Lessons Learnt from a Cross Border ARV Programme in Musina, South Africa*, Cape Town, MSF, Report, 2012, available at: http://www.msfastcess.org/sites/default/files/MSF_assets/HIV_AIDS/Docs/AIDS_report_ARTformobilepops_ENG_2012.pdf (last visited 11 Mar. 2016).

Knowing that the patients will be crossing the border back to Zimbabwe two to five times a year, a seven-step model of care was implemented, adapting the provision of medical services to patients' mobility. The model comprised a *patient held health passport* documenting current treatment and laboratory results. They were also given a *HIV road map* for Zimbabwe with information on where to access ART at their destination. Specific *adherence counselling sessions* inquired about patients' travel plans were in place. Mobile patients received a *referral letter* in case they needed to access healthcare during travel. To reduce the risk of running out of ARV medication, all patients planning to travel for more than two weeks received also a *three-month buffer stock of drugs* and an emergency pack of tail protection in case of treatment interruption. Upon return, a *questionnaire* was filled for each patient where continuity of ART was documented. In the monitoring system, a particular *temporary transfer out* classification was used for these patients to avoid double counting.

The project was conducted in partnership with the Limpopo Provincial Department of Health and the Foundation for Professional Development. It was handed over to the responsible authorities in 2013 after three years of implementation and successful results: 90 per cent of patients remained in care one year after starting their HIV treatment. After six months into treatment, 90 per cent had suppressed viral loads – a sign the medication was working as HIV was not detectable in their blood – and at 12 months it was 92 per cent. Such results are comparable to well-functioning programmes delivered in other parts of South Africa where the population is not as mobile.⁴⁷ The Musina model of care is a successful example of the adaptation of health services to patients' mobility. It responded to the challenge posed by a circular migration pattern: patients close to a border, moving back and forth and somehow able to plan their movements in advance. Similar models of care could be developed for other types of mobility taking into account the variety of mobility patterns in the region.

5.3. Integrating mobility in regional HIV and TB care: the “Corridor Project”

The Musina model took place at the local level, but regional models of care for mobile HIV and for patients are few and far between. Some attempts, such as the SADC HIV and AIDS Cross Border Initiative, have been trying to address the problem, but it is most likely that the countries involved are currently more focused on their internal health policies than on a coordinated approach.⁴⁸ As discussed above, the process is complicated by a general lack of data concerning numbers, migration patterns, and migrants' access to healthcare in the region. Similarly, MSF programmes lack data on how mobility affects the quality of services and healthcare. Information on aspects such as patients' travel plans and coping mechanisms is not routinely collected, thus only observation and anecdotal evidence from health workers in MSF supported clinics or in the communities is available.

47 MSF, *New Roots for Rural Health: Challenging Unequal Access in South Africa*, Cape Town, MSF, Report, 2013, available at: http://www.msf.org/sites/msf.org/files/musina_new-roots-for-rural-health_south-africa.pdf (last visited 11 Mar. 2016).

48 SADC, *HIV and AIDS Cross Border Initiative*.

To address this scarcity of data, MSF commissioned a three-country study (South Africa, Mozambique, and Malawi), between 2012 and 2013, aiming to document short- and long-term migration patterns among HIV and TB patients among selected MSF projects and assess the impact of mobility on access to treatment and continuity of care.⁴⁹ Participants were drawn from four MSF project sites selected for reportedly high levels of mobility: the rural Nsanje district in southern Malawi, the cities of Tete and Maputo in Mozambique, and Johannesburg in South Africa. Participants were included in the study if they were HIV-positive, between the ages of 18 and 65 years and were either internal or cross-border migrants. The latter were also interviewed upon return to their home country, appearing in the study as “nationals”.

The results of this study showed that access to ART is problematic for migrants residing outside their home country. Only 17 per cent of people on ART accessed treatment in a clinic while they were abroad, and among those who did, 44 per cent felt discriminated in the health facilities, not only for their nationality but also for their HIV status. Almost 30 per cent of the participants interrupted their treatment and a significant correlation between treatment interruption and drug supply strategy was discovered: 46 per cent of the respondents who had received one month of supply stopped their treatment, compared to 33 per cent of those with two months of supplies and only 13 per cent those with three months of supplies.

