



# **MIGRATION HISTORY TOOL**

**LIMPOPO REGION**

**PRELIMINARY REPORT**

## Summary

<b>1. INTRODUCTION</b> .....	5
<b>1.1. Background</b> .....	6
<b>1.2. Study Rationale</b> .....	7
<b>2. METHODOLOGY</b> .....	8
<b>3. RESULTS</b> .....	12
<b>3.1. Reception Centre</b> .....	12
3.1.1. General Characteristics .....	12
3.1.2. Global Migration .....	13
3.1.3. Life at the last residence in the country of origin .....	16
3.1.4. Current migration .....	18
3.1.5. Life in South Africa.....	19
3.1.6. Detention.....	23
3.1.7. Access to Health at the Reception Centre .....	29
3.1.8. Future Plans.....	30
3.1.9. Chronic and Infectious diseases .....	31
3.1.10. Sexual and reproductive health.....	33
3.1.10.1 Sexually transmitted infections (STIs) .....	33
3.1.10.2 Family Planning .....	36
3.1.10. Sexual Violence .....	37
3.1.11. Alcohol abuse and mental health.....	38
3.1.12. Main Recommendations .....	42
<b>3.2. Musina</b> .....	43
3.2.1. General Characteristics .....	43
3.2.2. Global Migration.....	44
3.2.3. Life at Origin.....	47
3.2.4. Current Migration.....	49
3.2.5. Life in South Africa and in Musina .....	50
3.2.5.1. Living Conditions in Musina .....	50
3.2.5.2. Life Conditions in South Africa .....	52
3.2.5.3. Exposure to Violence .....	54
3.2.5.4. Access to Health .....	54
3.2.5.5. Food Insecurity.....	56
3.2.6. Future Plans .....	57
3.2.7. Sexual and Reproductive Health .....	60
3.2.8. Sexual Violence.....	64
3.2.9. Alcohol abuse and Mental Health.....	65
3.2.9.1 Alcohol Abuse.....	65

3.2.9.2	<i>Anxiety and Depression Index</i> .....	66
3.2.9.3	<i>Coping Mechanisms</i> .....	67
3.2.10	Main Recommendations .....	68
<b>3.3.</b>	<b>Malawian migrants</b> .....	69
3.3.1.	Context and General Characteristics.....	69
3.3.2.	Global Migration .....	70
3.3.3.	Life at the last residence in the country of origin .....	72
3.3.4.	Current Migration.....	74
3.3.5.	Life in South Africa.....	75
3.3.6.	Future Plans .....	77
3.3.7.	Chronic and Infectious diseases .....	78
3.3.8.	Sexual and reproductive health .....	78
3.3.9.	Sexual Violence .....	80
3.3.10.	Alcohol abuse and mental health.....	81
3.3.11.	Main Recommendations .....	83
<b>3.4.</b>	<b>Cross Border Population</b> .....	83
3.4.1.	Respondents' Main Characteristics and Household Information.....	83
3.4.2.	Migration of Household Members.....	85
3.4.3.	Migration History.....	89
3.4.4.	Food Insecurity .....	91
3.4.5.	Child's Health .....	93
3.4.6.	Chronic and Infectious Diseases .....	95
3.4.7.	Sexual and Reproductive Health .....	96
3.4.7.1.	<i>Sexually Transmitted Infections</i> .....	96
3.4.7.2.	<i>Maternal Health</i> .....	97
3.4.8.	Violence Exposure and Transactional Sex.....	99
3.4.9.	Alcohol Abuse and Mental Health .....	100
3.4.10.	Main Conclusions.....	102
<b>3.5.</b>	<b>Comparative Analysis</b> .....	102
3.5.1.	Chronic and Infectious Diseases .....	103
3.5.2.	Sexual and Reproductive Health .....	106
3.5.3.	Sexual Violence .....	111
3.5.4.	Mental Health and Alcohol Abuse .....	112
3.5.5.	Summary of the Comparative Analysis .....	115

## Executive Summary

Since 2000, Médecins Sans Frontières (MSF) has been a key health care provider to displaced populations in the Limpopo Region. Not only has the organization successfully implemented a model of care to Zimbabwean migrants working in the province's farms, as it has also been an essential player in the supply of medical assistance to deportees coming through Beitbridge Reception Centre. Nevertheless, gaps in information remained latent and available data was not comprehensive in terms of migrants' medical needs.

The Limpopo Mobility Survey was designed to produce reliable evidence on mobility trajectories and its links with migrants' health outcomes. Through an adaption of the Life History Calendar methodology – the so-called Migration History Tool – it aimed to generate a thorough descriptive analysis of five key populations that had the Limpopo region as origin, transit and destination site. Those were Zimbabwean deportees coming through Beitbridge Reception Centre (RC); migrants and asylum seekers of several nationalities staying in Musina; Malawians using Beitbridge as a waiting area; cross-border population living in rural Beitbridge; and different groups heading to South Africa via Beitbridge crossing points. Our results have shown that, in spite of sharing the condition of migrant, the several populations coming through the region display completely different mobility trajectories; reasons to flee from their respective home areas; and health needs. Successful operations in the site must, therefore, take the uniqueness of each migrant group into account.

Although most indicators are quite concerning across all groups analysed, some aspects deserve special attention. Musina seems to display, in general, the most distressing health needs. As we have tried to point out, this is probably due to particularities of Burundians and Congolese, who go through dreadful migratory journeys and intense violence in their countries of origin, but also as a result of inadequate health care assistance and poor living conditions in the city. Our results show that Central Africans are particularly hampered from accessing medical care in the site. For all migrants, however, Musina is not merely a transit point. Rather, it is a place where displaced populations are getting trapped for lengthy periods of time, 9 months on average, without receiving sufficient support. Sexual violence, particularly among men, is at concerning levels – not coincidentally, Musina is also where we have found some of the acutest mental health needs.

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

availability of condoms – a truly alarming combination of factors. Following these findings, we recommend that post assault care packages are better advertised at the centre, coupled with stigma reduction interventions. Our results also justify the continuity of HIV testing and treatment activities, as per the extremely high prevalence rates encountered. Furthermore, we hope that Digital Health Promotion strategies can also be used to communicate migrants about mental health support services in destination sites - Johannesburg, Pretoria and Polokwane – even if these are provided by partner organizations. Linked to that, the findings from all sites analysed unfolded the propensity of Zimbabwean men, in particular, to engage in harmful consumption of alcohol, which we believe can be linked to problematic assimilation courses in South Africa. We suggest that deeper assessments on substance use are carried out in sites of medium-long term stay.

Our analysis has also tried to showcase the unmet demands for sexual and reproductive health care among Malawian men and, specially, women going through Beitbridge. Those, we believe, may be linked to human trafficking networks operating in the site. Among this population, there is an urgent need for family planning; STI diagnose and treatment; HIV education; and post-assault care. To be successful, the assistance needs to be gender-specific and take into account language and cultural particularities.

With respect to the crossing points, preliminary data did not reveal very unique trends, with exception from the high rates of sexual abuse encountered – more information on that regard will be presented in a second report. In accordance to that, our results indicate that in the villages, migration has an overall positive effect on health indicators of people left behind. Other concerns, particularly with regards to sexual and reproductive health, do not seem to be particularly linked to mobility patterns. We did not find strong evidence of violence or accidents in crossing areas.

Last but not least, we hope that the georeferenced information collected on displaced populations' future destinations may shed light on sites where future needs-assessments could be conducted. These include, but are not restricted to: Johannesburg, Polokwane, Durban and Cape Town. Our data has revealed that each of these cities is favoured by different nationalities, with Cape Town being particularly preferred by Central Africans, whereas Durban seems to be a congregation site for Malawians. Zimbabweans, on their turn, are mainly destined to Johannesburg and Polokwane, although Johannesburg seems to be a place of settlement for all groups studied. Among our respondents who were already living in South Africa, we have evidenced that xenophobic attacks were one of migrants' main concerns and that many had already gone through an episode of the kind in the country – few, however, were the ones who looked for medical care afterwards. The results, hence, justify that all projects in the region have a focus on medical and psychological treatment of migrants enduring violence in its multiple forms.

## **INTRODUCTION**

### **1.1. Background**

Beitbridge and Musina are border towns located respectively in Zimbabwe and South Africa, separated by a short distance of 20 kilometres. The border is currently one of the busiest in the Southern Africa region and is used by migrants coming from Zimbabwe, Malawi, Zambia, the Democratic Republic of Congo (DRC), Burundi and even from further away countries, such as Pakistan, Somalia and Ethiopia. Because it is the scenery of a number of different migratory flows, the region presents a rather peculiar dynamic. Whereas some people cross the border directly through the Centre of Beitbridge - many across the bridge that connects the two countries- others prefer to use rural crossing points that link them straight with South African farms.

Medecins Sans Frontieres' (MSF) activities in the region date back to the year 2000 when the organization first worked in the country. In the Zimbabwean side, MSF has, in 2016, firstly opened up a small clinic at the Reception Centre providing primary health care to the Zimbabwean deportees coming from South Africa. At the same time, and now in collaboration with the Ministry of Health and Child Care (MoHCC) in the country, HIV testing services targeting the hot spots in Beitbridge town were launched. In 2017, the organization began to support the Dulivadzimu council clinic with human resources, gap filling for the pharmacy, and laboratory support. In 2018, MSF has expanded its scope to provide a comprehensive Out Patient Department (OPD) package to the migrants received at the Reception Centre. Throughout 2018 and 2019 several assessments have been conducted along the Limpopo River in order to understand the gaps in terms of health care provision to people on the move. The main project's objective for the past years has been to create innovative and replicable models of care for migrant populations that can be piloted in Beitbridge, disseminated and lead to policy changes in Zimbabwe, the region and other MSF projects.

MSF South Africa has also played a key role in migration matters in general and in the Province of Limpopo in specific. Since 2010, the mission has developed what was called the 'Musina model of Care', a strategy targeted at agricultural workers based in distant farms. The idea was to create a mobile approach with core minimum services, including Antiretroviral Treatment (ART) and Tuberculosis (TB) treatment for those who could not access clinics. After achieving successful rates of treatment continuation, the activities have been handed over to SA authorities in 2013. More recently, after a quick need's assessment, an emergency project was established in the so-called men's shelter in Musina Town. The evaluation showed inappropriate water and sanitation facilities at the site, as well as difficulties to access health care in the public clinics and hospitals.

## **1.2. Study Rationale**

Although the Limpopo Area is a very well-known context for MSF, information on migrant needs in the region is limited. Available IOM data is neither updated nor comprehensive in terms of health demands. Our main research objective was, therefore, to determine critical health demands among different groups that had the Limpopo region as their origin, transit or destination site, and understand how such challenges are intertwined with specific mobility trajectories. In order to accomplish such goal, we chose to conduct a quantitative study, which could draw statistically representative conclusions on each of the chosen target populations in a given period of time.

Following an initial evaluation visit conducted in 2018, five main target populations have been identified: cross border Zimbabwean population living along the Limpopo River; Zimbabwean deportees sent to Beitbridge Reception Centre; Malawian migrants passing through an informal settlement in Beitbridge named ‘Magogo’s House’; and migrants and asylum seekers in Musina. In addition, Zimbabwean migrants have also been interviewed in crossing points along the Limpopo River.

For each of these target populations, different sampling methodologies and survey instruments have been designed. While the sampling strategies took into account the distribution of these groups in the catchment areas; the questionnaires were built according to their mobility patterns and specific issues. The present report is, hence, constructed in five chapters. The initial four aim to present the results found for each target population, whereas the final brings in a brief comparison among the different groups.

This was the first survey to describe the sociodemographic profile, health-seeking behaviour and migratory trajectories of migrants and refugees in the Limpopo area. There are four main justifications for the analysis. Firstly, learning about health needs and mobility trends will be essential to better design and allocate resources in the Beitbridge and Musina projects. Secondly, helping these interventions to develop well informed and solid activities can be useful to replicate successful clinical models to mobile populations in other sites. Finally, grounded data will be fundamental to support advocacy strategies in an integrated, regional level. The idea is that, by having access to retrospective information, we have been able to grasp the situation of these mobile populations not only in their origin countries, but also in transit areas, and places of destination.

## 1. METHODOLOGY

In order to understand the interrelationships between migrants' health and their living conditions before, during and after the journey, the Brazilian Medical Unit (Bramu) has designed a data collection technique specifically tailored to MSF necessities. The idea was based on the Life History Calendar methodology (LHC), which has as its main purpose to gather good-quality, detailed retrospective data.

Traditionally, migration histories in quantitative research have usually been collected through one or two simple questions, such as: 'Where did you live in 2006?' and "where did you live prior to being in your current residence?'. With only these two inquiries, however, researchers would miss out all mobility steps that happened between the chosen date threshold and the last residence, as well as what happened prior to that date. If dealing with highly mobile populations, this could represent a great loss of information. The Life History Calendar, on the other hand, aims to gather all person's information of past residences in a table format of easy visualization. The format was thought to aid respondents to remember specific events, which hence diminished memory errors and research bias.

In light of the high complexity of migration patterns in the Limpopo region, we have decided to apply the Life History Calendar methodology in the survey, this time through the use of a new data collection software, specifically tailored to this data collection technique. The software has been designed with the sponsorship of MSF's Transformational Investment Capacity (TIC). The questionnaires inserted into the program comprised several modules on health issues – such sexual and reproductive health; chronic conditions; infectious diseases; violence exposure; and mental health<sup>1</sup>. Each of these modules were linked to the person's past migratory experiences, current migratory experiences and future plans. Surveyed people were asked to report all places in which they had lived for more than three months (Global Migration), and, in some cases, all the places they passed through in the most recent international journey (Current Migration) through a table format. This allowed us to capture not only people's first and last residence, but internal mobility preceding international migration, as well as return and remigration patterns. All migration specific questions comprised a georeferenced component, which automatically pinpointed places in a map and generated specific geographic coordinates that were later analysed in the form of simple tabulations or maps.

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<sup>1</sup>For matters deemed too sensitive, like sexually transmitted infections or sexual violence, audio questions were recorded so that migrants could answer without the assistance of the interviewer, thus avoiding disclosure and social desirability biases.

The present research was evaluated and approved by MSF Ethical Review Board<sup>2</sup>, the Medical Research Council of Zimbabwe (MRCZ)<sup>3</sup> and the Human Research Ethics Committee of the University of Witwatersrand, South Africa<sup>4</sup>. All participants were given an informed consent form, previously approved by the ethical boards, which has been thoroughly explained by interviewers, highlighting the uses of the research, risks, benefits and confidentiality terms. Because the interview could trigger disturbing memories, all groups were accompanied by psychologists or mental health nurses. Interviewers were trained to identify signs that would lead to referral. Participants have also been referred to MSF nurses and doctors, in Beitbridge, and to Musina Hospital and Clinic, in Musina, when reporting medical needs. In Musina, 65 people have been referred to medical services. Survey interviewers in Zimbabwe have also participated in one collective debriefing session at the end of the activity. The same could not be replicated in Musina due to the Coronavirus epidemic and the immediate lock down.

The questionnaires have been previously translated to five languages: English, Venda, Shona, Ndebele and Swahili and the interviews were conducted in the language the respondent felt more comfortable with. Survey inclusion criteria included being 18 years or older; being an accompanied minor, between 15 and 17 years old; being fluent in one of the aforementioned languages; and not showing signs of cognitive impairment or drug abuse at the moment of the interview.

## **2.1. Population and Sampling**

As aforementioned, each target population was differently distributed in the catchment areas, which entailed different sampling strategies.

For the Cross-Border families, the research was conducted in three villages in the eastern and western sides of the border, namely Chikwarakwara, Dite and Sashe. The villages were chosen purposively, in accordance to project's priorities. In these communities, the survey was household based. Other points of interview included crossing points, namely Pounding, Lutumba and Gate 2, all areas in rural portion of Beitbridge. At the crossing points, three main different populations can be encountered: cross border population living in rural Limpopo villages; migrants from Zimbabwe inner areas; and international migrants. We only had access to Zimbabwean migrants in such points.

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<sup>2</sup>Protocol Number: 1875a

<sup>3</sup>Protocol Number: MRCZ/A/2518

<sup>4</sup>Protocol Number: H19/06/42

Because we knew we would encounter people with radically different experiences at the crossing points, we have chosen to apply different questionnaires at the site. One was focused on participants who lived in cross border villages; whereas the other was focused on Zimbabwean inner areas. Interviewers, however, encountered several difficulties to distinguish both groups. Due to these limitations, we will still perform a consistency check of the information gathered in these locations to be presented in the second report. What we were able to introduce, concerning the crossing points, are the results of the questionnaires' common modules – i.e those encompassing health information, and not the particularities of respondents' mobility patterns. These have been presented in Section 3.5.

In Dite, Chikwarakwara and Shashe, one single sample size was estimated to represent the three villages, calculated using 95% confidence level and 5% confidence intervals. Because population distribution was known, the sample followed a two-step stratification process, firstly by the total population number in each town and later by sex and age. The households in each village were previously mapped, enumerated, and then randomly selected until the sample size was reached. Table 1 presents the total number of households sampled versus the number of valid questionnaires achieved, after a consistency check:

Table 1 - Number of Sampled Households and Achieved Sample Size, by Village, Cross Border Villages, Beitbridge, 2020

Village	Number of sampled households	Achieved Sample Size
Dite	182	180
Sashe	115	117
Chikwarakwara	43	42
Total (N)	340	339

At Crossing Points, the sampling process was less rigorous, especially because the total population size or distribution was not known. Sample sizes have been calculated according to informal reports of how many people would cross on a two weeks' time, also using 95% confidence level and 5% confidence intervals.

Table 2- Calculated Sample and Achieved Sample Size, Crossing Points

Research Site	Sample Size	Achieved Sample Size
Pounden	-	22
Gate 2	-	31
Mike	-	31
Lutumba	-	93
Total (N)	120	177

At the Reception Centre, the population was known, as all migrants are required to register before using MSF/Ministry of Health (MoH) services. In order to estimate the sample size before implementation, we calculated the average number of people in a 2 weeks-time that had arrived at the Centre in the previous three months, summing up to 432 people. At this site, we chose to draw an optimum-allocated stratified random sample, using a confidence level of 95% and confidence intervals of 5%. The stratification was done according to gender only, as MSF teams do not record age groups. We believe stratification by gender was enough since, given the nature of this migratory flow, age variability is not significant. Optimum allocation was chosen because the number of women arriving at the Centre is too small and the sample size calculated through proportionate allocation would not allow us to draw inferences for this subgroup. Selection of participants followed convenience criteria.

Table 3–Calculated Sample Size and Achieved Sample Size, by Sex, Reception Centre, Beitbridge, 2020

Sex	Sample Size	Achieved Sample Size
Men	190	182
Women	42	56
Total (N)	232	238

The Magogo’s house in Beitbridge presents pretty much the same difficulties in terms of sampling as the crossing points. Because it is run by a traditional leader, no registers are kept of how many people enter daily or the proportion of men to women. Magogo herself estimated that 300 hundred arrive at the place per week. Sample sizes used this estimation and were calculated to be representative of the population that passed through the site in a two-weeks’ time. Selection of participants followed convenience criteria.

Table 4- Calculated Sample Size and Achieved Sample Size, Magogo’s House, Beitbridge, 2020

	Sample Size	Achieved Sample Size
Total (N)	169	178

In the case of international migrants in Musina, total population numbers are hardly available, since the Home Affairs office of South Africa does not release its official numbers. We worked, hence, with informal data of three catchment areas: Men’s shelter, Women’s Shelter and Lodges. People have been classified according to the place they were staying, although many have been interviewed in the surroundings of the home affairs office, due to difficulty to find them at shelters or lodges during day time. Selection of participants followed convenience criteria.

Table 5- Calculated Sample Size and Achieved Sample Size, by Site, Musina, 2020

Research Site	Calculated Sample Size	Achieved Sample Size
Total (N)	443	442

## 2. RESULTS

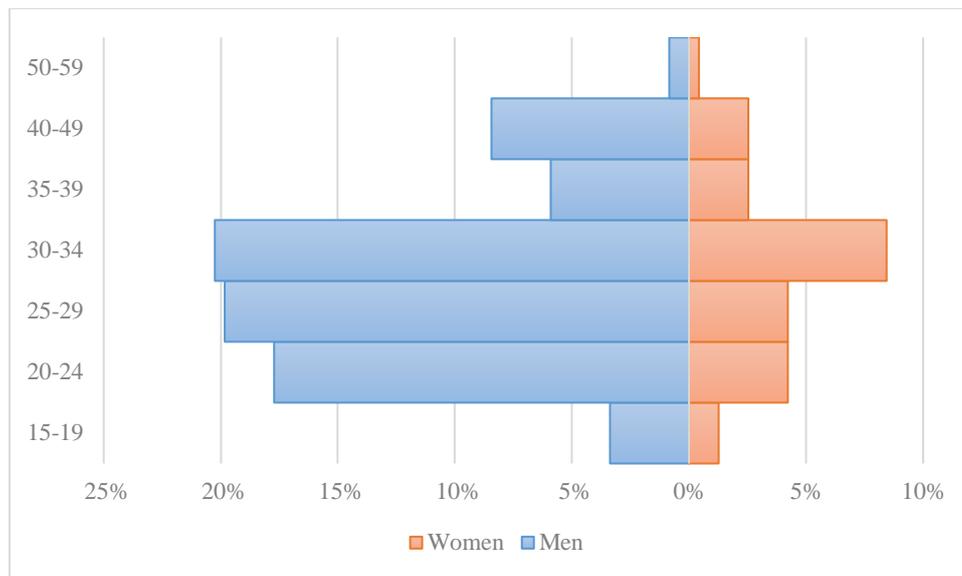
### 3.1. Reception Centre

#### 3.1.1. General Characteristics

The majority of the 238 interviews conducted at the Reception Centre were carried out with men. In fact, as described in the methodology, the share of women arriving in the site is probably even lower, but we have purposively overrepresented this group in order to be able to make statistical inferences.

Age variation is low, with 74% of the interviewees being aged between 20 and 35 years old. All respondents were Zimbabwean with only three of them having dual citizenship. Regarding education, 12% did not complete primary education, 54% had complete primary education or incomplete secondary, 31% had complete secondary or incomplete tertiary education and 3% had completed tertiary education.

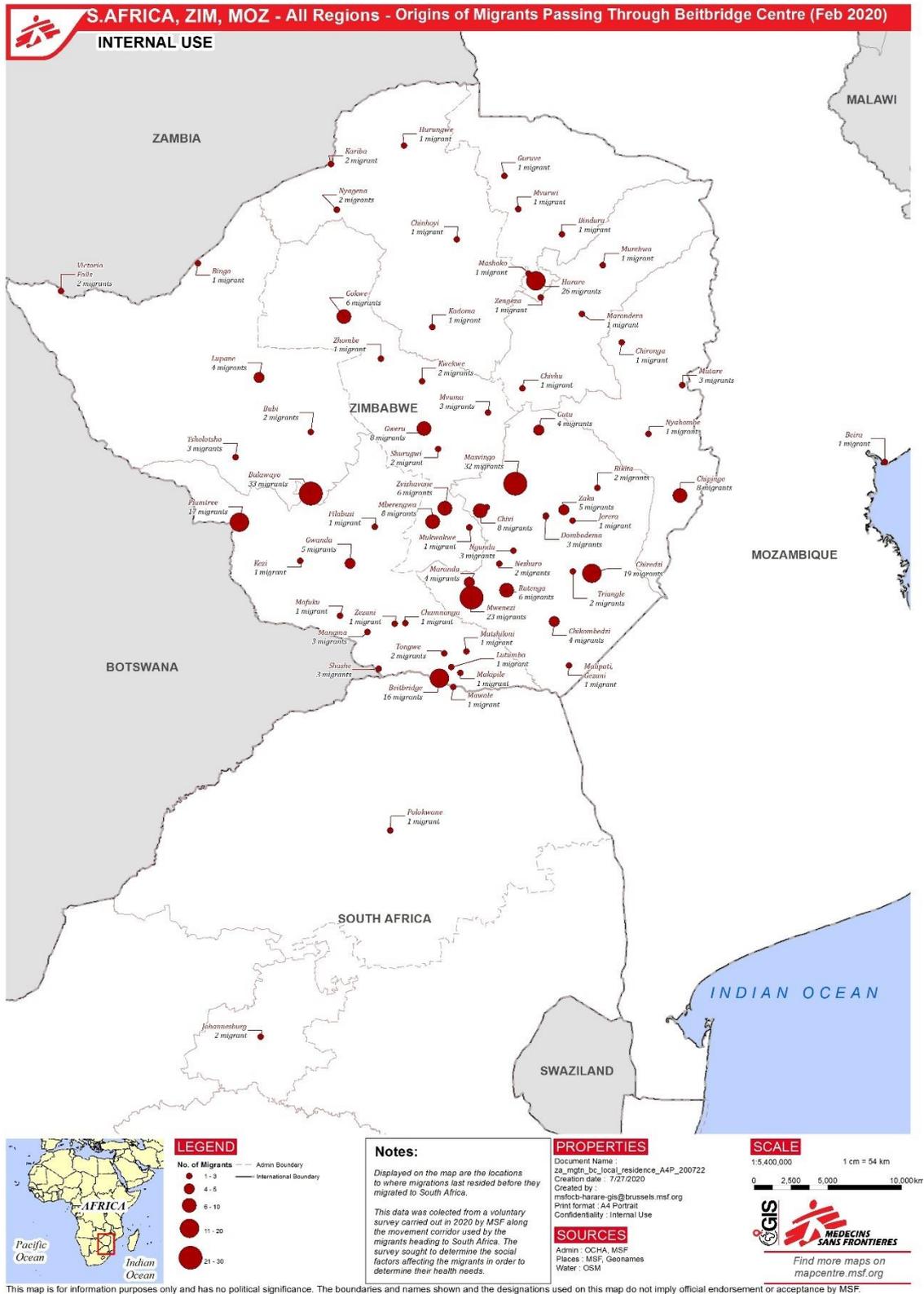
Figure 1 - Age and Sex Distribution, Reception Centre, Beitbridge, 2020



### 3.1.2. Global Migration

Interviewees reported having lived for more than three months in between one and even different cities or villages, with an average of 3.1 locations per respondent. 69% of respondents were born in rural areas, and the 31% who were born in urban settings came from cities such as Bulawayo, Chiredzi, Harare, Masvingo and Plumtree.

Figure 2 –Place of Last Residence in Country of Origin, Reception Centre, Beitbridge, 2020



In general, Zimbabwean deportees migrated to an urban setting before heading to South Africa, which suggests the existence of an internal rural-urban flow preceding the international journey, a phenomenon usually called step migration.

The main reasons listed by our respondents to leave their country of origin were “Job search” and “Wanted better living conditions” (Table 6), confirming that the main pull factors driving Zimbabwean international migration are of an economic character. The predominance of economic motivations as reasons for leaving are coherent with the main difficulties faced by respondents in their last residence in Zimbabwe, which were unemployment, financial challenges and food insecurity. In spite of the known alarming levels of political persecution and civil unrest in the country, none of our participants listed political-related factors as a driver of out-migration.

In terms of gender differences, although “Job search” seems to affect both genders similarly, the search for better living conditions was a more predominant reason to leave the country for men than for women, whereas motivations involving family, such as family gathering or starting a new family, were more common among our female respondents:

Table 6 - Reason to leave last residence in country of origin by sex, Reception Centre, Betibridge, 2020<sup>5</sup>

Sex	Men	Women	Total
Main Reason to Leave	Percentage (%)		
Eviction	0.78	0.00	0.60
Wanted better living conditions	31.78	15.79	28.14
Job search	86.82	78.95	85.03
Education opportunities	1.55	0.00	1.20
Gather with family	5.43	18.42	8.38
To start a new family	0.00	5.26	1.20
Following a family member	0.78	0.00	0.60
Other	3.88	7.89	4.79
Valid cases	168	48	217
P= 0.016**			

<sup>5</sup> The table displays the results of a multiple answer type of question – for those, respondents were able to choose more than one alternative that matched their answers. In such cases, percentages do not total 100%, as each represents the share of people who selected the alternative. The valid cases represent the number of respondents who answered to the question. Throughout this report, other tables in this format will be presented.



Indeed, orphanhood rates seem to be strongly related to the high percentage of young population living in extended or complex households, which are slightly more common in rural areas (50.5% out of the total in urban areas and 61.3% in rural settings).<sup>6</sup>

Food scarcity affects more than half of migrants at least some months a year (see table 7). Additionally, more than 57% reported to feel unsafe in Zimbabwe. Safety is, however, a subjective concept, and when participants were asked about the reasons why they felt insecure in their last residence, many reported factors that were not necessarily linked to crime or violence, like financial hardships (31.4%) or being orphans (17.6%):

Table 7 – Frequency of feeling hungry and unsafe in last residence, Reception Centre, Betibridge, 2020

Feeling Hungry or Unsafe	Frequency of feeling hungry	Frequency of feeling unsafe
Frequency	Percentage (%)	
Almost every month	6.72	1.68
Some months, but not all of them	43.70	8.82
Rarely	7.14	12.18
Never	42.44	77.31
Total (%)	100.00	100.00
Total (N)	238	238

Regarding the characteristics of the migrant’s household in their last residence, 28.6% of the interviewees fetched water from unprotected wells, rivers, streams or dams, and 24.8% had no access to a sanitation facility in the house. In fact, 61.3% of interviewees lived, back in Zimbabwe, in a residence falling under at least one degree of poverty, according to the household Poverty Index<sup>7</sup>.

The strong effect that food scarcity and financial hardships has on interviewees’ wellbeing at the origin reinforces the notion that, among deportees coming through the Reception Centre, migration seems to be mainly driven by economic motivations. Zimbabwe has been generally

<sup>6</sup> For the purposes of this report, household arrangements were divided into 5 categories: single-parent households, composed only by a head of household and their children, or a head and their parents; couples without children, in which there is only the head of household and their spouse; couples with children, in which there is a head, their spouse, and their children; single-person households; complex households, in which there are at least two kin-related people and one person not kin-related; non-family households, in which all people are non kin-related; and, finally, extended households, in which there are only kin-related persons, but at least one household member is not part of the nuclear family.

