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A qualitative study exploring sexual and reproductive health needs among a sample of foreign migrants living in six locations in Southern Africa

Latifat Ibisomi[1], Alexandra Spyrelis[2], and Mulekya F. Bwambale[3]

Abstract

Migrants in Southern Africa often lack access to adequate sexual and reproductive healthcare (SRH), which deepens their vulnerability to poor health outcomes. This paper highlights results from a rapid assessment undertaken in six countries in the Southern African Development Community (SADC) region to inform the implementation of the "SRHR-HIV Knows No Borders" project. In-depth interviews were conducted with 16 adult foreign migrants residing in 10 high migration communities where the project was implemented. Data were analysed thematically using an inductive approach. Respondents were found to have good knowledge about HIV, STIs, and male condoms, although they lacked awareness about other contraceptive methods. Many respondents reported barriers to accessing SRH services, mostly as a result of a lack of legal documentation and due to discrimination from healthcare workers. SRH interventions among foreign migrant populations in the Southern African region should focus on developing awareness about contraceptives and ensuring inclusivity within the healthcare system.

Keywords: Migrants; sexual reproductive health; SADC region; healthcare access

Introduction

The increase in human mobility within and across borders has important implications for policy, particularly with regard to issues of migration, development, public health, and security. While there is no universally accepted definition for the term 'migrant' under international law, it generally refers to a person that moves away from their usual place of

[1] Latifat Ibisomi, Nigerian Institute of Medical Research; and School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, South Africa. E-mail: Latifat.Ibisomi@wits.ac.za

[2] Alexandra Spyrelis, Independent researcher, South Africa. E-mail: aspyrelis@gmail.com

[3] Mulekya F. Bwambale, International Organization for Migration, Pretoria, South Africa. E-mail: fbmulekya@iom.int

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residence, either temporarily or permanently, for a variety of reasons, including for economic, safety, or social reasons (IOM, 2019). There are many different types of migrants, whether documented or undocumented, including migrants seeking work or asylum, refugees, migrants displaced by violence or climate disasters, and victims of trafficking. Approximately 3% of the global population live in a different territory or State to the one in which they were born (Skeldon, 2018). In Southern Africa, approximately 8 million of the 354 million inhabitants are migrants (United Nations Department of Economic and Social Affairs (UNDESA), 2019).

Migrant health refers to differences in the health status between migrants and populations in origin and destination countries (IOM, 2020). The relationship between migration and health is a complex one that can either deepen migrant vulnerability or strengthen their resilience. Migrants may face greater health risks as a result of poor working conditions or a lack of access to affordable healthcare, or their health may improve as a result of living in a safer environment or accessing better health facilities in their destination country (IOM, 2020). Migration is thus deemed a social determinant of health that affects health and wellbeing in various ways, both at the individual and population level, in addition to other individual and structural factors (Davies et al., 2006). While migration may not automatically make migrants vulnerable to negative health outcomes, many migrants struggle to access healthcare or delay seeking care, whether for legal reasons or due to stigma or other factors. ((IOM), 2020). Thus, while migration does not cause illness in itself, the conditions and circumstances surrounding the process of migration can create risks to the physical, mental, and social wellbeing of migrants (Curtis et al., 2005; Davies et al., 2009).

Within sub-Saharan Africa, migration is a key predictor of HIV risk, with migrants at increased risk of contracting the virus due to a number of cultural, sociological, human rights, and health-related challenges (Nicholas et al., 2016; UNAIDS, 2014). Access to sexual and reproductive health (SRH) information and care is vital to overcome the HIV/AIDS pandemic. However, migrants face a number of barriers in accessing SRH care in the region. Common barriers reported in the literature include stigma and discrimination by healthcare providers, language barriers, inadequate or inaccurate knowledge of services, and a lack of financial resources to pay for care (Human Rights Watch, 2009; Veary et al., 2010; Zihindula et al., 2015). Furthermore, the legality of migrants' status in the country of destination can determine the level of access they have to health and other social services (Davies et al., 2006).