The study also found that around 70 per cent of the patients interviewed were travelling by road – which is particularly significant because the route, the border posts, and the means of transport are the same for all categories of mobile populations and most of them follow the main highways. The M1 highway running from Egypt to South Africa has been identified as one vector of HIV transmission and for that reason has been nicknamed the “AIDS Highway”.⁵⁰ In the Southern Africa region it crosses Malawi, Mozambique, Zimbabwe, and South Africa. One example of how roads can play a significant part in HIV and TB transmission is in Tete Province in Mozambique, through which the M1 passes. The recent development of mining activities and the subsequent economic boom have begun to attract internal and cross-border migrants to the province, and the result is a high concentration of different high risk groups present on the province’s roads, particularly commercial sex workers, truck drivers, and miners as well as forced migrants transiting on the highway to South Africa.

Based on this study, MSF identified areas for intervention that might address problems such as treatment interruption related to drug supply, the lack of testing in receiving and sending communities, misunderstanding of treatment courses, limited or no access to services for migrants outside their home countries, and discrimination against migrants at health facilities. MSF then set up the “Corridor Project”, a new intervention that offers targeted health services along the main transport corridors, including transit routes, border areas, and other destination hubs in the east of the Southern African region (Malawi and Mozambique). The project aims at

49 A. Incerti, “Three-Country Study Documenting the Impact of Mobility on Access to HIV and TB Services in Southern Africa”, MSF Internal Report (on file with the authors).

50 J. Amon & K. Todrys, “Access to Antiretroviral Treatment for Migrant Populations in the Global South”, *International Journal of Human Rights*, 6(10), 2009, 154–177.

providing tailored and comprehensive health services for hard-to-reach, mobile, and marginalised key populations, specifically migrants (internal and cross-border) and mobile workers, such as truck drivers, mineworkers, and commercial sex workers (especially young girls), who are frequently present at border posts and along the region's highways. At time of writing, the project is being implemented in Mozambique on the Tete-Mbeira corridor. The project also aims to implement a regional and transnational approach to improve continuation of care and cross-border referrals of mobile populations – a model that includes night clinics, refilling drugs, and adapted adherence counselling sessions. MSF intends to advocate for other strategies to increase general access to care such as “test and treat”, in which the patient starts treatment immediately, regardless of his or her CD4 count. All this serves to create a specific model of care for key populations such as migrants and other mobile populations. Collaboration with national health systems in the countries involved will be crucial to realising the project.

6. CONCLUSION AND ANALYSIS

MSF's experience with people on the move in the Southern African region demonstrates that, in spite of the identified challenges, it is possible to significantly improve HIV/TB treatment access, adherence, and retention for mobile populations. It points to the importance of integrating patients' mobility into the provision of healthcare services, which can be achieved through tailored models of care and the strengthening of referral systems. These reduce defaulting or lost to follow-up patients, as well as increase access to care. Until now, the lack of reliable data on the impact of mobility on continuity of care and on health systems, and the absence of adapted models of care and coordination between countries, has made it difficult for health authorities to plan efficient mobility-responsive health interventions. This represents a regional challenge that can be overcome only with the appropriate tools and the necessary political willingness. The on-going harmonisation of ART guidelines in Southern Africa, although country specific and not regionally coordinated, is an opportunity to develop regional models and activities to ensure healthcare for mobile populations.

Progress will only be possible with the creation of cross-border and regional referral systems. Common tools, such as the “health passport” and mobility-sensitive counselling sessions, will have to be adopted at all levels and used in all health facilities in the region. Prevention strategies should also be adapted to mitigate the risk of new infections in mobile populations. Such regional models of care in Southern Africa will require a high level of collaboration between actors involved in the provision of health services, including employers of migrant workers. Governments are responsible for ensuring that migrants have access to healthcare and that immigration policies do not work at cross purpose with individuals' right to health or indeed with public health strategies. The private sector, especially mining and transport companies, will also have to play an important role in facilitating information and access to health services.