<sup>7</sup> For the purpose of this study, a Poverty Index was created to fit the information collected on the household at the last residence in the country of origin. The structure of the index and the weight given to each indicator has been done following the model set by S. Alkire (2018). 0 means that the household has no poverty dimensions; whereas 1 indicates that the household presents all 4 poverty dimensions measured. The different dimensions were access to clean water, sanitation facilities in the household, overcrowding ratio and asset ownership.

recognized as a source of mixed-migration flows, comprising both people displaced by political persecution and poverty, as well as encompassing different forms of cross border movements. (Crush et al., 2015; Chan and Primorac, 2007; Crush and Tevera, 2010). It is not entirely clear why we did not find at the RC those who had been victims of politically-motivated violence, as we did in Musina, for example. Nevertheless, our results reinforce the notion of survival migration, one marked by the lack of sufficient means of living, to characterize the out-flow from Zimbabweans to South Africa (Betts, 2010).<sup>8</sup>

#### 3.1.4. Current migration

Following questions on their living conditions at the origin, we asked participants about their most recent migratory journey from Zimbabwe to South Africa.

The means of transportation used by migrants on their way to the foreign country were mainly car (61.57%) and bus (40.17%), followed by walking (19.6%). Migration journeys are generally short and 71.63% of interviewees did not sleep in the city or place they were passing through. When they did, they slept primarily on the street or in the vehicle (12.8% and 4.5% of cases, respectively).

There are certain cities and districts busier than others in terms of migratory routes<sup>9</sup>. For instance, 48% of the migrants had gone through Beitbridge, 33.3% had been in Lutumba, 21.5% had been through Ngundu and 20.4% had been in Bubi. Some other cities and districts with high migration flows were Rutenga (19.4%), Masvingo (18.2%), Mwenezi (10.6%) and Bulawayo (8.2%).

Some areas are more likely to be chosen as ‘sleeping’ sites for migrants on their journey, as the Mwenezi district, where 44% of the respondents stayed overnight, and Beitbridge, Masvingo and Rutenga, where around a quarter of the migrants slept when passing through (Table 8).

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<sup>8</sup> According to Betts (2010), the concept of survival migration can be defined as "persons outside their country of origin because of an existential threat to which they have no access to a domestic remedy or resolution."

<sup>9</sup> A map of migratory routes will be delivered for the second report.

Table 8 – Sites of Transit, by Percentage of People who slept in the Location, Reception Centre, Beitbridge, 2020

Name of the Village/City	Slept in the Location	Did not Sleep in the Location	Total	Total (N)
Percentage (%)				
Beitbridge	25.69	74.31	100.00	144
Bubi	23.53	76.47	100.00	68
Bulawayo	11.11	88.89	100.00	27
Gwanda	16.67	83.33	100.00	48
Lutumba	23.64	76.36	100.00	110
Masvingo	25.00	75.00	100.00	60
Mwenezi	44.12	55.88	100.00	34
Ngundu	19.72	80.28	100.00	71
Rutenga	25.00	75.00	100.00	64
Valid cases	238			

Contrary to expectations, most migrants did not experience episodes of physical violence or health problems along the route (less than 3% of our interviewees). When people did go through what they called physical violence, most reported thefts. As we will discuss throughout the report, our results suggest that accidents in the crossing areas are uncommon; and neither have we found evidence of *maguma-gumas* operating along the Limpopo river.

### 3.1.5. Life in South Africa

More than 90% of the respondents had lived in South Africa for more than three months at the time of the interview, with most having spent 5.4 years on average in the country. Cities like Johannesburg, Polokwane, Pretoria and Thohoyandou were the most common last residences of deportees interviewed. Surprisingly, Musina, which was expected to be purely a transit city, turned out to be the last residence in South Africa for 4.4% of the interviewees:

Table 9 - Place of last residency in South Africa, Reception Centre, Reception Centre, Beitbridge, 2020

City	Frequency (N)	Percentage (%)
Johannesburg	71	34.47
Musina	9	4.37
Other	61	29.61
Polokwane	41	19.90
Pretoria	13	6.31
Thohoyandou	11	5.34
<b>Total</b>	<b>206</b>	<b>100.00</b>

Johannesburg is the most popular residence for migrants, with neighbourhoods such as Hillbrow and Diepsloot being common destinations within the city. The Sheshogo neighbourhood is also a common place of residence in Polokwane. No specific neighbourhoods were mentioned for Pretoria, Thohoyandou or Musina. (Figure 4)

5.5% of the interviewees reported to be unemployed in South Africa, with joblessness affecting female respondents more than male interviewees (20% of women were unemployed, against 1% of men). The unemployment rate is higher in Musina (11.1%) compared to the rest of the cities. When it comes to housing conditions, the percentage of respondents living on the street was also greater in that city: 11% of the migrants were living in the street, whereas the average for all the locations is 4.6%.

Regarding family structure, 60% of the interviewees lived in South Africa with at least one family member, although most were not what we call nuclear family, i.e. spouse and children. In fact, only 41% of the interviewees who lived with their spouse and 13.8% of the ones who lived with their children in the country of origin also shared residence with them in South Africa. The data suggest that most migrants are leaving their families behind in the country of origin – a pattern that is reinforced by results found among the cross-border population in rural Beitbridge. (Section 5.4)

When it comes to the struggles faced by migrants when living in South Africa, the interviewees listed robberies (39.3%), fear of arrest (34.7%) and xenophobia (30%) as their main concerns. Despite fear of xenophobia and discrimination being widespread across all the main cities, it is particularly high in Johannesburg, where 35% of the migrants noted it down as one of their main causes of distress. Indeed, half of the interviewees experienced some kind of discrimination in South Africa, and 37% had suffered at least one episode of physical assault in the country, with men being more subject than women to both of them:

Figure 4 - Place of last residency in South Africa, Reception Centre, Reception Centre, Beitbridge, 2020

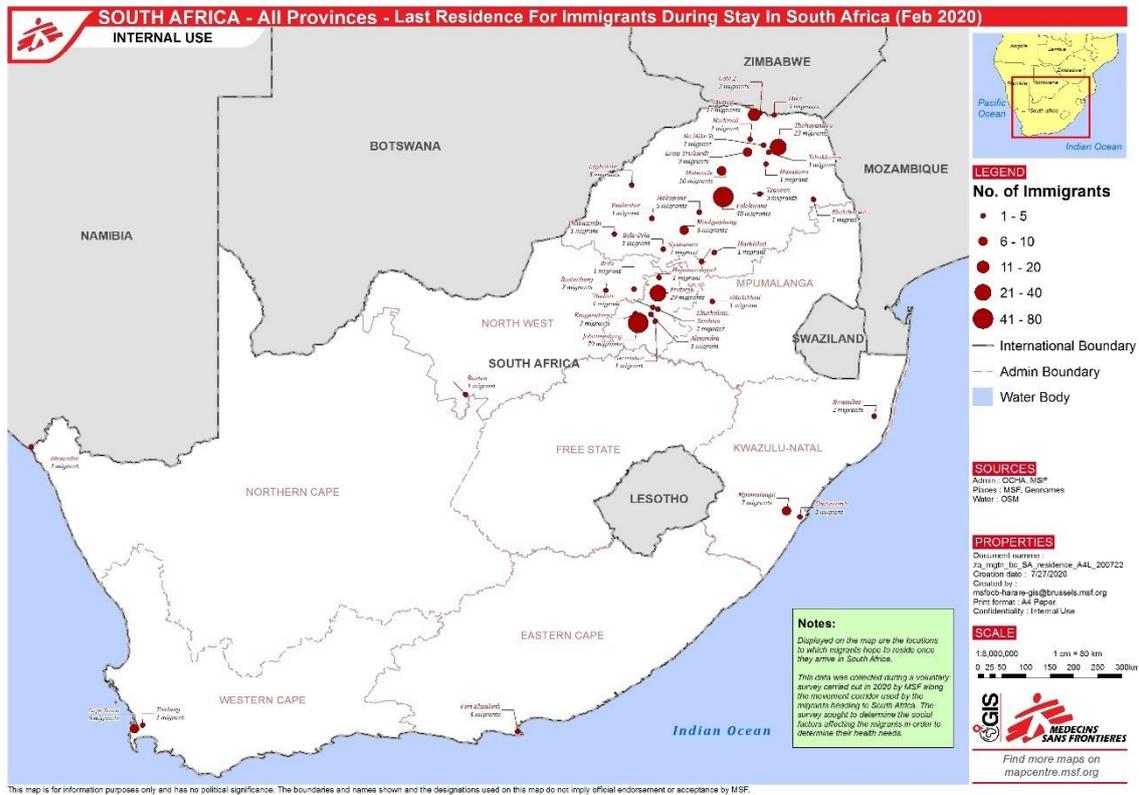
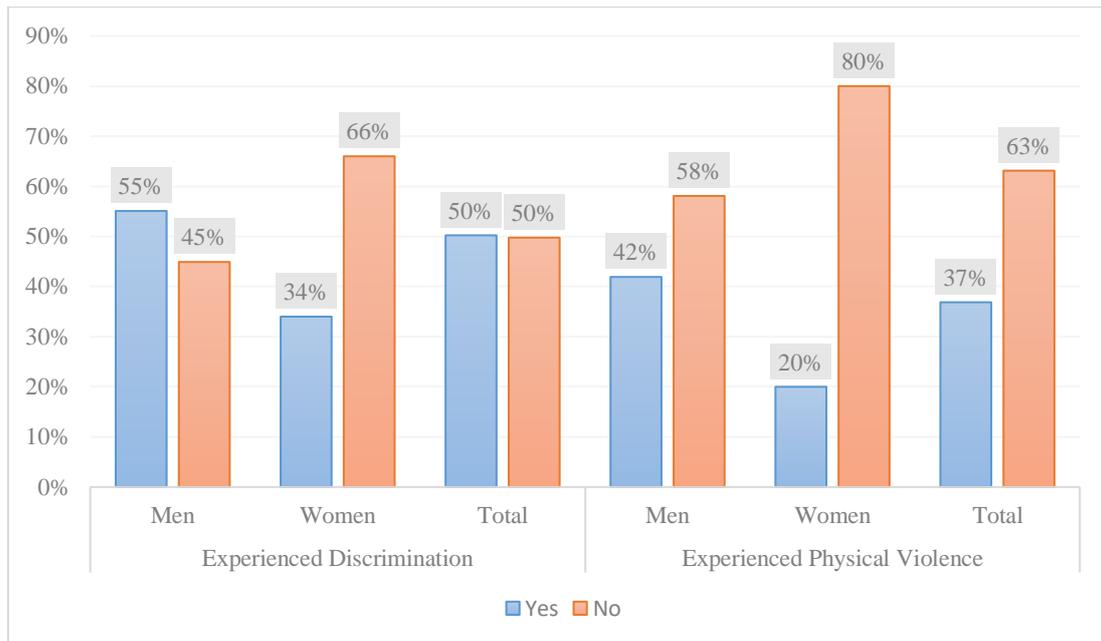


Figure 5 - Experienced Discrimination and Physical Violence in last residence in South Africa by sex, Reception Centre, Beitbridge, 2020



Johannesburg is the place where most of the interviewees felt unsafe, with more than 25% of the respondents feeling always unsafe and 31.3% feeling occasionally unsafe in the city, as showed in Table 10.

Table 10 - Frequency of feeling unsafe in South Africa by Main Cities, Reception Centre, Beitbridge, 2020

City	Johannesburg	Musina	Other	Polokwane	Pretoria	Tohoyandou	Total
Frequency	Percentage (%)						
Always	25.37	11.11	12.28	8.11	7.69	10.00	15.54
Occasionally	31.34	22.22	21.05	32.43	23.08	30.00	27.46
Rarely	13.43	44.44	28.07	32.43	30.77	40.00	25.39
Never	29.85	22.22	38.60	27.03	38.46	20.00	31.61
Total (%)	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Total (N)	67	9	57	37	13	10	193

The main reasons interviewees felt unsafe in their last residence in South Africa were fear of the police/being arrested and crime. Once again, Johannesburg stands out for the number of respondents who felt unsafe due to xenophobia (30.4%) – a result that is obviously related to recent spurs of anti-foreigners attacks in the city in 2019 and 2017.

Table 11–Reason to feel unsafe in South Africa by Main cities, Reception Centre, Beitbridge, 2020

City	Johannesburg	Musina	Other	Polokwane	Pretoria	Tohoyandou	Total
Reasons to feel Unsafe	Percentage (%)						
Crime/robberies	32.61	42.86	29.41	40.74	25.00	25.00	33.08
Exploitation at work	0.00	14.29	2.94	0.00	0.00	0.00	1.54
Fear of police/arrest	32.61	28.57	47.06	33.33	37.50	75.00	39.23
Violence-unspecified	4.35	0.00	2.94	3.70	25.00	0.00	4.62
Xenophobia	30.43	14.29	17.65	22.22	12.50	0.00	21.54
Total (%)	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Total (N)	46	7	34	27	8	8	130

Regarding the reasons to feel unsafe in the main cities in South Africa, it must be noted that the number of observations in some cities is too little to draw conclusive results.

Although, on average, interviewees had spent more than five years in South Africa and most of the migrants who needed medical care determined that it was very easy (47.1%) or fairly easy (39.3%) to receive medical assistance, almost 40% had never accessed medical treatment in the

country. In cases they had, they were sometimes charged for the service. A third of the interviewees who looked for medical care after being physically assaulted had to pay in order to be treated, and the average price for the service was US\$78. It is, indeed, curious how the objective challenges to access health care do not impact the way people perceive ‘easiness to reach assistance’. Migrants’ health seeking behaviour could be, in fact, affecting the way they perceive illnesses or the need to look for appropriate treatment, particularly following an episode physical assault.

Yet, the perception of difficulty to receive medical assistance varies across cities. For instance, people deemed to have more challenges accessing care in Pretoria and Johannesburg, where 25% and 16.6% of migrants responded, respectively, that medical assistance was either difficult or almost impossible to get.

### 3.1.6. Detention

There are three main facilities where international migrants are sent to following detention: police stations, prisons and the Lindela Repatriation Centre. For the purposes of this study, we assumed that those who had been sent to prisons were originally detained for common crimes – although further investigation would be necessary to confirm the assumption.

Most respondents were detained on the street (52%) or at the workplace (22%) with men being arrested more often at work and women, on the street. Once detained, 22% of the interviewees were asked to bribe police officers, 4.2% were not informed about the reasons of detention and less than half of them were offered legal aid, as displayed in table 12. The results indicate serious violation of migrants’ rights at the moment of arrest. Many were still subject to physical violence by police officers (21.1% of the male interviewees and 5.4% of female respondents). Yet, even more concerning is the fact that more than half of interviewees were not given the possibility to communicate with their families at any point during detention (Table 13)

Table 12 - Percentage of People who have been exposed to Human Right's Violence, by Type of Event, Reception Centre, Beitbridge, 2020

Type of Event	Police officers asked for bribe	Was physically assaulted	Was informed about the reasons of detention	Was offered legal aid
Percentage (%)				
Yes	22.03	17.37	95.76	51.27
No	77.97	82.63	4.24	48.73
Total (%)	100	100	100	100
Total (N)	236	236	236	236

Table 13 - Time after the arrest until the deportee was given the right to communicate with family, Reception Centre, Beitbridge, 2020

Time	Frequency (N)	Percentage (%)
After a few hours	54	23.48
One day after	14	6.09
2-6 days after	16	6.96
A week after	4	1.74
More than a week after	13	5.65
Never	129	56.09
Total	230	100.00

Following detention, migrants go through a number of different facilities before being deported. Our respondents had been to 2.6 facilities on average, with some passing through 6 different places. In general, migrants had spent 136 days in detention, although 25% of them had spent more than three and a half years incarcerated before being deported. Despite total time in detention being similar for men and women, male respondents seem to go through a higher number of detention facilities before being deported.

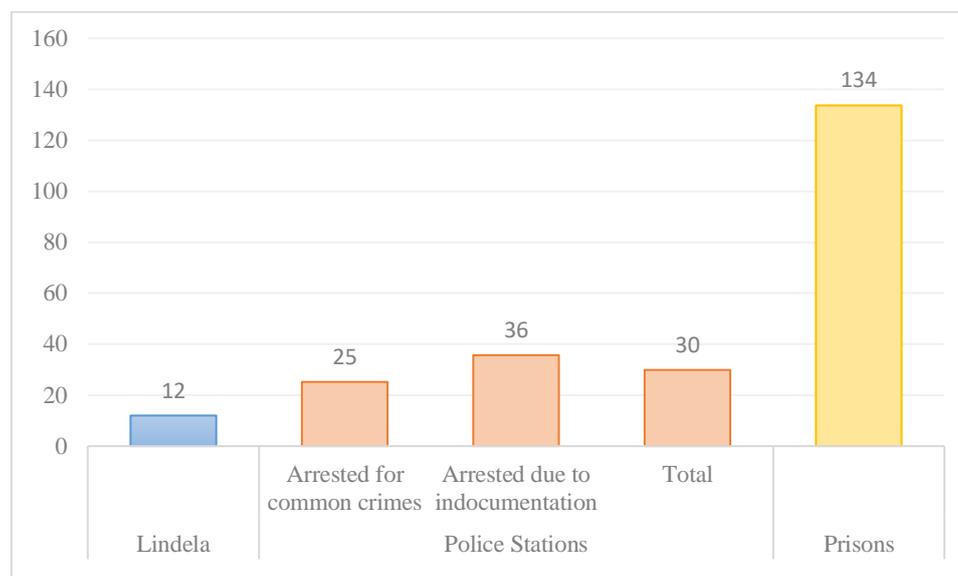
Contrary to the expectations, only 29.6% of interviewees had been to the Lindela Repatriation Centre and 64.4% of them had been at least in one prison, indicating that, for the most part, the primary cause of arrest was a common crime.

Table 14 – Type of Facilities Deportees had gone through, Reception Centre, Beitbridge, 2020

Type of Facility	Frequency (N)	Percent of cases (%)
Lindela	69	29.61
Police Station	227	97.42
Prison	150	64.38
Valid cases	233	

The average number of days spent in each detention facility changes depending on the facility type and whether the migrant went to prison or not. The mean number of days spent in the Detention Centre (Lindela) was 12 days, against 29.9 days spent in police stations and 133.7 days in prisons. The length of stay in police stations for interviewees who were detained only because of their migrant condition, i.e had not been to prison, is 35.7 days - ten days longer than the respondents who were detained for common crimes:

Figure 6 - Average number of days spent in each Type of Facility, Reception Centre, Beitbridge, 2020



Even though much is known about Lindela, little has been said about general conditions, access to health care and human rights violations in police stations. That is the reason why we have asked our participants about general living conditions in the facility where they stayed the longest, regardless of its type. Police stations are the kind of structure where 51% of our respondents had stayed lengthiest periods of time, against 44% who had been detained for longest in a prison, and 5% who spent most days in Lindela.

As it can be seen in Table 15, living conditions in police stations are poorer when compared to the ones in Lindela or in most prisons studied. In police stations, less than half of respondents had their own bed, and they were also considered the dirtiest of the three types of facilities analysed. (Table 15) Also based on this data, the places considered as having worst conditions were the Sheshego and the Lephallale Police Stations.

Table 15 - Living Conditions by Type of Facility, Reception Centre, Beitbridge, 2020

	Lindela	Police Stations	Prisons	Total	Total (N)
Type of Bed		Percentage (%)			
Had own bed	100.00	45.00	66.02	57.02	134
Shared the bed or slept in the floor	0.00	55.00	33.98	44.98	101
Total	100	100	100	100	235
Cleanliness of Beds					
Clean or indifferent	91.67	53.51	69.61	62.72	143
Dirty	8.33	46.49	30.39	37.28	85
Total	100	100	100	100	228
Cleanliness of Bathrooms					
Clean or indifferent	75	68.33	87.38	77.02	181
Dirty	25	31.67	12.62	22.98	54
Total	100	100	100	100	235

When it comes to access to health, only 26% of the interviewees had been tested for HIV and 9.4%, for Tuberculosis, most of them in Lindela or in the prisons. In police stations, the rates are much as smaller, as showed in Table 16.

Table 16 - Tested for HIV and TB by Type of Facility, Reception Centre, Beitbridge, 2020

Testing	Tested for HIV	Tested for Tuberculosis
Type of Facility	Percentage (%)	
Detention Centre	50.00	16.67
Police Station	7.50	1.67
Prison	44.66	17.48
Total (%)	25.96	9.36
Total (N)	61	22
P= 0.000***		

Just a few people had medical problems while detained, but medical attention was only available to half of them. Health care was only accessible to 1/3 of respondents staying at police stations:

Table 17 - Medical assistance available by Type of Facility, Reception Centre, Beitbridge, 2020



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

Being a migrant was seen as an impediment to accessing medical care in the three types of facilities. The reason why most people did not look for medical care, or did not find an available service, was related to their migratory status. One respondent who was in prison and had a health problem described his rationale for not seeking attention in the following way: “All illegal immigrants were not allowed access to healthcare services as they were said to be there temporarily” (Zimbabwean, male interviewee).

That is, actually, a powerful testimony requiring further examination. In fact, despite being regarded as temporary, and therefore hinged from accessing health care, our findings show that irregular migrants end up de facto staying lengthy periods of time in detention facilities before being sent back to Zimbabwe. In the meantime, ½ of them cannot access medical services when needed.

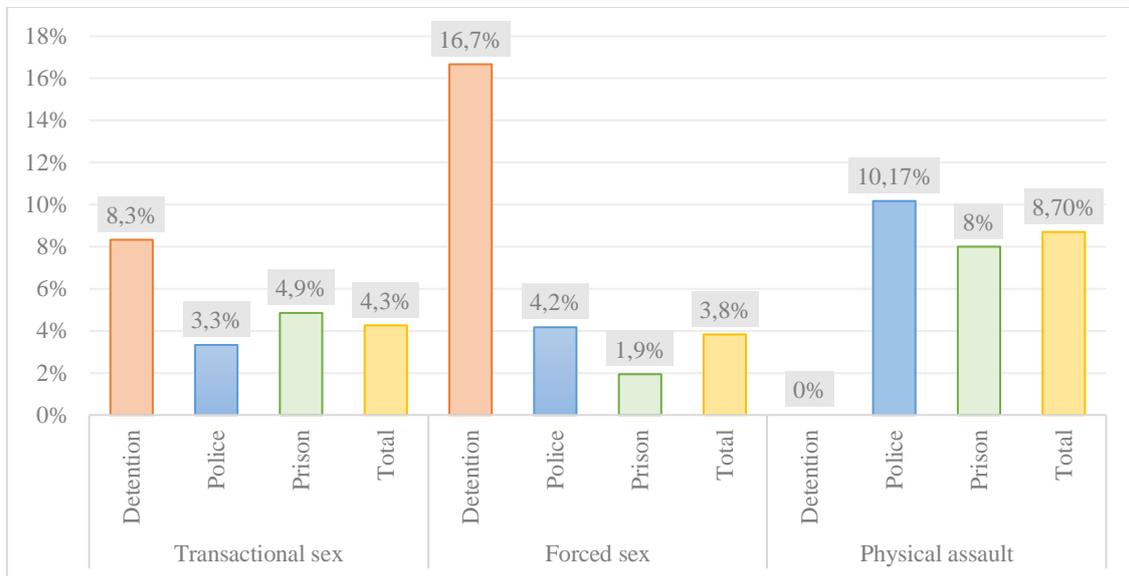
We have also asked participants if they had access to condoms while detained, and how easy was it to access them upon request or by default. Although rates are low for all facilities analysed, our results show that Lindela is the place where the protective method was least accessible. (Table 18)

Table 18 - Easiness to access condoms, by Type of Facility, Reception Centre, Reception Centre, Beitbridge, 2020

Type of Facility	Lindela	Police Stations	Prison	Total
Easiness to Access Condoms		Percentage (%)		
Yes, very easy	0.00	1.68	22.55	10.73
Yes, somewhat easy	0.00	3.36	12.75	7.30
No, a bit difficult	0.00	8.40	7.84	7.73
Not at all	50.00	28.57	17.65	24.89
Does not know	50.00	57.98	39.22	49.36
<b>Total</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>
<b>Total (N)</b>	<b>12</b>	<b>119</b>	<b>102</b>	<b>233</b>

The lack of access to condoms in Lindela is concerning, especially given the high rates of transactional and forced sex found in the facility. At the Repatriation Centre, 8.3% of interviewees reported they have had sex in exchange for money or other goods, and 16.7% admitted to have had sexual relationships against their will:

Figure 7 - Sexual and Physical Violence by Type of Facility, Reception Centre, Beitbridge, 2020



Whereas sexual violence is particularly high in Lindela, general physical violence was also common in police stations and prisons, where roughly 1/10 of our respondents had been victimized. Being forced to bribe the police officers was also common place, as showed in Table 19.

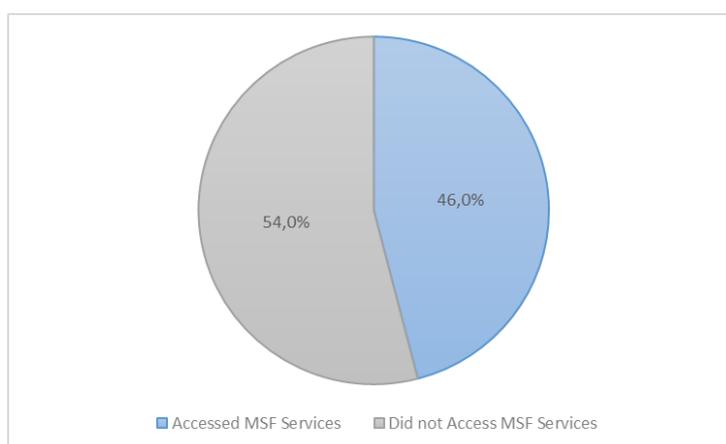
Table 19 - Percentage of Respondents who were forced to Bribe Police Officers, by Type of Facility, Reception Centre, Beitbridge, 2020

Type of Facility	Lindela	Police Stations	Prisons	Total
Has been Forced to Bribe		Percentage (%)		
Yes	16.67	12.93	20.20	16.30
No	83.33	87.07	79.80	83.70
Total	100.00	100.00	100.00	100.00
Total (N)	12	116	99	227
P= 0.355 (NS)				

### 3.1.7. Access to Health at the Reception Centre

Almost 46% of the deportees interviewed accessed MSF services provided at the Reception Centre:

Figure 8 - Percentage of Respondents who Accessed MSF services in Reception Centre, Beitbridge, 2020



However, this proportion might have been affected by the presence of the research team in the facility, as respondents were interviewed right after arriving to the Centre. 16% of our interviewees reported that the reason to not access the services was lack of time. Most, however, alleged that they did not need anything.

The main services accessed by deportees were general consultations; followed by HIV related services (testing and refill). Only few respondents sought mental health support or family planning:

Table 20 - Type of MSF Service Accessed at the Reception Centre, Beitbridge, 2020

Type of Service	Frequency (N)	Percentage of cases (%)
General Consultation	43	40.19
Family planning	8	7.48
Mental Health Support	12	11.21
HIV testing	34	31.78
ART refill	9	8.41
Other	19	17.76
Valid cases	107	

When we inquired participants what other services MSF should offer, only 14% asked for food.<sup>10</sup> 35% of them stated that MSF services were enough, and a few requested hygiene products such as soaps and sanitary pads. Lastly, two respondents requested more family planning options, and one called for a rehabilitation program for drug addicts.

### 3.1.8. Future Plans

Coupled with previous collected information on migrants' last residences, we have also gathered data on where respondents wished to settle next (next destination), as well as the place where they planned to stay for good (final destination). Although future migratory plans reveal only people's intentions, this outline may help us to understand mobility trends and pinpoint cities in which further assessments could be conducted.

Among the deportees interviewed, 40.8% planned on going directly to South Africa after leaving the Reception Centre:

Table 21 - Intended Next Destination Country, Reception Centre, Beitbridge, 2020

Country	Frequency (N)	Percentage (%)
South Africa	95	40.77
Zimbabwe	138	59.23
Total	233	100.00

<sup>10</sup> Because our respondents were provided with snacks and drinks during the interview it is possible that this could have biased their answers to this question.

When asked what their last intended destination was, or the site where they wished to settle, almost 75% of the respondents reported a city in South Africa, against 25% who were willing to establish residence in Zimbabwe.

The main reasons why respondents chose Zimbabwe as their intended final destination were ‘gathering with family members’ (64%) and ‘being free from deportation worries’ (27.6%). This result is, indeed, compatible with our previous findings, suggesting that most people have actually left nuclear family (i.e spouse and children) back in Zimbabwe. Although deportation may split families who were already reunited in South Africa, this does not seem to be the most common case. In fact, respondents chose South Africa as their intended final destination mainly by virtue of work opportunities (59%) and the desire for better living conditions (41%).

The most popular cities for final settlement were Johannesburg, Polokwane and Pretoria – similar to most migrants’ last residence in South Africa

Table 22 - Intended final destination by main cities Reception Centre, Beitbridge, 2020

City of Intended Final Destination	Frequency (N)	Percentage (%)
Johannesburg	61	26.41
Other	123	53.25
Polokwane	33	14.29
Pretoria	14	6.06
Total	231	100.00

### 3.1.9. Chronic and Infectious diseases

The Chronic and Infectious diseases modules of the questionnaires started with the question “*How do you rate your overall health?*” It is a question of subjective nature that aims to determine the interviewee’s self-perception of their health. Besides of being widely used in cross-country comparisons (OECD, 2017), it can be correlated with objective morbidity indicators, as well as measures of psychological well-being.