Irrespective of their legal status however, migrants continue to require access to SRH services, including HIV prevention and treatment, but often lack access to such given the highlighted barriers (UNAIDS, 2014). Various studies have demonstrated how the SRH needs of migrant populations are neglected, particularly among women and youth (Freedman et al., 2020; Ivanova et al., 2018; Mukondwa & Gonah, 2016). This paper focuses on the SRH and HIV-related needs, preferences, and experiences of a sample of foreign migrants residing in six Southern Africa countries.

Methods

The paper is derived using data from a broader, exploratory rapid assessment study undertaken prior to the implementation of a regional sexual and reproductive health and rights (SRHR) intervention titled the "SRHR-HIV Knows No Borders" project (SRHR-HIV Knows No Borders Project, 2019) conducted to ensure that the intervention was aligned with

the needs of the target groups. The project was implemented in six Southern African Development Community (SADC) countries from 2016 to 2020 by a consortium comprising of the International Organization for Migration (IOM), Save the Children Netherlands (SC), and the University of the Witwatersrand's School of Public Health, South Africa (WSPH). The project aimed to improve SRHR and HIV-related outcomes among people living and working in high migration communities, particularly migrants, adolescents and young people, and sex workers. Project interventions sought to create awareness of and demand for SRHR-HIV services, and to facilitate the accessibility and supply of such (International Organization for Migration, 2016). The WSPH was the lead agency on the project, and provided technical oversight, project management, and also managed data collection through country-based consultants. A steering committee, consisting of project managers and monitoring and evaluation officers from each consortium member, was created to oversee the study. Six independent in-country consultants were recruited to supervise data collection (one per country), which was conducted by a team of trained fieldworkers consisting of between eight and 28 data collectors and data entry clerks (depending on the number of project sites). All project researchers had experience working with vulnerable populations and had backgrounds in public health, counselling, or the social sciences.

This paper is focussed on the SRH needs of adult foreign migrants, who were interviewed as part of the broader study to identify gaps in their SRHR-HIV awareness, needs, and related contextual factors. For the purposes of the study, adult foreign migrants were defined as persons older than 18 years that had moved across an international border, regardless of their legal status and whether the move was voluntary or not. Data were collected from 16 adult foreign migrants living in the 10 high migration border towns where the project was implemented, namely: Hhohho in Eswatini (formerly Swaziland); Maputsoe in Lesotho; Mwanza and Mchinji in Malawi; Ressano Garcia and Cassacatiza in Mozambique; Nkomazi and Ekurhuleni in South Africa; and Katete and Chipata in Zambia.

Table 1. Number of migrants interviewed per country

	Country						
	Eswatini	Lesotho	Malawi	Mozambique	South Africa	Zambia	Total
Number of migrants interviewed	2	2	4	2	4	2	16

Procedure

The fieldwork teams received intensive training on the study over a period of three days, which included training on the study rationale, objectives, methods and tools, and ethical considerations. The interviews were conducted between April and December 2018. The interview guide consisted of open-ended questions and probes on themes around foreign migrants' SRH knowledge, access to SRH and other care, and their broader experiences living in their host countries. The interview guide was translated into the relevant local languages for the target communities, and piloted by the implementing partners in each country in areas outside of the study communities.

A purposive sampling approach was used to recruit foreign migrants who were living and working in the communities involved in the project. A rapid mapping exercise was undertaken in each site to identify hotspots where migrants resided, and migrants were recruited using snowball sampling. Trained fieldworkers from partner organisations implementing the study

collected qualitative data from the recruited participants, after they were provided with information about the study and gave their consent via signing an informed consent form. Interviews were conducted in the languages commonly spoken by the target population (including English), audio-recorded, and transcribed verbatim, after which they were translated into English for analysis by the data collection teams.

