



**NO REFUGE,
ACCESS DENIED:
MEDICAL AND HUMANITARIAN
NEEDS OF ZIMBABWEANS
IN SOUTH AFRICA**

Photo: © Austin Andrews

Zimbabweans sleep in the shadows of a stairwell in the Central Methodist Church in downtown Johannesburg. The Church provides a 'safe haven' where thousands of Zimbabweans seek refuge every night.



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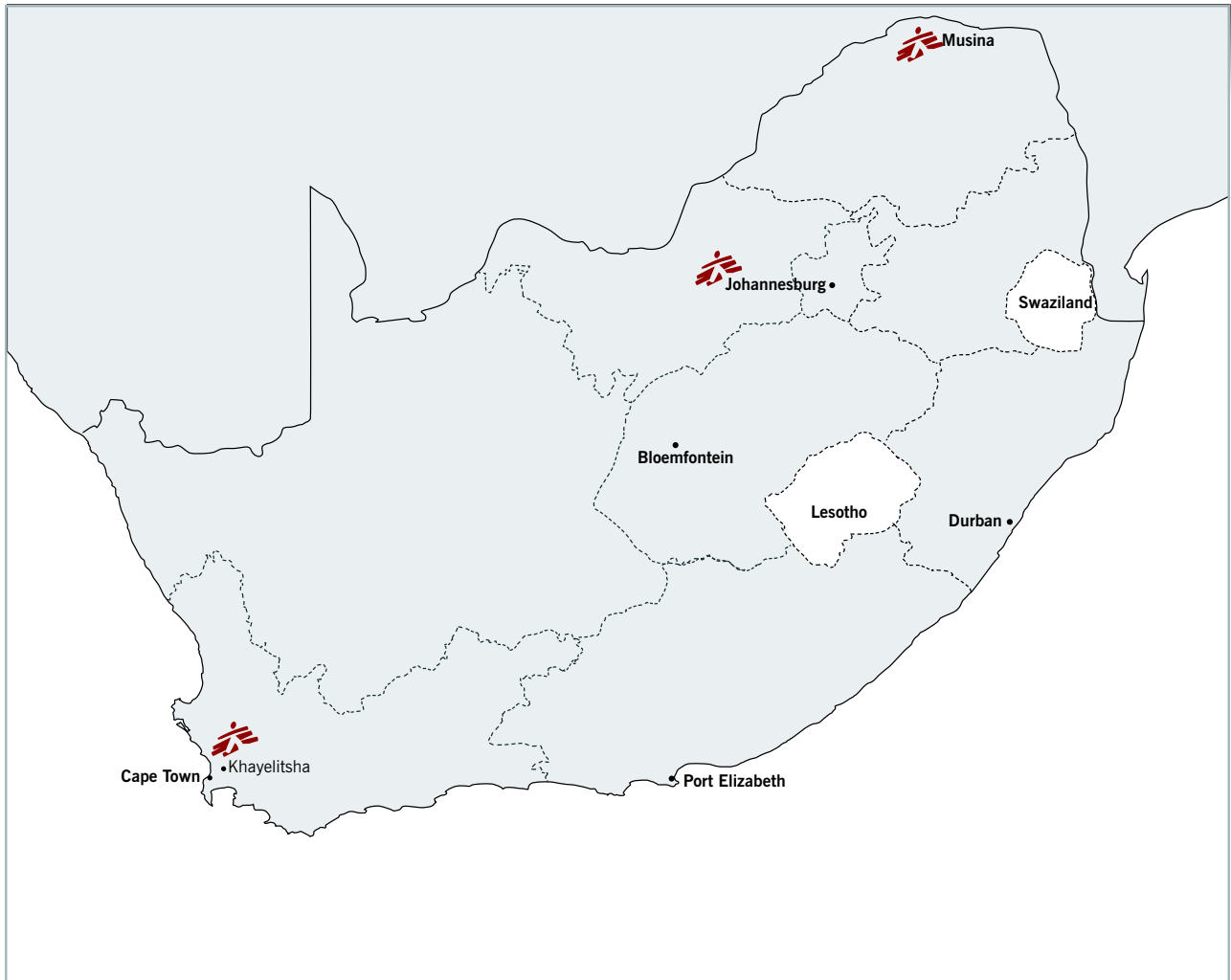
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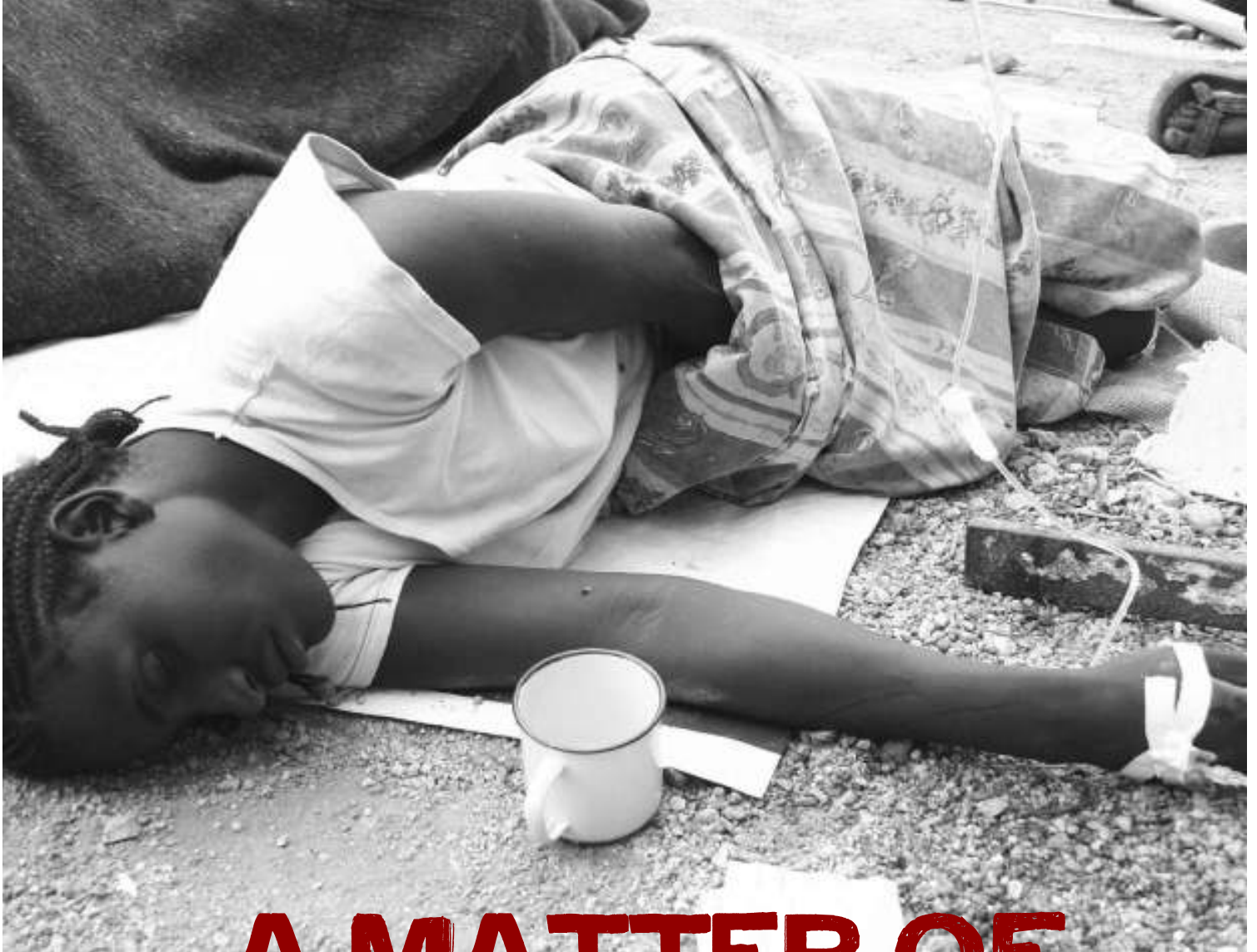
MSF in South Africa



Médecins Sans Frontières (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, health care exclusion and natural or man-made disasters. The organisation works in more than 60 countries throughout the world and has been working in South Africa since 1999 providing HIV/AIDS and TB treatment, as well as care for survivors of sexual violence, in Khayelitsha (Western Cape) and HIV/AIDS treatment in Lusikisiki (Eastern Cape). MSF started providing medical and humanitarian assistance for Zimbabweans seeking refuge in Musina and Johannesburg in 2007. MSF also has a large presence in Zimbabwe, treating more than 25,000 people on antiretroviral therapy in the country and, most recently, deploying a major emergency intervention and treating more than 50,000 patients in response to the cholera epidemic.