Table 23 - Overall Health Rating, Reception Centre, Beitbridge, 2020

Rating	Frequency (N)	Percentage (%)
Very good	57	23.95
Good	116	48.74
Regular	54	22.69
Bad	10	4.20
Very bad	1	0.42
<b>Total</b>	<b>238</b>	<b>100.00</b>

Table 24 shows the prevalence self-reported chronic diseases among respondents. The number of interviewees who acknowledged having heart disease, diabetes, a chronic respiratory disease and high cholesterol is extremely low. This could be by reason of a real low prevalence of such conditions among this population, or, as a result of underdiagnose:

Table 24 - Reported Prevalence of Chronic Conditions, Reception Centre, Beitbridge, 2020

Answer	Yes	No	Does not Know	Total	Total (N)
Chronic Conditions	Percentage (%)				
High Blood Pressure	4.20	92.02	3.78	100.00	238
Heart Disease	0.84	97.90	1.26	100.00	238
Diabetes	0.42	97.06	2.52	100.00	238
Chronic Respiratory Disease	1.68	95.80	2.52	100.00	238
High Cholesterol	0.42	96.64	2.94	100.00	238

High blood pressure (HBP) is the only disease that had a significant number of reported cases. Alarmingly, 40% of the interviewees who claimed suffering from hypertension were not under treatment.

Besides of chronic conditions, we have also asked our respondents if they had ever had a diagnosis of a few relevant infectious diseases, such as malaria, measles, tuberculosis, hepatitis and cholera. The percentage of respondents who have had any of such diseases in the last year was also extremely low. Again, one hypothesis for this outcome is insufficient testing and diagnosis.

Lastly, participants were asked whether they had had any unspecified sign or symptom in the two months prior to the interview (the list of symptoms was read to respondents). 25% of participants presented at least one of the listed symptoms recently, most commonly fever, persistent cough, diarrhoea and skin rashes:

Table 25 – Unspecific Signs and Symptoms reported for the last two months, Reception Centre, Beitbridge, 2020

Signs and Symptoms	Frequency (N)	Percentage of cases (%)
Fever	29	12.18
Persistent cough [5 days or more]	23	9.66
Difficult breathing	8	3.36
Diarrhea	20	8.40
Blood in the stools	1	0.42
Vomiting [more than once in 12hrs]	2	0.84
Skin rash/irritation	17	7.14
Inability to eat or drink	8	3.36
None	178	74.79
Valid cases:	238	

Less than half of deportees who presented any of the listed signs and symptoms looked for medical care, which can be related to difficulties in accessing treatment during detention. In fact, although the signs and symptoms are unspecific and not clinically validated, the fact that nearly 10% of respondents reported to have had persistent cough and fever in the last two months has called our attention. In a context of incarceration, in which people have stayed detained for three months on average, and where HIV prevalence is high, the findings justify the adoption of extensive TB testing upon arrival to the centre, followed by compatible health promotion strategies.

### 3.1.10. Sexual and reproductive health

#### *3.1.10.1 Sexually transmitted infections (STIs)*

At the Reception Centre, HIV awareness is considerably high compared to other research sites, with 96.6% of the interviewees having heard about the disease before. When asked how HIV was transmitted, most people mentioned unprotected sex, sexual intercourse with an infected person (with no mention to condom use) and sharing razor blades or sharp objects. Other respondents answered mother to child transmission (2.2%), contact with sores or blood (1.7%) and blood transfusions (1.3%)

Table 26 - Main Reported Modes of HIV Transmission, Reception Centre, Beitbridge, 2020

Reported Mode of HIV Transmission	Total of cases (%)
Sex with an infected person	29.73
Unprotected sex	41.55
Sharing razor blades/sharp objects	13.85
Valid Cases	238

Knowledge on HIV transmission is relatively adequate, as only 16.3% of the interviewees did not quote unprotected sex or sexual intercourse with an infected person as its main modes of transmission. Gender is related to HIV knowledge, with men seemingly more well-informed than women. Education has also proved to be positively correlated with good comprehension of HIV.

As expected, gender has an effect on general HIV testing. Women are tested on a higher proportion than men (94.6% of women had been tested, against 78% of men), which is probably related to Antenatal Care.

Yet, there is no difference between men and women on the use of the HIV testing services offered at the Reception Centre, where 26.4% of the respondents were tested. Once more, however, the proportion of people who used the service might have been affected by the presence of the MSF research team in the facility, as 23.2% of respondents reported lack of time as an explanation for not getting tested. Interestingly, 38.4% did not test because they did not think of it and 7.2%, because they were not aware of the service.

In line with the general trend in Zimbabwe, women are disproportionately affected by HIV (UNAIDS, 2020). Nevertheless, the prevalence rate we have found among female respondents is even higher than the one reported for the general adult population in the country (12.8%), as showed in Table 27.

Table 27 - HIV status by Sex, Reception Centre, Reception Centre, Beitbridge, 2020

Sex	Men	Women	Total
HIV Status	Percentage (%)		
Positive	5.11	22.64	9.17
Negative	94.89	77.36	90.83
Total (N)	176	53	229
Total (%)	100.00	100.00	100.00
P = 0.000***			

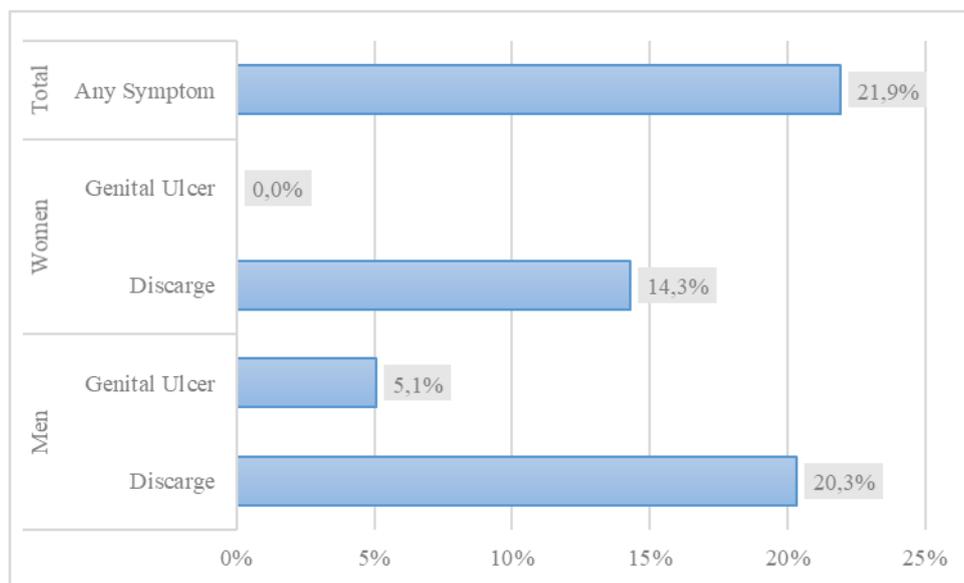
Interviewees with positive HIV test results are older, have a better knowledge of HIV transmission (100% answered unprotected sex as main way of transmission) and perceive their health as being worse compared to the people who reported negative results. The perceived health status and mental health indicators among people who were HIV positive will be further discussed in Section 3.1.12.

Although 95% of the HIV positive respondents stated that they took antiretroviral medication regularly during detention, only half of them had taken it on the day of the interview or the day before. On average, people had taken ART 13 days prior to the date of the interview, with that number ranging from 0 to 119 days. The data indicate that there might be a misconception on what it means to take antiretroviral medication on a regular basis.

Further analysis on the presence of other symptoms related to STIs was carried out among sexually active interviewees. For the purposes of this study, we considered as sexually active a person who had had sexual relationships since the beginning of 2019. These represented 43.6% of our respondents.

Interestingly, 35% of participants who were detained before 2019 reported being sexually active, which would imply that they engaged in sexual relationships during detention. Although this could represent a misunderstanding of the question time frame, the result is consistent with the high presence of STIs' signs among interviewees and the reported difficulties to access condoms during detention. Signs of sexually transmitted infections is high among all sexually active people, with nearly 22% of the deportees presenting discharge or genital ulcer, as portrayed in Figure 9.

Figure 9 - Signs of Discharge and Genital Ulcer, by Sex, Reception Centre, Beitbridge, 2020



The high percent of STIs signs among deportees is also consistent with the overall low use of condoms. Only 28.4% of the respondents had used condom in all sexual relationships since the beginning of the year, with men alleging to use condoms more often than women (33.3% of men and only 10.5% of the women). Finally, it is noteworthy that we have found no difference in condom use between HIV positive respondents others.

### 3.1.10.2. Family Planning

Although consistent condom use among sexually active people is relatively low, 75.9% of respondents (or their partners) who did not plan to have children used some kind of contraceptive, with that rate increasing among married participants.

Table 28 - Use of Contraceptive Methods, by Sex, Reception Centre, Beitbridge, 2020

Marital Status	Married	Single	Total
Use of Contraceptive Methods	Percentage (%)		
Yes	85.09	60.56	75.88
No	14.91	39.44	24.12
Total (N)	114	71	185
Total (%)	100.00	100.00	100.00
P=0.002***			

The most popular contraceptive method is the pill, which is used by 40.3% of respondents (or by their partners), followed by condoms and injectable. As it is showed in Table 29, the use of pills is particularly high among married interviewees. On the other hand, the adoption of mid to long term family planning methods is alarmingly low for single women who do not wish to get pregnant, suggesting a significant unmet need for contraception within this population.

Table 29 - Type of Contraceptive Method used, by marital status, Reception Centre, Beitbridge, 2020

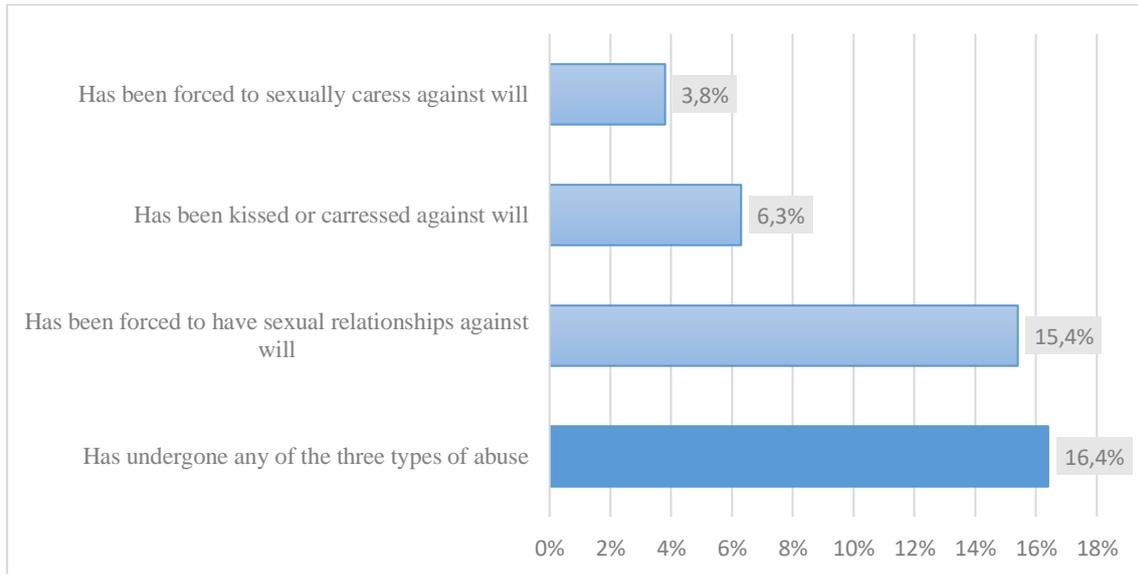
Marital Status	Married	Single	Total
Type of Contraceptive	Percentage (%)		
Condom	14.43	58.54	28.19
Injectable	26.80	9.76	22.15
Implants	6.19	7.32	6.71
Pill	50.52	17.07	40.27
Emergency Contraception	2.06	0.00	1.34
Lactation	4.12	0.00	2.68
Other	0.00	7.32	2.68
Valid Cases	101	41	142

### 3.1.10. Sexual Violence

As extensive research has shown, migrants and refugees in South Africa often feel the burden of sexual violence many times in their lives: in origin countries, transit areas, and in destination (Mhlongo et al., 2018; Giorgio et al., 2016). The repeated trauma may have innumerable consequences to their health and mental wellbeing that cannot be undermined. Further difficulties include the challenge to access health care, and especially psychological support, in the country of destination. As we will further discuss, migrants from various origins frequently report fear of deportation and discrimination from health professionals, which may obviously have even more detrimental consequences to events so filled with stigma, such as those involving sexual abuse.

Because questions on sexual violence may suffer from high non response bias, we have chosen to adopt the ballot-box technique, meaning that respondents heard the questions on the tablet and answered them on their own. Since the questions were audio-based and, taking into consideration the high illiteracy rates among this population, we have chosen to limit inquiries to 'yes' or 'no' alternatives, without specific delimitation of where events of abuse happened. We have limited the question time-frame to experiences taking place since February 2019, although, as revealed in Section 3.1.6, we had already asked about abuse happening in detention facilities. Figure 10 reveals the results of the general inquiries on sexual violence:

Figure 10 - Episodes of Sexual Violence in the Last Year, by Type of Abuse, Reception Centre, Beitbridge, 2020



In the last 12 months, 16.4% of de portees experienced some kind of sexual abuse, and the number of people who were forced to have sexual relationships against their will is particularly high (15.4% of all respondents). Interestingly, none of the three types of sexual abuse is related to gender, revealing that both men and women are equally vulnerable. The findings, coupled with the ones portrayed in Figure 9, reveal the importance of offering extensive post-assault treatment to men and women arriving to the Reception Centre.

### 3.1.11. Alcohol abuse and mental health

Whereas various works have outlined the higher risk of displaced populations that develop psychiatric disorders, with emphasis on depression, anxiety disorders, and post-traumatic stress disorder, evidence with regards to substance use remains scarce, especially among migrants and refugees in the Global South (Johnson, 2009; Lindert et al. 2008; Horyniak et al., 2016).

During interviews, de portees were asked about their alcohol consumption habits, like the quantity and frequency of alcohol consumption, based on the Alcohol Use Disorders Identification Test (AUDIT), a score developed to determine harmful consumption of alcohol (Babor et.al, 2001) <sup>11</sup>.

<sup>11</sup> There are different versions of the AUDIT test, depending on the number of questions asked to the interviewees. For instance, the original AUDIT is a ten-question test and the AUDIT-C is a shorter three- questions version designed to perform a briefer screening test, and in both tests each question scores from 0 to 4 points (depending on the answer). Therefore, the original test has a maximum score of 40 points, and the original scale is 0-7 points for Low risk, 8-15 for Medium risk, 16-19 for High risk and 20-40 for Addiction likely. The AUDIT applied to the study was designed to fit better the migrant's characteristics and the context of the interview, and it resulted into a halfway version of the

The results of the alcoholism index are quite concerning among Zimbabwean deportees, especially men. Percentages of interviewees falling under the high risk and addiction likely categories were extremely high. 4.4% of the male respondents were at high risk or having harmful alcohol consumption habits, and 8.2% were likely to have an alcohol addiction. On the contrary, very few women presented a high addiction risk (1.8%) and none were likely to have an alcohol addiction:

Table 30 - Harmful Consumption of Alcohol Indicator, by Sex, Reception Centre, Beitbridge, 2020

Sex	Men	Women	Total
Indicator	Percentage (%)		
Low risk	67.58	91.07	73.11
Medium risk	19.78	7.14	16.81
High risk	4.40	1.79	3.78
Addiction likely	8.24	0.00	6.30
Total (N)	182	56	238
Total	100.00	100.00	100.00
P = 0.000***			

Throughout this report, we will be comparing alcohol consumption habits among the different studied groups, taking into account gender, nationality and migratory status. The comparison has been useful because it has shown that high alcohol consumption is more typical among male Zimbabwean migrants than for any other group. Although alcohol consumption is not related to time spent in South Africa or in detention, work status or discrimination suffered, one hypothesis to that result is that Zimbabwean migrants increase their alcohol consumption habits after migrating to South Africa, as part of an assimilation strategy. South Africa shows much higher rates of alcohol consumption than Zimbabwe (WHO, 2016) and the assimilation hypothesis could be further reinforced by trends we found among cross border population (Section 3.1.4).

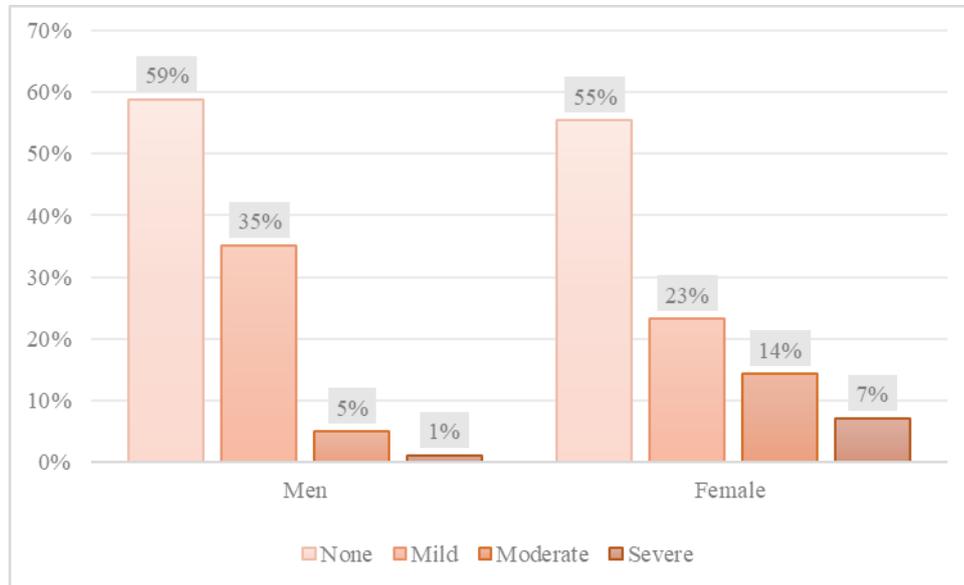
Whereas alcohol consumption results have been more concerning among male deportees, more worrying depression and anxiety indicators were found among female interviewees. To assess mental health conditions, the anxiety index GAD-7 (Spitzer et al., 2006) and the depression index PHQ-9 (Kroenke et al., 2009) were used. The indexes have different categories according to the severity of the symptoms: the anxiety index has four indicators (None, Mild, Moderate and

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original test and the AUDIT-C. Seven questions were asked to the interviewees on quantity, frequency and problems related to alcohol consumption, and the thresholds that separate the risk categories were adapted to fit the new scale, which resulted into the following: 0-4 points for Low risk, 5-9 for Medium risk, 10-11 for High risk and 12-28 for Addiction likely.

Severe), and the depression index has five (None, Mild, Moderate, Moderately Severe and Severe)<sup>12</sup>.

Figure 11 - General Anxiety Disorder Indicator, by Sex, Reception Centre, Beitbridge, 2020

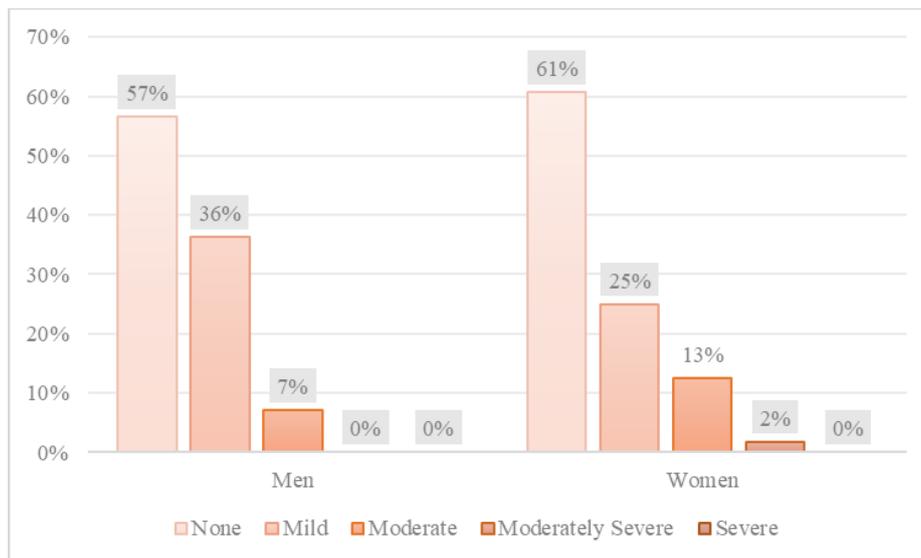


As showed in in Figure 11, 21% of the female deportees displayed moderate or severe symptoms of anxiety disorder, versus 6% of the male interviewees. Regarding depression, symptoms are also more severe in women, among whom 15% of had moderate to moderately severe scores (Figure 12). The results could be correlated to higher HIV prevalence among women and to factors such as family separation following detention.

Among the questions that composed the depression and anxiety scores, we asked interviewees if they had self-hurting or suicidal thoughts during the past two weeks. The results of this question were particularly concerning, as around 13% of the deportees had thought of hurting themselves or committing suicide recently. Among women, findings are even more disturbing: 7.1% of them had had self-hurting thoughts more than half of the days during the past two weeks, versus 1.6% of men.

<sup>12</sup> The indicators for the PHQ-9 depression index have been adapted to fit the new scale, since the original version has eight questions and the one used for the present study has seven. The original score for the indicators is 0-4 points for None, 5-9 for Mild, 10-14 for moderate, 15-19 for Moderately severe and 20-27 for severe, and the scale currently used scores only 20-24 for severe.

Figure 12 - Depression Severity Indicator, by Sex, Reception Centre, Beitbridge, 2020



Symptoms of mental health conditions are related to health perception (the more severe the symptoms for depression and anxiety are, the worse the perceived health rating is), and according to our expectations, HIV results are correlated with depression and anxiety indicators.: 14.3% of people living with HIV showed moderate or moderately severe symptoms for depression, and 33.3% displayed moderate or severe symptoms for anxiety, against 7.7% (for both indexes) of HIV negative migrants. Surprisingly, anxiety and depression indexes were not related to time spent in South Africa nor in detention.

When asked to describe what concerned them the most and the mechanisms to cope with stress, respondents could answer freely. Coping mechanisms were then classified according to the brief COPE inventory, a method that classifies the techniques for dealing with stress into 14 different categories, depending on the properties of the coping strategies and their emotional or problem-oriented focus (Carver, 1997).

In order to cope with stress, around 36% of all Zimbabwean deportees distract themselves (like sleeping, listening to music or socializing), around 19% adopt a disengaging behaviour (they do not do anything, do not think about it or they “let go”) and 13% recur to emotional or instrumental support (talk about their problems with somebody or ask for advice).

However, results are extremely different by sex. On one hand, 19.6% of the women rely on religion (they pray, go to church or read the bible), and 8.9% vent to release their emotions (by crying or screaming). On the other hand, 20% of the men lean on substance abuse (by drinking alcohol, smoking cigarettes or doing drugs), which coincides with the previous findings on

Zimbabwean male deportees having a higher tendency to develop harmful use of substances. (Table 31)

The findings suggest acute mental health needs both among women, who are especially prone to present high depression and anxiety symptomatology; and among men, who tend to engage in unhealthy coping strategies such as substance abuse. Although these needs cannot be successfully targeted at the Reception Centre, they must be taken into account in present and future migration projects based in South Africa.

Table 31 -Type of Coping Mechanisms, by Sex, Reception Centre, Beitbridge, 2020

Sex	Men	Women	Total
Type of Coping Mechanism	Percentage (%)		
Active coping	0.56	1.79	0.85
Religion	12.78	19.64	14.41
Using emotional/instrumental support	13.89	12.50	13.56
Self-distraction	36.67	35.71	36.44
Venting	1.11	8.93	2.97
Substance use	20.00	5.36	16.53
Behavioral disengagement	20.00	17.86	19.49
Unclassified	1.11	1.79	1.27
Valid cases	236		
P = 0.096***			

### 3.1.12. Main Recommendations

- Migrants' main destinations areas, such as Johannesburg (particularly Hillbrow and Diepsloot) and Polokwane (Seshego) could be used as sites for future needs-assessments;
- MSF projects based in destination cities should adopt a comprehensive package of care adaptable to different forms of violence. That is justifiable given the alarming rates of exposure to xenophobic attacks, particularly in the area of Johannesburg;
- Link up with initiatives such as the Xenowatch, organized by the African Centre for Migration and Society (ACMS) for the monitoring of xenophobic attacks;
- Advocate for condom availability in Lindela Repatriation Centre;
- Advocate for the provision of health assistance to undocumented migrants who are staying in prisons, who should not be denied care based on their nationality;
- Conduct deeper investigation on living conditions, length of stay, and barriers to health care among migrants staying lengthy periods of time in police stations;

- Given the extremely high rates of sexual abuse in Lindela, design a health promotion strategy targeted at the identification of survivors who could receive immediate post-assault care at the RC;
- Create health promotion campaigns focused on increasing awareness of STIs signs and symptoms among deportees and the importance of looking for early medical attention in those cases;
- Increase the awareness about the services being offered at Reception Centre, with particular emphasis to mental health support and family planning, but also HIV testing and treatment; possibly advertising the services in more languages, such as Ndebele and Venda;
- It should be noted that only a few migrants requested for food at the RC and that the data did not suggest high food insecurity within detention facilities;
- Provide more options of mid and long-term family planning methods, informing especially unmarried women about its benefits;
- Increase rapid screening of Diabetes and Tuberculosis at the Centre;
- Conduct an assessment on alcohol abuse and addiction among Zimbabwean men in a site of medium-long term stay, such as in Tshwane or in the future Musina project. MSF could either provide punctual support, or link up migrants to a specialized organization. This type of service could be advertised at the Reception Centre and/or through digital health promotion activities;
- Advertise mental health support services available to migrants in main destination cities, linking up with other organizations if necessary.

## **3.2. Musina**

### 3.2.1. General Characteristics

In Musina, as in the other sites analysed, the population is not evenly distributed in terms of sex and age, with most being concentrated in the 20-24 and 25-29 age groups. Men represented 80% of our sample size.

Besides of these two main demographic variables, most of our analysis will also be based on the encountered nationality groups, i.e Zimbabweans (31.5% of the sample), Burundians (17.6%) and Congolese (50.9%).<sup>13</sup> As it will be later discussed, nationality seems to have an important effect on health seeking behaviour, exposure to violence and most health indicators. It is important to

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<sup>13</sup> An important limitation of the study is that, due to language and cultural barriers, we have not been able to reach Somalis, Eritreans and Ethiopians – important subgroups that have Musina as transit point. Further research or assessments should try to target these populations, preferably through the use of cultural mediators.

note, though, that sex and nationality may have confounding effects, mainly because sex distribution is extremely different among the three groups analysed (See Table 32). This is the reason why we have usually correlated separately indicators against these two variables. Furthermore, in order to be able to run bivariate tests, we have often divided the groups between Zimbabweans and non-Zimbabweans (Central Africans). As it will be discussed, Zimbabweans often present much distinct indicators than the other groups, which may be attributed to language, cultural specificities, as well as particularities of their mobility trajectories.

Figure 13 - Age and Sex Distribution, Musina, 2020

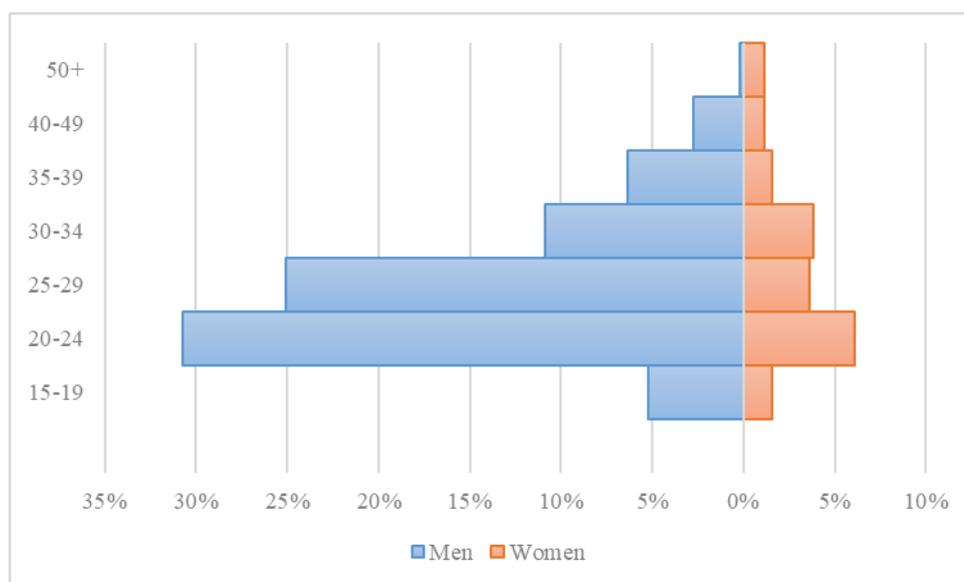


Table 32 - Sex Distribution, by Nationality, Musina, 2020

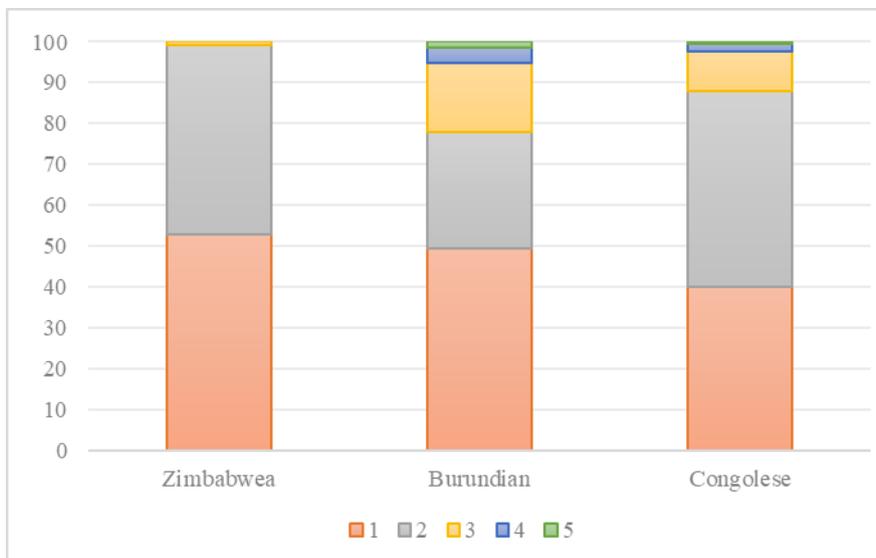
Nationality	Zimbabwean	Burundian	Congolese	Total
Sex	(%)			
Men	68.12	98.7	82.51	80.82
Women	31.88	1.3	17.49	19.18
Total (%)	100.00	100.00	100.00	100.00
Total (N)	138	77	223	438

### 3.2.2. Global Migration

Migrants in Musina are probably the most mobile of all populations studied, with most having lived in 3 cities or villages until the moment of the interview. It is important to note that we have considered a residence as any place the person has lived for three months or longer interruptedly. In this sense, while many of our interviewees reported South Africa as their last/current residence (44.93%), an important bulk (55.07%) are recently arrived in the country.