Data analysis

The English transcripts were loaded into Atlas.ti version 8 and analysed thematically, using an inductive, data-driven approach (Braun & Clarke, 2006). An initial analysis was conducted by reading the transcripts repeatedly, which were then coded manually within Atlas.ti. The codes were reviewed to establish patterns in the data which were used to generate themes. The themes were reviewed and refined to ensure that they accurately presented the data and were subsequently finalised and named.

Ethical considerations

Ethical approval for the rapid assessment study was obtained from research councils in each of the six countries where the project was implemented. Approvals were also sought from provincial authorities, ministries of education and health, and health service delivery points in each of the countries to conduct the studies at the selected project sites. The fieldworkers were trained in ethical procedures as part of their broader training on the study. The fieldworkers explained the information sheet developed for the study to each respondent before collecting written informed consent, which detailed its purpose, objectives, risks, and benefits, prior to the interview. Participation in the study was entirely voluntary. The fieldworkers scheduled the interviews at locations that ensured participant safety and confidentiality, and distressed respondents or those requiring further care were referred as needed. A number of steps were followed in order to ensure participants' privacy and confidentiality, including the use of codes instead of participant names, and storing the data and consent forms in secured rooms and electronic files with access limited to the research team.

Results and discussion

A total of sixteen foreign migrants (eight males and eight females) were interviewed across the 10 project sites in the six countries. Many migrants were from surrounding countries in the SADC region and some did not have legal documentation for residence in their host country. The duration of stay of foreign migrants in their destination countries varied, with some having moved more than a decade prior to the time of the study.

Awareness of condoms and other contraceptive methods

The study participants were well informed about the risks of unprotected sex, namely the risk of contracting HIV and other STIs, and unintended pregnancy. All of the participants interviewed were aware of male condoms as a form of protection against these risks. A few respondents also mentioned female condoms and other contraceptive methods, such as the pill or injectables. However, knowledge about these methods was not widespread. A few of the respondents reported knowledge of indigenous or folkloric methods, such as herbal teas to prevent pregnancy, while others had mentioned the withdrawal method or abstinence. Respondents understood how condoms provide protection from STIs and pregnancy by

providing a barrier for the mixing of bodily fluids, but did not understand how other contraceptive methods work to prevent pregnancy. Many respondents had learned about condoms and other preventive methods at health facilities, either from clinic staff or through awareness campaigns at health facilities. Some reported learning about these methods at school and from the radio.

> *"If I knew of other methods, I would use them. I have heard that there are some methods which are for 3 years. I think that would be good, but I do not have adequate information on them."* (Female migrant, Zambia)

> *"I learnt about these [methods] from friends and from health staff in the health centres, and some organisation that was doing awareness here in the community."* (Female migrant, Zambia)

> *"Condoms stop sperm from entering the woman and fertilisation does not happen. I'm not sure how contraceptives work."* (Male migrant, Lesotho)

> *"Getting pregnant is not something that will happen all the time, but diseases like STI's are sexually transmitted. Not mentioning the big ones like HIV, those are the things that can possibly go wrong."* (Male migrant, Eswatini)

Access to and use of contraceptive methods

All of the respondents had reported using male condoms and reported being able to access them easily, within walking distance of their homes, either freely in public spaces such as the post office and clinics, or at affordable prices in nearby shops. There was a clear preference for male condoms given their benefits (namely ease of use and dual protection). Only a few respondents reported using other contraceptive methods, such as the pill or injectables to prevent pregnancy. The few migrants that were using other contraceptive methods were able to access these at the local clinics.

> *"I am comfortable with using condoms as they do not only prevent pregnancy but also protect against the infection of STD and HIV."* (Male migrant, Lesotho)

> *"Condoms are found from the shops, public toilets, and hospitals and they are always available."* (Female migrant, Lesotho)

> *"My wife uses the injection and its working for her because she's not getting pregnant."* (Male migrant, South Africa)

Given the general lack of knowledge and understanding among migrants about contraceptive methods other than male condoms, it is suggested that interventions designed to address this need should involve an educational component to ensure the correct usage of such methods.