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A MATTER OF SURVIVAL

“25% percent of the entire Zimbabwean population has fled Zimbabwe to neighbouring countries, especially South Africa, as a matter of survival. They are raped, beaten, and robbed while crossing the border, they struggle to find basic shelter and other assistance in South Africa, and they are subjected to xenophobic violence, abuse, and neglect, even when trying to access health care. There have been some positive developments in the past month regarding the legal status of Zimbabweans seeking refuge in South Africa, but the jury is still out on whether these new policies will improve the deplorable conditions in which they live.”

- Rachel Cohen, MSF Head of Mission in South Africa

Photo: Joanna Stavropoulou/MSF, A woman receives treatment for cholera in the southern town of Beitbridge, Zimbabwe, on the border of South Africa. The recent cholera outbreak in Zimbabwe was Africa's worst in more than 15 years, killing over 4,300 people

Summary

Each day, thousands of Zimbabweans cross the border into South Africa, many risking their lives to flee economic meltdown, political turmoil, and a critical lack of access to health care in their country.

In the past several years, the crisis in Zimbabwe has given rise to food insecurity, an unprecedented cholera epidemic, political violence, rampant unemployment, an escalating HIV crisis and the near-total collapse of the health system. This breakdown in Zimbabwe has driven nearly one-quarter of the entire population into neighbouring countries, particularly South Africa.

And despite claims that Zimbabwe is 'normalising' following the establishment of a Government of National Unity, Zimbabweans continue to cross the border every day, legally and illegally, in massive numbers as a matter of survival.

Upon arrival, many Zimbabweans endure further suffering in South Africa, without access to proper health care, shelter or safety. During their journey to and within South Africa, they are subjected to violence, physical and verbal abuse, police harassment, inhumane living conditions and xenophobic attacks.

The South African Constitution guarantees access to health care and other essential services to all those who live in the country – including refugees, asylum-seekers, and migrants – regardless of legal status. However, in practice, the fear of arrest, deportation, and xenophobia, coupled with a lack of accurate information about their rights, has kept many Zimbabweans from accessing basic services necessary for survival. Today, Zimbabweans are still often charged exorbitant fees to access public facilities despite policies to the contrary, turned away from hospitals when they need admission, discharged prematurely, or subjected to harsh treatment by health staff in the public services.

In 2007, Médecins Sans Frontières (MSF) opened two projects to respond to the specific health needs of Zimbabweans seeking refuge in South Africa.

MSF mobile clinics, operating in and around Musina town at the border with Zimbabwe, in addition to a fixed MSF clinic at the Central Methodist Church in Johannesburg, provide general primary health care, referrals to existing hospitals or specialised medical facilities, and other humanitarian assistance, including shelter, water and food.

MSF medical teams treat 4,000-5,000 Zimbabweans each month, mainly for respiratory tract infections, including a substantial proportion of tuberculosis; sexually transmitted infections; gastro-intestinal and diarrhoeal conditions; and stress-related ailments. More than 30% of HIV tests performed are positive. Yet, this is just the tip of the iceberg. There are thousands more Zimbabweans who never come forward to access MSF or other health services, choosing instead to protect themselves by becoming invisible in South African society.

Because many patients have endured multiple traumatic events and exhibit symptoms of post-traumatic stress, MSF also provides psychological support in both Musina and Johannesburg. In addition, MSF teams treat a rising number of survivors of sexual violence and see a worrying increase in the number of unaccompanied children travelling from Zimbabwe into South Africa.

The recent announcement by the South African Department of Home Affairs that a new system will be put in place to regularise the legal status of Zimbabweans in South Africa, and to stop the systematic deportation of Zimbabweans, is a welcome departure from the government's previous policy of aggressive harassment, arrest, and deportation. Whether the fate of vulnerable Zimbabweans in South Africa will improve depends upon how and when these new policies will be put into practice.

This report highlights the plight of Zimbabweans seeking refuge in South Africa, the appalling conditions in which they live, and their ongoing lack of access to adequate protection, shelter, and basic services, particularly health care, in South Africa.



Zimbabweans under attack: a chronology of desperation

- **January 2008:** Police raid the Central Methodist Church in Johannesburg, detaining 350 people, before a court interdict secures their release. The presiding judge refers to the treatment of the detainees as being worse than during the days of apartheid.
- **March 2008:** Increase in political tension, violence, and intimidation in Zimbabwe on the eve of general elections.
- **May 2008:** Xenophobic attacks erupt in Alexandra township in Johannesburg, then spread throughout Gauteng and to Western Cape and Kwa-Zulu Natal, killing 62 people and displacing more than 100,000.
- **June 2008:** Continued increase in election-related violence in Zimbabwe prior to the run-off elections.
- **July 2008:** Department of Home Affairs opens Reception Office at Musina Showground. Thousands of Zimbabweans previously in hiding flock to seek asylum.
- **November 2008:** Department of Health declares a cholera outbreak primarily affecting Zimbabweans in Limpopo Province, and later Gauteng, Mpumalanga, and other provinces.
- **February 2009:** 100 police and 'Red Ants' attempt to raid people sleeping in front of the High Court next to the Central Methodist Church, harassing, intimidating, and arresting Zimbabweans sleeping on the street.
- **March 2009:**
 - South Africa authorities forcibly expel thousands of Zimbabweans from Musina Showground.
 - Thousands of Zimbabweans flee from Musina to Johannesburg, the majority to the Central Methodist Church. More than 4,000 people seek refuge inside and around the Church at the height of the crisis.
 - Local businesses in Johannesburg's Central Business District (CBD) sue the municipality, City of Johannesburg, and the Central Methodist Church, complaining that the thousands of Zimbabweans and the crowded and unhygienic environment around the Church are bad for business.
 - Local businesses erect large metal gate in front of the Church to prevent Zimbabweans from being able to sleep in the direct vicinity of the Church, effectively cutting people off from the Church and subjecting them to extreme vulnerability and potential violence and abuse.
- **April 2009:** Department of Home Affairs, under pressure from NGOs and human rights groups, announces special dispensation permit under the Immigration Act for those without legal documents and a moratorium on deportations. However, arrests and deportations continue, roll out of the special dispensation is slow, and confusion remains high, leading to continued chaos and uncertainty.
- **May 2009:**
 - DHA announces a new 90-day 'visa free' entry permit, but it only applies to Zimbabweans who have travel documents.



WE ARE HERE BECAUSE WE WERE **SUFFERING** **IN ZIMBABWE**

“Things are really not well in Zimbabwe. My children live only on one or two meals per day. My family is hungry. No bread, no soap, no meat; these things are not available or if they are, we cannot afford it. I came to South Africa so that maybe my family can survive this crisis.”

- A Zimbabwean man in his 30s (MSF patient in Musina)

Photo: © Dirk-Jan Visser, A Zimbabwean child stands before the empty shelves of a big supermarket in Bulawayo. Zimbabwe is currently the most food-aid dependent country in the world.

Fleeing Zimbabwe

Over the past several years, an estimated three million Zimbabweans have crossed the Limpopo River into South Africa. The situation has become particularly acute in the past year and a half.¹

In Zimbabwe, currently the most food aid-dependent country in the world, seven million people out of the remaining population of nine million are presently food insecure;² Africa's worst cholera outbreak in more than 15 years struck 100,000 people, killing over 4,300;³ 15% of the adult population is HIV-positive;⁴ 94% of the population is unemployed;⁵ and several reports have claimed thousands were beaten and intimidated by government security and paramilitary forces during last year's electoral cycle. The cholera epidemic was widespread, affecting all provinces, and the general case fatality rate (CFR) was above 5% even after an emergency response was established, whereas the rate for a controlled epidemic is defined by a rate of one percent or less. This signalled a near total lack of capacity of public services, including water, sanitation, and health systems, to cope.

Political instability and mismanagement led to economic freefall with skyrocketing inflation exceeding a staggering 89 sextillion percent.⁶ The economic collapse brought about a virtual standstill in industrial and agricultural production, severe shortages of essential goods, and a near-collapse of basic infrastructure and public services, including the once-vaunted health system. MSF has been working in Zimbabwe since 2000 and witnessed a continuous deterioration of the humanitarian situation during this period.⁷

The establishment of a Government of National Unity in February 2009 has led some to speculate that the situation in Zimbabwe has 'normalised' and Zimbabweans who fled to neighbouring countries should now return home. But the political and economic situation in Zimbabwe today is far from stable and the health system continues to exist in a state of near-collapse. As a result, Zimbabweans will continue to flee to South Africa in desperation and will require both guaranteed protection and proper assistance to address their medical and humanitarian needs.