Among all nationalities, Burundians were the ones going through most countries, with 22.08% having lived in three different countries or more. Overall, 14.52% of the migrants interviewed fixed residence in a third country, between their place of origin and South Africa, living in the last transit country for 3.8 years on average. Transit countries, as expected, vary by origin (Table 33), with Burundians reporting most frequently Malawi as one of their transit areas. Zimbabweans have hardly ever been to any country other than Zimbabwe and South Africa. Surprisingly, only a small percentage of our interviewees from the Great Lakes region have lived for more than 3 months in Zimbabwean camps, such as Tongogora.

Figure 14 - Number of Countries the Person has lived by the time of the interview, by Nationality, Musina, 2020



Most of our interviewees were born in urban areas (72.51%), mostly in Gweru, Harare and Masvingo, in Zimbabwe; Bujumbura and Rumonge in Burundi; Bukavu, Kinshasa, Lubumbashi and Uvira in DRC. For half of respondents, the last residence in the country of origin is the same as the place of birth, with no particular trend of rural to urban mobility preceding international migration. Furthermore, and contrary to expectations, Burundians and Congolese move less internally than Zimbabweans, as showed in Table 34

Table 33 - Percentage of People who have been through Transit Countries, by Transit Country and Main Nationalities. Musina, 2020<sup>14</sup>

Nationalities	Zimbabwean	Burundian	Congolese	Total
Transit Countries	Percentage (%)			
Angola	0.0	0.0	0.4	0.2
Burundi	0.0	3.9	5.8	3.7
Congo	0.0	0.0	0.9	0.5
DRC	0.0	6.5	3.6	3.0
Kenya	0.0	1.3	0.0	0.2
Malawi	0.0	11.7	4.9	4.6
Mozambique	0.7	0.0	0.0	0.2
Rwanda	0.0	0.0	1.3	0.7
Tanzania	0.0	9.1	0.9	2.1
Uganda	0.0	1.3	0.4	0.5
Zambia	0.0	3.9	3.1	2.3
Zimbabwe	1.4	5.2	3.1	3.0
Valid Cases	138	77	223	438

Table 34 - Last residence at origin versus Place of birth, by Nationality, Musina, 2020

Nationality	Zimbabweans	Burundians	Congolese	Total
	Percentage (%)			
Place of birth is the same as last residence in the origin	42.75	57.14	52.91	50.46
Place of birth is different from last residence in the origin	57.25	42.86	47.09	49.54
Total (%)	100.00	100.00	100.00	100.00
Total (N)	138	77	223	438

In the same tonic, it is important to remark the differences between motivations to leave the country of origin among the three main nationalities. Similar to deportees in Reception Centre, Zimbabweans in Musina stress economic reasons as pull factors much more often than their Burundian and Congolese counterparts. The latter, on their turn, seem to be more frequently affected by violence and political persecution (Table 35). Although this result is somehow expected, we should have in mind how such particularities affect migrants' main stressors and mental health indicators. Finally, in terms of gender, Zimbabwean men and women display

<sup>14</sup> The Table displays all transit countries people have lived by the time of the interview, and not only the last. When people of a specific nationality are born in a different country (ex. DRC migrants born in Burundi) they may have as transit country the country of their own nationality (ex: DRC migrants may have DRC as a transit country).

similar reasons to move. On their turn, Congolese women seem more prone to list family related issues and less frequently job search and fleeing from violence as pull factors than Congolese men.

Table 35 -Reason to leave Last Residence in Country of Origin, by main Nationalities, Musina, 2020

Nationality	Zimbabwean	Burundian	Congolese	Total
Main Reason to Leave Country of Origin	Percentage (%)			
Eviction	0.00	0.00	1.69	0.96
Wanted better living conditions	5.45	0.00	5.08	4.31
Job search	92.73	36.11	34.75	50.24
Education opportunities	0.00	5.56	5.08	3.83
Gather with Family	1.82	0.00	4.24	2.87
Change on marital status	0.00	0.00	0.85	0.48
To start a new family	0.00	0.00	3.39	1.91
Family conflicts	0.00	5.56	1.69	1.91
Victim of violence	0.00	47.22	31.36	25.84
Victim of political prosecution	0.00	5.56	5.93	4.31
Victim of natural disasters	1.82	2.78	0.85	1.44
Food insecurity	0.00	2.78	0.00	0.48
Following a family member	5.45	13.89	7.63	8.13
Deportation	0.00	0.00	0.85	0.48
Other	1.82	5.56	13.56	9.09
Valid Cases	138	77	223	438

### 3.2.3. Life at Origin

In line with their main reasons to move, migrants experience different situations in their home countries with regards to unsafety, poverty, and lack of basic commodities. Whereas Zimbabweans, again, seem to be particularly affected by poverty, lack of water and electricity and food insecurity, Congolese and Burundians are hit by general violence, violence by rebel groups and war. (Table 36) This is not to say that those from Central Africa experience fewer financial restrictions. In fact, violence could be such an evident concern that poverty does not appear as one of the main reported problems among Burundian and Congolese displaced populations.

In reality, when calculating the poverty indicator at the last place of residence in the country of origin, we have found that Burundians were significantly poorer than Congolese, who, by their turn, were significantly poorer than Zimbabweans. Again, by this we do not imply that

Zimbabweans were not deprived, but, in fact, that violence may gain precedence over poverty in people's discourse. When asked specifically about insecurity, 67.5% of Burundians reported to feel unsafe at least on some months, against 45.2% of Congolese and 26.8% of Zimbabweans. Insecurity itself, however, is a very subjective concept, and respondents have listed widely different reasons for feeling unsafe, as showed in Table 37.

Lastly, an interesting result is that, in Musina, we have found more Zimbabwean migrants who had left their country due to political persecution than at the Reception Centre. The former were also more likely to list violence as a reason to feel unsafe than deportees arriving to Beitbridge. Again, the reason behind that difference is still unclear.

Table 36 - Main Problems of Last Residence at the Country of Origin, by main Nationalities, Musina, 2020

Nationality	Zimbabwean	Burundian	Congolese	Total
Main Problems	Percentage (%)			
Access to education	12.32	1.30	10.76	9.59
Access to health	6.52	1.30	4.48	4.57
Employment	55.07	50.65	31.39	42.24
Food scarcity	26.81	23.38	7.17	16.21
Insecurity	4.35	70.13	53.81	41.10
Lack of water/electricity	20.29	1.30	3.14	8.22
Poverty	25.36	16.88	12.56	17.35
Violence	2.90	2.60	8.52	5.71
Violence by rebel groups	0.00	12.99	13.45	9.13
War	0.72	6.49	9.42	6.16
Valid Cases	138	77	223	438

Table 37 - Reason to feel unsafe in Last Residence at the Country of Origin by main Nationalities, Musina, 2020

Nationality	Zimbabwean	Burundian	Congolese	Total
Reason to Feel Unsafe	Percentage (%)			
Conflicts in the community	10.64	7.94	9.23	9.17
Crime	10.64	6.35	7.69	7.92
Deportation/Migrant status	2.13	0.00	1.54	1.25
Discrimination	0.00	0.00	2.31	1.25
Insecurity	2.13	9.52	6.92	6.67
Lack of freedom	0.00	3.17	0.00	0.83
Other	21.28	0.00	3.08	5.83
Police violence	2.13	0.00	1.54	1.25
Political violence	17.02	11.11	1.54	7.08
Poor infrastructures	4.26	1.59	1.54	2.08
Poverty	12.77	0.00	1.54	3.33
Violence	8.51	3.17	10.77	8.33
Violence by rebel groups	8.51	50.79	36.92	35.00
War	0.00	6.35	13.08	8.75
Witchcraft	0.00	0.00	2.31	1.25
<b>Total</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>
<b>Total (N)</b>	<b>138</b>	<b>77</b>	<b>223</b>	<b>438</b>

Whereas Zimbabweans seem to be distressed by political violence, in specific, Burundians and Congolese are specially afflicted by generalized violence caused by rebel groups or ‘war’, as they would name it. Zimbabweans are also more prone to refer to poverty as a cause of insecurity. Interestingly, educational achievement is correlated with the reported reasons to feel unsafe. If those with complete tertiary education are more likely to talk about political violence; migrants with no formal or low education have a higher tendency to report generalized violence caused by rebel groups. Another key distinction is that women seem to be more afflicted by conflicts in the community than political violence or civil unrests.

#### 3.2.4. Current Migration

Migration to South Africa among migrants and refugees in Musina is, in its majority, non-familiar, meaning that most people (53.7%) started the journey along; and 24.1% with someone who was not a family member. Only 3.6% of those who lived with a spouse at the origin travelled with them to SA. Similarly, although more expressive, 11.5% of those who lived with their children at

the origin brought them along. As expected, however, women are much more prone to travel with their offspring (38.89% of the ones who had children back home) than men.<sup>15</sup>

Throughout the route, 9.8% of people have experienced an episode of violence. Women are more likely than men to have gone through so (13.16% of women against 8.86% of men). In terms of nationality, Burundians are much more affected than the rest, with almost 20% having experienced violence in their journey, although most episodes consist of robberies without physical assault, in general at the Mozambican border.

In total 12.4% of respondents reported a health problem along the journey, with most of them referring to diarrhoea, flue, headache and cough. 2 people reported having Malaria, even though others with the same condition could have been undiagnosed. Reasons not to look for medical help along the journey included cost of assistance (24.4%) fear of deportation (20.7%) and feeling that it was not serious enough (17.2%).

### 3.2.5. Life in South Africa and in Musina

The module on Life in South Africa has only been answered by those who had arrived in the country for three months or longer prior to the date of the interview. This was the case of 54.52% of our respondents. We have also asked about life in Musina, specifically, to all respondents regardless of how long they had been there. Because many people have Musina as their last/current residence in the country, the results of both sections will be presented jointly.

#### *3.2.5.1. Living Conditions in Musina*

Our interviewees had been in Musina for 9 months, on average. This is way longer than what would be common for a transit point. In fact, our results reinforce the notion that migrants and asylum seekers are becoming trapped in the city for increased periods of time. Conversely, the infrastructure of support to mobile populations in Musina, including shelters and health facilities, are not coherent with the extended periods of time they remain in the site.

Zimbabweans, and especially Zimbabwean women, are the ones staying longer periods in the city, with 16 months on average, against 9 months for Burundians and 6 months for Congolese. Migrants stay in Musina for many different reasons, which certainly has an impact on their life

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<sup>15</sup>Persons traveling with the migrant should not be mistaken with those they are effectively living with in Musina, as they may have gathered with a family member once in South Africa. This will be explored in the section Life in Musina.

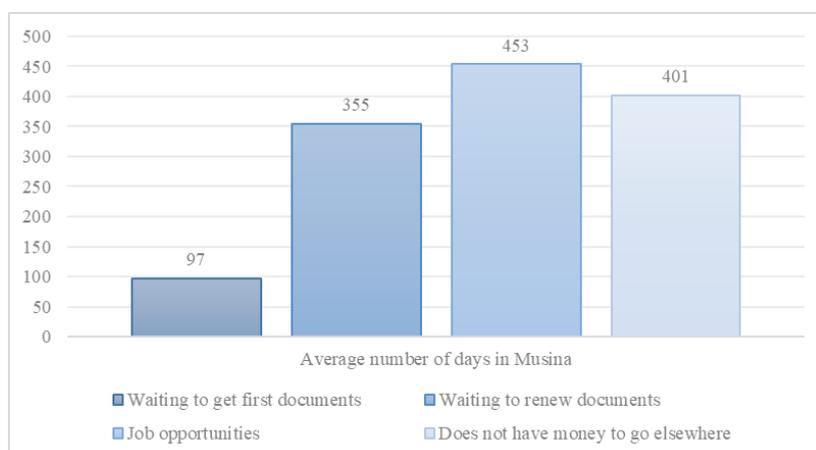
conditions and length of stay in the city. The majority alleged to be waiting to get the first documents, but waiting to renew documents and employment appear as important reasons as well:

Table 38 - Reasons for being in Musina, Musina, 2020

Main Reason for Being in Musina	Frequency (N)	Percentage of cases (%)
Waiting to get first documents	197	44.87
Waiting to renew documents	96	21.87
Does not have funds to go elsewhere	22	5.01
Waiting for smugglers to cross	1	0.23
Waiting for someone	6	1.37
Other	18	4.10
Employment	89	20.27
Looking for safety	12	2.73
Looking for better living conditions	16	3.64
Valid Cases	439	

Reasons are much dependent on sex and nationality, once more. 61.31% of Congolese and Burundians are waiting to get their first documents, and 29.51%, waiting to renew documents – only 2.62% of them reported employment as a motivation to stay. 60.45% of Zimbabweans, on the other hand, are in Musina to look for a job, with that percentage increasing to 82.93% among Zimbabwean women. Among those in Musina to get their first documents, the length of stay was 4 months on average, against 1 year for those waiting to renew documents and 1 year and 4 months for the ones who are there to work. (Figure 3). The fact that asylum seekers only interested in renewing their documents have to stay in Musina for such protracted periods is startling. It reveals how disruptive the asylum-seeking process in South Africa can be.

Figure 15 - Average Number of Days in Musina, by Reason to be in the City, Musina, 2020



We have also categorized people by their place of residence/stay in Musina. However, it should be noted that this information may be biased in relation to the survey sites and challenges to reach the population living in specific places. What strikes our attention, however, is the high percentage of Burundians living on the streets, as showed in the Table 39.

Table 39 - Place of stay in Musina by main nationalities, Musina, 2020

Nationality	Zimbabwean	Burundian	Congolese	Total
Place of Stay	Percentage (%)			
Lodge	7.46	11.69	22.42	15.90
Shelter	85.07	33.77	64.13	65.21
Street	2.24	54.55	5.83	13.36
Someone's house	2.99	0.00	4.93	3.46
Other	2.24	0.00	2.69	2.07
<b>Total (%)</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>
<b>Total (N)</b>	<b>134</b>	<b>77</b>	<b>223</b>	<b>434</b>

### 3.2.5.2. Life Conditions in South Africa

In general, women had been in South Africa longer than men, which could help explaining why they were more frequently employed than male respondents (68.28% of men were unemployed, against 46.30% of women). In fact, it is remarkable how, despite being in South Africa for a while, most people we interviewed did not consider themselves as employed or self-employed. The situation, once more, seems to afflict the three main nationalities analysed differently: whereas Zimbabweans are more likely to be working, Burundians and Congolese seem to have increased chances of not finding a job (Table 40).

Table 40 - Work status in South Africa, by main Nationalities, Musina, 2020

Nationality	Zimbabwean	Burundian	Congolese	Total
Work Status	Percentage (%)			
Self-employed	13.95	2.78	7.89	9.32
Employed	23.26	25.00	23.68	23.73
Unemployed	53.49	72.22	68.42	63.56
House-worker	9.30	0.00	0.00	3.39
<b>Total (%)</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>
<b>Total (N)</b>				

We believe that language barriers may be accountable for the high joblessness rates among Central Africans, which could also explain other specific challenges that will be later discussed.

Unemployment was indeed quoted as a main problem of life in South Africa among 15.29% of our respondents. Others referred mainly to discrimination/xenophobia (19.42%); food scarcity (14.05%); home affairs (12.40%); crime (11.16%) and shelter conditions (8.68%). It should be highlighted that many of these problems refer to living conditions in Musina, where some respondents have residence, meaning that they have been staying there for three months or longer. Food scarcity seems to be particularly relevant for male interviewees (16.49%), who do not have access to regular meals in the shelter.

26.78% of our respondents feel unsafe in South Africa always or occasionally. Interestingly, reasons to feel unsafe vary deeply by gender (Table 41). Whereas women reported more often violence and insecurity (non-specified), men were more likely to quote xenophobia or lack of documentation. This could indicate that men are more of a target in terms of xenophobic violence and police operations than women – result that is agreeing with the data from the Reception Centre.

Table 41 -Reason to feel unsafe in South Africa, by Sex, Musina, 2020

Sex	Men	Women	Total
Reason to Feel Unsafe		(%)	
Because of lack of documentation	15.07	0.00	12.22
Because of migrant condition/Xenophobia	27.40	17.65	25.56
Crime	24.66	17.65	23.33
Doesn't know	1.37	0.00	1.11
Employment	0.00	11.76	2.22
Fear of deportation	10.96	5.88	10.00
Insecurity (Unspecified)	2.74	11.76	4.44
Lack of freedom	2.74	0.00	2.22
Loneliness	1.37	0.00	1.11
Lots of noise	0.00	5.88	1.11
Other	1.37	5.88	2.22
Poor sanitation	1.37	0.00	1.11
Poverty	2.74	0.00	2.22
Violence	8.22	23.53	11.11
Total (%)	100.00	100.00	100.00
Total (N)	73	17	90
Fisher's exact test 0.024**			

### *3.2.5.3. Exposure to Violence*

As discussed previously for Zimbabwean deportees at the Reception Centre, foreigners are particularly exposed to violence in South Africa. Among our respondents in Musina, 23.24% had already been physically assaulted in the country; whereas 52 people, or 11.85% of the sample size, went through so in Musina.

In Musina, both men and women had been similarly exposed to violence, although the share of men suffering attacks or robberies in South Africa, in general, is higher (26.7% of men against 11.11% of women). Burundians, once more, appear as more vulnerable than others, with 20.78% having experienced physical assault in Musina, versus 13.43% of Zimbabweans and 8.07% of Congolese. Sex and nationality may be imbricated for that specific variable, but it is possible that leaving in the street represents an additional factor of vulnerability for Burundian men.

When asked to describe their last episode of violence in Musina, or in South Africa in general, respondents could answer freely. It is difficult to know for sure the nature of the attacks, but most seem to involve robberies, followed some times by intense physical violence. 3 people reported to have been raped in Musina, one as described below:

I walked across a guy when I was from church and he asked to use my phone and I refused, then he grabbed my hand and I handed over my phone. Then he asked for money and I refused, then he grabbed me, pulled me to a corner and he took off my clothes and took my phone. He raped me and started to beat me asking why I refused that I had money. He continued to beat me and I tried to run away but he threw me with a stone and I fell. He continued to beat me without feeling any pity. (Zimbabwean woman)

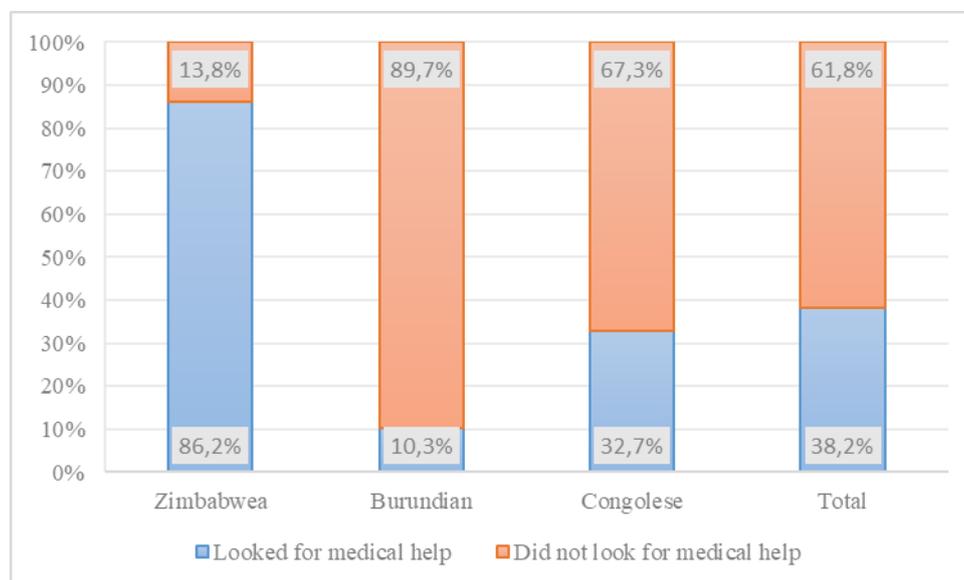
In Musina, half of people going through a physical event of violence, suffered a disability as a result: 19.23% experienced vision loss, 15.48% difficulty breathing, 11.54% difficulty remembering things, and 21.15%, limp. In spite of how serious the attacks were, 80% did not look for medical help afterwards, which uncovers a serious barrier to treatment. We believe, in fact, that people may be even more unwilling to visit the clinic or hospital after an event of violence, than for any other health issue, due to fear of having to report the episode to the police.

### *3.2.5.4. Access to Health*

28.25% of our respondents had had a health problem in Musina, but 61.29% did not look for medical aid. However, once more, health seeking behaviour seems to be highly dependent on nationality (Figure 16). Zimbabweans are much more prone to search clinical aid than their

Central African counterparts. Once more, language barriers and a sense of discrimination could have a very significant effect on the attitudes of migrants from different origins:

Figure 16 - Health Seeking Behaviour following a Health Problem, by Nationality, Musina 2020



When asked why they did look for specialized assistance, the reasons reported by the various groups differed significantly, revealing why their health seeking behaviour may be so contrasting (Table 42). It should not be noted, nevertheless, that the number of Zimbabweans not looking for medical help (4) may be too low to take reliable conclusions.

Table 42 - Reason to not look for medical help in Musina, by main Nationalities, Musina, 2020

Nationality	Zimbabwean	Burundian	Congolese	Total
Reason not to Look for Medical Help	Percentage (%)			
Did not think it was necessary	75.00	8.57	13.89	14.67
Distance to nearest health clinic	25.00	0.00	5.56	4.00
Cost of assistance	0.00	14.29	19.44	16.00
Locomotion Problems	0.00	0.00	11.11	5.33
Fear to be deported	0.00	54.29	36.11	42.67
Xenophobia/Bad attitude from health professionals	0.00	2.86	13.89	8.00
Language barrier/cultural barriers	0.00	82.86	27.78	52.00
Other	0.00	2.86	16.67	9.33
Valid cases	4	35	36	75

It seems that Burundians and Congolese are particularly affected by discrimination, xenophobia and language barriers. The same pattern was observed when we asked respondents about health

seeking behaviour in South Africa, not Musina specifically. Zimbabweans also reported to have been to health facilities more times and to find it easier to access medical care than other nationalities (Table 43 and Table 44). Because health seeking behaviour varies deeply by sex, table 44 brings a comparison using men only, although the same pattern is observed for women. When asked about the reasons why access to health care in South Africa was difficult, 73.68% of Zimbabweans quoted risk of deportation, whereas Central Africans seem more affected by xenophobic attitudes from health professionals (41.18% versus 26.38% of Zimbabweans).

Table 43 - Number of Medical Consultations in South Africa, by Nationality, Musina, 2020

Nationality	Zimbabweans	Central Africans	Total
Frequency	Percentage (%)		
More than 5 times	16.39	5.56	9.09
Bertween 3 and 5 time	11.48	3.97	6.42
Between 1 and 2 times	18.03	17.46	17.65
Never	54.10	73.02	66.84
Total (%)	100.00	100.00	100.00
Total (N)	94	260	354
P=0.011**			

Table 44 - Difficulty in accessing Medical Care, by Nationality, Men only, Musina, 2020

Nationality	Zimbabweans	Central Africans	Total
Rating	Percentage (%)		
Very easy	41.18	13.91	23.73
Farily easy	10.59	21.19	17.37
Difficult	10.59	23.18	18.64
Almost impossible	1.18	1.32	1.27
Never needed medical help	36.47	40.40	38.98
Total (%)	100.00	100.00	100.00
Total (N)	85	144	229
P=0.000***			

### 3.2.5.5. Food Insecurity

Food insecurity is an important factor leading to increased vulnerability in Musina. For this specific topic, we have taken only those people who are considered to be resident in the city, i.e have been there for 3 months or longer. Almost 70% of our respondents reported not having access

to three meals a day on most days. The percentage increases to almost 77% when only men are considered.

Most surprising, however, is again the differences in terms of nationality, with almost 95% of Burundian men not having access to three meals on most days, against 34.78% of Zimbabweans (Table 45). Besides of residence location, part of this difference may be accountable to differential job statuses, as Central Africans reported more frequently than others not having access to work in South Africa.

Table 45 - Frequency of having at least Three Meals a Day, by Nationality, Men only, Musina, 2020

Nationality	Zimbabwean	Burundian	Congolese	Total
Frequency	Percentage (%)			
Every day	17.39	0.00	8.70	9.09
Some days	17.39	5.26	15.22	13.64
Rarely	39.13	31.58	23.91	29.55
Never	26.09	63.16	52.17	47.73
Total (%)	100.00	100.00	100.00	100.00
Total (N)	23	19	46	88

### 3.2.6. Future Plans

As most migration literature stresses, social networks are extremely important in determining when, where and how migrants wish to establish residence. Such social networks are usually determined by family ties, nationality, ethnicity and other cultural factors and can be clearly visualized in our analysis.

As highlighted in Table 46, whereas Congolese and Burundians seem to show preference for Cape Town and Durban, Zimbabweans are more likely to go to Johannesburg, Pretoria and Polokwane. Interestingly, Musina also appears as a place of settlement to all groups studied, again reinforcing the idea that it is not merely a site of transit.

When asked where they want to go as a final or definite destination, most report the same place they intend to go next. However, there is still a share of people who plan to return to their place of origin, or to another city in their country of birth (19.82% of respondents), most notably Harare, Masvingo, Kinshasa, and Lubumbashi. Reasons to go back to country of origin most frequently include gathering with family members and being free from deportation worries.

Table 46 - Intended Next Destination, by Nationality, Musina, 2020

Nationality	Zimbabwean	Burundian	Congolese	Total
Main Cities	Percentage (%)			
Cape Town	10.20	35.38	30.48	25.71
Durban	5.10	10.77	8.56	8.00
Harare	6.12	0.00	0.53	2.00
Johannesburg	21.43	33.85	15.51	20.57
Musina	16.33	13.85	16.58	16.00
Other	17.35	4.62	18.72	15.71
Polokwane	7.14	1.54	1.07	2.86
Pretoria	16.33	0.00	8.56	9.14
Total (%)	100.00	100.00	100.00	100.00
Total (N)	138	77	223	438

### 3.3.7 Chronic and Infectious Diseases

In general, the perceived health status among migrants in Musina is pretty poor, even more so when we take into consideration that most people are in their mid-twenties. More than 20% of our respondents rated their health as bad or very bad, with that share increasing to 27.87% among Central Africans. In fact, the difference between Zimbabweans and non-Zimbabweans is once more significant. Men are also more prone to qualify their health as bad or very bad than women, which is a very peculiar trend in relation to most health statistics available for country-levels (OECD, 2017). The differences in self-reported health status by sex are also counterintuitive when we take in consideration the main chronic conditions reported by men and women (Table 48), as female respondents declared more often having HBP or Chronic Respiratory Disease (CRD). As we will discuss, we believe that gender differences in perceived health are probably related to poorer mental health indicators among men.

Table 47 - Overall Health Rating, by Main Nationalities, Musina, 2020

Nationality	Zimbabweans	Central-Africans	Total
Overall Health Rating	Percentage (%)		
Very good	43.07	23.93	29.86
Good	43.07	34.10	36.88
Regular	9.49	14.10	12.67
Bad	4.38	22.30	16.74
Very bad	0.00	5.57	3.85
Total (N)	100.00	100.00	100.00
Total (%)	137	305	442
P=0.000***			

For all chronic diseases taken into account, Zimbabweans show higher self-reported prevalence rates. This, however, may be the result of better testing and diagnosis in the country of origin or even in South Africa, as this population seems to have fewer barriers to access health care. It should be stressed, though, that an 8.33% of HBP rate among women (and 12.82% among Zimbabwean women) should not be disregarded, especially as we consider the mean age of our respondents. Among people with a diagnosis of HPB, almost 30% were not receiving treatment at the time of the survey.

Table 48 -Reported Prevalence of Chronic Diseases, by Sex, Musina, 2020

Sex	Men	Women	Total
Chronic Diseases	Percentage (%)		
High Blood Pressure/Hypertension (HBP/H)	1.95	8.33	3.16
Heart disease (HD)	1.95	1.19	1.81
Diabetes	0.28	0.00	0.23
Chronic Respiratory disease (CRD)	1.67	3.57	2.03
Cholesterol	0.84	0.00	0.68
Total (N)	359	84	443

With regards to infectious diseases, only Malaria seemed relevant and worthy of analysis with 11.51% of participants having had the disease since 2019. The percentage rises to 23.38% among Burundians. It should be noted, however, that in most cases Malaria was self-diagnosed, especially among Central Africans. For the latter, only 24.4% received specific anti-malaria treatment, against 100% of Zimbabweans. This data may reveal two concurrent phenomena: the tendency of respondents to identify malaria as a cause of most infectious diseases' symptoms; but also, the low testing, diagnose and treatment rates of the disease among Burundians and

Congolese – who most probably contracted the illness still in their country of origin or journey or are having it reactivated. In fact, specific attention should be given to migrants recently arrived to Musina showing malaria symptomatology.