Structural and health system barriers

While a few respondents had never attempted to access SRH care from facilities in their host countries, many experienced difficulties with this, mostly due to a lack of proper immigration documentation, such as visas, residency permits, or refugee/asylum seeker permits. Some of the respondents that visited health facilities reported having been denied treatment, sent to the back of the clinic queue, or referred to the police for a clearance certificate if they could not produce identification. One respondent with no proper legal documents avoided

accessing SRH services altogether as he feared being identified and reported to the police. To address these challenges, respondents reported either travelling back to their home countries to seek SRH care, seeking care from traditional healers, or relying on friends that had the correct documentation to get medication on their behalf.

> *"Being a non-national, even though I have my passport, I was told to get the [health] service from where I belong."* (Male migrant, South Africa)

> *"The nurse told me to go and get a police permit before I can receive treatment. I have no permit and it is difficult to get here in Zambia."* (Female migrant, Zambia)

> *"Being a foreign national is challenging because they will want your documents. When you are very sick, they don't pay attention to you because you're a foreign national."* (Female migrant, South Africa)

> *"I just go to Mozambique to access health services at the hospital."* (Male migrant, Malawi)

> *"We tell our friends with documents to get drugs for us at the clinics."* (Male migrant, Zambia)

This finding is consistent with the experiences of foreign migrants across Southern Africa, who are often excluded from SRH services by government and development partners (IOM, 2012; Vearey et al., 2018). Further, migrants' avoidance of accessing public health services altogether for fear of deportation has also been reported elsewhere in the region (IOM, 2010). This has important implications for public health. For instance, migrants already receiving antiretroviral therapy (ART) may experience disruptions in treatment, while fear around how they will be treated at health facilities may hinder uptake of prevention services, thereby exacerbating SRH-HIV risks and outcomes (Médecins Sans Frontières, 2012; Vearey, 2016).

On the other hand, some respondents reported being able to access SRH care easily, suggesting that the negative experiences were not universal. Where respondents had accessed SRH services at local clinics, it was mostly for screening purposes (such as HIV testing and pap smears) and care during childbirth. A few respondents had also sought other medical services, such as treatment for specific ailments and screening for other diseases such as diabetes and tuberculosis (TB).

> *"We are satisfied with how they treated us [at the clinic]. They did not mistreat us because we are foreigners."* (Female migrant, South Africa)

> *"Most of the time I go and get tested for sugar diabetes. I have also tested for TB with sputum, but I have not yet tested with the machine. I also check my HIV status."* (Female migrant, Eswatini)

Other challenges associated with being a foreign migrant

In addition to the challenges reported around accessing SRH care, the respondents reported experiencing discrimination within their communities, where community members interfere with their businesses and treat them poorly. These experiences included xenophobic violence, where they were chased from their homes and had their business stock looted. Some respondents had also encountered harassment or discrimination from the police. Language was also a challenge for the respondents who struggled to communicate with others in their destination country. Finally, some respondents found it challenging to obtain the required legal documentation in their host countries; one migrant reported that she had received illegal documents unknowingly, which she only realised when her application for a government

service was denied. Experiences of discrimination were not true for all respondents, some of whom reported being treated well by other community members.

> *"Usually, there are problems with enforcement officers. They sometimes follow us in the communities where we stay, and our neighbours inform the police and show them where we stay."* (Male migrant, Zambia)

> *"One of the citizens of the community was calling our son names that they are not South Africans and all sorts of nasty things, so my partner and I went to talk to her as adults, but we ended up having disagreements to the extent that we ended up involving the police. The police said we, as foreigners, are wasting their time and government resources and also said foreigners are a problem. They said we should leave and not bother them with our unnecessary problems."* (Female migrant, South Africa)

> *"There is no difference or discrimination because there are many Zambians here, just as there are many Malawians in Zambia."* (Female migrant, Malawi)

These experiences are consistent with those reported in other settings in the region. Xenophobic violence is well-documented in countries like South Africa, and while legal frameworks aim to ensure the rights of foreign migrants, their broader marginalisation in society and lack of social protection substantially increases their vulnerability to violence from state employees and citizens alike (Landau & Wa Kabwe-Segatti, 2009).