"All of us people at the Showground [Musina], we are not here because we want to be. We are here because we were suffering in Zimbabwe. The masses are hungry – they are running from their own country."

A 33-year-old man staying at a temporary shelter in Musina

"Everything was tough. You couldn't use the money to buy even a loaf of bread. That is what pushed me to leave the country. Everything was deteriorating – there was no water. It was about eight years without running water. You could get it for about two hours a day – you had to get up around midnight."

A 28-year-old Zimbabwean man in Musina

"I am an elderly man, but they still knocked me to the ground and beat me while I was lying down. I went to the hospital. When my personal history was taken, I told them that I had been beaten up. The medical staff at the hospital told me that it was my fault for getting involved in politics and they refused to treat me. I decided to come to South Africa."

A Zimbabwean man in his 60s (MSF patient in Musina)

"The problem with Zimbabwe for me is the way they treat pregnant women. First you have to go to the hospital and get a card – you pay R450 just for the card. Then when you are about to give birth you have to buy your own equipment – the blankets, the gloves, all the medical equipment that is needed. If you are going to have a normal birth they charge you R1,500 and if it is a C-section, you have to pay R4,500. That's why I came here – I couldn't get the money."

A 23-year-old Zimbabwean woman who crossed the border alone 8 months pregnant, staying at a temporary shelter in Musina



**NO
ENTRY**

24 672 6914

NO REFUGE ACCESS DENIED

“Sometimes we ask patients that come to our clinic why they didn’t seek health care before coming to us. A frequent answer to this is: ‘I can’t go to the hospital, I don’t have papers. I will have to show my documents and if they find out I don’t have them, they will arrest me.’”

- An MSF nurse in Johannesburg

Photo: © Austin Andrews, Silhouettes walk behind a “NO ENTRY” sign at the Showground in Musina. Today Zimbabweans are no longer allowed to sleep at the Showground. If they do, they are either chased away or arrested and detained.

The South African government's response

Neglect and deportation

Despite the fact that many Zimbabweans risk their lives to flee Zimbabwe, the South African government has historically characterised Zimbabweans in the country as 'voluntary economic migrants' and aggressively deported them. Until recently, approximately 17,000 Zimbabweans were deported each month by South African authorities, according to United Nations and the South African Department of Home Affairs (DHA) figures.

According to DHA, in Musina alone, more than 30,000 Zimbabweans applied for asylum from July to December 2008. Just 53 (0.1%) were granted refugee status.⁸ In addition to granting refugee status to very few people, regular bottlenecks in the asylum-seeking process created a situation where a large concentration of people lived in inhumane conditions while awaiting documentation.

The government's aggressive deportation strategy, combined with a lack of legal status and a dysfunctional asylum-seeking process, has hampered the ability of Zimbabweans to realise their rights and access the assistance to which they are entitled under national and international law. As a result, Zimbabweans have been more vulnerable to abuse by police, immigration officials, criminals, and employers.

In April 2009, under pressure from numerous non-governmental organisations, legal, and human rights groups, the DHA announced plans to enact new measures to regularise the legal status of Zimbabweans in South Africa. Zimbabwean nationals would be eligible for a special dispensation permit under Section 31(2)(b) of the Immigration Act, which would allow them to stay in the country legally for up to 12 months and to have the right to work, study, and to access health care and other basic services. However, they would not have the right to housing or to social grants.⁹ At the same time, the DHA announced a moratorium on deportations of Zimbabwean nationals. In May 2009, a second announcement was made allowing Zimbabweans a 90-day 'visa-free entry' into South Africa.

These positive policy steps are significant and if implemented appropriately, taking the specific humanitarian needs of Zimbabweans in South Africa into full consideration, may fundamentally change the dire conditions under which Zimbabweans currently live in South Africa. However, they have yet to translate into significant changes on the ground for the majority of Zimbabweans. Experience in the past month reveals several concerns and potential pitfalls, including:

- The new special legal exemption has yet to be enacted, no clear timeframe for implementation has been given, and a lack of clarity over the new permits has created confusion and uncertainty. As a result, Zimbabweans are still living in fear and are subjected to ongoing harassment and intimidation.
- Another worrying concern is that the 12-month permit will be issued under the Immigration Act. This may allow the United Nations Refugee Agency, UNHCR, to abdicate its international protection responsibility. This potentially means that there is no one responsible or accountable for addressing the needs of Zimbabweans in relation to shelter, for example. The government of South Africa has clearly said that housing will not be a right to which Zimbabweans are entitled and, as 'migrants' do not fall under their mandate, the UNHCR may refuse to play a role in ensuring appropriate shelter.
- Even after the announcement of the moratorium on deportations, the South African Police Services (SAPS) continued to deport Zimbabweans, refusing to observe the DHA directive. Over Easter alone there were 736 deportations from Musina, as local police refused to recognise the new DHA policy.
- The 90-day 'visa-free entry' into South Africa requires that Zimbabweans hold a passport or emergency travel document. Obtaining a passport in Zimbabwe can cost up to R 6,800 (US\$ 820), so this measure will have little tangible benefit for the most vulnerable, who cannot afford passports. They will continue to cross the border through non-official channels, still susceptible to the same abuses, violence and lack of access to services as before the policy change.

Gaps in access to health care

Since 1996, South Africa has had a policy of free primary health care services for everyone in the public health system. The South African Constitution guarantees the right to access to health care for all. In September 2007, the Department of Health (DOH) released a Revenue Directive¹⁰ reaffirming that refugees and asylum-seekers with or without a permit have the right to access health services and should be treated for free at any primary health care facility and exempted from hospital admission fees if without appropriate resources. They are also entitled to access any antiretroviral therapy (ART) service point, and treatment should be free.

In addition to this, the HIV & AIDS and STI Strategic Plan for South Africa (2007-2011) includes migrants, refugees, and asylum-seekers with or without legal documents, and the DOH released a statement in April 2007 clarifying that patients

do not need to be in possession of a South African identity book in order to access ART in particular.¹¹

Despite such guarantees, it is clear that these policies are not uniformly applied. Zimbabweans attending MSF clinics in both Musina and Johannesburg have explained that they face significant barriers trying to access public health structures. Zimbabweans attempting to access the health system by themselves are often either harassed or hindered from obtaining the services they need, particularly in hospitals. Those that are granted admission, usually in the event of a life-threatening emergency, are often charged exorbitant fees and discharged prematurely, including when they are still very sick and vulnerable.

And now that the legal status of Zimbabweans may primarily be granted through an exemption in the Immigration Act, it is not clear whether these guarantees will still be considered applicable for all Zimbabweans in need of health services.

'Once they know you are foreign, the treatment is different'

"Once they know you are foreign, the treatment is different. But if you are accompanied by the MSF social assistant, then the treatment is okay because they know she is there to assist and she always speaks on your behalf, so you get treatment."

– An MSF patient in Johannesburg

"Our team referred an unconscious Zimbabwean patient to a hospital in Johannesburg. His condition was a result of assault, and the patient presented with a severe head injury. At the hospital, the matron in charge refused to attend to the patient who was in need of critical emergency care, claiming that the patient was not able to say his name, so she was not willing to attend to him. This is shocking. Every medical professional has an obligation to provide care to a patient who is presenting with a life-threatening condition."

– Dr Eric Goemaere, Medical Coordinator, MSF in South Africa

“I had a patient who was pregnant, and we sent her to the hospital. When she got there, the water had already broken. They took her to the nurses. When they looked at the patient and where she had come from – she produced her papers – they said ‘A foreigner?’, and they just walked away. They left her on the gurney.”

– An MSF doctor in Johannesburg



“One woman was very ill. She had malaria and was HIV-positive. She was in bad condition, her temperature was very high. And we referred her to hospital, but then she came back the following day. We saw that she still wasn’t well, so we wanted to return her to the hospital, but she said she did not want to go there. We asked her why and she said the nurses told her, ‘You are dirty, you are smelly. You go back to Zimbabwe with your dirtiness.’

– An MSF health worker in Musina

Photo: © Austin Andrews, Two young women waiting outside the MSF clinic at the Central Methodist Church in Johannesburg.

“A Zimbabwean mother brought her six-year old child to our clinic. The child had been raped. She was examined by our medical doctor and prophylactic treatment was given. Our counsellor did an initial counselling session with the mother and referred them to Child Welfare. From there they were referred to the hospital for further medical follow-up. The child was turned away from the hospital because she and the mother did not have legal documentation. It is unacceptable and inhumane to refuse treatment for a six-year old child who needs essential medical care after she has been raped. Not having legal documents cannot be a reason to deny access to health care.”