More than half of our respondents showed unspecific signs of infections in the 2 months prior to the conduction of the survey. These high rates may be intrinsically linked to poor living conditions in Musina, especially access to clean water and appropriate sanitation facilities. Table 49 reveals how the place of stay in the city may be related to such signs, with particular focus to those living in the street and at the men’s shelter, although conditions at women’s shelter may also be related to high rates of cough, diarrhoea, and skin rash. Those living in lodges are, apparently, less prone to report such conditions.

Table 49 -Unspecified Signs and Symptoms Reported in the last two months, by Place of stay in Musina, only migrants who have had in Musina for 2 months or longer, Musina, 2020

Place of Stay in Musina	Lodge	Men's Shelter	Women's Shelter	Street	Total
Signs and Symptoms			(%)		
Fever	15.63	24.56	26.92	37.5	25.49
Persistent cough	0	9.65	15.38	25	11.27
Difficult breathing	3.13	4.39	3.85	31.25	8.33
Diarrhoea	0	6.14	11.54	12.5	6.86
Blood in the stools	0	0.88	0	15.63	2.94
Vomiting	0	1.75	0	3.13	1.47
Skin rash/irritation	3.13	6.14	11.54	15.63	7.84
Inability to eat or drink	3.13	2.63	19.23	31.25	9.31
None	84.38	61.4	46.15	34.38	58.82
Valid Cases	32	114	26	32	204

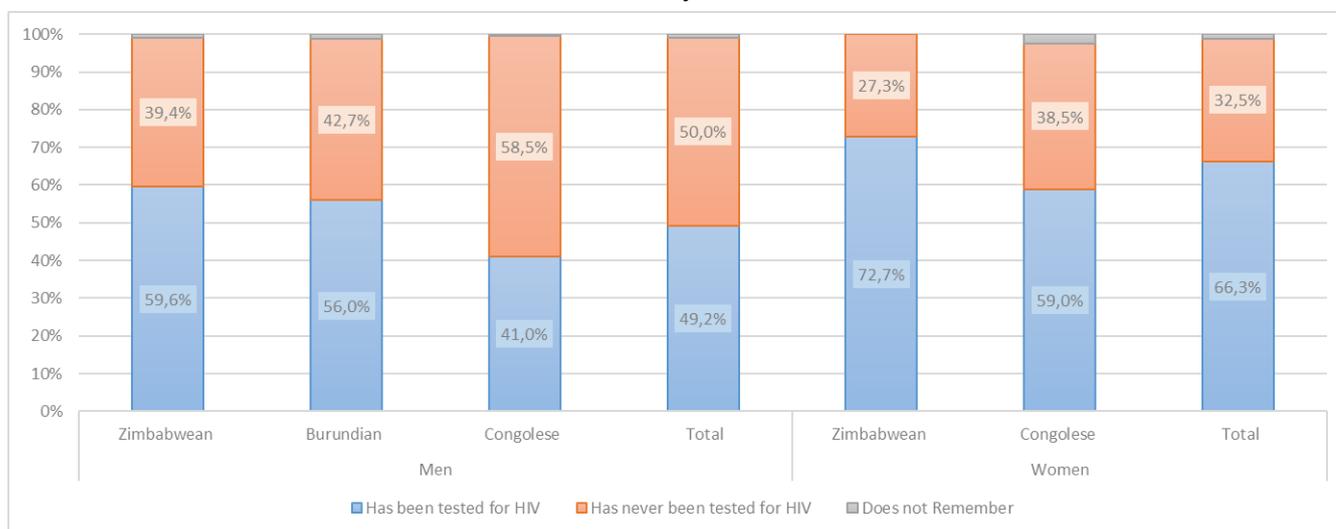
### 3.2.7. Sexual and Reproductive Health

Among migrants interviewed in Musina, 13.38% (59 people) had never heard of HIV, which is an important share of the population. When asked about the main modes of HIV transmission, 55.43% quoted unprotected sex; 28.16% mentioned sexual intercourse (with no specific mention to condom use); 10.79% reported sharing razor blades or sharp objects; 10.26% sharing needles. Others still talked about prostitution, sexual immorality, or sleeping with multiple partners. Apparently, among this population, HIV is frequently linked to pre-conceptions of what is regarded as moral and immoral sexual activity.

It should be highlighted that almost 17% of respondents who had heard of HIV did not mention sexual intercourse, alone, as a main way of transmission of the disease. These are 123 people, or 27% of our sample, with very poor knowledge of HIV.

Another important result can be visualized in Figure 18, in which we can see that Congolese, in particular, are not being frequently tested, both men and women, when compared to other nationalities. It is striking that almost 60% of Congolese men have never been tested for HIV. On average, migrants have been tested more than 1 year prior to the survey date and only 20% did so in Musina.

Figure 17 - Percentage of Respondents who have ever been tested for HIV, by Sex and Nationality, Musina, 2020



HIV prevalence is relatively low with only 6.47% of respondents reporting to be HIV positive. Women, however, are more prone than men to be living with the disease, as well as Zimbabweans— prevalence among Zimbabwean women is 21.88%, a striking result. Time since last test, however, could underestimate the percentage of men with the disease. Among those who self-reported to be HIV positive, almost half were not taking medication or had taken it more than 30 days before the interview.

Table 50 – Reported HIV Status by Sex and Nationality, Musina, 2020

Sex	Men				Women		
Nationality	Zimbabwean	Burundian	Congolese	Total	Zimbabwean	Congolese	Total
HIV Status	Percentage (%)						
HIV Positive	8.93	0.00	2.67	4.05	21.88	4.35	14.55
HIV Negative	76.79	100.00	94.67	90.17	78.13	95.65	85.45
Does not remember	7.14	0.00	0.00	2.31	0.00	0.00	0.00
Did not receive	0.00	0.00	1.33	0.58	0.00	0.00	0.00
Did not answer	7.14	0.00	1.33	2.89	0.00	0.00	0.00
Total (%)	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Total (N)	56	42	75	173	32	23	55

Coupled with low HIV knowledge, migrants are also infrequently using condoms. Among those who are sexually active (i.e had a sexual relationship since January 2020), only 34.17% had used condoms. Even among those who are single, only 46.8% had had protected sexual intercourse. More worrying, perhaps, is that 42.86% of those who are HIV positive reported not wearing condoms in the most recent sexual relationship.

All the aforementioned results are coherent with the high STIs symptomology found among our respondents. In total, 19.5% reported having discharge or genital ulcer: the percentage is even higher among those from Burundi, as showed in Table 51.

Table 51 - Percentage of People Reporting Discharge or Genital Ulcer, by Nationality, Musina, 2020

Nationality	Zimbabwean	Burundian	Congolese	Total
Discharge or Ulcer	Percentage (%)			
Yes	20.31	27.63	16.29	19.53
No	79.69	72.37	83.71	80.47
Total (%)	100.00	100.00	100.00	100.00
Total (N)	128	76	221	425
P=0.095*				

With regards to family planning, and in line with the higher health literacy and access to health among Zimbabweans, Central Africans once more show lower use of contraception (Table 52). It should be remarked that we have only asked questions about family planning to those who reported not wanting to have children at the moment. The result is, therefore, a proxy for unmet need of contraception. Some of the reasons not to use contraception, among those who had sexual

intercourse recently, include not wanting to or not being married (Table 53). In fact, there seems to be a misconception that only married women are entitled to use family planning. Reasons such as ‘does not want to’; ‘does not trust the methods’ or ‘it destroys the womb’ have only been mentioned by migrants from Burundi and Congo.

Table 52 - S/he or partner is using contraceptive methods, only those who are sexually active, by Sex and Nationality, Musina, 2020

Sex	Men				Women		
Nationality	Zimbabwean	Congolese	Burundian	Total	Zimbabwean	Congolese	Total
Contraceptive	Percentage (%)						
Yes	65.22	54.55	33.33	46.58	61.54	19.51	22.02
No	34.78	45.45	66.67	53.42	38.46	80.49	77.98
Total (%)	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Total (N)	23	11	39	73	13	12	25
Fisher exact test for men only, by nationality 0.048**							
Fisher exact test for women only, by nationality 0.002***							

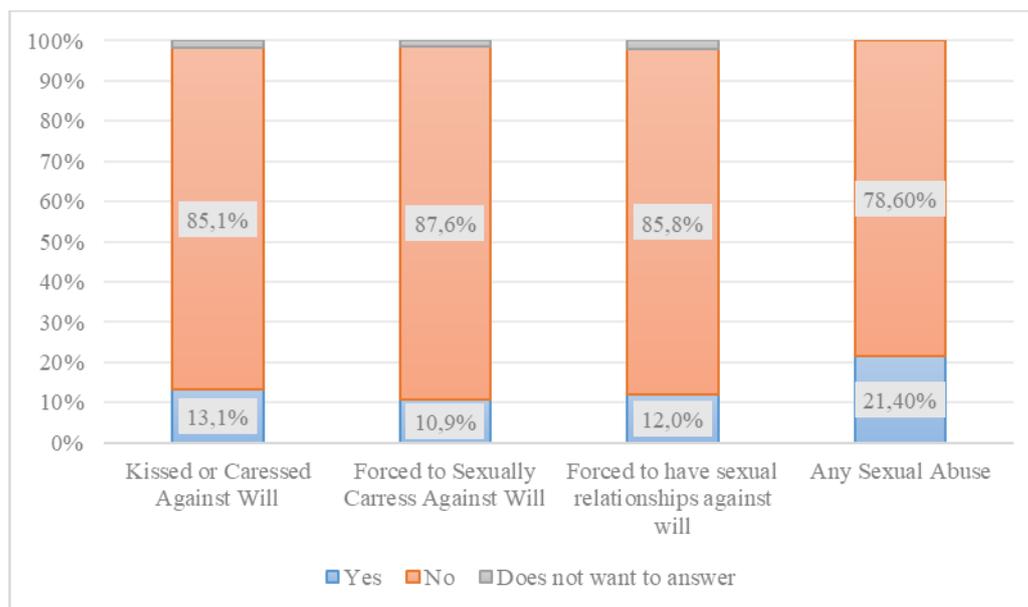
Table 53 - Reason not to use any contraceptive, only those who had since the beginning of the year, Musina, 2020

Main Reason not to use any method	Frequency (N)	Percentage (%)
Does not know	2	4.08
Does not trust the methods	1	2.04
Does not want to	11	22.45
Has a partner/is married	2	4.08
It destroys the womb	3	6.12
Menopause/inability to give birth	1	2.04
Other	1	2.04
S/he is single/divorced	23	46.94
S/he is too old	1	2.04
S/he is too young	1	2.04
Sexual inactive	2	4.08
Traditional methods	1	2.04
Total	49	100.00

### 3.2.8. Sexual Violence

Figure 18, displays the percentage of people who reported to have suffered sexual abuse in the last year. In total, 95 migrants reported having gone through at least one of the three enumerated types of abuse very recently, or 21.4% of our sample.

Figure 18 - Percentage of People who have gone through an Episode of Sexual Abuse in the last year, by Type of Abuse, Musina, 2020



Now, what remarkable is the fact that men report much more frequently than women to have gone through sexual violence. The result is somewhat counterintuitive as it is known that in Congo, particularly, women are frequently used as sexual targets by rebel groups. One hypothesis is that the one-year time frame privileged experiences happening in South Africa and in Musina, particularly. No difference in exposure to sexual violence was found by nationality.

Indeed, once we limit the analysis to people who have been living in Musina for one year or longer, the differences on sexual abuse by sex are even more prominent, as showed in Table 54. Whereas migrants recently arrived may also have gone through sexual abuse in Musina, we know, almost for sure due to the question time frame, that the episode took place in the city for the ones who were residing there for longer than 1 year. Among the one-year residents, abuse has most often happened to those staying in the men's shelter. In fact, 30% of men living at the shelter for 1 year or longer have suffered sexual violence in the last year. The indicator confirms anecdotal information gathered during data collection, when interviewers reported high incidence of sexual abuse and transactional sex in the site.

Table 54 - Experience of Sexual Abuse in the Last year, by Sex and Time in Musina, Musina, 2020

	All Migrants			Only Migrants who had been in Musina for 1 year or longer		
Sex	Men	Women	Total	Men	Women	Total
Abused	Percentage (%)					
Yes	23.96	10.71	21.44	24.56	4.35	18.75
No	76.04	89.29	78.56	75.44	95.65	81.25
Total (%)	100.00	100.00	100.00	100.00	100.00	100.00
Total (N)	359	84	443	57	23	80
All Migrants, by Sex P=0.008**						
Only migrants in Musina for 1 year or longer, by Sex Fisher =0.055*						

In most cases of sexual abuse, condom was used (54.7%), although men are more prone to have used it than women. When suffering sexual violence most people do not look for medical help afterwards (75.43% did not reach assistance) – no women who suffered sexual violence looked for clinic support. The data reveals, therefore, that not only are migrants highly exposed to sexual violence, but also that access to health following assault is extremely troublesome.

### 3.2.9. Alcohol abuse and Mental Health

#### 3.2.9.1 Alcohol Abuse

In Musina, alcohol abuse, as most other variables here analysed, shows great variability in terms of nationality. Similar to results found at the Reception Centre, Zimbabweans, especially Zimbabwean men, show significantly higher rates of harmful use of alcohol than other nationalities:

Table 55 - Harmful Consumption of Alcohol, by Nationality, Musina 2020

Nationality	Zimbabweans	Central Africans	Total
Alcoholism Index	Percentage (%)		
Low risk	79.71	90.49	87.13
Medium risk	11.59	5.57	7.45
High risk	2.17	2.30	2.26
Addiction likely	6.52	1.64	3.16
Total (%)	100.00	100.00	100.00
Total (N)	138	305	443
P=0.005***			

It is not entirely clear why Zimbabwean men show increased risks of alcohol abuse when compared to others. The trend could be linked to factors such as religion or mode of assimilation of this particular group in South Africa.

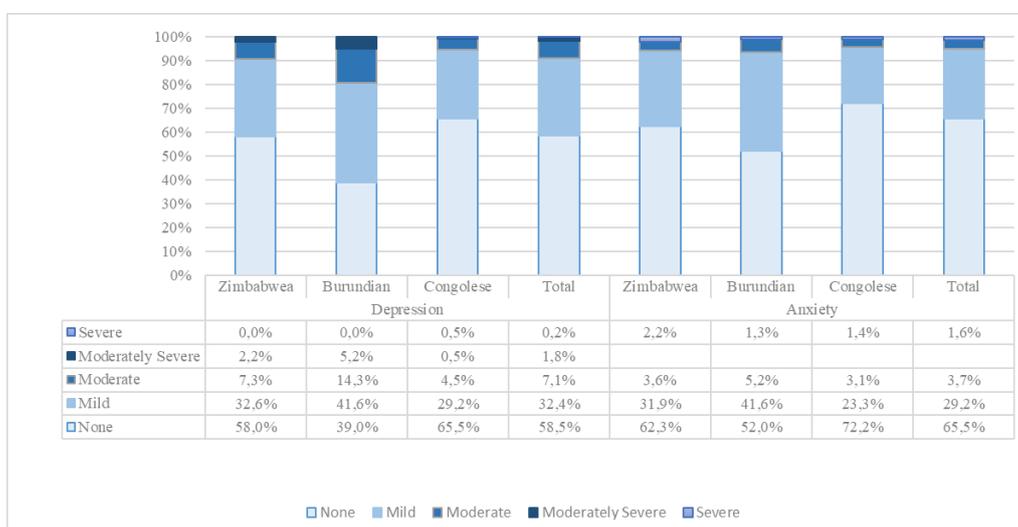
### 3.2.9.2 Anxiety and Depression Index

Family separation; violence, including sexual abuse, at the origin, transit and destination; unemployment; food scarcity; and barriers to health care are all aspects that might impact negatively the psychological wellbeing of displaced populations in Musina. All such factors could also help explaining the particularly poor mental health indicators found among Burundian migrants and asylum seekers in the analysed site, with 9.5% displaying moderate to severe depression scores and 6.5% moderate to severe anxiety scores. As previously outlined, this group is more prone to have lived in transit countries; to have fled from armed violence; to experience poor living conditions in Musina, including physical assault; and to face discrimination when accessing health care.

Once we control by nationality, both men and women display similar depression and anxiety indicators. Factors such as HIV status, employment, or sexual abuse do not seem to be correlated with the two indicators analysed.

Another worrying finding is that 23.74% of migrants reported having suicidal or self-hurting thoughts on at least some days. The percentage rises to 37.66% among Burundian respondents. That is a clear indicative that urgent mental health support operations targeting migrants are needed in the site.

Figure 19 - General Anxiety Disorder Indicator and Depression Severity Indicator, by Nationality, Musina, 2020



### 3.2.9.3. Coping Mechanisms

It is not enough to measure mental health indicators, without taking into consideration how displaced populations react to life stressors. In table 56, we show how coping mechanisms are also dependent on sex and nationality. Most notably, men are more likely than their female counterparts to resort to self-distraction and substance use; whereas women rely more frequently on religion and instrumental support, i.e help from other people. These results may be, in fact, closely linked to findings previously discussed, as women are, for example, more prone to be in Musina with a family member, especially their children. They are also less affected by physical violence or sexual abuse in the site, which could help explaining why they feel more confident to lean on other people's assistance. In fact, social support perception was particularly higher among female than male respondents, with 67.86% of women thinking that they had someone to talk to when feeling lonely, against only 48.32% of men.

When asked about their main life stressors, most people reported poverty, employment and food scarcity. Men seem more worried about employment, lack of documentation and insecurity, whereas women are particularly troubled by the inability to provide for their families.

Table 56 - Coping Mechanisms, by Sex and Nationality, Musina, 2020

Variable	Sex			Nationality		
	Men	Women	Total	Zimbabwean	Central Africans	Total
Type of Coping						
	Percentage (%)					
Active coping	0.28	0.00	0.23	0.74	0.00	0.23
Planning	1.13	0.00	0.92	0.74	0.99	0.92
Humour	0.57	0.00	0.46	0.74	0.33	0.46
Religion	9.07	17.86	10.76	12.59	9.93	10.76
Emotional Support	4.82	15.48	6.86	9.63	5.63	6.86
Self-distraction	69.69	53.57	66.59	50.37	73.84	66.59
Venting	0.28	1.19	0.46	0.74	0.33	0.46
Substance use	7.93	3.57	7.09	14.07	3.97	7.09
Disengagement	7.08	9.52	7.55	11.11	5.96	7.55
Unclassified	0.57	3.57	1.14	2.96	0.33	1.14
Total cases	353	84	437	135	302	437
P= 0.000***				P=0.001***		

### 3.2.10 Main Recommendations

- When setting up a project in Musina, we recommend that the team identifies the needs and provides assistance to migrants and asylum seekers living in the street, besides of the shelters and lodges, due to their increased vulnerability;
- Design and implement a comprehensive mental health program that integrates promotion and prevention; stigma reduction interventions targeted at sexual abuse survivors and people living with HIV; case finding; treatment and follow up. The program should be broader than strict HIV counselling. Specific focus should be given to men living at the shelter, and to strengthening their coping mechanisms to deal with life stressors and trauma;
- Provide comprehensive post-assault treatment in the main sites where migrants are concentrated. Mental health support should also be available to those who had been victims of abuse in origin or transit countries. Health promotion strategies aimed at identification and care of sexual abuse survivors need to be gender sensitive;
- Provide and advocate for independent medical care in cases of physical assault, through a process in which the migrant is not required to report the case to the police if he/she is not willing to;
- Tackle discrimination and xenophobia in health care, particularly towards Central Africans, providing Swahili, Lingala and French translation services at Musina clinic and Musina hospital. Further sensitization – through peer educators -could be given at shelters, lodges and street on the rights of migrants to access health care and how to proceed in case that right is denied. Training and sensitization on migrant's health should also be provided to health care professionals at the Musina clinic and hospital;
- Provide rapid testing and linkage to care for common chronic conditions, specially HPB and Diabetes;
- Provide Malaria testing, treatment and/or linkage to care, among migrants in Musina, with a focus on recently arrived Central Africans.
- The high rates of people with unspecified signs and symptoms may indicate that water and sanitation infrastructure should be improved not only at the men's shelter but also at the women's shelter;
- Promote mass HIV testing at shelters and street areas with appropriate counselling and linkage to care;
- Design health promotion activities focused on HIV education, targeting mainly Burundian and Congolese populations. These should try to disentangle disease prevention from notions of 'moral' and 'immoral' sexual activity.

- Raise awareness on main STIs symptomatology, providing testing and treatment for Syphilis, Gonorrhoea, Hepatitis C, among others;
- Provide and sensitize women, in particular, on mid and long-term family planning options, tackling main misconceptions, with a particular focus on Congolese female migrants;
- Conduct a deeper assessment on substance use among Zimbabwean men and, if necessary, integrate a drug/alcohol treatment module to mental health activities;
- Use evidence from the survey to advocate for quicker documental procedures for asylum seekers coming to Musina to renew their papers;
- Future needs assessments could be conducted at Cape town and Durban, focusing on Congolese and Burundian communities arriving to South Africa.

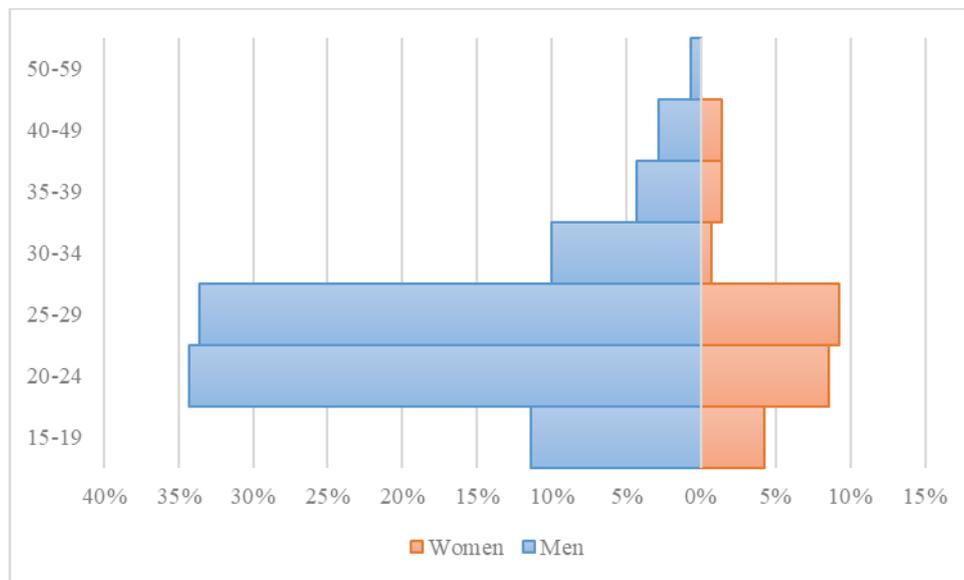
### **3.3.Malawian migrants**

#### **3.3.1. Context and General Characteristics**

Among the different nationalities passing through Beitbridge, Malawians follow a unique path, in which they wait a couple of days or even weeks before crossing to South Africa at the so called ‘Magogo’s house’ or its surroundings. The Magogo’s house is an informal shelter run by a Malawian traditional leader. The site is used as a location of reunion of migrants and smugglers. There, people wait for others to send in resources that can be used to bribe authorities at the South African border. During our survey, there have been informal reports of sexual trafficking networks operating in the location. The information is indeed agreeing with innumerable denunciations of human trafficking schemes that use Malawi as both a source and transit area for victims of exploitation. (Banda, 2017) As we will show, our findings suggest high demands for sexual and reproductive care in the site, including post-assault care.

During the survey, 178 migrants were interviewed at Magogo’s house, all Malawian nationals. The age and gender distributions are similar to that of deportees and migrants in Musina, with men making up 79.8% of the sample, and women 20.25%. Respondents’ age is concentrated in the 20-29 age group, as showed in the pyramid bellow. Because the number of women interviewed was small, it was sometimes difficult to draw statistically significant conclusions by gender.

Figure 20 - Age and Sex Distribution, Malawian Migrants, Magogo's House, Beitbridge, 2020



With regards to the main sociodemographic variables of Malawian migrants, it has called our attention that 58.4% of the respondents had not finished primary education, and that, despite being very young, more than half of the interviewees were married or in a consensus union.

### 3.3.2. Global Migration

All the interviewed migrants were born in Malawi, mostly in rural areas (65.6% of the total). Most of our respondents were originated from the city of Mangochi and its surroundings. Others were born in different locations in the southern region of Malawi and a few came from the central region, where the capital Lilongwe is located.

Almost 70% of migrants interviewed had only lived in one country, Malawi, but most had resided in several places within the country before migrating to South Africa. In general, men were more mobile than women, having lived in 2.7 places before moving abroad, whereas women's average is 1.9. The data indicate a high degree of internal migration within Malawi before moving to South Africa:

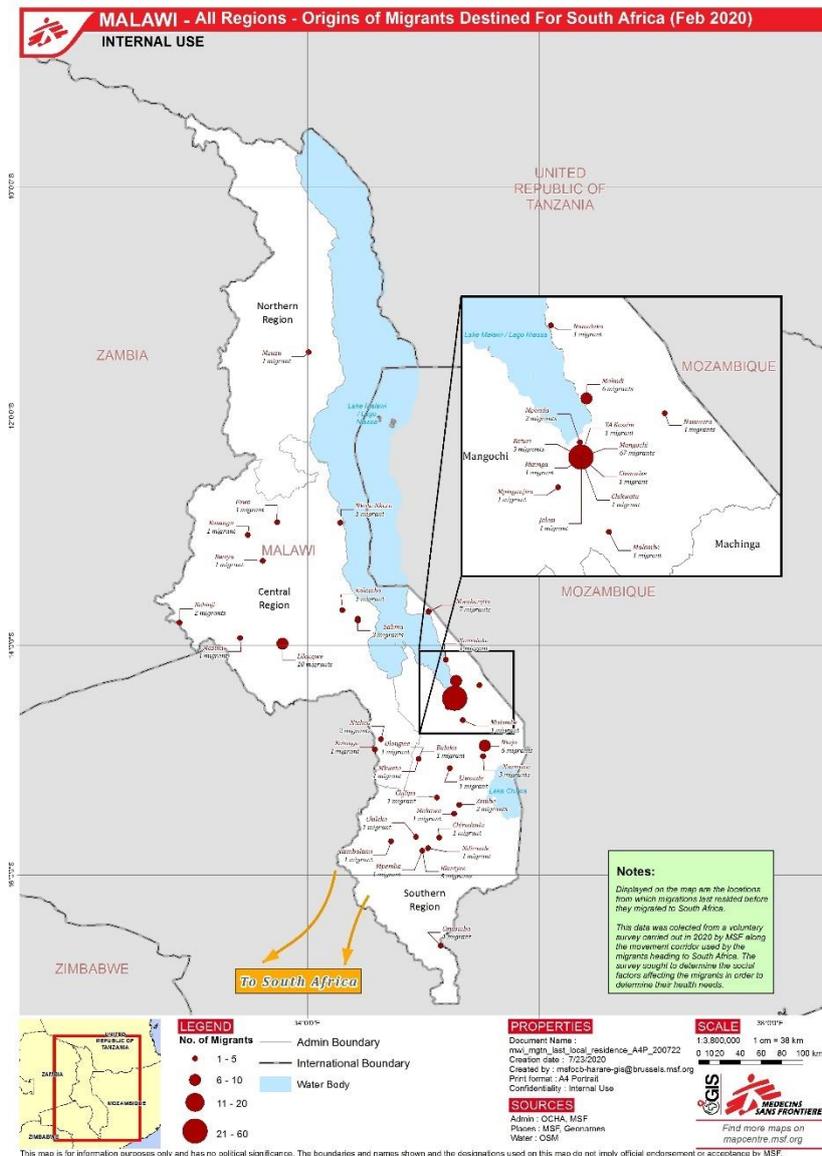
Table 57- Number of Different Places where Respondents have lived, Malawian Migrants  
House, Beitbridge, 2020

Number of Places	Frequency (N)	Percentage (%)
1	40	26.14
2	36	23.53
3	46	30.07
4	21	13.73
5	7	4.58
7	1	0.65
8	1	0.65
10	1	0.65
<b>Total</b>	<b>153</b>	<b>100.00</b>

Contrary to expectations, the last residence in Malawi before migrating abroad is rural for most migrants (69.2%), which discards the thesis of step migration as we have found among Zimbabwean displaced populations. Interestingly, the last residence in Malawi and the place of birth was the same for 73% of the migrants interviewed, suggesting that, despite high internal migration patterns, respondents returned to their place of birth before heading to South Africa. The main hypothesis for this result is that internal migration is of seasonal or circular character, probably linked to agricultural labour.

The last residence of 95% of the respondents is Malawi, hence indicating that respondents move directly to South Africa, without residing in transit countries.

Figure 21 - Last Residence in Malawi, Malawian Migrants, Magogo's House, Beitbridge, 2020



### 3.3.3. Life at the last residence in the country of origin

When asked about the main problems in their last residence, 41% of our interviewees reported lack of money or poverty; 40.4%, food insecurity and 26.4%, unemployment.

Unemployment seems, indeed, to be an important root of distress for many Malawian migrants, as in the other groups so far described. Nevertheless, when compared to Zimbabwean deportees and migrants in Musina, more people at Magogo's declared to have suffered from lack of food and poverty in their home town. The trend is most likely related to the high percentage of

respondents previously residing in rural areas and relying on farming as their main source of income.