Inadequate, discriminatory, or poorly managed SRH care for migrants can have multiple negative consequences for both the health of migrants and the communities in which they reside, particularly with regard to communicable diseases like HIV and STIs. The fear of stigma or detention can deter migrants from seeking SRH care, such as treatment for STIs, which in turn can contribute to onward transmission (Thomas, 2016). Screening, surveillance, and linkage to care among migrants in the region is therefore critical in controlling communicable diseases, particularly in the case of cross-border migration (IOM, 2020). While migrants are not a heterogenous group and thus have different needs, resilience factors, and health vulnerabilities, the provision of universal health coverage, harmonised ART systems within the SADC region, and a coordinated regional response wherein migration issues are integrated into regional health systems policy and planning, can ensure positive health outcomes for all (Veary, 2014; Walls et al., 2016). Targeted awareness campaigns and the provision of mobile health services within migrant-dense communities and workplaces, such as informal worksites and truck driver routes, as well as education of healthcare workers around the rights and vulnerabilities of migrant populations are also key (Camlin et al., 2018; IOM, 2010; Michalopoulos et al., 2016; Veary et al., 2011). The results of this study highlight the current gaps in the provision of SRH for foreign migrants who require equitable and sustainable care to achieve optimum health and to prevent the onward transmission of communicable diseases in the region.

Limitations

While the study team expended efforts to minimise social desirability bias, foreign migrants may have withheld information or their true experiences of access to SRH and HIV services out of fear of punitive consequences. Further, the use of a snowball sampling approach likely included foreign migrants that were more willing to participate in the study, which may not represent the broader foreign migrant population. While the migrants interviewed during the

study reported similar experiences despite being in differing destination countries, only a few migrants were interviewed at each site, which limits the applicability of the results to the broader migrant communities in these areas.

References

Braun, V., & Clarke, V. (2006). *Using thematic analysis in psychology*. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa.

Camlin, C. S., Cassels, S., & Seeley, J. (2018). *Bringing population mobility into focus to achieve HIV prevention goals*. Journal of the International AIDS Society, 21(Suppl 4).

Curtis, T., Kvernmo, S., & Bjerregaard, P. (2005). *Changing living conditions, life style and health*. International Journal of Circumpolar Health, 64(5), 442–450.

Davies, A., Basten, A., & Frattini, C. (2006). *Migration: A Social Determinant of the Health of Migrants*. Geneva, IOM.

Davies, A., Basten, A., & Frattini, C. (2009). *Migration: A social determinant of the health of migrants*. Eurohealth, 14 16(1), 10–12.

Freedman, J., Crankshaw, T. L., & Mutambara, V. M. (2020). *Sexual and reproductive health of asylum seeking and refugee women in South Africa: understanding the determinants of vulnerability*. Sexual and Reproductive Health Matters, 28(1).

Human Rights Watch. (2009). *No Healing Here: Violence, Discrimination and Barriers to Health for Migrants in South Africa*. New York, Human Rights Watch.

International Organization for Migration (IOM). (2016). *SRHR-HIV Knows No Borders: Improving SRHR-HIV Outcomes for Migrants, Adolescents and Young People and Sex Workers in Migration-Affected Communities in Southern Africa 2016 - 2020*. Geneva, IOM. https://southafrica.iom.int/programmes/ migration-and-health 22

IOM. (2010). *Regional Assessment on HIV-prevention Needs of Migrants and Mobile Populations in Southern Africa*. Geneva, IOM.

IOM. (2012). *Migration, Human Mobility and HIV: Access to Prevention and Care*. Geneva, IOM.

IOM. (2019). *International Migration Law: Glossary on migration*, IML Series No. 34. Geneva, IOM.

IOM. (2020). *The World Migration Report*. Geneva, IOM.