While addressing the challenges posed by mobility, it is equally important to consider other migration-related risks and their humanitarian consequences. Violence,

labour exploitation, sexual abuse, and discrimination have a direct impact on people's well-being, as well as their ability to access healthcare and the likelihood of them adhering to their treatment. State immigration policies can make this worse. The example of Southern Africa, as reported in this article, demonstrates how the restrictions placed on migration forces these populations into a zone of invisibility and places them at greater risk of exploitation and violence, as well as reduces their ability to access health services. In this context, immigration policies cannot be adopted in a public health vacuum, as they present great dangers to the health of both individuals and communities – and particularly people suffering from HIV and TB.

Authorities must tackle discrimination inside and outside health facilities to ensure vulnerable patients are not turned away or forced to go underground. More adapted health-sensitive immigration policies must be adopted to prevent the continuation of what is already considered today a health emergency in a region with limited resources and capacity to respond. The challenge for humanitarian organisations in addition is vast. In a world where human mobility and forced displacement are becoming more regular and intense, pressures on health services as well as the lack of political support for universal care has made the provision of medical assistance even more urgent. In this respect, MSF has been advocating in the region not only for access to HIV care for all in need regardless of legal status, but also for the respect of migrants' rights and the provision of "migrant-friendly" health services. Yet, many of the medical needs our teams are confronted with, as described in this article, are the direct result of state practices and policies rather than the direct effect of displacement, epidemics, or other humanitarian crisis.

The different interventions detailed in this article show how border regimes, especially the most restrictive can negatively affect people's health. For vulnerable migrants borders do not only represent a political and legal barrier, but also a high-risk zone for their health and dignity. Borders are of concern to humanitarian organisations as they are areas where violence and human rights violations are likely to happen, in all regions of the world. They are also seen by States and citizens as protection from imported diseases. If humanitarians are used to providing services in border areas due to the high level of violence there and the need for delivery of essential supplies, they are now increasingly faced with the reality of the border itself as a source of humanitarian and medical needs. New challenges are appearing for humanitarian medical actors that are directly emerging from the interaction between human needs and restrictive migration policies. In the Mediterranean Sea and on the Western Balkan route, MSF has deployed teams to respond to the challenges of death at sea, to the needs of refugees and migrants forcing European borders that remained desperately closed to their suffering, treating eye infections due to tear gas, and shrapnel wounds inflicted by border guards. In Europe, our patients are also mobile, crossing several borders in the course of a week. MSF teams are adapting to the mobility of their patients, using the health passport to make sure chronic diseases will be duly treated on the way as well as upon arrival.

If Europe and Southern Africa are two very different regions dealing with different patterns of mobility and associated health-risks, both regions are struggling to adopt comprehensive and health and protection-sensitive migration policies. With 60 million people currently forcedly displaced across the world and in need of a safe

heaven, restrictive migration policies are having a greater cost than ever on human health. While MSF recognises the sovereign right of the State to manage and control migration flows into their territory, the organisation has denounced the dramatic impact of restrictive migration policies both in Europe and South Africa. If MSF's field experience can be used to mitigate the impact of mobility on adherence to chronic care, it is more difficult and somehow ethically challenging to propose assistance models to mitigate the impact of restrictions imposed on populations' movements. Even if in many ways the assistance MSF provides at borders and in detention centres is mitigating the negative effects of state policies or inadequate responses, they cannot be acceptable long-term solutions to unsafe migration management. When humanitarian actors have to respond to the needs emerging from state border control it is often because States do not have the means to sustain their own – restrictive – policies in full respect of human rights and dignity. When this happens, humanitarians, because they are providing assistance regardless of people's legal status or reasons to move, are in a privileged position to assist but also to denounce the source of the suffering they are witnessing: a policy-made humanitarian crisis.