Figure 22 - Word Cloud Analysis, Main Problems of Last Residence in Malawi, Malawian Migrants, Magogo’s House, Beitbridge, 2020



In fact, the poverty index found among Malawian migrants is higher than for any other group analysed— even when compared to Burundians and Congolese. At least 88% of interviewees came from households with some degree of poverty, meaning that the residence lacked access to proper water or sanitation facilities, that is was overcrowded and/or it did not have basic assets. Such results are compatible with the levels of food scarcity found in migrants’ home areas: more than half of Malawians interviewed revealed to feel hungry on at least some months in their last residences. 20% also said to feel unsafe – when asked why, instead of reporting violence related reasons, most listed factors such as lack of food, drought or financial challenges. The findings, hence, reinforce the survival character of Malawian diaspora and could even suggest the existence of environment-led mobility. Previous research has in fact emphasized the importance of ‘shocks’ on Malawian’s out-migration from rural areas – these shocks are intimately linked to agricultural pests, rapid increase in prices of grains, droughts, and floods. (Anglewicz and Myroniuk, 2018)

Table 58 - Frequency of Feeling Hungry and Feeling Unsafe in Last Residence in Malawi, Malawian Migrants, Magogo's House, Beitbridge, 2020

Variable	How often would feel hungry	How often would feel unsafe
Frequency	Percentage (%)	
Almost every month	16.29	1.12
Some months, but not all of them	36.52	12.36
Rarely	32.58	6.18
Never	14.61	80.34
Total (%)	100.00	100.00
Total (N)	177	177

In general, Malawian migrants interviewed lived in extended family arrangement (60%). Overall, 39.3% resided with their children and 30.3% with their spouse and none were in polygamous marriages.

#### 3.3.4. Current Migration

The length of migratory' trajectories among Malawians is short, lasting, on average, less than 12 days; and migrants hardly ever stop throughout the journey. Most of them travel alone, both men and women. Travelling unaccompanied could, in fact, turn female migrants particularly vulnerable to violence or sexual assault through the journey. The findings also indicate that this type of mobility is of non-familiar character, with most migrants leaving spouses and children back home.

Table 59 - Migrants' Travel Companions, Migrants Interviewed at Magogo's House, Malawian Migrants, Magogo's House, Beitbridge, 2020

Travel Companions	Frequency (N)	Percentage of cases (%)
Spouse	1	0.56
Other relative	18	10.17
Friends	46	25.99
Neighbors	2	1.13
Others	4	2.26
Alone	112	63.28
Valid Cases	177	

Despite the journey being quite short, 21.5% of the respondents suffered some form of violence, mainly bribes and robberies in Mozambique (where Burundians also reported similar events); few of the episodes described involved actual physical assault. However, a description made by a woman on a sexual assault episode she suffered during the journey matches the informal reports collected during the survey implementation: “Some men that were travelling were touching my breasts or caressing in an attempt to have sex with me”. (Malawian female interviewee). Lastly, only 5.6% of the interviewees reported having any health problem in the journey, most of which consisted of minor illnesses.

### 3.3.5. Life in South Africa

Out of all Malawian migrants interviewed, only 32% had previously lived in South Africa for more than three months. Since most were concentrated in Durban and Johannesburg, it is possible to analyse some aspects of both destinations:

Table 60 - Main Cities of last Residence in South Africa, Malawian Migrants, Magogo’s House, Beitbridge, 2020

Name of the City	Frequency (N)	Percentage (%)
Durban	18	40.91
Johannesburg	13	29.55
Other	13	29.55
<b>Total</b>	<b>44</b>	<b>100.00</b>

Unemployment rate for Malawians in South Africa is low regardless of the city, as only 3.5% of the respondents were unemployed. 71.9% lived with at least one family member, who were mostly siblings, aunts or uncles. Only a few were with their spouses or children.

Unemployment (52.6%), physical assaults (26.3%), fear of arrest (22.8%) and xenophobia (17.5%) were the main problems faced by Malawians in South Africa. In fact, guided by the Zimbabwean case, we expected Johannesburg to be the city with worse perception of security and most physical assault reports. But for Malawians, the riskiest destination appears to be Durban, as revealed in Table 61.

Table 61 - Frequency of feeling unsafe in the neighbourhood of residence in South Africa, by main Cities, Malawian Migrants, Magogo's House, Beitbridge, 2020

Feeling Unsafe	Always	Occasionally	Rarely	Never	Total
City of Last Residence	Percentage (%)				
Durban	50.00	54.55	36.36	16.67	38.64
Johannesburg	30.00	9.09	27.27	50.00	29.55
Other	20.00	36.36	36.36	33.33	31.82
<b>Total</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>
<b>Total (N)</b>	<b>10</b>	<b>11</b>	<b>11</b>	<b>12</b>	<b>44</b>

Xenophobia and robberies were the main reasons that made Malawians feel unsafe in Durban whereas in Johannesburg it was the fear of arrest, although, again, numbers at this level are very small.

Table 62 - Reason to Feel Unsafe in the neighbourhood of residence in South Africa, by Main Cities, Malawian Migrants, Magogo's House, Beitbridge, 2020

Reason to Feel Unsafe	Fear of arrest	Robberies	Xenophobia	Total
City of Last Residence	Percentage (%)			
Durban	20.00	60.00	57.14	46.88
Johannesburg	40.00	20.00	14.29	21.88
Other	40.00	20.00	28.57	31.25
<b>Total</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>
<b>Total (N)</b>	<b>10</b>	<b>10</b>	<b>7</b>	<b>27</b>

Discrimination and physical assaults are common among Malawian migrants living in South Africa; 73.7% of the respondents had been discriminated and 28% had been physically assaulted at least once, with that percentage rising to 50% among migrants previously residing in Durban.

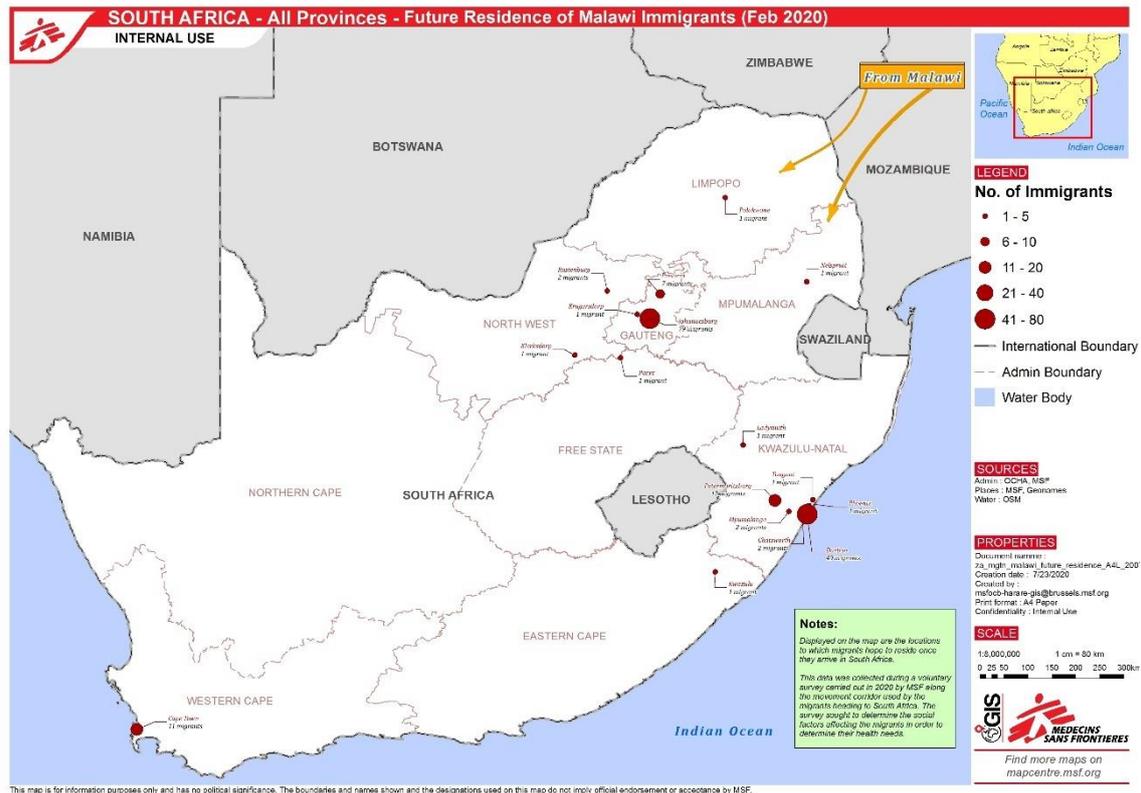
Although our findings are based in very few observations, the results are consistent with the wave of xenophobic attacks that took place in both cities in last years, recently peaking in 2017 and 2019 (ACMS, 2019). In Durban, violence outbreaks have forced thousands of Malawian migrants to return home. (IOM, 2017)

Regarding access to medical care, 45% of the interviewees that lived in South Africa had never accessed medical care; rates are similar for both men and women. Most people alleged that they never needed clinical attention – a similar trend as the one found for Zimbabwean deportees at the Reception Centre.

### 3.3.6. Future Plans

After leaving Beitbridge, most migrants planned to get by car or bus to their next destination in South Africa. Favourite cities included Johannesburg, Durban, Pietermaritzburg and Cape Town

Figure 23 - Map of Indented Next Destination, Malawian Migrants, Magogo’s House, Beitbridge, 2020



Similar to Zimbabweans and Central Africans, it is not a surprise that Johannesburg figures as a popular destination for Malawian migrants heading to South Africa. The Durban area, however, has shown to be particularly favoured by this group. As corroborated by other reports and literature on international migration in the area, Durban hosts an important Islamic community, serving as a point of attraction for Muslim migrants reaching out across the sub-continent, mostly Malawians and Senegalese (Shahid, 2017).

Once more, men and women show different reasons to choose a particular destination. Although the search for employment opportunities was an important factor for both genders, gathering with a family member was the reason pointed out by 30.6% of our female respondents.

### 3.3.7. Chronic and Infectious diseases

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

Table 63 - Percentage of People who Reported Chronic and Infectious diseases, Malawian Migrants, Magogo's House, Beitbridge, 2020

Chronic Diseases	Yes	No	Does not know	Total	Total (N)
Percentage (%)					
High Blood Pressure	2.25	92.70	5.06	100.00	178
Heart Disease	2.81	92.13	5.06	100.00	178
Diabetes	0.56	98.31	1.12	100.00	178
Chronic Respiratory Disease	0.00	98.88	1.12	100.00	178
High Cholesterol	0.00	100.00	0.00	100.00	178
Malaria (Since Jan.2019)	37.64	60.67	1.69	100.00	178
Dengue (Since Jan.2019)	0.00	98.31	1.69	100.00	178
Tuberculosis (Since Jan.2019)	0.00	98.31	1.69	100.00	178
Cholera (Since Jan.2019)	0.00	100.00	0.00	100.00	178
Measles (Since Jan.2019)	0.56	98.88	0.56	100.00	178
Hepatitis (Since Jan.2019)	0.56	97.19	2.25	100.00	178

Contrary to the displaced populations from Burundi or Congo in Musina, most migrants from Malawi who had Malaria were diagnosed by clinicians (88.1%) and received specific treatment (86.1%). Almost all respondents who underwent treatment were prescribed some kind of medication, being Lariam (LA) the most common of them. The findings suggest better access to Malaria treatment in Malawi, than in Central Africa, even when most people come from rural areas. Because incidence rates are so high, and journeys are so short, the results also indicate that some Malawians could arrive in Beitbridge with Malaria symptomatology.

### 3.3.8. Sexual and reproductive health

Most Malawian migrants are aware of HIV, and familiarity with the disease is positively correlated to education. 93.2% of interviewees had heard about the illness before, and the proportion increases among those who have attained a higher degree of education.

When asked about the main ways through which HIV is transmitted, 77.1% of our Malawian interviewees answered unprotected sex or sex with an infected person. However, and similarly to what happened in Musina, there is a significant share of respondents who listed “sleeping around” (10.8%) or “cheating” (9%) as a main mode of infection. The idea that the disease may be linked to ‘immoral’ sexual activity seems to be recurrent among our participants, with Zimbabweans probably being an exception.

79.8% of Malawian migrants interviewed had been tested before for HIV, most of them in Malawi. Women had been more recently tested than men, on average (135 days prior to the date of the interview against 274 for men). Overall, only 3.5% of the respondents reported to be living with HIV, with no significant difference between genders.

Condom use is low among Malawian migrants, as only 52.4% of sexually active respondents used the barrier method in their last sexual relationship. The results are consistent with the extremely high proportion of Malawians who presented some sign of sexually transmitted infection (43% of the sexually active participants). As will be discussed in Section 3.5, the percentage of respondents reporting genital ulcer at Magogo’s place is the highest of all groups interviewed, which is agreeing with the concerning levels of sexual abuse among Malawian migrants presented next.

Again, numbers at this level of disaggregation are rather small, but our findings also show extremely low use of mid and long-term family planning methods among Malawian single women, such as pills, implants or injectable (Table 64). Even though most of them report condom as their main contraceptive option, there is no clarity about its consistent utilization. Findings at this point, hence, suggest an urgent unmet need for better sexual and reproductive health care at the site.

Figure 24 – Percentage of People who Reported Discharge or Genital Ulcer, by Sex, Malawian Migrants, Magogo’s House, Beitbridge, 2020

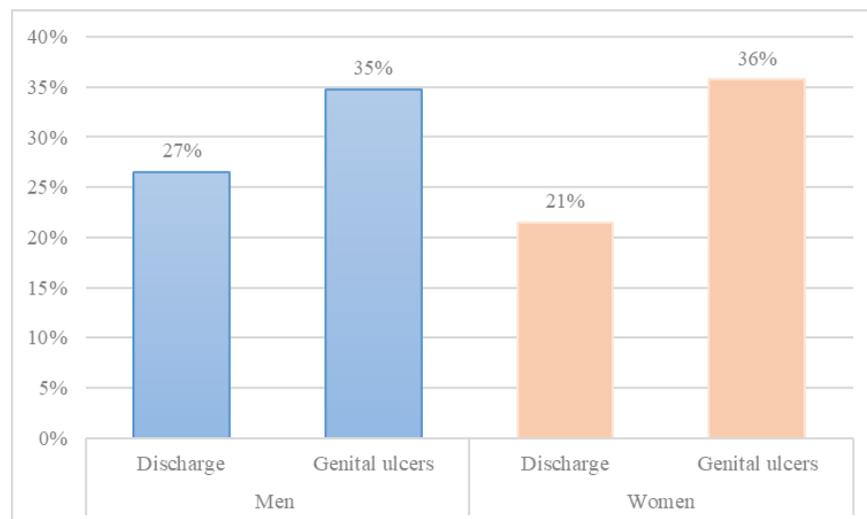


Table 64 - Type of Contraceptive Method used, by sex and marital status, sexually active people only, Malawian Migrants, Magogo’s House, Beitbridge, 2020

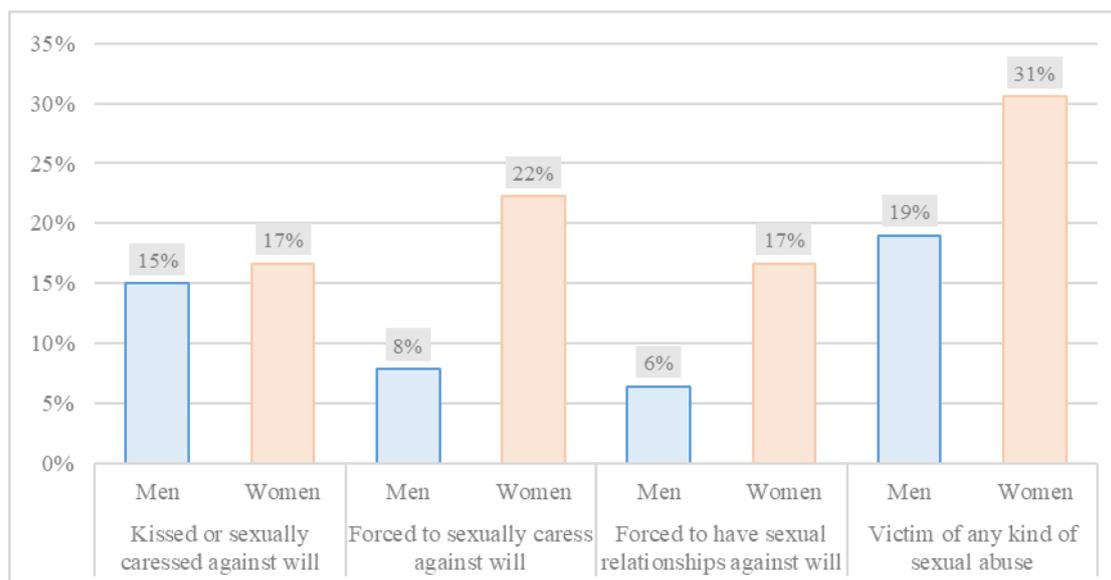
Variable	Men	Women	Total	Married	Single	Total
Type of Contraceptive	Percentage (%)					
Condom	70.27	20.00	59.57	34.78	90.91	62.22
IUD	2.70	0.00	2.13	4.35	0.00	2.22
Injectable	13.51	60.00	23.40	39.13	4.55	22.22
Implants	10.81	20.00	12.77	17.39	4.55	11.11
Pill	2.70	0.00	2.13	4.35	0.00	2.22
Total	100.00	100.00	100.00	100.00	100.00	100.00
Total (N)	37	10	47	23	22	45
P = 0.020**				Pr = 0.004***		

### 3.3.9. Sexual Violence

When asked about sexual violence, we did not inquire interviewees about the exact date of the episodes or its location. It is difficult, hence, to determine whether they took place throughout the journey or in their country of residence. The extremely high rates of abuse found, however, seem highly correlated with the current STI symptomatology reported by our respondents. It should be no coincidence, thus, that Malawian migrants present both the highest rates of discharge and genital ulcers, on one hand, and of sexual abuse, on the other. In fact, given the results encountered, we believe that risky sexual activities have taken place not long ago.

Marital status is related to sexual abuse, and female single migrants are particularly vulnerable: 35.7% had gone through an episode of sexual violence very recently. As displayed in Figure 4, women are more prone than men to undergo all kinds of abuse, although violence against men should neither be disregarded.

Figure 25 - Percentage of Respondents who have been Sexually Abused in the last year, by Type of Abuse and Sex, Malawian Migrants, Magogo’s House, Beitbridge, 2020



The survey, alone, is not sufficient to entirely understand the type of smuggling and human trafficking activities operating in the site, and how they relate to the extremely concerning levels of sexual abuse found. We believe, however, that more targeted and gender specific activities on post-assault care in the location are not only necessary from a strictly medical point of view, as they could also improve MSF’s current understanding of human trafficking networks operating across the Malawi-South African corridor.

### 3.3.10. Alcohol abuse and mental health

Only a few male Malawian migrants presented signs of harmful alcohol consumption, which, as previously highlighted, could be associated with religious aspects. Regarding mental health disorders, 10.7% of Malawian migrants displayed moderate to severe symptoms of depression; and 9.5%, moderate to severe signs of anxiety. Differently from Musina and the Reception Centre, men presented more worrying signs of anxiety than women (11.3% of male respondents versus 2.8% of women)

However, what was truly noticeable among the results encountered are the strong linkages between sexual violence experiences, depression (Table 65) and anxiety symptomatology. The

finding reveals that, if offered at the site, post assault care must include a one-shot mental health consultation component. That implies a change in the current set up of the team, which would require at least one female mental health nurse fluent in Chichewa.

Table 65 - Depression Severity Indicator, by Recent Episode of Sexual Abuse, Malawian Migrants, Magogo’s House, Beitbridge, 2020

Sexual Abuse Exposure	Recent Episode of Sexual Abuse	No Recent Episode of Sexual Abuse	Total
Depression Severity Indicator	Percentage (%)		
None	36.84	63.87	57.87
Mild	44.74	27.86	31.46
Moderate	15.79	7.86	9.55
Moderately Severe	0.00	0.71	0.56
Severe	2.63	0.00	0.56
Total (%)	100.00	100.00	100.00
Total (N)	38	140	178
P = 0.015**			

With respect to stress management techniques, Malawian migrants present similar trends as the rest of the groups, tending to rely mainly in self-distraction (46.3%), religion (12.8%) or emotional support from family or friends (7.3%) to cope with stress. Very few respondents lean on substance use as means to endure difficulties.

Lastly, when asked about main stressors, Malawi migrants most often quoted not being able to support family, poverty and food scarcity. In fact, food scarcity appeared more frequently among Malawians than for any other group, even those in Musina. When asked what they meant by lack of food, people referred both to situations lived in Malawi, which relates to findings in Section 3.3.4, and to hunger at the moment. During the time of the survey, we have encountered people who had not eaten for 3 days. Lack of food obviously impacts health care provision aimed at this population, as explained by one of the respondents who self-reported to be living with HIV: “I’m sick I want food so that I can take my pills” ; other still reported “I’m hungry I feel like falling if I can have food I will be ok”. In fact, our data suggests that food insecurity is much more evident among displaced Malawian population going through Beitbridge, than among migrants at the Reception Centre, who would have most likely eaten the day prior to deportation.

### 3.3.11. Main Recommendations

At the Magogo's place we recommend a targeted intervention focused on Sexual and Reproductive Health, which should encompass as main components:

- Routinary SGBV screening and post-assault care, including stigma reduction interventions. The health care strategy should be gender sensitive and count with the presence of at least one female nurse/health promoter who is fluent in Chewa or Nyanja. Because of high turn-over at Magogo's place, interventions should take place on at least every 3-4 days;
- Common STIs screening and treatment, including health promotion strategies focused on the recognition of common signs and symptoms of sexually transmitted infections. Among women, sensitization could be coupled with the distribution of sanitary pads/menstrual cups and provision of long-term family planning methods;
- Run quick HIV prevention talks, combined with the distribution of condoms to both men and women;

Additionally, we recommend:

- Detection and treatment of people with Malaria symptomatology, given the high rates of migrants reporting a recent episode of the disease;
- Due to high food insecurity at the place, which could have a great impact on the provision of health care aimed at this population, we recommend meal distribution to migrants going through Magogo's or a partnership with an organization that could offer so;
- Collection of testimonies that could help MSF to better understand sexual trafficking activities involving Malawian women in the site and in destination areas;
- Future needs assessment could be conducted in Malawians main cities of settlement, such as Johannesburg and Durban.
- In line with results from Section 3.2., the Mozambican border is probably the place where most events of violence happened (Biliwili border in specific). Further assessments could also be carried out in the site.

## **3.4. Cross Border Population**

### 3.4.1. Respondents' Main Characteristics and Household Information

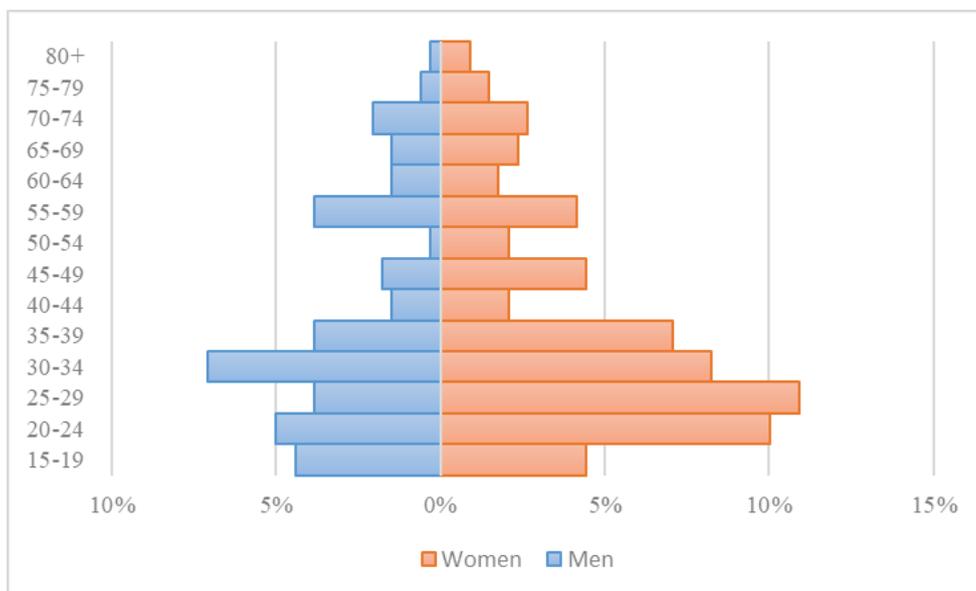
In order to understand not only the plight of migrants but of their families left behind, we have run the mobility survey in the so-called cross border villages along the Limpopo river. We have also applied the same questionnaire to the cross-border population we interviewed at the crossing

points, namely Pounden, Gate 2 and Mike. Nevertheless, in face of the reasons mentioned at the introduction of this report, we have chosen not to mix their answers in this section, a part from few punctual observations. Most health data from the population we interviewed at the crossing points is portrayed in Section 3.5.

At the three villages analysed, Dite, Chikwarakwara and Shashe, the population was not evenly distributed in terms of sex. The sex ratio, meaning the number of men per every woman, was significantly low in all rural Beitbridge, as indicated by the last population Census of 2010. The same data indicated an imbalance with regards to age distribution, with a significant population share concentrated in young age groups (0-15 years old) and older age groups (65+). Both patterns most probably indicate the existence of an important migratory exodus of adult men and to a lesser extent, adult women. As it will be further discussed, our hypothesis was that such mobility patterns could have an impact on the health status of the population left behind, majorly women, children and the elderly.

Knowing the population structure beforehand, we have stratified our sample in terms of sex and age, for the three sites alike. The pyramid bellow displays the distribution we have found among our respondents. As it is possible to see, there is a shortness of men, in comparison to women, in all age groups bellow 55.

Figure 26 - Age and Sex Pyramid, Cross-Border Population, Rural Beitbridge, 2020



Sex imbalances may also be explained by over mortality of men as the number of widowed women indicate. As showed in Table 66, 17.92% of women interviewed have lost their husbands, compared to only 3.15% of men. ¼ of widowed women were below 47 years old. Those young

widowhood rates most probably indicate high male mortality due to HIV, although we have insufficient data to reach a definite conclusion.

Regarding employment rates, our data indicates that roughly 70% of this population does not work. Among the ones working, most are self-employed as farm laborers (subsistence agriculture), broom-makers, sales-persons or repair workers. Only 2% of people were working for someone else. The rates of joblessness encountered are extremely high, even when compared to national statistics (Zimstat, 2019), revealing that most family income should come from aid or from people living abroad.

In terms of access to basic commodities and infrastructure, we have encountered that 15.63% of the households interviewed have inadequate water sources (collect water from unprotected borehole or river/stream); and 53.39%, inadequate sanitation facilities (no facility at all). When calculating poverty indicators, through the multidimensional poverty methodology indicated, we have found that households in Shahse are significantly better-off than in Dite and Chikwarakwara, which relates to other results that that will be later discussed.

Table 66 - Marital Status, by Sex, Cross-Border Population, Rural Beitbridge, 2020

Sex	Men	Women	Total
Marital Status	Percentage (%)		
Married	62.99	58.49	60.18
Single	31.50	17.45	22.71
Widowed	3.15	17.92	12.39
Divorced	2.36	6.13	4.72
Total (N)	127	212	339
Total (%)	100.00	100.00	100.00

#### 3.4.2. Migration of Household Members

Apart from asking respondents' main characteristics we have also inquired our interviewees about all people currently residing in their residence and on those who currently live abroad, but who frequently come back to the household (at least once a year). Through this question, we intended to capture international circular migrants – mainly those who worked in South African farms but who still maintained ties with their family at the origin. It should be noted, hence, that due to the design of the question, we have not included those people currently residing in other sites and who for a variety of reasons, do not circulate on a frequent basis.

In spite of the question limitation, we have still found surprisingly high shares of households with the so-called international circular migrants, or migrants who maintained physical ties with the origin. As showed in Table 67, 59% of the residences we visited had at least one international migrant who came back to the origin on an annual basis. There was not significant difference in the presence of international migrants among the three villages.

Table 67 - Percentage of Households with at least one International Migrant, Cross-Border Population, Rural Beitbridge, 2020

	Frequency (N)	Percentage (%)
Household with International Migrant	200	59.00
Household without International Migrant	139	41.00
<b>Total</b>	<b>339</b>	<b>100.00</b>

In line with what we already knew from the population distribution, we have found that most international migrants are men (61.80%) in their 30s (mean age is 30.8 years old). Differently from the unemployment rates found among current Zimbabwean residents, most international migrants (66.7%) are employed for someone else, as showed in Table 68. In most cases, non-residents were the child or sibling of the respondent. Still, 27.78% of women interviewed were married to an international migrant. The important number of left-behind women led us to investigate whether the departure of the husband could have any effect on their mental health, sexual and reproductive health and exposure to violence (See results in Sections 3.4.7 and 3.4.8).

Table 68 - Employment Status of International Migrants, Cross-Border Population, Rural Beitbridge, 2020

Employment Status	Frequency (N)	Percentage (%)
Self-employed	21	9.46
Employed for someone else	148	66.67
Housework	1	0.45
Retired	1	0.45
Unemployed	35	15.77
Child bellow 15	16	7.21
<b>Total</b>	<b>222</b>	<b>100</b>

Not only have migrants left spouses at the origin, as many of them (41.1%) were also responsible for a child remaining in Zimbabwe. This important finding also remounts to one of our main research questions in relation to cross border population: would out-migration of adults have any effect on the health of children staying in Zimbabwe?