– Bianca Tolboom, Nurse and Project Coordinator, MSF in Johannesburg

“Sometimes we ask patients that come to our clinic why they didn’t seek health care before coming to us. A frequent answer to this is: ‘I can’t go to the hospital, I don’t have papers. I will have to show my documents and if they find out I don’t have them, they will arrest me.’

– An MSF nurse in Johannesburg



CROSSING THE BORDER

“A 16-year-old-girl crossed into South Africa with her two aunts and four men. When the group was at a farm about 30 kilometres south of Musina, they slept in the bush. At dawn they were ambushed by a group of guma-gumas. As she was running, the young girl tripped and fell. One of the guma-gumas then searched her and took her money. He then proceeded to violently rape her. Her genitalia were bruised. She was infected with an STI. She cannot sit up straight and can hardly walk. She has missed her period and could be pregnant from the rape. She said she could not go to the hospital for fear of being deported.”

– Sara Hjalmarsson, MSF Nurse and Project Coordinator in Musina

Violence, chronic disease, and epidemic outbreaks in Musina

A harsh arrival on the banks of the Limpopo River is the first experience of South Africa for many Zimbabweans. It is here where scores of Zimbabweans are beaten, robbed, and sometimes raped by criminal gangs known as the 'gumagumas.'

For newly arrived Zimbabweans who do not have an established network in Musina town, there are few options for shelter. They seek refuge in churches, along the railroad, and in the surrounding bush. Many others find temporary seasonal work on commercial farms along the border.

Initially, it was difficult for MSF teams to reach Zimbabweans in Musina who needed medical assistance, as most were hiding for fear of arrest or deportation. This dynamic started to shift in July 2008 when a Department of Home Affairs (DHA) Refugee Reception Office opened at Musina Showground, an open field in the centre of Musina town, to enable Zimbabweans to register and have their claims for asylum processed. Large numbers of Zimbabweans began to gather openly in the Showground, the only place in the town where they could avoid being arrested for not possessing asylum-seeking papers or other legal documentation.

In the months that followed, the number of people that started queuing at the Showground to obtain their papers, coupled with major bottlenecks in the asylum-seeking process, resulted in significant needs for basic shelter, water, sanitation, food and health care.

By February 2009, an estimated 4,000 Zimbabweans were sleeping at the Showground each night without any proper shelter, protection, or assistance. It became a *de facto* refugee camp, yet government authorities refused to recognise it as such. As a result, none of the minimum international standards for such a camp were observed. Thousands of Zimbabweans slept crowded together out in the open, exposed to the harsh sun during the day and the cold at night. They had no access to adequate food, water, sanitation, shelter or health care and efforts by non-governmental organisations (NGOs) to provide

basic humanitarian assistance were systematically blocked by local authorities.

In March 2009, despite the ongoing flow of Zimbabweans, the DHA ordered everyone to leave Musina Showground, providing no alternative shelter or protection. Today, people are no longer allowed to sleep at the Showground. If they do so, they are either chased away or detained.

Those Zimbabweans who cannot afford passports or an emergency travel permit continue to cross the border illegally. The number of people arrested at the border and in Musina fluctuates. However, in May 2009, up to 400 people were being detained in unacceptable conditions each day in a detention centre.

Shelter remains a pressing concern. While faith-based organisations have established a few temporary shelters in Musina where Zimbabweans can stay for three days on average, the conditions of these shelters are inadequate and they are often completely overloaded. However, there is little else available. As winter approaches, some nights there are more than 600 people crowded into a shelter that should not host more than 300 people. As shelters are overburdened, many others hide in the bush.

MSF ran a daily mobile clinic at the Showground until May 2009 when the DHA Reception Office was moved to a private compound; the mobile clinic now operates just outside the Showground. In addition to the daily clinic near the Showground, MSF operates mobile clinics on farms along the border and in specific fixed points in Musina town. Medical teams in and around Musina play an essential role in epidemic surveillance as they provide mobile diagnostic services including rapid testing for HIV, syphilis, and malaria. Samples are sent to the National Health Laboratory Services (NHLS) for TB, cholera, and dysentery detection, limiting the risk of epidemic spread. MSF mobile medical teams also provide general curative services, care for sexual and gender-based violence (SGBV), and psychological support.

Approximately 2,000 consultations are carried out each month. The main illnesses MSF teams diagnose and treat are respiratory tract infections,

sexually transmitted infections, particularly HIV, diarrhoeal and gastro-intestinal diseases, and stress-related ailments. In addition, there has been a significant increase in the number of cases of sexual violence.

Sexual violence

Through its mobile clinics, MSF treats violence-related injuries, most often rape and sexual assault, as well as beatings, deep knife wounds, broken bones, and whip marks – a combination of trauma experienced during the border-passage from Zimbabwe and in Musina town.

Women and children are particularly vulnerable to brutal attacks by 'guma-gumas' (local gangs), Zimbabwean soldiers, and police. Finding immediate care is critically important after a sexual assault to prevent HIV, sexually transmitted infections, hepatitis, and pregnancy. Treatment to prevent HIV infection has to start within 72 hours and emergency contraception is possible within five days. However, of those who manage to seek care in Musina, most do so more than 72 hours after the rape has occurred, explaining that the delay was because they did not know where they could turn for treatment or needed to secure their legal papers before seeking care. Many victims also often experience feelings of shame as a result of sexual assault, which prevents them from seeking the treatment they need early enough.

In April 2009, MSF expanded its services for survivors of sexual violence to address this important and unmet need and now has a fixed clinic for survivors of sexual and gender-based violence (SGBV).

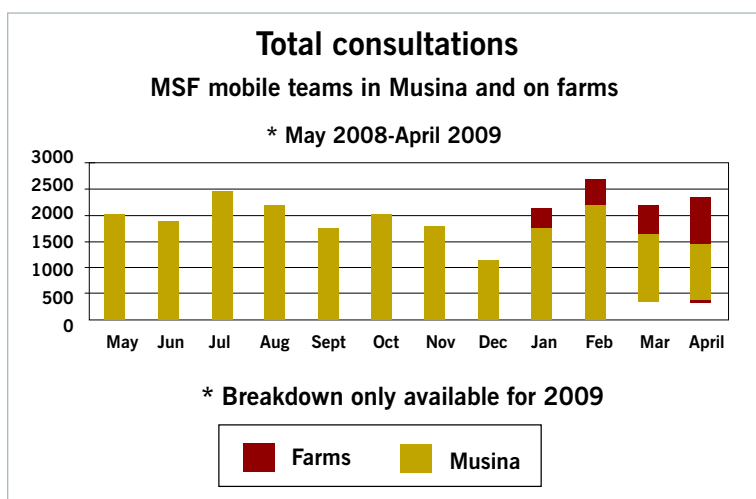
More than 75% of clients seen by MSF in April were raped while crossing the border, and nearly 60% were raped by more than one perpetrator. Seventy percent of the time, rapes were perpetrated with an armed threat (gun, knife, etc.) and almost 50% of clients had injuries due to associated violence.

The Department of Health (DOH) does not require survivors of SGBV to report to the police before accessing medical services but in practice many health providers, including in Musina Hospital, are telling survivors they must first lay a charge. This means that emergency medical treatment, including post-exposure prophylaxis to prevent HIV-infection, is often hindered or delayed.

HIV/AIDS and TB in a highly mobile population

High rates of HIV infection among Zimbabweans attending MSF mobile clinics in Musina pose specific challenges. In April 2009, out of 319 HIV tests done 35% of patients tested in MSF mobile clinics in Musina were HIV-positive (positivity rates are particularly high on farms). MSF teams diagnose and treat opportunistic infections and maintain a buffer stock of antiretrovirals (ARVs) for patients who have run out of drugs. Patients on ARVs, and those clinically eligible for antiretroviral therapy (ART) but not yet initiated, are referred to accredited ART sites. However, patients working on farms are often not allowed by farm owners to leave to attend clinics and cannot afford transportation to town. The fact that the population is highly mobile poses major challenges for follow-up of referrals, treatment adherence, and continuity of care once initiated.

Although there are high levels of suspected TB in and around Musina, only a small number of the sputum samples collected return positive for TB. This can be explained by the high TB/HIV co-infection rate (direct sputum microscopy only detects approximately 40% of active TB cases in high HIV prevalence settings) and the lack of availability of more precise methods (there is no access to sputum culture at the Musina NHLS lab). Still, for those who have a confirmed TB diagnosis, there are long turn-around times for receiving lab results and follow-up is a challenge. By the time the MSF team receives a positive result, patients have usually moved on from Musina and there is no way to trace them.