Ivanova, O., Rai, M., & Kemigisha, E. (2018). *A Systematic Review of Sexual and Reproductive Health Knowledge, Experiences and Access to Services among Refugee, Migrant and Displaced Girls and Young Women in Africa*. International Journal of Environmental Research and Public Health, 15(8), 1583.

Landau, L. B., & Wa Kabwe-Segatti, A. K. (2009). *Human Development Impacts of Migration: South Africa Case Study*. In Human Development Research Paper No. 2009/05. UNDP.

Médecins Sans Frontières. (2012). *Providing antiretroviral therapy for mobile populations: Lesson learned from a cross border ARV programme in Musina*, South Africa. Gevena, MSF.

Michalopoulos, L. M., Ncube, N., Simona, S. J., Kansankala, B., Sinkala, E., & Raidoo, J. (2016). *A qualitative study of migrant-related stressors, psychosocial outcomes and HIV risk behaviour among truck drivers in Zambia*. African Journal of AIDS Research, 15(3), 219-26.

Mukondwa, K., & Gonah, L. (2016). *Accessing Adolescent Sexual and Reproductive Health Services among Undocumented Migrants in South Africa: A Documentary Review*. Medical Journal of Zambia, 43(4), 247–251.

Nicholas, P. K., Mfono, N., Corless, I. B., Davis, S. M., O'Brien, E., Padua, J., Ahmed, S., Sheldon, L. K., Oas, K., Sadler, L., Nicholas, T. P., Jabour, S., Alexandre, N., Fevrin, F., Dubois, S., & Fortinsky, S. (2016). *HIV vulnerability in migrant populations in southern Africa: Sociological, cultural, health-related, and human-rights perspectives*. International Journal of Africa Nursing Sciences, 5, 1–8. https://doi.org/10.1016/j.ijans.2016.09.003

SRHR-HIV Knows No Borders Project. (2019). *Sexual and Reproductive Health and Rights (SRHR)-HIV Knows No Borders Stories of Change and Best Practices*.

Skeldon, R. (2018). *International migration, internal migration, mobility and urbanization: Towards more integrated approaches*. Geneva, IOM.

Thomas, F. (2016). *Handbook of Migration and Health*. Edward Elgar Publishing.

UNAIDS. (2014). *The Gap Report*. Geneva, UNAIDS.

United Nations Department of Economic and Social Affairs (UNDESA) (2019). International Migrant Stock. Geneva, UNDESA.

Vearey, J. (2016). *Mobility, migration and generalised HIV epidemics: a focus on sub-Saharan Africa*. In F. Thomas (Ed.), Handbook on migration and health (pp. 340–356). Edward Elgar Publishing.

Vearey, J., de Gruchy, T., Kamndaya, M., Walls, H. L., Chetty-Makkan, C. M., & Hanefeld, J. (2018). *Exploring The Migration Profiles of Primary Healthcare Users in South Africa*. Journal of Immigrant and Minority Health, 20(1), 91–100. https://doi.org/10.1007/s10903-016-0535-7

Veary, J. (2014). *Healthy migration: A public health and development imperative for south(ern) Africa*. South African Medical Journal, 104(10), 663–664.

Veary, J., Richter, M., Núñez, L., & Moyo, K. (2011*). South African HIV/AIDS programming overlooks migration, urban livelihoods, and informal workplaces*. African Journal of AIDS Research, 10(Supp 1), 381-91.

Veary, J., Wheeler, B., & Jurgens-Bleeker, S. (2010). *Migration and health in SADC: A review of the literature*. Geneva, IOM.

Walls, H. L., Veary, J., Modisenyane, M., Chetty-Makkan, C. M., Charalambous, S., Smith, R. D., & Hanefeld, J. (2016). *Understanding healthcare and population mobility in southern Africa: The case of South Africa*. South African Medical Journal, 206(1), 14–15.

Zihindula, G., Meyer-Weitz, A., & Akintola, O. (2015). *Access to Health Care Services by refugees in Southern Africa: A Review of Literature*. Southern African Journal of Demography, 16(1), 7–35.