Table 69 - International Migrant, by Children Left Behind and Remittances, Cross-Border Population, Rural Beitbridge, 2020

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

Remarkably, many of them are also responsible for sending money or goods (remittances) to their households at the origin (63.64%). As displayed in Table 70, almost all households that receive such financial or material help use the resources to buy food (95.5%). Half also divert the aid to child’s education, while others use it in health care. According to our findings, remittances do not represent only punctual help: households that act as recipients of international money were, in fact, significantly richer than others. The results prove the fundamental importance of revenue from international migrants on the well-being of the population living across the border. This tendency relates to classic migration literature, which stresses the role of mobility on the diversification of income sources among rural households in the Global South. (Stark and Bloom, 1985)

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

Table 70 - Use of Remittances, Cross-Border Population, Rural Beitbridge, 2020

Use of Remittances	Frequency (N)	Percentage of cases (%)
Buying resources for farming	26	17.81
Improving housing conditions	33	22.60
Food	141	96.58
Health	54	36.99
Child's education	66	45.21
Other	11	7.53
Valid cases	146	

Beyond financial matters, international migration also provokes a rearrangement of care systems in families that should not be disregarded, as showed in Table 71. Migrants with international migrants are more frequently extended, i.e have people with different kinship ties (uncles, aunts, grandparents, adult siblings) cohabitating in a single household. They are also more likely to be single parented, probably indicating the migration of a men who leaves spouse and children at the origin.

Table 71 - Household Arrangements by Presence of International Migrant, Cross-Border Population, Rural Beitbridge, 2020

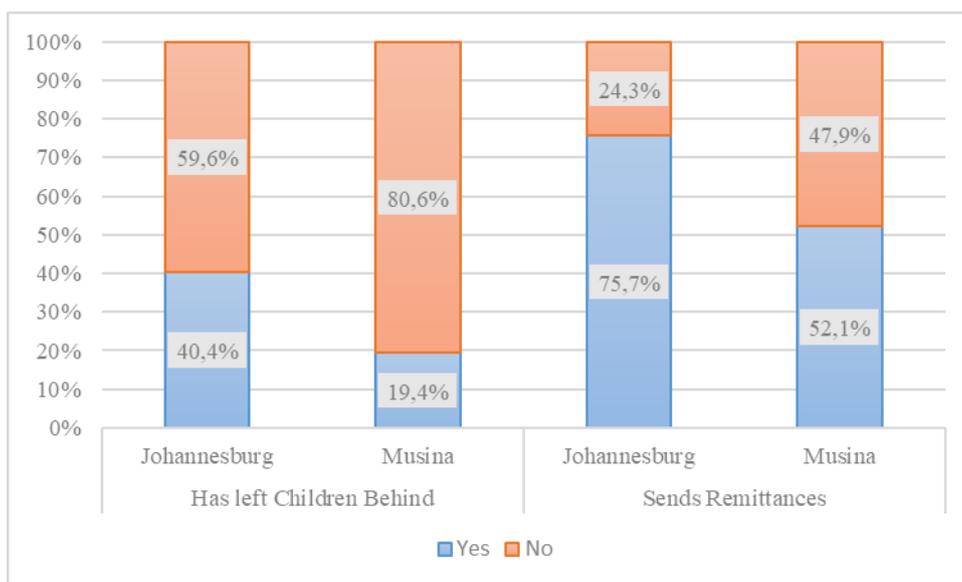
Presence of International Migrant	Household with International Migrant	Household without International Migrant	Total
Household Arrangement	Percentage (%)		
Couple with Children	7.00	27.34	15.34
Single Parent Household	18.50	11.51	15.63
Single Household	2.00	7.19	4.13
Couple without Children	3.50	2.16	2.95
Extended Households	67.50	49.64	60.18
Complex Households	1.50	2.16	1.77
Total (%)	100.00	100.00	100.00
Total (N)	86	253	339
P=0.000***			

Another question that motived the study of this group was whether the intense out migration along the border generated skipped generation households or 'child and elderly only' arrangements—meaning those in which grandparents lived alone with their grandchildren. Contrary to expected, these arrangements were insignificant, as most left behind children lived either alone with their mother and siblings, or in extended arrangements with many other relatives, even if they had the

grandmother as the main caregiver. The impact of having an older caregiver on the child’s health will be further discussed in Section 3.4.5.

Figure 27 highlights international migrants’ main destinations. Surprisingly, many of them were not working in farms as we once thought, but rather in big urban Centres, mostly Johannesburg. It is also worth pointing out how the migrant residence is tied to household care arrangements and remittances. As displayed in Figure 28, our data showed that those heading to Johannesburg are much more likely to send financial support back home and leave children behind than the ones who are living in Musina (city or rural areas). The findings demystify the idea that people living along the Limpopo River migrate solely to South African farms in the Musina region. In fact, most financial support received by households at the origin seems to come from migrants residing in Johannesburg.

Figure 27 - Migrants who have left Children Behind and who Send Remittances, by Current Residence in South Africa, Cross-Border Population, Rural Beitbridge, 2020



### 3.4.3. Migration History

In order to capture recurrent, circular migration, we have also asked our respondents whether they had lived in another country in the last year, for at least 1 month. To those who did, we have also asked about all places where they stayed during the year and how life conditions in the last residence abroad were.

To our surprise, only 54 people, or 15.9% of our respondents, had lived in a foreign country since January 2019. Among those, almost all had been in South Africa only once. These findings

suggest that intense circulation, for residence purposes, is not that common across borders. Nevertheless, one important limitation of our study was that we have not asked about pendular movements across borders for medical or commercial reasons, i.e those visits that last one day or a few days maximum. We have only inquired about health access in South Africa and Zimbabwe to those who had effectively lived in a foreign country for at least 1 month, although we do have some indication about circulation of people for medical purposes in Sections 3.4.6 and 3.4.7.

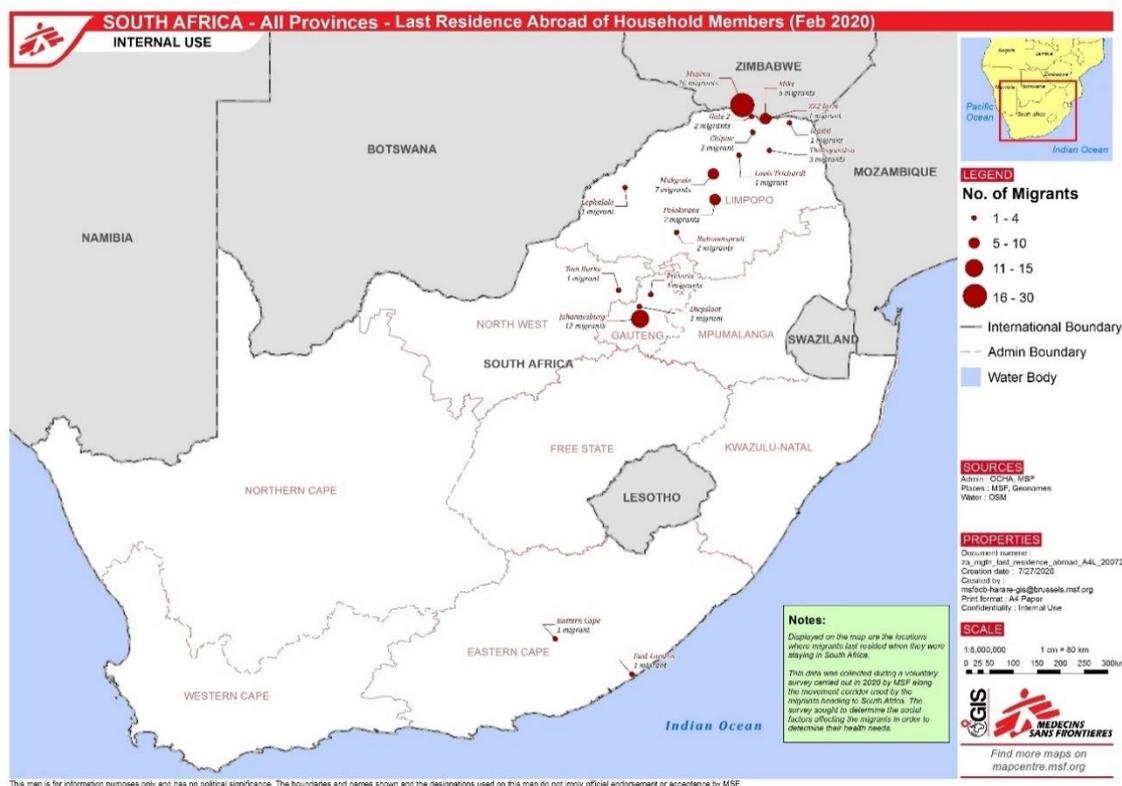
Figure 28, reveals that most our respondents had lived in Musina region, although some were also heading to Johannesburg. Most people referred to Musina city, but we are unsure if they meant the district, including urban and rural areas, or only the urban portion. Places like Mike, Malale, Madimbo, Gate 2, Gate 7 and Kumapurazi are also relevant. When going to Musina, most people stated that their main motivation was to look for a job or have better living conditions.

When crossing the border, we asked respondents if they had faced any challenges, such as an event of violence, or health problem. None of our interviewees had had a health problem; only one suffered a light injury; and 2 were victims of robbery. The same patterns were found for migrants we interviewed at the crossing points. The results indicate that most of the river crossing happens smoothly, and is probably part of the day to day life of the population living in this area.

When inquired about their health access in Zimbabwe and South Africa we have found that most of these ‘circular’ migrants used equally Zimbabwean and South African services and also for similar purposes. Surprisingly, for 93.3% of them stated to have encountered no difficulties to access health care in South Africa. More details about access to health in both countries will be discussed in the following modules – now including all interviewees.

When it comes to living conditions in the foreign country, the majority of persons had access to adequate sanitation, ventilated rooms, and 3 meals a day. Only a few had been assaulted or had a health emergency, and when they did they found medical support. The same patterns were found when we took only people who were farm workers in South Africa – now including also the ones interviewed at the crossing points.

Figure 28 - Last Residence in South Africa, Cross-Border Population, Rural Beitbridge, 2020



### 3.4.4. Food Insecurity

In the present research, we did not collect clinical nutritional measures, but rather, questions on food deprivation.<sup>16</sup> Table 72 brings in the results of one of the inquiries. In general, respondents did not admit feeling hungry frequently – only 13.02% reported to feel so almost every month. We do not believe that the answer to these questions was biased, as it happens in some surveys designed specifically for food programs. In fact, respondents reporting to have cut or skip meals due to lack of resources lived in significantly poorer households than others.

<sup>16</sup> We have asked three questions in the food insecurity module: “In the last year, did you feel hungry because there was not enough money to buy food?”; “In the last year, how often did you have at least three meals a day?”; “In the last month, did you cut or skip meals because there was not enough money to buy food?”. The questions were based on the Household Food Insecurity Access Scale (HFIAS) for Measurement of Food Access: Indicator Guide. (Coates, Swindale and Bilinsky, 2007)

Table 72 – Frequency of Feeling Hungry due to Lack of Resources, Cross-Border Population, Rural Beitbridge, 2020

Frequency of Feeling Hungry	Frequency (N)	Percentage (%)
Almost every month	44	13.02
Some months, but not all of them	90	26.63
Rarely	82	24.26
Never	122	36.09
<b>Total</b>	<b>338</b>	<b>100.00</b>

Also, as previously discussed for the poverty indicators, there seems to be important differences in food access rates among the three villages studied, with Shashe showing higher food access in relation to Dite and Chikwarakwara:

Table 73 – Percentage of People who have skipped or cut meals in the last month due to lack of resources, by Village, Cross-Border Population, Rural Beitbridge, 2020

Village	Dite	Shashe	Chikwarakwara	Total
Food Scarcity	Percentage (%)			
Skipped Meals	56.67	42.74	66.67	53.10
Did not Skip Meals	43.33	57.26	33.33	46.90
<b>Total (%)</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>
<b>Total (N)</b>	<b>180</b>	<b>117</b>	<b>42</b>	<b>339</b>

Lastly, we tried to assess the impact of having an international migrant in the household on food scarcity. We have assumed that there are no inequalities in the household with regards to food access, meaning that the answer of each respondent represented the overall situation of the people living in the residence. As it would be expected from what has been outlined so far, those living in households that receive international remittances were less likely to have cut or skipped meals in the last month. The finding is also consistent with our data on use of remittances, which are frequently employed in the purchase of food resources. Interestingly, having an international migrant is not, per se, an advantage with regards to food availability.

Because international remittances represent an asset to households, we have also investigated if those which had children left behind were less likely to report food scarcity. As previously discussed, children with international migrant parents seem to be more protected, in financial matters, than others. The table below confirms this pattern, revealing that young people below 15 with parents abroad are less likely live in households reporting food shortage than others:

Table 74 - Children Left Behind in the Household, by Food availability, Cross-Border Population, Rural Beitbridge, 2020

Household Arrangements	Households with Left Behind Children from International Migrants	Households with children, but no children left behind from International Migrants	Total
Food Availability	Percentage (%)		
Lack of Food	44.44	61.33	55.00
No Food Shortage	55.56	38.67	45.00
Total (%)	100.00	100.00	100.00
Total (N)	90	150	240
P=0.011**			

### 3.4.5. Child's Health

Even though the importance of international remittances on the wellbeing of families is widely recognized, migration scholars have been extensively debating the impact of transnational living arrangements on children left behind. If children certainly benefit from revenues of migrant parents, they may be profoundly impacted by prolonged separation. (Mazzucato and Shans, 2011; Dreby, 2007) Some studies have found that distresses are especially higher when the mother is the one who leaves (Parreñas, 2005) – this debate has in fact generated the theory of ‘care drain’, which postulates that the international migration of women would generate a crisis of care in the Global South.

In order to understand the impact of international migration on children living in the cross-border villages, we have asked questions about all children (0-15) living in the households analysed. Data comprised information on vaccination, infectious diseases’ signs and symptoms and access to health care. We have also collected figures on parents’ migratory status, as well as details about caretakers. One important limitation of our survey, however, was that we did not collect data on children’s mental health, as these would have to be self-reported through a specifically designed methodology.

Table 75 reveals the surprisingly high percentage of children with international migrant parents (mother, father or both) – almost 40.5% of the 274 children surveyed. If we go beyond international migration also to analyse those with absent parents (living in other cities, dead or missing), we see that 27.9% of children do not have mother in the household and 58.1% do not live with their father (Figure 29).

Table 75 - Migratory Status of Children’s Parents, Cross-Border Population, Rural Beitbridge, 2020

Migratory Status of Parents	Frequency (N)	Percentage (%)
Father is an international migrant	71	25.91
Mother is an international migrant	33	12.04
Both parents are international migrants	7	2.55
Neither parent is an international migrant	163	59.49
<b>Total</b>	<b>274</b>	<b>100</b>

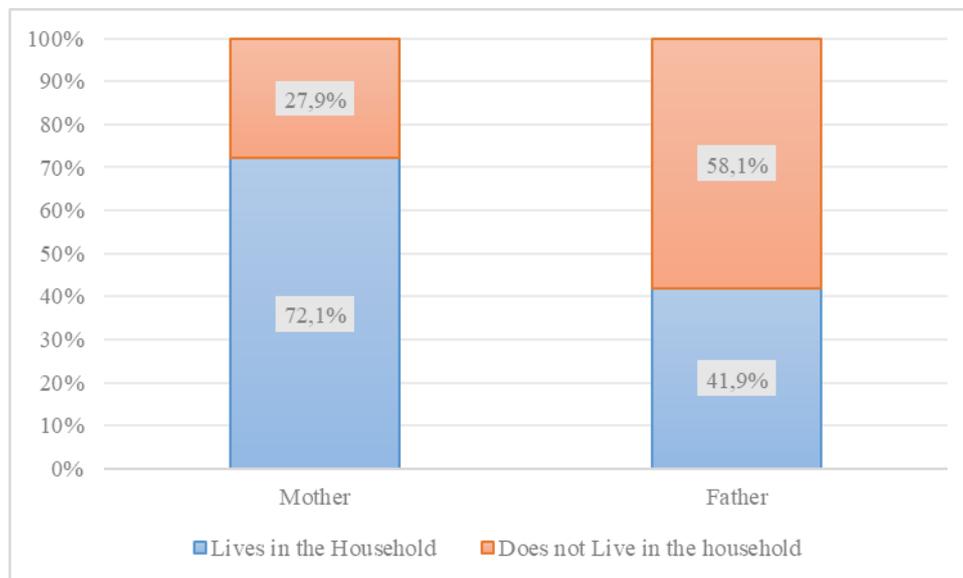
For most children with absent fathers, the mother is the one who takes up the main caregiving responsibilities. On the other hand, once the mother leaves or dies, the caretaker usually becomes a significantly older woman (16.2 years older than the average caretaker), who is most probably the grandmother.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

Guided by the international literature on the matter, one of our questions was “does the migration or absence of the mother – and the consequent transference of caregiving roles to an older person – has a negative impact on children’s health”? Whereas we do not have all the necessary elements to answer to this question, our results most likely indicate that having a migrant or absent mother does not significantly alter the probably of a 0-5-year-old child to be vaccinated, although the number of small children with absent mothers is rather small. Neither does it seem to impact the likelihood of a 0-15-year-old to present sings/symptoms of infectious diseases or be taken to a medical facility in case of illness.<sup>17</sup>

It is possible that the little impact of mother’s absence on child’s health, through our selected indicators, relates to a naturalization of extended and child fostering arrangements that is very particular of Southern and West African regions (Mazzucato and Shans, 2011). More in depth, and possibly mixed-methods studies, however, would be necessary to come to more solid conclusions on that regard.

<sup>17</sup> A further analysis of the questions on child’s health will be provided for the second report, as it requires a reshape of the database.

Figure 29 - Percentage of Children with Absent Fathers and Mothers, Cross-Border Population, Rural Beitbridge, 2020



### 3.4.6. Chronic and Infectious Diseases

In general, 60% of our respondents have rated their overall health as good or very good – although older females were much more likely to qualify their health as bad or very bad than others. As it will be discussed, this may be linked with HIV status or mental health indicators.

With regards to general chronic diseases, respondents have reported most often to present high blood pressure. Prevalence of the condition in the general population is 9.73%, with the rating increasing to 22.62% among people aged 50 years old or plus. Among those with HBP, 40% were not being treated – a worrying result. Reports of common infectious diseases, including Malaria, were not significant.

Table 76 - Percentage of People who Report to have Chronic Conditions, Cross-Border Population, Rural Beitbridge, 2020

Chronic Disease	Yes	No	Does not Know	Total	Total (N)
Percentage (%)					
High Blood Pressure	9.73	85.55	4.72	100.00	339
Heart Disease	1.47	93.81	4.72	100.00	339
Diabetes	0.29	95.28	4.42	100.00	339
Chronic Respiratory Disease	0.59	97.94	1.47	100.00	339
High Cholesterol	0.00	94.99	5.01	100.00	339

### 3.4.7. Sexual and Reproductive Health

#### 3.4.7.1. *Sexually Transmitted Infections*

91.4% of our respondents had already heard of HIV, which is a generally low rate compared to the other sites covered by the study. The pattern could probably be explained by the age distribution of our interviewees. In fact, those who had never heard of HIV were 10 years older, on average, than the rest, and also less educated.

Not only people interviewed at the cross border villages were more prone to had never of heard of the disease, as they were also less likely to point out ‘unprotected sex’ or ‘sexual intercourse with an infected person’ as a main way of transmission (31.27% of the interviewees did not mention one of these modes). Among those who did not mention these transmission modes, most reported not to know how a person gets HIV; others quoted ‘sharing sharp objects/razor blades’; and many said ‘contact with blood and sores’. Mother-to-child transmission was also often reported by respondents. It is worrisome that many people living in the villages are not aware of HIV main transmission mode, even when they rightfully list other infection paths such as vertical transmission. There was no significant difference among Dite, Chikwarakara and Shashe, in that regard.

84.11% of our respondents had been tested for HIV, with no significant difference among men and women. Again, older respondents were less likely to had been tested. Reported HIV prevalence was 15.41% - a bit higher than national average for Zimbabwe- with no imbalance among men and women. Table 79 reveals, still, HIV status by women’s marital condition: although numbers are relatively small, the share of widows with the disease is surprising: 1 in every 3, which could indicate the previous death of a husband from the disease.

Table 77 - HIV Test Results, by Marital Status, Cross-Border Population, Rural Beitbridge, 2020

Marital Status	Married	Single	Widowed	Divorced	Total
HIV test results	Percentage (%)				
Positive	12.61	22.58	33.33	8.33	16.85
Negative	86.49	70.97	58.33	83.33	79.78
Indeterminate	0.00	3.23	0.00	0.00	0.56
Did not receive the results	0.90	0.00	4.17	0.00	1.12
Does not want to answer	0.00	3.23	4.17	8.33	1.69
Total (N)	111	31	24	12	178
Total (%)	100.00	100.00	100.00	100.00	100.00

Once diagnosed with HIV, half of respondents were out of medication for more than 20 days. Still, they all reported to be taking the pills regularly, as prescribed by the doctor. As happened in other sites, there seems to be a misunderstanding about what the regularity of HIV treatment should be and a mismatch between what people say and the number of days they had been out of treatment.

26.12% of our interviewees presented at least one symptom of STIs, such as discharge or genital ulcer – this rate increases significantly once we take only those who are single or divorced. These results coupled with low HIV knowledge and relatively high HIV prevalence indicate a latent need for sexual and reproductive healthcare among the populations analysed.

Table 78 - STIs Signs or Symptoms, by Marital Status, Cross-Border Population, Rural Beitbridge, 2020

Signs and Symptoms	STIs symptoms	No STIs Symptoms	Total
Marital Status		(%)	
Married	19.00	81.00	100.00
Single	45.83	54.17	100.00
Widowed	33.33	66.67	100.00
Divorced	57.14	42.86	100.00
Total (%)	26.12	73.88	100.00
Total (N)	35	99	134

#### 3.4.7.2. Maternal Health

We have asked women about whether they had children before and some more specific questions when the child was below 5 years of age. The reason to limit the time frame about maternal health questions was to avoid memory bias or collecting information about experiences that happened too long ago.

Overall, 86.7% of women interviewed (15+) had given birth prior to the date of the interview. Among the 30 who had not, 4 were pregnant, indicating extremely high fertility rates<sup>18</sup>. More surprising, perhaps, is that 66.67% of adolescents aged 15-19 years old had already started childbearing. Although we do not know adolescent pregnancy rates for older cohorts<sup>19</sup>, this percentage is already extremely high considering that in rural Zimbabwe, in general, only 16%

<sup>18</sup> Fertility rates were not calculated because, in the absence of birth registers, they would require the collection of complete reproductive histories, i.e all births and dates, of women interviewed.

<sup>19</sup> Since we have only asked the age of the last child, and not the first, it is not possible to determine how many women aged 19+ had children when they were 15-19 years of age.

of girls aged 15-19 had children or were pregnant. (Ministry of Health and Child Care, 2016). By ages 25-29, women interviewed had on average 2.32 children.

One in every three women had children born in South Africa, among which most had birth registers in that country – indicating that issuing a birth certificate in SA is not a problem. ANC consultations, on the other hand, were mostly done in Zimbabwe – with only 12.64% of women with recent childbearing having crossed the border for a consultation. For the few who had, half lived in a foreign country in the last year. It is possible to believe, hence, that occasional visits to the other side for ANC are not as frequent as we once imagined.

Table 79 -Women who had ever had children by the time of the interview, by age groups, Cross-Border Population, Rural Beitbridge, 2020

Childbearing	Has given birth before	Has never given birth	Total
Age Groups	Percentage (%)		
15-19	66.67	33.33	100.00
20-24	80.95	19.05	100.00
25-29	88.10	11.90	100.00
30-34	97.30	2.70	100.00
35-39	92.86	7.14	100.00
40-49	91.67	8.33	100.00
50-59	89.47	10.53	100.00
Total (N)	186	27	213
Total (%)	87.32	12.68	100.00

With regards to quality and frequency of ANC visits, we have encountered important differences among the villages. Whereas on average, women visited the doctor for the first time at 13 weeks, and 5.2 times in total, thus indicating a relatively adequate access to maternal health; the gap between Shashe (the wealthiest of the villages) and Chikwarakwara is alarming. Whereas in the former, women visit the doctor for ANC 6 times on average, in the latter, they have gone only 3.5 times. In most cases, female respondents in Chikwarakwara allege that they did not see the need to do more frequent check-ups. The findings indicate that women in Chikwarakwara are probably not adequately informed about antenatal care. In line with that finding, in Chikwarakwara unmet need for contraception was also significantly higher than in the other villages.

Last but not least, we did not find any relationship between women’s ANC visits and the migratory status of their husband.

### 3.4.8. Violence Exposure and Transactional Sex

One of the key questions that drove our analysis of the cross-border population living along the Limpopo River was to understand whether women left behind were more vulnerable to domestic and sexual violence. We also investigated if they had higher tendency to rely on transactional sex as a source of income.

We first asked our interviewees about general (non-sexual) violence they had suffered in the last year, including robberies with or without physical violence, threats and assaults out of argument. The results indicate relatively low exposure, as displayed in Table 80. More importantly, yet, is that we did not find any differences among men and women; or among women with international migrant husbands. Whereas, due to the ethical reasons, we did not include specific questions on domestic violence, the inquiries were formulated so to include violence occurring within or outside the household. We warn, however, that domestic violence could have been underreported.

Table 80 - Type of Physical Violence Experienced, Cross-Border Population, Rural Beitbridge, 2020

Type of Physical Assault	Frequency (N)	Percentage (%)
Robbed with physical violence	5	1.47
Robbed without physical violence	9	2.65
Threatened or cheated to give money or goods, or to behave in a specific way	10	2.95
Assaulted out of abusive attitude or an argument	9	2.65
None	307	90.56
Valid Cases	340	

Differently from the general physical assault module, we asked our respondents through audio-based questions whether they had ever incurred in transactional sex – either offering or demanding – and if in those cases, condom was used. 25 of our interviewees, or 7.4% of our sample admitted to have offered sex in return of money or goods in the last year. Surprisingly, again, there was no difference among men and women. Other common variables, such as poverty index, having an international migrant in the household, having an international migrant husband, education or age did not seem to be correlated to transactional sex.

Perhaps the most interesting finding was that sex work – or its more subtle forms – was most often indicated by those people who had lived in South Africa in the last year. It is a good indication (due to question time frames), thus, that these types of activities are more common in the foreign country. Among those with a recent experience of transactional sex and residence

abroad, most were living in urban areas, even among migrants interviewed at the crossing points. The results are consistent with levels of exposure to sexual abuse found in displaced populations with previous experience of residence in big South African cities, who we interviewed at the Reception Centre or Musina. Although reports of transactional sex are common in rural farm areas, we did not find evidence of those in our survey.

8.66% of men reported to have offered money for sex recently, among which most were married and did not use condoms. Men who had lived in South Africa were not more likely to demand payed sex. Although numbers at this point are very small, it seems that all women in the region are at risk of contracting HIV from their husband’s unsafe sexual activities – there is no indication that those with international migrant spouses are particularly vulnerable

When it comes to sexual violence, we did not find specifically alarming levels in the villages– at least when compared to other sites, as it will be later explored. Interestingly, men and women were also equally exposed to abuse; yet, survivals were significantly younger than others.

#### 3.4.9. Alcohol Abuse and Mental Health

Once more, men seem particularly at risk of harmful consumption of alcohol in relation to their female counterparts: 8.66% of the men we interviewed in Dite, Chikwarakwara and Shashe were at high risk or likely addicted to the substance. Interestingly, those in households that received remittances were substantially less at risk. As we will see, remittances are also linked to better general mental health indicators.

Table 81 - Harmful Consumption of Alcohol Indicator, by Remittances, Cross-Border Population, Rural Beitbridge, 2020

Household Receives Remittances	Yes	No	Total
Alcoholism Indicator	Percentage (%)		
Low or Medium Risk	98.64	95.31	96.76
High Risk or Addiction Likely	1.36	4.69	3.24
Total (%)	100.00	100.00	100.00
Total (N)	147	192	339
P=0.087*			

Whereas this could be a spurious correlation and more robust models and qualitative data would be necessary to explain such relationship, remittances seem to have a clear impact on income, and most importantly, on food security. They could, therefore, have a critical influence on the wellbeing of families living across the border.

9.43% of our interviewees displayed moderate to moderately severe depression indicators, which is at similar levels of other sites analysed. Although there was no difference by sex, other variables seemed to have a key relationship with the development of depression symptoms. Those are mainly HIV status, alcoholism, transactional sex, and sexual violence. Most interestingly, women who had husbands in other countries were less likely to display depression symptomatology, as showed in Table 82. Anxiety was also negatively correlated with remittances.

When asked about their main stressors, most people talked about food insecurity, poverty, unemployment, lack of money and inability to pay school fees. Those are much in line to what we have encountered among Zimbabwean migrants interviewed at the Reception Centre and Musina. Notably only 3 people mentioned something that was related to migration- such as being away from husband or from family.

In Dite, Chikwarakwara and Shashe, we have also asked respondents, besides of individual coping strategies, whether they were aware of any community support mechanisms. Nearly half of people pointed out some form of collective help: funeral contributions; pooling money or food distribution were the most common. Remarkably, Chikwarakwara once more stood out, as the village where less people reported some kind of group support network, as showed in Table 83.

Table 82 - Depression Severity Indicator, by Migratory Status of Spouse, Women only, Cross-Border Population, Rural Beitbridge, 2020

Depression Indicator	None or Mild	Moderate - Severe	Total (%)	Total (N)
Migratory Status of Spouse	Percentage (%)			
In the household	88.46	11.54	100.00	52
International Migrant	98.15	1.85	100.00	54
Total (%)	92.73	7.27	100.00	106
Fisher = 0.08*				

Table 83 - Collective Support Mechanism, by Village, Cross-Border Population, Rural Beitbridge, 2020

Village	Dite	Shashe	Chikwarakwara	Total
Coping Mechanisms	Percentage (%)			
Collective Support Mechanism	46.11	52.99	28.57	46.31
No Support Mechanism	53.89	47.01	71.43	53.69
Total	100.00	100.00	100.00	100.00
Total (N)	180	117	42	339
P=0.024**				

#### 3.4.10. Main Conclusions

In general, the analysis in the cross-border villages revealed that migration has a positive impact on the overall health of people left behind, and that includes children with absent parents and spouses from international migrants. In line with most literature on the matter, we have found that remittances represent an asset to households in the region with possible repercussions to residents' health outcomes.