Cholera outbreak

In October 2008, MSF medical teams at the Showground in Musina town started to notice an increase in the number of cases of acute watery diarrhoea and reported this to local health authorities. There were also sporadic cases of bloody diarrhoea. Considering the lack of clean water and basic sanitation facilities available for Zimbabweans at the Showground at the time, MSF had grave concerns that diarrhoeal diseases could spread rapidly to the thousands of people staying at this makeshift 'refugee camp'.

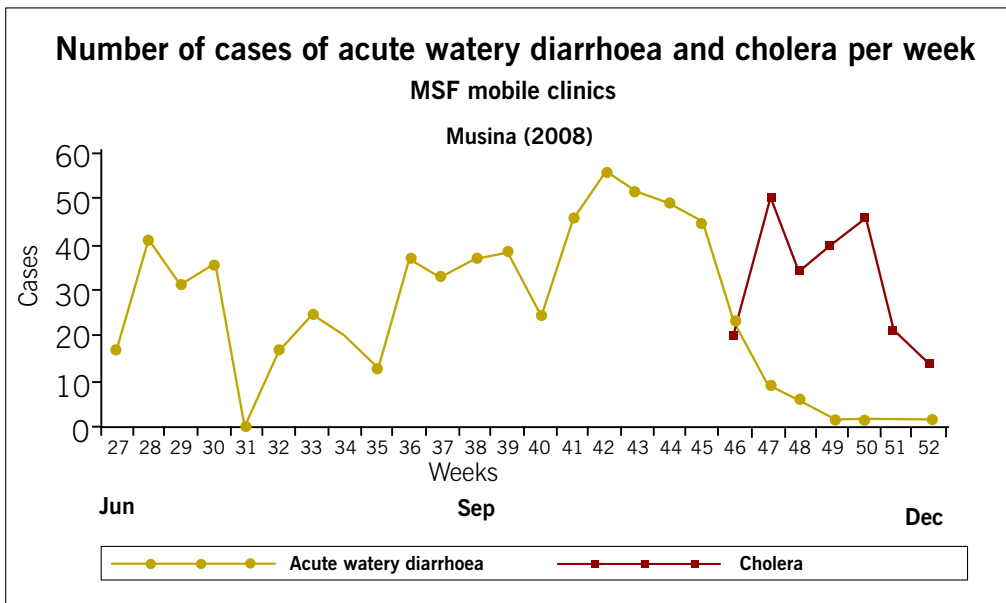
The following month, a cholera outbreak was confirmed in Beitbridge, just across the border in Zimbabwe. The MSF team in Beitbridge was reinforced by an emergency medical team and a major shipment of medical and logistical supplies was sent to Beitbridge Hospital to create on-site treatment capacity on the Zimbabwean side of the border. Days later a cholera outbreak was confirmed in Musina itself. MSF began screening people at the Showground and other sites to identify those with potential signs of cholera for treatment and/or referral to Musina Hospital. MSF also carried out hygiene promotion, water and sanitation improvements, and education and awareness-raising activities. In Limpopo Province MSF diagnosed and either treated or referred hundreds of cholera cases.¹²



Photo: Rachel Cohen/MSF,

An MSF nurse treats a patient at a mobile clinic on a farm outside Musina town.

The graph below shows the increase in the number of cases of acute watery diarrhoea at the Showground in the month of November and the appearance of suspected cholera cases once the outbreak was confirmed in Limpopo (epidemic surveillance of acute watery diarrhoea at the Showground illustrates that several cases were very likely cholera prior to week 46 but they were not diagnosed as such until the DOH declared the outbreak and announced a new case definition).



‘There were 13 men watching us all the time and they raped us every day’

“There were seven of us, all girls. We were just friends, not relatives. I was the youngest of them. We got on a bus to Beitbridge and when we got off these men were saying that if we don’t have money to cross, we could come with them. We opted to go in their cars. They said border jumpers travel at night so we drove around from 6 pm to 7 am. We went to so many different places I didn’t know where we were any more. Then they stopped at one place in the forest and this became our sort of home for the next four months. There were 13 men watching us all the time and they raped us every day. Eventually they started to let us go to urinate by ourselves and that is how we escaped. Now I am four months pregnant. I left Zimbabwe because I am an orphan – I am the breadwinner for my siblings and I came to find food and find a way to support them. Now I don’t know what I am going to do, how I am going to take care of them.”

– A 17-year-old Zimbabwean girl at the MSF mobile clinic, Musina Showground

“Last night we learned of a group of 500 women and children who attempted to swim across the crocodile-infested Limpopo River to reach South Africa, only to fall prey to local bandits known as ‘guma-guma.’ Five of the women who crossed were raped, and two babies were literally taken off their mothers’ backs and thrown into the river to drown.”

– An MSF health worker in Musina

“A 16-year-old-girl crossed into South Africa with her two aunts and four men. When the group was at a farm about 30 kilometres south of Musina, they slept in the bush. At dawn they were ambushed by a group of guma-gumas. As she was running, the young girl tripped and fell. One of the guma-gumas then searched her and took her money. He then proceeded to violently rape her. Her genitalia were bruised. She was infected with an STI. She cannot sit up straight and can hardly walk. She has missed her period and could be pregnant from the rape. She said she could not go to the hospital for fear of being deported.”

– An MSF nurse in Musina



“Life here became difficult when I was raped. I was looking for work and I found a security guard who said there were some people who wanted a maid to work in the house. I went with him and got into a car. There were three other men and two women. One woman wanted to jump out of the car and they blindfolded her. When I started screaming they let me out of the car with that guy in the forest, and he raped me. Afterwards, he beat me up. Then he left me there. Later, when I got tested for HIV, I tested positive.”

– A 38-year-old Zimbabwean woman at Central Methodist Church, Johannesburg

“Every week we see women coming to our mobile clinics in Musina after being raped. They have tried to go to the hospital for emergency medical treatment, but at the hospital they have been refused medical treatment if they have not first reported the case to the police. Most of these women did not dare to go to the police and therefore they were left without the critical medical treatment needed to prevent HIV and other conditions within 72 hours after the rape.”

– Sara Hjalmarsson, MSF Nurse and Field Coordinator in Musina

“Most women who are raped have no one to talk to, no food, no shelter, no money, and no one who can help them overcome the traumatic experience. We have seen several cases where women are raped at the border crossing and later again in Musina. They have serious health needs and deep psychological scars.”

– Angie Huyskens, MSF Psychologist in Musina

Photo: © Austin Andrews,
A temporary women's
shelter at the Old Catholic
Church in Musina.



SEARCHING FOR SAFETY

“There was a patient who worked here in the centre of Johannesburg with two other Zimbabweans, and their South African colleagues had said several times already, ‘We don’t want you here. Go back to Zimbabwe. You’re taking our jobs.’ One night they told him they were having a team meeting and they went into a room, closed the doors, and one of the guys started to beat the Zimbabweans with a sjambok, which is a kind of whip. The other South African colleagues were all watching and singing. It was of course very traumatising. The patient told me he does not want to go back to work, and he does not know where to go. He just wants to stay inside the church building because that’s the only place where he feels relatively safe.”

– Bianca Tolboom, MSF Nurse and Project Coordinator in Johannesburg

Photo: © Austin Andrews, The busy scene at the intersection of Smal and Pritchard Streets as Zimbabweans arrive at the Central Methodist Church to seek shelter for the night, bedding down in cramped conditions either inside or outside on the pavement.

Central Methodist Church in Johannesburg

Although there are tens of thousands of Zimbabweans living in Musina at any given time, the majority do not stay long. Johannesburg is the final destination for most Zimbabweans. Today, Johannesburg's inner-city is home to millions of refugees, asylum-seekers, and migrants of all nationalities.

The Central Methodist Church in downtown Johannesburg provides a 'safe haven', where thousands of Zimbabweans seek refuge each night, either in the Church itself or on the street in front. People live in crowded, unhygienic conditions, filling nearly every inch of available space inside the five-storey building. Up to 2,000 people sleep on pews, stairs, and the hard floor of the Church. Outside on the footpath, hundreds and sometimes thousands of Zimbabweans who cannot squeeze into the Church sleep among cardboard boxes, as close to the building as they can get.

Since December 2007, MSF has operated a fixed clinic connected to the Central Methodist Church, and works in close collaboration with the Church community to provide basic health services and referral of patients to the public health system for more specialised medical treatment. In addition to providing basic health care, the key aim of the MSF clinic is to actively facilitate access for Zimbabweans to existing health services in Johannesburg.

In the past year, the number of consultations has steadily increased, starting with 750 patients per

month in early 2008 and reaching more than 2,700 patients in March 2009. Initially, the MSF clinic was primarily frequented by Church residents. However, today more than 50% of the Zimbabwean patients are from outside the Church area – an indication of the poor access to healthcare elsewhere in the area for Zimbabweans.

As with the mobile MSF clinics in Musina, the main diagnoses at the MSF clinic at the Central Methodist Church are respiratory tract infections, sexually transmitted infections, diarrhoeal and gastro-intestinal conditions, and stress-related ailments. Minor therapeutic procedures are also carried out (dressing, injections, sutures). There is a small dispensary and on-site lab at the clinic, where rapid tests are carried out and samples are taken for analysis at the NHLS.

However, in the last several months, the Central Methodist Church has increasingly come under threat. In February and March 2009, Zimbabweans in and around the Church were faced with a police raid and legal action by neighbouring businesses. Due to increased overcrowding in both the Church and sidewalks outside, businesses complained that the thousands of Zimbabweans and the unhygienic and cramped environment were bad for business. Consequently, they erected a large, imposing iron gate in front of the Church building. This effectively barred Zimbabweans directly from the Church, leaving them exposed to the violence on the streets.

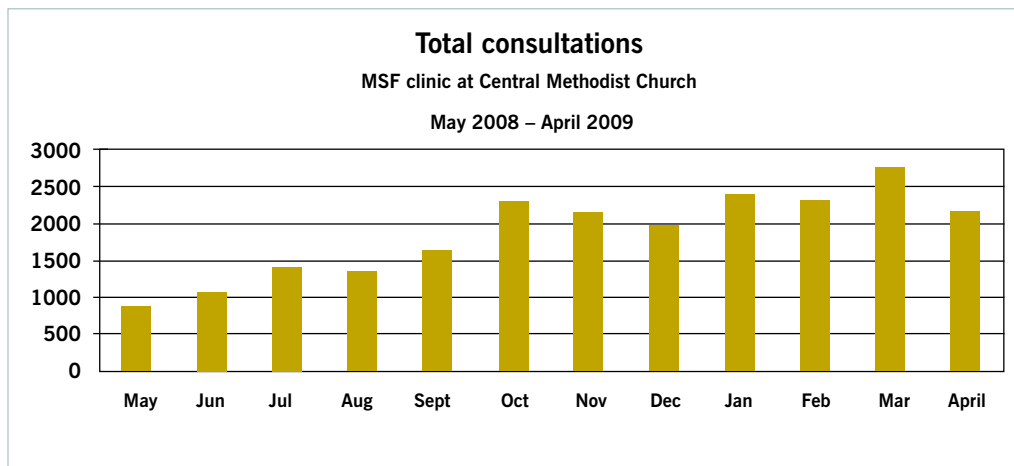




Photo: © Dirk-Jan Visser, Zimbabweans sleep on the floor of the Central Methodist Church at night with nowhere else to stay

Photo: © Shayne Robinson/EPA, A Zimbabwean patient is treated by an MSF doctor and nurse at the MSF clinic at the Central Methodist Church.

Communicable diseases and outbreak response

As in any overcrowded and unhygienic setting, people staying in the Central Methodist Church in Johannesburg are exposed to a serious risk of communicable disease outbreaks. This risk is mitigated, at least in part, by effective collaboration between MSF and the Gauteng Department of Health (DOH). MSF carries out epidemic surveillance and prevention, and works with the DOH to intervene rapidly in case of epidemic outbreaks.

In response to the November 2008 cholera outbreak, MSF, in collaboration with the DOH, organised an emergency response to help prevent the spread of cholera and ensure quick access to treatment for patients presenting with cholera symptoms. The emergency response included active case finding; rapid detection and referral of patients through a network of Church residents and community leaders; isolation of symptomatic patients and treatment of moderate cases at a small oral rehydration unit; and referral of severe cases to hospital. MSF also carried out hygiene promotion and information and education campaigns in high-risk areas and places with large concentrations of

Zimbabweans, such as bus stations, taxi ranks, food distribution points, and densely populated residential buildings.

MSF teams introduced key measures to improve the hygiene and sanitation conditions both inside and outside the Church by providing mobile latrines, repairing the toilet system inside the Church, deploying special cleaning and disinfection teams and providing hand-washing points and containers at entrance points where food vendors could clean their cooking tools.

MSF also collaborates closely with the DOH in response to other communicable diseases diagnosed. In March 2009, a patient living at the Central Methodist Church was diagnosed with meningococcal meningitis. The diagnosis was confirmed the following day, close contacts were identified by MSF staff, and prophylaxis provided by DOH was administered within 24 hours. The health education teams from both MSF and DOH met and coordinated activities to ensure that the population living in and around the Church were well informed about the disease.

Facilitating access to secondary and specialised care

One of the main aims of the MSF clinic in Johannesburg is to facilitate access to health care for Zimbabweans who are otherwise not accessing the health system due to fear of arrest, deportation, discrimination, or poor treatment. Each month, MSF refers approximately 80 patients to secondary and specialised services in Johannesburg, primarily for TB treatment and other chronic diseases, ART initiation for HIV, emergencies related to trauma, comprehensive care for victims of sexual violence, and acute severe conditions such as pneumonia requiring hospital-level care.

The key to ensuring patients are admitted when referred is a confirmed diagnosis, an MSF referral letter, and the accompaniment of an MSF 'social assistant.' MSF also subsidises hospital fees, a major barrier for Zimbabweans who cannot afford to pay for the treatment they urgently need and are still charged high amounts.

This system works well for the few who are able to access services through MSF. However, there are thousands of Zimbabweans in need of health services who face major obstacles, as illustrated by testimonies from MSF patients and health workers.



The plight of unaccompanied children

During the past year, MSF has witnessed a steady increase in the number of unaccompanied children coming to Musina and to the Central Methodist Church in Johannesburg.

At the Central Methodist Church there has been a sharp increase in the number of unaccompanied minors arriving – particularly in the first half of 2009. As of May 2009 there were 150 children between seven and 18 years staying at the Church. These children are extremely vulnerable and exposed to many forms of abuse.

To respond to this critical situation, MSF started a special counselling programme for unaccompanied minors. Three counsellors work with the children, providing emotional, educational and psychological support. Children frequently ask for help to find a place where they feel more protected and where living conditions are more suitable. Many children battle to sustain themselves in this situation, sometimes leading to very worrying behaviour and survival strategies.

MSF has repeatedly expressed concerns to the Department of Social Development and UNICEF

about the situation the children face, providing a list of names and relevant details about each individual child. Despite the fact that key organisations and agencies are fully aware of the extreme vulnerability of this group, no viable solution has yet been proposed or implemented.

Photo: © Dirk-Jan Visser, Two Zimbabwean children seek shelter in the Central Methodist Church in Johannesburg.

“Some have lost both parents due to HIV/AIDS or other causes. They weren’t going to school; some of the children were heading the family themselves. One 12-year-old boy was looking after his sisters who were 7 and 5. Some realised that their parents no longer had the means to look after them, so they just decided they had to grow up overnight and say this is what I’m going to do. During their journeys some have been exploited. Some have been raped. A 12-year-old girl was raped in Pretoria, and she ended up here. She got an infection and her behaviour completely changed after that. Once something like that happens to a child you fear for more abuse.”

– An MSF counsellor, Johannesburg

Xenophobic violence erupts



Photo: © Erin Trieb, Victims of xenophobic violence wait in long lines before moving into temporary tent-housing in Johannesburg in June 2008.

In May 2008, targeted xenophobic attacks erupted in Alexandra township. The violence rapidly spread across Johannesburg and to several other cities and provinces in South Africa (Gauteng, Western Cape, and Kwa-Zulu Natal), killing 62 people, injuring 670 and causing the displacement of approximately 100,000 foreign nationals, including large numbers of Zimbabweans.

In the immediate aftermath of the violent attacks, MSF provided emergency medical assistance, treating approximately 150 violence-related injuries, including gun shot wounds, stab wounds, lacerations, burns, and other injuries in the first days of the emergency in Alexandra, Diepsloot, and other areas affected by the violence.

In the subsequent weeks, as the violence subsided, mobile MSF teams provided health care, blankets, plastic sheeting, and hygiene kits in 15 community halls, police stations, and churches to which people fled for safety in Johannesburg, and later in seven temporary 'camps' established by the government. The main pathologies treated were those related to displacement, such as diarrhoea, respiratory infections, and stress-related illnesses.

From May to September, a total of 11,000 medical consultations and an additional 11,000 mental health consultations were carried out in the camps in Johannesburg and Pretoria, as well as in Cape Town, where MSF also responded to the needs of displaced foreign nationals in Khayelitsha. In addition, MSF distributed 10,000 blankets and 10,000 hygiene kits.