We believe, thus, that any possible MSF intervention in cross border villages does not make much sense from a 'mobility' perspective. It should be noted, nevertheless, that these populations do have health needs which seem to be unrelated to migration, such as poor understanding of HIV among the elderly; high HIV prevalence among widowed women; low adherence to treatment; high rates of adolescent pregnancy; high rates of STIs; and poor ANC specially in Chikwarakwara.

We have also noted that sexual violence and alcohol abuse are more prominent about people who had recently been to South Africa – a result that is in line with findings from the other sites.

Last but not least, we have found no evidence that people are physically assaulted at the border – and that includes the population interviewed at the crossing points. Neither have we encountered confirmation that living conditions at farms are particularly concerning, including access to emergency treatment.

### **3.5. Comparative Analysis**

Because it is sometimes difficult to evaluate health indicators on their own, we have tried to provide in this section a brief comparative analysis of key selected variables per site and nationality. The summary of sites is showed in Table 84. By villages, we will hereafter refer to Dite, Chikwarakwara and Shashe. By crossing points, we refer to Mike, Ponde, Gate 2 and Lutumba – and we also take advantage from this passage to discuss the health information gathered from migrants in these locations.

Table 84 - Number of Respondents, by Survey Location, Musina and Beitbridge, 2020

Research Site	Frequency (N)	Percentage (%)
Reception Centre	238	17.31
Magogo's House	178	12.95
Villages	339	24.65
Crossing Points	177	12.87
Musina	443	32.22
<b>Total</b>	<b>1,375</b>	<b>100.00</b>

Before continuing, we should take into consideration that each population analysed presents different demographic distributions that will certainly impact their health indicators. That is especially true for the villages, in which, as previously explained, the mean age of our respondents was significantly higher. Because sex ratios were also distinct among the various sites, we have also tried to present differential results by sex. However, for further analysis, in order to curb the effect of these and other key variables, more robust statistical models should be drawn.

Table 85 - Sex Distribution and Mean Age of Respondents, by Survey Location, Musina and Beitbridge, 2020

Study Location	Men	Women	Total	Mean Age	Total (N)
	Percentage (%)				
Reception Centre	76.47	23.53	100.00	29.95	238
Magogo's House	79.78	20.22	100.00	26.33	178
Villages	37.46	62.54	100.00	38.65	339
Crossing Points	46.89	53.11	100.00	30.25	177
Musina	81.04	18.96	100.00	26.92	443
<b>Total</b>	<b>64.95</b>	<b>35.05</b>	<b>100.00</b>	<b>30.69</b>	<b>1,375</b>

### 3.5.1. Chronic and Infectious Diseases

When we asked our respondents to rate their own health, most regarded it as good or very good. However, distributions vary widely across study sites (Table 86). As we would expect, a higher percentage of people rating their own health as bad or very bad was found at the cross-border villages, where the mean age of our respondents was substantially higher. Notably, however, the worst self-perception of health among all surveyed populations was encountered in Musina,

where migrants interviewed were only 27 years old, on average. Once we take only men, the disparities between Musina and the other sites are even more alarming.

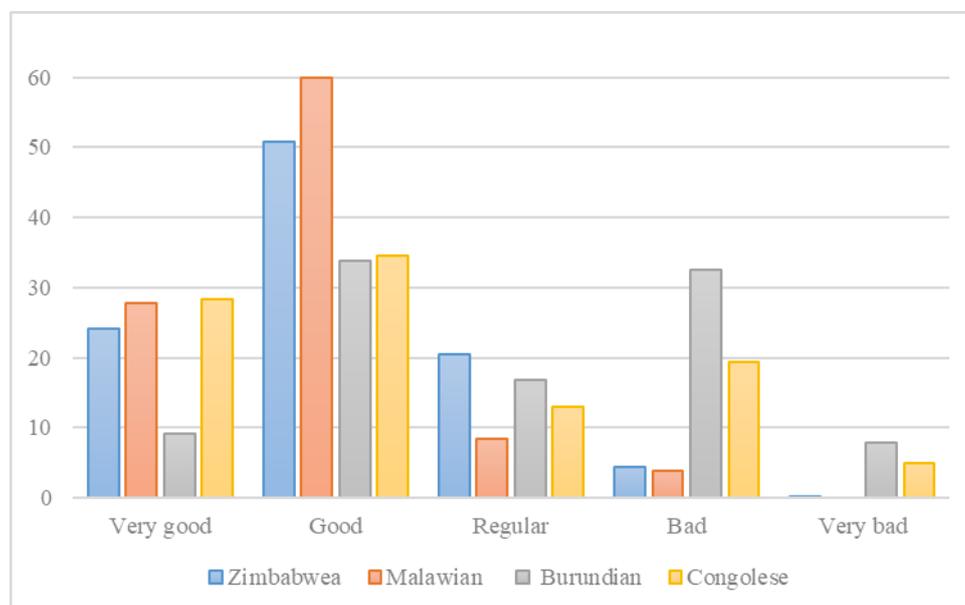
Table 86 - Self-Perception of Health, by Survey Location, Musina and Beitbridge, 2020

Study Location	Reception Centre	Magogo's House	Villages	Crossing Points	Musina	Total
Health Rating	Percentage (%)					
Very good	23.95	27.53	18.58	9.60	29.86	23.14
Good	48.74	60.67	40.41	59.89	36.88	45.85
Regular	22.69	7.87	26.25	25.99	12.67	18.85
Bad	4.20	3.93	13.27	4.52	16.74	10.48
Very bad	0.42	0.00	1.47	0.00	3.85	1.67
Total	100.00	100.00	100.00	100.00	100.00	100.00
Total (N)	238	178	339	177	442	1374

By looking at the differences among migrants by nationality<sup>20</sup>, across all sites, it is clear that Central Africans, and especially Burundians, are the ones with worse perception of their own health, as showed in Figure 30. Whereas this cannot be accounted to ‘objective’ aspects such as HIV status, or the prevalence of chronic diseases, factors related to psychological wellbeing, exposure to violence and food insecurity could be key determinants of why migrants in Musina, particularly those from Burundi and DRC, are rating their own health so poorly.

<sup>20</sup> Hereafter, when we compare migrants by nationality across all survey sites, we exclude respondents from the cross-border villages (Dite, Shashe and Chikwarakwara).

Figure 30 - Overall Health Indicator, by Nationality, Migrants Only, Musina and Beitbridge, 2020



Overall reported prevalence of chronic diseases is relatively low at all studied places. The only condition that was found to be relevant is high blood pressure. Table 87 reveals the percentage of respondents who reported to have one or more of the diseases listed, although we should take such results with caution. As previously discussed, in countries where diagnose is poor, these figures could be highly underestimated.

Table 87 - Reported Prevalence of Chronic Diseases, by Study Site, Musina and Beitbridge, 2020

Study Site	Reception Centre	Magogo's House	Villages	Crossing Points	Musina	Total
Diseases	Percentage (%)					
High Blood Pressure	4.20	2.25	9.73	5.08	3.16	5.09
Heart Disease	0.84	2.81	1.47	0.56	1.81	1.53
Diabetes	0.42	0.56	0.29	0.56	0.23	0.36
Chronic Respiratory Disease	1.68	0.00	0.59	2.26	2.03	1.38
High Cholesterol	0.42	0.00	0.00	0.00	0.68	0.29
<b>Total</b>	<b>238</b>	<b>178</b>	<b>339</b>	<b>177</b>	<b>442</b>	<b>1374</b>

Whereas, most people did not report having diseases such hepatitis, cholera, or measles, 28.73% of our respondents had presented at least one unspecific sign or symptom in the past two months. These are most probably related to poor water and sanitation conditions in their places of stay. Musina and the Crossing Points were the sites where people reported more symptoms – at the Crossing Points, the worst indicators were found in Pounden and Mike.

Whereas fever had been most often reported at Magogo’s, Crossing Points and Musina; skin rash was particularly frequent in Musina and the Reception Centre. The high rates of people reporting skin problems is consistent with poor sleeping conditions and overcrowding in Musina shelters and in detention facilities. Besides of being the location where most people presented one of the listed signs and symptoms, Musina was also the spot where less respondents received medical attention following a medical problem (only 23.76% of all surveyed population).

Table 88 - Unspecified Signs and Symptoms, by Study Site, Musina and Beitbridge, 2020

Study Site	Reception Centre	Magogo's House	Villages	Crossing Points	Musina
Signs and Symptom	Percentage (%)				
Fever	12.18	18.54	8.51	22.03	22.88
Persistent cough	9.66	7.87	6.38	10.73	10.30
Difficult breathing	3.36	3.37	2.43	3.95	5.72
Diarrhoea	8.40	8.43	4.56	11.86	6.18
Blood in the stools	0.42	3.37	0.30	1.13	2.29
Vomiting	0.84	3.37	1.52	2.82	0.92
Skin rash/irritation	7.14	2.81	2.74	5.08	7.55
Inability to eat or drink	3.36	1.69	3.95	3.39	7.55
None	74.79	73.03	80.24	66.67	62.93
Valid Cases	238	178	339	177	443

### 3.5.2. Sexual and Reproductive Health

Overall, we have found poor sexual and reproductive health indicators among our respondents, and that includes low HIV testing, treatment and knowledge; high STIs symptomatology; and low family planning uptake.

In total, 14.91% of our respondents had recently presented discharge or genital ulcer. Once we breakdown by study site and sex (Tables 89 and 90), it is noticeable that the situation is particular serious among Malawians at Magogo’s house. It is also concerning among men in Musina and Zimbabwean crossing points.

Although discharge, *per se*, may be sometimes a poor predictor of an STI, it is alarming that 19.4% of women and 17.6% of men interviewed at Magogo’s house reported having a genital ulcer. As we will showcase in sequence, these results are in line with exposure to sexual violence among Malawians and migrants in Musina.

When it comes to HIV knowledge, 8.9% of respondents reported that they had never heard of the disease, with that rate being particularly high in Musina. As discussed in Section 3.2, Congolese were specially likely to say they were not aware of the illness (15.3% of our interviewees). When asked about the main transmission modes, migrants in Musina and at Magogo’s house were the least inclined to point out ‘unprotected sex’ or ‘sex with an infected person’ as mechanisms of infection (28.0% of interviewees at each site). Interestingly, Malawian migrants were by far the most predisposed to attribute HIV solely to promiscuity (18% of respondents). Those findings reinforce the urgency to design health promotion activities that disentangle HIV risk from perceptions of sexual morality. That is especially true for non-Zimbabwean migrants.

Table 89 - Discharge or Genital Ulcer, Men only, by Study Site, Musina and Beitbridge, 2020

Research Site	Reception Centre	Magogo's House	Villages	Crossing Points	Musina	Total
Symptom	Percentage (%)					
Yes	7.69	22.54	7.87	18.07	19.78	15.90
No	92.31	77.46	92.13	81.93	80.22	84.10
Total (%)	100.00	100.00	100.00	100.00	100.00	100.00
Total (N)	182	142	127	83	359	893
P=0.000***						

Table 90 - Discharge or Genital Ulcer, Women only, by Study Site, Musina and Beitbridge, 2020

Research Site	Reception Centre	Magogo's House	Villages	Crossing Points	Musina	Total
Symptom	Percentage (%)					
Yes	3.57	27.78	11.79	13.83	15.48	13.07
No	96.43	72.22	88.21	86.17	84.52	86.93
Total (%)	100.00	100.00	100.00	100.00	100.00	100.00
Total (N)	56	36	212	94	84	482
P=0.017***						

Table 91 - Percentage of People who have never Heard of HIV, by Study Site, Musina and Beitbridge, 2020

Research Site	Reception Centre	Magogo's House	Villages	Crossing Points	Musina	Total
Heard of HIV	Percentage (%)					
Yes	96.64	93.26	91.45	91.53	86.62	91.04
No	3.36	6.74	8.55	8.47	13.38	8.96
Total	100.00	100.00	100.00	100.00	100.00	100.00
Total	238	178	339	177	443	1375
P=0.006***						

Low knowledge of HIV among displaced population in Musina is totally compatible with low testing rates in the location. As showed in Figure 31, the estimation is alarmingly divergent from the other sites, revealing, once more, the high unmet demand for better SRH care in the city. Although the figures are especially worrying for Central Africans, the percentage of Zimbabweans who had never been tested for HIV in Musina is also higher than in all other places analysed (Table 92). Considering MSF activities at the place, testing rates at the Reception Centre also have room for improvement.

Figure 31 - Percentage of Respondents who have been tested for HIV, by Study Site, Musina and Beitbridge, 2020

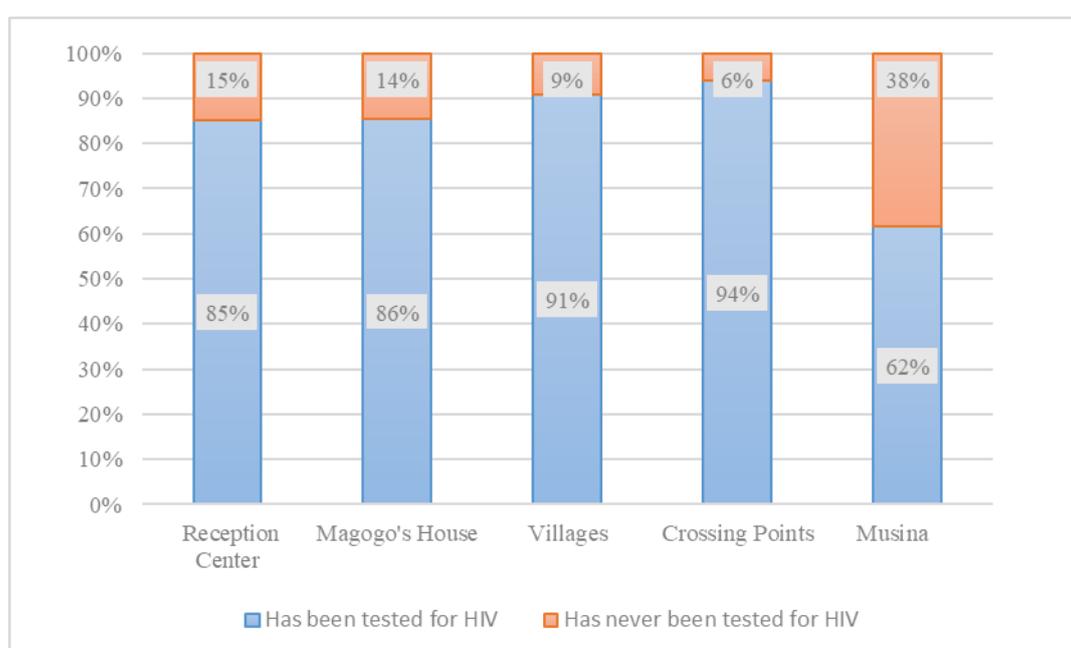


Table 92 - Percentage of People who have ever been tested for HIV, Zimbabwean only, by Study Site, Musina and Beitbridge, 2020

Study Location	Reception Centre	Villages	Crossing Points	Musina	Total
Ever been tested for HIV			(%)		
Has been tested for HIV	85.09	90.88	93.75	73.95	87.35
Has never been tested for HIV	14.91	9.12	6.25	26.05	12.65
Total (%)	100.00	100.00	100.00	100.00	100.00
Total (N)	228	307	160	119	814
P=0.000***					

In general, reported HIV prevalence among the population we surveyed is pretty high, especially among females (16% in total). For women, the highest rates were found at the Reception Centre (23%); whereas for men, in the villages (13%), although rates among female respondents were critically high in all sites covered by the survey. The findings indicate that HIV care should still be regarded as a top priority for MSF programs targeting displaced population in the region.

Finally, when it comes to family planning uptake among sexually active people, Musina once more stands out negatively: 48% of those who did not wish to have children soon were not at any contraceptive (Table 93). With regards to type of contraceptive method used, this is also the location where less people are relying on mid-term alternatives, such as implants, pills and injectable (Table 94). Among Malawians the use of condoms stands out over pills. In the villages, traditional methods, such as lactation and withdrawn are more significantly used than in other places, which is consistent with high fertility rates among women of all ages in those sites.

Figure 32 - Reported HIV Prevalence, by Study Site, Musina and Beitbridge, 2020

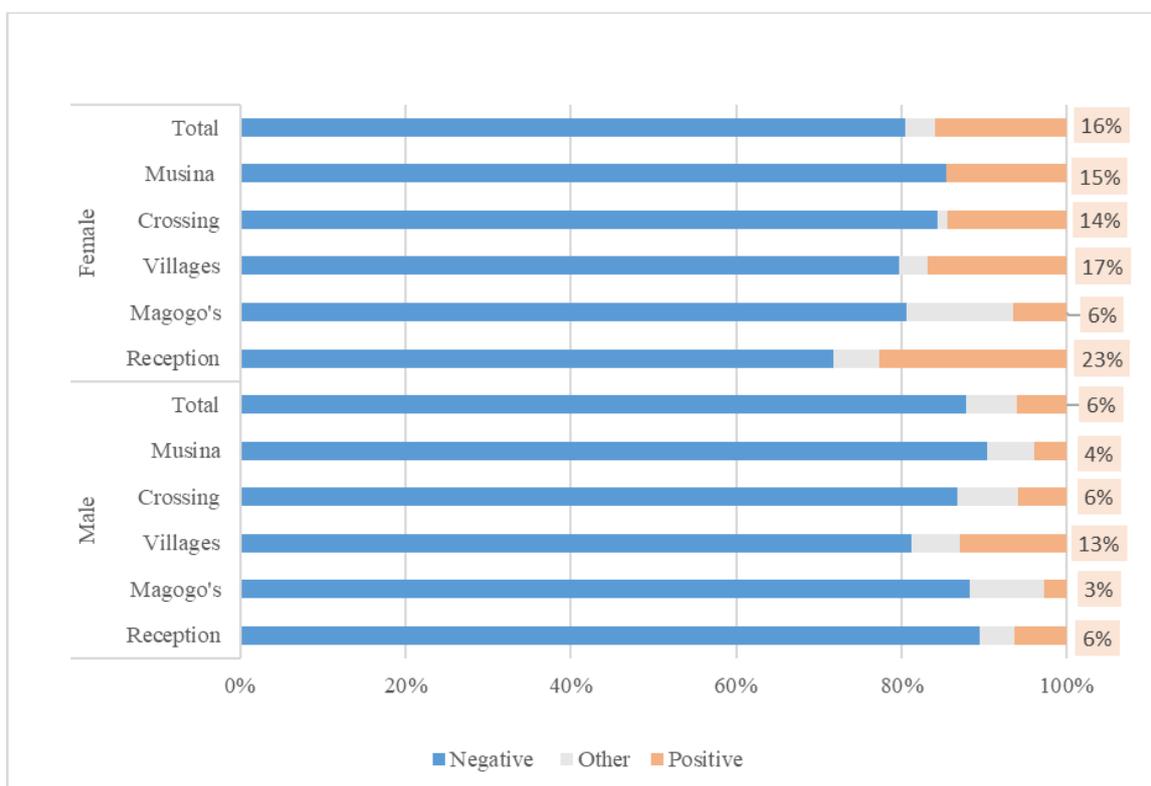


Table 93 - Percentage of Sexually Active People, who do not wish to have children soon, by Use of Contraceptive and Study Site, Musina and Beitbridge, 2020

Research Site	Reception Centre	Magogo's House	Villages	Crossing Points	Musina	Total
Uses Contraceptive	Percentage (%)					
Yes	77.03	79.66	62.07	75.61	48.00	66.09
No	22.97	20.34	37.93	24.39	52.00	33.91
Total	100.00	100.00	100.00	100.00	100.00	100.00
Total	74	59	145	82	100	460
P=0.000***						

Table 94 - Percentage of Sexually Active People, by Type of Contraceptive used and Study Site, Musina and Beitbridge, 2020

Study Site	Reception	Magogo's House	Villages	Crossing Points	Musina
Type of Contraceptive	Percentage (%)				
Condom	29.82	59.57	26.67	20.97	66.67
IUD	0.00	2.13	1.11	1.61	4.17
Injectable	26.32	23.40	36.67	30.65	12.50
Implants	5.26	12.77	3.33	4.84	12.50
Pill	35.09	2.13	33.33	41.94	8.33
Emergency Contraception	3.51	0.00	1.11	0.00	0.00
Lactation method	3.51	0.00	5.56	1.61	2.08
Withdrawn	0.00	0.00	2.22	1.61	0.00
Other	1.75	0.00	0.00	1.61	2.08
Valid Cases	60	47	99	65	52

### 3.5.3. Sexual Violence

16.7% of our respondents had gone through an episode of sexual abuse in the last year – be it unwanted caresses or non-consensual sex. Due to ethical reasons, we did not ask details of the events, such as perpetrators and exact location, which is an obvious limitation of our analysis.

When it comes to sexual violence, there are also some key differences by sex at some sites that should not be disregarded (Tables 95 and 96). In general, men seem to be more exposed to abuse in its broader sense in all locations, except for Magogo's house. Once we ask specifically about unwanted sex – or rape – rates equalize between men and women, and become even more prominent for Malawian females.

It is noteworthy the high exposure of men to abuse in all sites, but particularly in Musina, where, as discussed, conditions at the shelter are particularly concerning. The findings justify the design of a health care strategy that is gender sensitive, aimed at reducing stigma and barriers to treatment for both sexes. Post-assault care packages should be available and advertised at Reception Centre, Magogo's house, Crossing Points and in Musina. For Malawians, although rates are high for both genders, women seem to be particularly vulnerable, with 30.5% having been exposed to abuse and 16.6% going through a recent episode of rape. Although the time of abuse is unknown, these results match the high percentage of people with symptoms of discharge and genital ulcers in the location, suggesting recent unsafe sexual activity.

Table 95 - Percentage of People who have undergone one or more episodes of Sexual Violence in the last year, by Study Site, Men only, Musina and Beitbridge, 2020

Study Site	Reception Centre	Magogo's House	Villages	Crossing Points	Musina	Total
Sexual Violence			Percentage (%)			
Yes	17.03	19.01	11.81	16.87	23.96	19.37
No	82.97	80.99	88.19	83.13	76.04	80.63
Total (%)	100.00	100.00	100.00	100.00	100.00	100.00
Total (N)	182	142	127	83	359	893
P=0.000***						

Table 96 - Percentage of People who have undergone one or more episodes of Sexual Violence in the last year, by Study Site, Women only, Musina and Beitbridge, 2020

Study Site	Reception Centre	Magogo's House	Villages	Crossing Points	Musina	Total
Sexual Violence			Percentage (%)			
Yes	14.29	30.56	6.60	15.96	10.71	11.83
No	85.71	69.44	93.40	84.04	89.29	88.17
Total (%)	100.00	100.00	100.00	100.00	100.00	100.00
Total (N)	56	36	212	94	84	482
P=0.000***						

#### 3.5.4. Mental Health and Alcohol Abuse

Throughout this report, we have tried to emphasize the particular tendency of Zimbabwean men to engage in harmful consumption of alcohol. Once we look across all study sites, it is possible to see that this is a steady tendency – there is no significant difference among survey locations, as showed in Table 97. Interestingly, alcohol consumption seems to be lower only in the villages. However, we have also showed that, in Dite, Chikwarakwara and Shashe, addition is more likely among those who have lived recently in South Africa. The findings suggest that once in the foreign country, Zimbabwean men may become more prone to alcoholism.

Table 97 - Alcohol Abuse Indicator, by Study Site, Zimbabwean Men Only, Musina and Beitbridge, 2020

Study Site	Reception Centre	Villages	Crossing Points	Musina	Total
Alcohol Abuse Indicator	Percentage (%)				
Low or medium risk	87.29	91.34	84.34	87.23	87.84
High Risk or Addiction Likely	12.71	8.66	15.66	12.77	12.16
Total (%)	100.00	100.00	100.00	100.00	100.00
Total (N)	182	127	83	94	485
P=0.477 (NS)					

When it comes to mental health indicators analysed – anxiety and depression –we have found some key disparities among women. As showed in Tables 98, 99 and 100, female migrants at the Reception Centre seem particularly prone to develop anxiety and depression disorders. That is true even when we take only Zimbabwean women across all locations. Although it is not entirely clear the reason behind the finding, high HIV prevalence among women at the Centre could be one cause. Other factors such as family separation and lengthy detention periods could be also at the bottom of these results. In fact, women at the Reception Centre with indication of anxiety disorders quoted ‘wellbeing of family member’ or ‘being arrested’ as main concerns more often than other female participants in the same situation.

Table 98 - Depression Severity Indicator, by Study Site, Women Only, Musina and Beitbridge, 2020

Study Site	Reception Centre	Magogo's House	Villages	Crossing Points	Musina	Reception Centre
Depression Indicator	Percentage (%)					
None - Mild	85.71	88.89	91.51	97.87	96.43	92.74
Moderate -Severe	14.29	11.11	8.49	2.13	3.57	7.26
Total	100.00	100.00	100.00	100.00	100.00	100.00
Total (N)	56	36	212	94	84	482
P=0.003***						

Table 99 - Anxiety Disorder Indicator, by Study Site, Women Only, Musina and Beitbridge, 2020

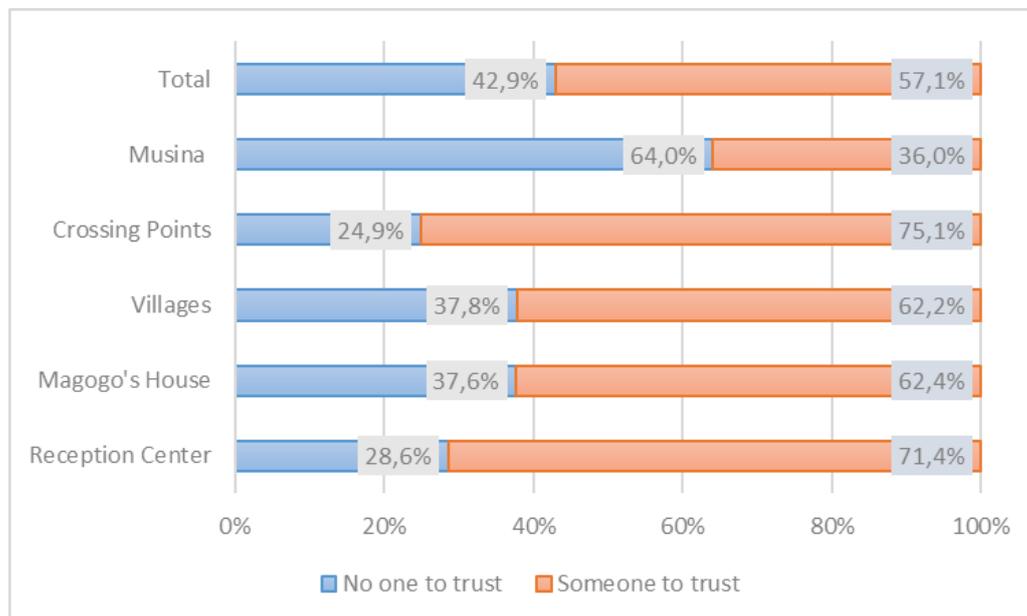
Study Site	Reception Centre	Magogo's House	Villages	Crossing Points	Musina	Reception Centre
Anxiety Indicator	Percentage (%)					
None - Mild	78.57	97.22	95.75	96.81	95.24	93.98
Moderate -Severe	21.43	2.78	4.25	3.19	4.76	6.02
Total	100.00	100.00	100.00	100.00	100.00	100.00
Total (N)	56	36	212	94	84	482
P=0.000***						

Whereas depression and anxiety disorders for men are somewhat similar across locations, we have found important variations among the main nationalities. Central African men, and especially Burundian, show particularly concerning levels of depression disorders and suicide ideation (Table 100). As previously discussed, this could be both linked to their particularly poor living conditions in Musina and also to lengthy migration trajectories. In fact, of all sites analysed, Musina is also where displaced populations have lower perception of social support - 60% believe they have no one to trust helping personal problems. (Figure 33)

Table 100 - Suicide or Self-hurt Ideation in the past two weeks, by Main Nationalities of Migrants, Across Study Sites, Men only, Musina and Beitbridge, 2020

Nationality	Zimbabwean	Malawian	Burundian	Congolese	Total
Suicide Ideation	Percentage (%)				
Yes	16.20	6.94	38.16	22.83	18.24
No	83.80	93.06	61.84	77.17	81.76
Total	100.00	100.00	100.00	100.00	100.00
Total	358	144	76	184	889
P=0.000***					

Figure 33 - Perception of Social Support (Someone to Trust Solving Problems), by Study Site, Musina and Beitbridge, 2020



### 3.5.5. Summary of the Comparative Analysis

From what has been outlined, we can say that migrants in the Limpopo region do not have homogenous needs. In fact, we have demonstrated that Central Africans tend to have had longer journeys and very different motivations to migrate, when compared to Zimbabweans, which certainly has an impact on their mental health indicators. Zimbabwean men, on the other hand, seem more likely to display harmful assimilation habits, such as alcohol consumption, whereas Malawian women are probably more likely to have undergone sexual assault than all other groups analysed. In short, we believe that the condition of migrant or asylum seeker should not reduce the experiences of our patients to one – before being a displaced person, they have unique histories, concerns and traumas. Their specificities need to be taken into account in the design of a successful health care program.

Table 101, therefore, brings in a summary of critical health needs found among all populations studied, when they are analysed comparatively.

Table 101 - Brief Summary of Main Health Needs, by Study Site, Musina and Beitbridge, 2020

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

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