The xenophobic attacks of May 2008 were preceded by several significant events witnessed by MSF, the most striking of which was a violent police raid on the Central Methodist Church in January 2008. During the night of 31 January 2008, police raided the Central Methodist Church and detained approximately 350 people who were seeking refuge there. The MSF team gained access to the detainees taken to Johannesburg Central Police Station and were able to assess their health conditions.

The team found suspected fractured ribs, possible lung contusions, patients with chronic illnesses, and patients on treatment for HIV and TB, who lost their treatment during the arrest. Police refused MSF's repeated requests for patients in need of referral to be immediately taken to hospital. After a rapid civil society response, a court interdict eventually resulted in the detainees being released.

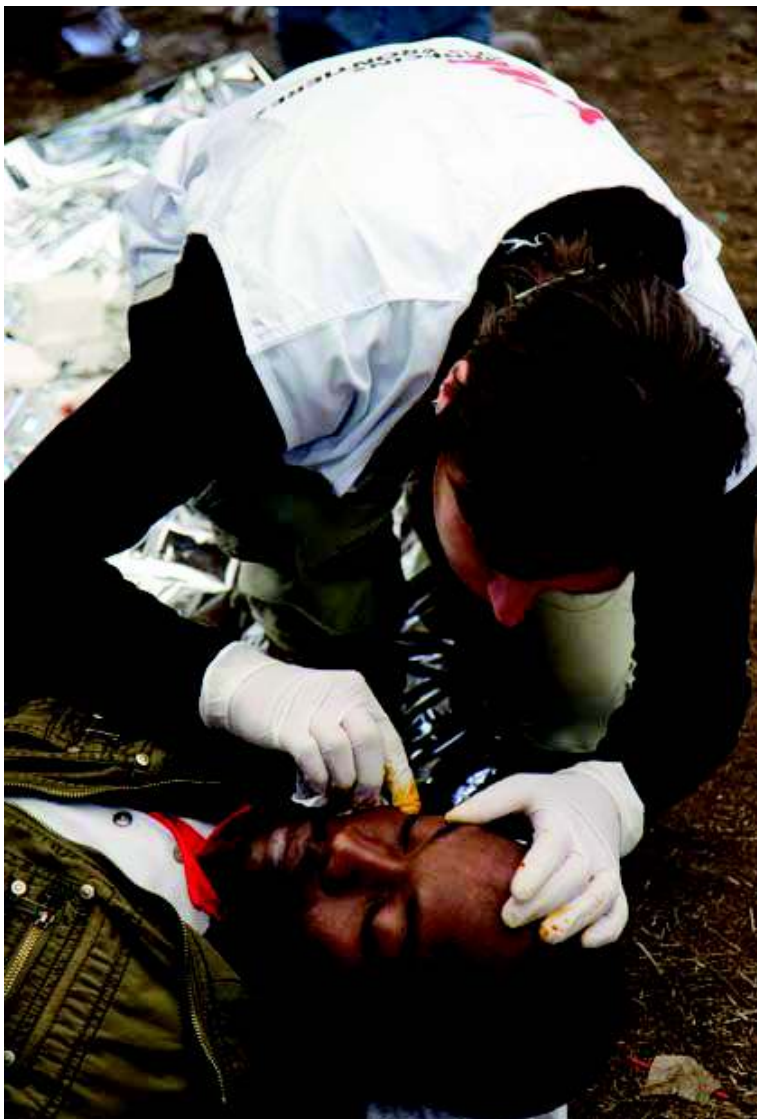
'Everyone is failing to protect us'

"I have just been attacked in my home. The reason I came to South Africa is because of fear – I came looking for asylum, but South Africa has also neglected us. Everyone is failing to protect us. I just want to find a safe and peaceful place to live. It seems like South Africa can't accommodate Zimbabweans anymore. Again, I have no food and clothes. I am back in the same situation that I was in back in Zimbabwe."

– A 40-year-old Zimbabwean man treated by MSF in Thokoza Community Hall, May 2008

"Some people are good, they say 'Come into my house, I want to give you something.' Other people there were some who shouted at us when we were getting water – 'There is no water for Zimbabwean people.' They said there is water for South Africans only. And sometimes when we are looking for food we are told 'Go away – you mess up our space.' Life here is tough."

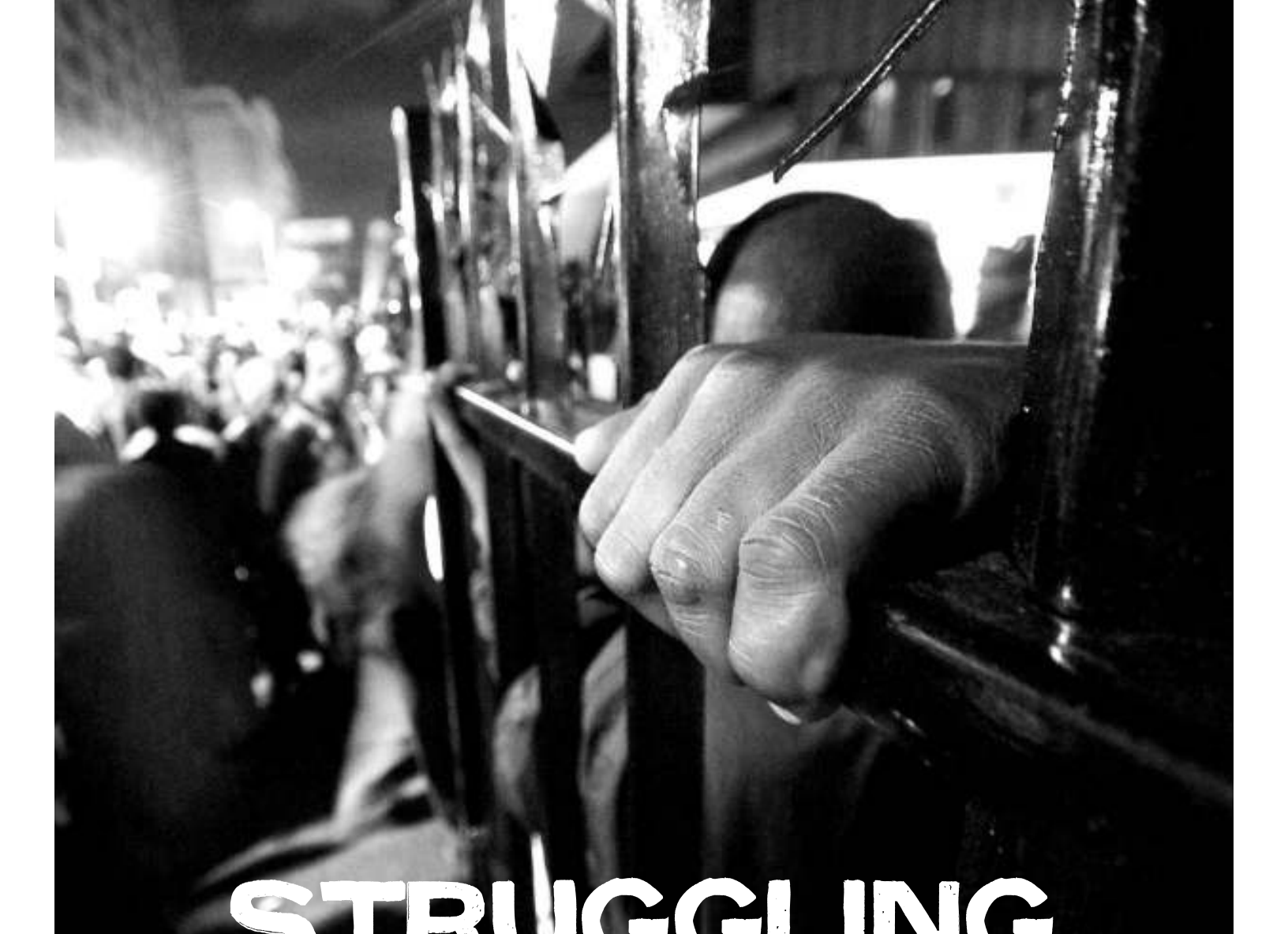
– A 23-year-old Zimbabwean man sleeping outside the Central Methodist Church, Johannesburg



"There was a patient who worked at a cleaning company here in the centre of Johannesburg with two other Zimbabweans, and their South African colleagues had said several times already, 'We don't want you here. Go back to Zimbabwe. You're taking our jobs.' One night they told him they were having a team meeting and they went into a room, closed the doors, and one of the guys started to beat the Zimbabweans with a sjambok, which is a kind of whip. The other South African colleagues were all watching and singing. It was of course very traumatising. The patient told me he does not want to go back to work, and he does not know where to go. He just wants to stay inside the church building because that's the only place where he feels relatively safe."

– Bianca Tolboom, MSF Nurse and Project Coordinator in Johannesburg

Photo: Henrik Glette/ MSF, MSF nurse treats a rubber bullet wound, following xenophobic attacks in Johannesburg.



STRUGGLING TO SURVIVE IN THE SHADOWS

Photo: © Austin Andrews, A hand clasps the metal fence, erected by local businesses, in front of the Central Methodist Church at night.

Conclusion

Zimbabweans continue to face an economic crisis, political instability, and poor access to basic services, including health care, in their country. They flee to South Africa as a matter of survival. On arrival in South Africa they do not find refuge, but instead are faced with an unacceptable continuation of their suffering, without access to proper health care, shelter, or safety.

MSF medical teams witness the daily failure of both the South African government and UN agencies to ensure that the basic medical and humanitarian needs of vulnerable Zimbabweans are met.

The South African Constitution guarantees access to health care and other essential services to all who live in the country – including refugees, asylum-seekers, and migrants – regardless of legal status. But in reality, Zimbabwean patients continue to be rejected, charged exorbitant fees, subjected to long delays or inappropriate treatment, or prematurely discharged, placing health care out of reach for many. This is a breach of medical ethics and violates the Constitution.

The government of South Africa must do more to ensure that health staff is properly informed about the rights of refugees, asylum-seekers, and migrants to access the public health system, regardless of legal status. In addition, it is essential that secondary and specialised care is free for those Zimbabweans who cannot afford it, as no patient in need of health care should be denied access for financial reasons.

Every day, MSF teams treat sick and vulnerable Zimbabweans who are falling through the cracks in South Africa: victims of violence; people with basic ailments as well as life-threatening chronic diseases such as HIV and TB; and people with psychological conditions linked to the trauma they have endured. MSF provides counselling and psycho-social support for particularly vulnerable patients,



especially unaccompanied children and survivors of sexual violence, and responds to emergency needs resulting from xenophobic attacks and disease outbreaks when they arise.

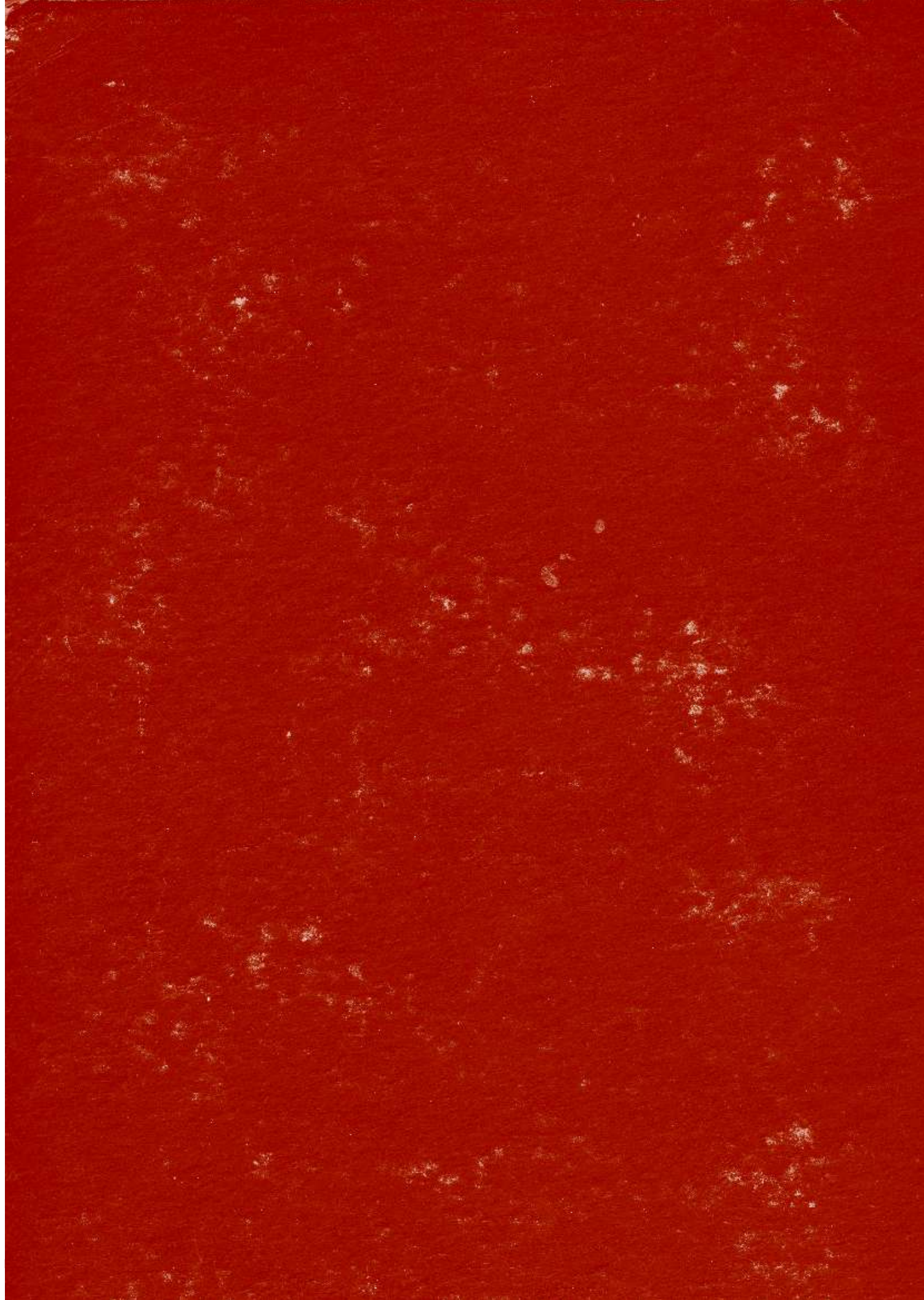
Government and relevant UN agencies must take special urgent steps to ensure that emergency medical care for survivors of sexual violence is not hindered or delayed and that unaccompanied children have access to shelter, protection, counselling, legal documentation, health care, education, and other basic rights.

While there have been positive developments in the past months to regularise the legal status of Zimbabweans in South Africa and to stop deportations of Zimbabweans, these measures have yet to translate into tangible improvements in the lives of most Zimbabweans seeking refuge in South Africa. Until this happens, Zimbabweans will continue to suffer, struggling to survive in the shadows of South African society.

Photo: © Austin Andrews, Night falls over a temporary men's shelter in Musina.

References

1. According to information obtained from the DHA by the South African History Archives (SAHA) and the University of Witwatersrand, between 2000 and March 2008, there were 66,578 new applications for asylum from Zimbabweans. Of these, 710 applicants were granted refugee status and 4,040 were rejected. Over 62,000 cases remain pending. In the first quarter of 2008, there were more than 10,000 Zimbabwean asylum-seekers – more than applied in the entire year of 2005 – and only 19 approvals.
2. International Federation of Red Cross and Red Crescent Societies, 2009. 100,000 cases: The spectre of cholera remains in Zimbabwe
3. WHO, 2009. WHO Daily Cholera Updates. 20 May 2009
4. UNAIDS, Zimbabwe Country Profile, November 2008. <http://www.unaids.org/en/CountryResponses/Countries/zimbabwe.asp>
5. Mail & Guardian - Zim unemployment skyrockets. Mail & Guardian. 30 January 2009
6. Hanke, S. 2008. New Hyperinflation Index (HHIZ) Puts Zimbabwe Inflation at 89.7 Sextillion Percent, CATO Institute. <http://cato.org/zimbabwe>
7. Beyond cholera: Zimbabwe's worsening crisis, MSF, February 2009.
8. South Africa is a signatory to the 1951 Refugee Convention and the Organisation of African Unity (OAU) Refugee Convention. According to the OAU convention, a refugee is a person who, "Owing to external aggression, occupation, foreign domination or events seriously disturbing or disrupting public order in either a part or the whole of his or her country of origin or nationality, is compelled to leave his or her place of habitual residence in order to seek refuge elsewhere." The government, supported by UNHCR, has historically taken the position that the vast majority of Zimbabweans in South Africa are not refugees and that the situation in Zimbabwe does not warrant a group application of the OAU Convention-based refugee definition.
9. Section 31(2)(b) Permits for Zimbabwean Nationals in South Africa, Consortium for Refugees and Migrants in South Africa, April 2009.
10. DOH Revenue Directive-Refugees/Asylum-Seekers With or Without Permit (BI 4/29 REFUG/ASYL 8 2007).
11. BI 4/29/ART, April 2007.
12. At the same time, MSF teams in Zimbabwe mobilised a massive emergency response to the unprecedented cholera epidemic raging across that country, treating more than 50,000 cases in all but one Zimbabwean province.





MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS