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ACCESS TO AND UTILISATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES: A STUDY OF MIGRANT WOMEN IN SIX SOUTHERN AFRICAN COUNTRIES.

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A Thesis Submitted in Fulfilment of the Requirements for the Degree of Doctor of Philosophy in Public Health

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Declaration

I, Christine Chawhanda, student number 1502472, declare that this thesis is my own original work except where indicated and referenced. The thesis has not been submitted before for any degree or examination at this or any other University or Institution.

Signed:  Date: 01 November 2022

Dedication

To God the Almighty who never ceased to fulfil his promises. I also dedicate this to my children, husband and parents may this be your source of inspiration.

Conference presentation from this study

Chawhanda, C, Ogunlela, T, Mapuroma, R, Ojifinni, O, Bwambale, MF, Levin, J and Ibisomi, L. Comprehensive sexuality education in six Southern African Countries: Perspectives from learners and teachers. 8th African Population Conference, Entebbe, Uganda, 18-22 November 2019.

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Abstract

Background

Migrant health including sexual and reproductive health (SRH) is an important global public health concern and universal access to SRH services is one of the key milestones towards fulfilling the sustainable development goals. An increase in female international migrants in Africa has been documented between the years 2000 and 2020. Most of these migrants are in the reproductive age group 15- 49 years with the average age of international migrants being 39 years. The migration of people of reproductive age has important implications for public health and in particular, access to and utilisation of SRH services. Literature has shown that globally (including in Southern Africa) there are inequalities in accessing and utilising SRH services between migrants and non-migrants. Migrants are usually denied access to public health services or are hesitant to access public health facilities due to fear of being deported especially when they do not have legal residence status. Being a migrant has been associated with compromised access to and utilisation of health care, including SRH services. Therefore, the purpose of this study is to investigate the factors associated with access to and utilisation of SRH and HIV services among women in high migration communities. Furthermore, it, explores the experiences and coping strategies of migrant women in accessing and utilising SRH and HIV services as well as experiences and coping strategies of healthcare workers in providing SRH and HIV services to migrant women.

Methods

A mixed methods study design using both quantitative and qualitative methods was used. Data from a cross sectional survey conducted as part of the SRHR-HIV Knows No Borders Project in 2018, was used for the quantitative component. Logistic regression models were fitted to investigate factors associated with utilisation of sexual and reproductive health services among 2070 women aged 15-49 years in high migrant communities in six Southern African countries. For the qualitative component a phenomenological qualitative design that focuses on detailed exploration of an individual's lived experience of a phenomenon was used. The study population comprised of internal and international migrant women of reproductive age 18 to 49 years and healthcare workers who provide SRH and HIV services. Snowball sampling was used to recruit migrant women while healthcare workers were purposively sampled. In-depth interviews with five

internal migrants, eight international migrants and four healthcare workers were conducted from December 2019 to March 2020. Thematic analyses were carried out using NVivo 12.

Results

This study found that being an international migrant was associated with limited access to both condoms and HIV testing services. Access to condoms was found to vary between countries. Age, educational level, comprehensive knowledge about SRH, comprehensive knowledge about HIV, partner's age, partner's educational level and not experiencing IPV in the last 12 months were found to be associated with non-access to condoms. Significant differences in accessing HIV testing services were found by migration status. Other important factors for non-access to HIV testing services were country, educational level, marital status, comprehensive knowledge about SRH and comprehensive knowledge about HIV.

The results showed no evidence of an association between migration status and non-utilisation of modern contraceptive methods. Study country was found to be a significant factor with differences between countries in utilisation of modern contraceptive methods. Married and formerly married women had higher odds of not utilising modern contraceptive methods compared to never married women (aOR=1.51, 95% CI 1.08-2.14). In addition, employment status, comprehensive knowledge about HIV and comprehensive knowledge about SRH were found to be associated with utilisation of modern contraceptive methods. Similarly, partner's educational level and partner's employment status were found to be associated with utilisation of modern contraceptive methods.

There was no significant association between migration status and utilisation of SRH services. Access to healthcare facility and country were important factors in utilisation of SRH referral services. Married women (aOR=1.61, 95% CI 1.09-2.36) and formerly married (aOR=2.14, 95% CI 1.29-3.55) women had higher odds of utilising SRH referral services compared to never married women. For utilisation of intimate partner violence (IPV) services, internal (aOR=0.25; 95% CI 0.06-0.95) and international migrant women (aOR=0.25; 95% CI 0.05-1.21) had lower odds of utilising IPV services. Other factors significantly associated with utilisation of IPV services were age, religion and attitude towards wife beating.

The qualitative findings showed that both internal and international migrant women experienced language/communication challenges with international migrant women from Mozambique being the most affected. Migrant women experienced long waiting hours to obtain the required SRH services, negative healthcare worker attitude and discrimination based on migration status, age and HIV status. International migrant women were denied access to SRH and HIV services because they lacked the required documents. International migrant women and to a lesser extent internal migrant women faced negative healthcare worker attitude and discrimination based on migration status. The SRH and HIV services in Ekurhuleni were reported to be affordable, however, geographical inaccessibility resulted in the services being unaffordable because of transportation costs. The provision of SRH and HIV services by male healthcare workers was considered unacceptable by migrant women owing to religious and cultural beliefs. Healthcare workers highlighted experiencing language challenges, cultural and religious challenges, lack of referral or transfer letters and lack of language interpreters as the main barriers in provision of SRH services to migrant women.

Conclusion

Migration status is an important factor in determining women's access to condom, HIV testing services and utilisation of IPV services. Internal and international migrant women face challenges in accessing and utilising SRH and HIV services. This is attributed to language barriers, negative healthcare worker attitude, cultural and religious barriers, lack of formal referral services, and discrimination based on migration status, age and HIV status. Migrant women experience language/communication barriers with international migrant women from Malawi and Mozambique being the most affected. To ensure access to and utilisation of SRH services, there is a need for SRH awareness campaigns that target all women regardless of migration status. The findings highlight the need for strategies that tackle religious and cultural beliefs, age specific interventions, and country variations, encourage male involvement, women empowerment and autonomy in accessing and utilising SRH services. This study highlights the need for migrant friendly services including language interpretation and non-judgmental migrant youth friendly services in order to improve the experiences of both migrant women and healthcare workers in accessing and providing SRH services. There is a need for strengthening the referral system within South African health facilities and across the Southern Africa region and promotion of

collaboration with non-governmental organisations to minimise unavailability of services and waiting time.

Key words: Migration, Sexual and reproductive health, Intimate partner violence, Access, Utilisation, Socio-ecological model, Health Access framework, Southern Africa

Table of contents

Declaration ii
Dedication iii
Conference presentation from this study iv
Publications arising from this study v
Abstract vi
Table of contents x
List of Tables xvi
List of Figures xviii
List of acronyms xix
Acknowledgements xxi
Definition of terms xxiii
CHAPTER 1: INTRODUCTION 1
1.1: Background 1
1.2: Problem statement 5
1.3: Aim and objectives of the study 7
1.3.1: Aim 7
1.3.2: Specific objectives 7
1.4: Rationale 7
1.5: Organisation of the thesis 9
CHAPTER 2: LITERATURE REVIEW 11
2.1: Introduction 11
2.2: Global migration trends and levels 11
2.3: Migration levels and trends in Africa and in Southern Africa 11
2.3.1: The six Southern African countries 12
2.3.2: Initiatives to ensure access to and utilisation of SRH and HIV services in Africa 13
2.4: The SRH and HIV services focus of the study 14
2.4.1: Migrant women's contraceptive behaviour 14
2.4.2: Migrant women's utilisation of IPV services 16
2.4.3: Migrant women's access to and utilisation of HIV and AIDS services 18
2.4.4: Migrant women's utilisation of referrals for SRH services 18
2.5: Health outcomes as a result of inaccessibility and underutilisation of SRH services 19

2.6: Theoretical frameworks guiding the study 20
2.6.1 The Social Ecological Theory of McLeroy et al. (1988) 21
2.6.2 The Health Access Livelihood Framework 22
2.6.3 The conceptual framework 23
2.7: Summary of the chapter 25
CHAPTER 3: METHODOLOGY 26
3.1: Introduction 26
3.2: Study Setting 26
3.3: Study design 29
3.4: Data source and sample size 29
3.4.1: The SRHR-HIV Knows No Borders Project 29
3.4.2: Qualitative data 31
3.4.3: Study population 33
3.5: Data management 33
3.6: Statistical analysis 34
3.6.1: Variables and Measurement 36
3.6.1.1: Outcome variables 36
3.6.1.2: Explanatory variables 40
3.7: Ethical considerations 54
3.8: Summary 54
CHAPTER 4: RESULTS: ACCESS TO SRH SERVICES 56
4.1: Introduction 56
4.2: Access to SRH services 56
4.2.1: Access to condoms 56
4.2.2: Access to HIV testing services 67
4.3: Summary of chapter 78
4.3.1: Access to condoms 78
4.3.2: Access to HIV testing services 79
CHAPTER 5: RESULTS: UTILISATION OF SRH SERVICES 80
5.1: Introduction 80
5.2: Utilisation of SRH services 80
5.2.1: Utilisation of modern contraceptive methods 80
5.2.2: Utilisation of SRH referral services 91
5.2.3: Utilisation of IPV services 99

5.3: Summary of chapter 107
5.3.1: Utilisation of modern contraceptive methods 107
5.3.2: Utilisation of SRH referral services 107
5.3.4: Utilisation of IPV services 108
CHAPTER 6: QUALITATIVE RESULTS 109
6.1: Introduction 109
6.2: Characteristics of the participants 109
6.3: The five dimensions of access 112
6.3.1: Geographic accessibility of healthcare facility 113
6.3.2: Affordability of SRH and HIV services 114
6.3.3: Availability of SRH and HIV services 114
6.3.4: Adequacy of SRH and HIV services 115
6.3.5: Acceptability 116
6.4: Migrant women's experiences in accessing and utilising SRH and HIV services 117
6.4.1: Individual level factors 117
6.4.1.1: Migration status 117
6.4.1.2: Language barriers 117
6.4.2: Interpersonal factors 118
6.4.2.1: Family and friends support 119
6.4.2.2: Partner/spousal support 119
6.4.2.3: Utilisation of formal IPV services 120
6.4.3: Institutional factors 122
6.4.3.1: Healthcare facility requirements/standard operating procedures 122
6.4.3.2: Discrimination from healthcare workers 123
6.4.3.3: Healthcare workers attitude 123
6.4.3.4: Waiting time 124
6.4.3.6: SRH referral 125
6.4.4: Community factors 126
6.4.4.1: Support groups 126
6.5: Coping strategies of migrant women to access and utilise SRH and HIV services 126
6.5.1: Private healthcare facilities as alternatives 127
6.5.2: Unauthorised SRH service providers 127
6.5.3: Borrowing the required documents 127
6.5.4: Use of social media as support system 128

6.5.5: Silence 128
6.5.6: Borrowing from family and friends 129
6.6: Migrant women's suggested recommendations to ensure access to SRH services 129
6.6.1: Training of healthcare workers and provision of migrant friendly services 129
6.6.2: Provision of interpretation services and recruiting foreign healthcare workers 130
6.6.3: Provision of services to people without the required documents, action on complaints and stock outs 130
6.7: Experiences of healthcare workers in providing SRH and HIV services to migrant women 131
6.7.1: Language barriers 132
6.7.2: Unavailability of SRH and HIV services 132
6.7.3: Administration costs and hospital fees 133
6.7.4: Waiting time 133
6.7.5: Lack of documentation 134
6.7.6: Recurring sickness 135
6.7.7: Religious challenges 135
6.8: Healthcare workers' coping strategies 136
6.8.1: Patients as interpreters 136
6.8.2: Patient indexing 136
6.8.3: The use of medication containers 137
6.8.4: Community outreach programs 137
6.9: Healthcare workers' suggested recommendations to ensure access to SRH services for migrant women 137
6.9.1: Collaboration with non-governmental organizations (NGOs) 137
6.9.2: Provision of interpretation services 138
6.9.3 English language to be compulsory 138
6.10 Summary of the chapter 138
CHAPTER 7: DISCUSSION, CONCLUSION, AND RECOMMENDATIONS 141
7.1: Introduction 141
7.2: Discussion of results 141
7.2.1: Access to SRH services 141
7.2.2: Utilisation of SRH services 143
7.2.2.1: Utilisation of modern contraceptive methods 143
7.2.2.2: Utilisation of SRH referral services 144
7.2.2.3: Utilisation of IPV services 145

7.3: The dimensions of access 146
7.4: Experiences of migrant women in accessing and utilising SRH services 147
7.5: Experiences of healthcare workers in providing SRH and HIV services to migrant women 149
7.6: Strengths and limitations of the study 150
7.6: Conclusion 151
7.7: Contribution of the study 152
7.8: Recommendations 153
7.8.1: Research recommendations 153
7.8.2: Programme recommendations 154
7.8.3: Policy recommendations 154
REFERENCES 156
Appendices 169
Information sheets 169
Appendix 1: Information sheet – Migrant women 169
Appendix 2: Information sheet – Healthcare workers 171
Consent form 173
Appendix 3: Consent form for IDIs 173
Appendix 4: Consent form for digital recording 173
Interview guides 175
Appendix 5: Interview guide - Migrant women 175
Appendix 6: Interview guide – Healthcare workers 180
Appendix 7: Distress protocol for the study 185
Appendix 8: Codebook for data analysis 186
Ethical clearance 189
Appendix 9: Ethical clearance – Eswatini 189
Appendix 10: Ethical clearance – Lesotho 192
Appendix 11: Ethical clearance – Malawi 194
Appendix 12: Ethical clearance – Mozambique 195
Appendix 13: Ethical clearance – South Africa 196
Appendix 14: Ethical clearance – Zambia 200
Appendix 15: Ethical clearance - Wits HREC 202
Appendix 16: Ethical clearance - Ekurhuleni 203
Appendix 17: Policy brief 205
Appendix 18: The comprehensive sexuality education paper: 212

Turnitin report 213

List of Tables

Table 3.1: Outcome variables and respective explanatory variables 38
Table 3.2a: Outcome variables definition and operationalisation 42
Table 3.2b: Explanatory variables definition and operationalisation 45
Table 3.3: Quantitative data analysis 52
Table 3.4: Qualitative data analysis 53
Table 4.1: Distribution of explanatory variables by access to condoms in high migration communities of six Southern African countries N=2070 59
Table 4.2: Prevalence of access to condoms among women in high migration communities of six Southern African countries N=2070. 62
Table 4.3: Factors associated non-access to condoms among all women in high migrant communities of six Southern African countries. 64
Table 4.4: Factors associated with non-access to condoms among partnered women in high migration communities of six Southern African countries 66
Table 4.5: Distribution of explanatory variables by access to HIV testing services in high migration communities of six Southern African countries N=2070. 70
Table 4.6: Prevalence of access to HIV testing services among women in high migration communities of six Southern African countries N=2070. 73
Table 4.7: Factors associated with non-access to HIV testing services among all women in high migrant communities of six Southern African countries 75
Table 4.8: Factors associated with non-access to HIV testing services among partnered women in high migration communities of six Southern African countries 77
Table 5.1a: Distribution of utilisation of modern contraceptive methods by respondents' selected characteristics in high migration communities of six Southern African countries N=1677. 82
Table 5.1b: Prevalence of utilisation of modern contraceptive methods by respondents' selected characteristics in high migration communities of six Southern African countries N=1677. 85
Table 5.1c: Factors associated with current non-use of modern contraceptive methods among women in high migration communities of six Southern African countries. 88
Table 5.1d: Factors associated with current modern contraceptive non-use among partnered women in high migration communities of six Southern African countries. 90
Table 5.2a: Distribution of utilisation of SRH referral services by respondents' selected characteristics in high migration communities of six Southern African countries N=796. 92
Table 5.2b: Prevalence of utilisation of SRH referral services by respondents' selected characteristics in high migration communities of six Southern African countries N=796. 94
Table 5.2c: Factors associated with utilisation of SRH referral services among all women in high migration communities of six Southern African countries. 96
Table 5.2d: Factors associated with utilisation of SRH referral services among partnered women in high migration communities of six Southern African countries. 98
Table 5.3a: Distribution of utilisation of IPV services by respondents' selected characteristics in high migration communities of six Southern African countries N=525 101
Table 5.3b: Prevalence of utilisation of intimate partner violence by respondents' selected characteristics in high migration communities of six Southern African countries N=525. 104
Table 5.3c: Factors associated with current utilisation of IPV services among partnered women in high migration communities of six Southern African countries. 106

Table 6.1: Socio-demographic characteristics of the participants 110
Table 6.2: Themes derived from the data 110

List of Figures

Figure 2.1: The Conceptual Framework for the study 24
Figure 4.1: The prevalence of non-access to condoms among women in high migration communities in six Southern African countries, 2018 60
Figure 4.2: The prevalence of non-access to HIV testing services among women in high migration communities in six Southern African countries, 2018 71
Figure 5.2: The prevalence of non-use of modern contraceptive methods among women in high migration communities in six Southern African countries, 2018 83
Figure 5.3: The prevalence of utilisation of SRH referral services among women in high migration communities in six Southern African countries, 2018 93
Figure 5.4: The prevalence of utilisation of IPV services among women in high migration communities in six Southern African countries, 2018 10208

List of acronyms

AIDS: Acquired Immuno-deficiency Syndrome

ART: Antiretroviral Therapy

AYP: Adolescent and Young People

CSE: Comprehensive sexuality education

DEFF: Design effect

DHS: Demographic Health Survey

HCW: Healthcare workers

HIV: Human immunodeficiency virus

ICPD: International Conference on Population and Development

IOM: International Organization for Migration

ID: Identity document

IDIs: In-depth interviews

IPV: Intimate partner violence

IUD: Intrauterine device

LAM: Lactational amenorrhea

MIDSA: Migration Dialogue for Southern Africa

MOH: Ministry of Health

NDoH: National Department of Health

NGOs: Non-governmental Organizations

NSO: National Statistical Office

ORs: Odds Ratios

PHAMESA: Partnership on Health and Mobility in East and Southern Africa

PLHIV: People Living with HIV

PMTCT: Prevention of Mother to Child Transmission

SADC: Southern Africa Development Community

SAMRC: South African Medical Research Council

SCN: Save the Children Netherlands

SDGs: Sustainable Development Goals

Stats SA: Statistics South Africa

STIs: Sexually Transmitted Infections

SW: Sex workers

SRH: Sexual and reproductive health

SRHR-HIV: Sexual and reproductive health and rights- Human immunodeficiency virus

TB: Tuberculosis

TOP: Termination of pregnancy

UNAIDS: United Nations Programme on HIV/AIDS

UNDESA: United Nations, Department of Economic and Social Affairs

WHA: World Health Assembly

WHO: World Health Organization

WSPH: University of the Witwatersrand's School of Public Health

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Definition of terms

Sexual and Reproductive Health (SRH) is a state of complete physical, mental and social well-being in all matters relating to the reproductive system, which include positive and respectful approach to sexuality and sexual relationships as well as having safe sexual experiences, free of coercion, discrimination and violence [1,2]. It is a state where people have reproductive freedom including access to information and health services concerning family planning, pregnancy, fertility, sexual experiences, prevention and management of infections free of coercion, discrimination and violence [2].

Access is conceptualised differently in different settings. Many authors defined access as the ability to obtain needed services and it is defined by a set of dimensions including availability, adequacy, accessibility (distance), affordability and acceptability [3–6]. There is consensus in literature that economic, geographic, cultural, organizational, informational and individual factors may be barriers to or facilitators of access to health services including sexual and reproductive health services (SRH). This study uses the five dimensions of access and the agreed barriers in conceptualising access [3–6].

Utilisation in this study refers to the actual uptake of SRH and HIV services [6]. In this study it is utilisation of modern contraceptive methods, utilisation of SRH referral services and utilisation of services related to intimate partner violence.

Modern contraceptive use is defined as currently using any modern method to delay or avoid getting pregnant. The modern contraceptive methods are female sterilisation, male sterilisation, intrauterine device (IUD), injectables, implants, pill, male condom, female condom, diaphragm, foam/jelly, standard days, lactational amenorrhea method (LAM) and emergency contraception [7].

SRH referral services focused on are family planning counselling and services, prevention of sexually transmitted infections (STIs), management of STIs, emergency contraceptives, ante-natal

care, delivery of babies, post-natal care, pre-termination of pregnancy (TOP) counselling, TOP, TOP aftercare/Post-abortion care, prevention of gender based violence (GBV), management of GBV, Health promotion talks-HIV/STI, Health promotion talks-High risk pregnancy, pregnancy tests, HIV counselling and testing, condom provision, provision of antiretroviral drugs, HIV/AIDS management, prevention of mother-to-child transmission services, pap smear, HIV pre-exposure prophylaxis, HIV post-exposure prophylaxis and human papillomavirus vaccine.

Intimate partner violence is abuse or aggression in the form of physical and sexual abuse from a current or former intimate partner [8]. In this study IPV is encountering physical or sexual violence from a current or former intimate partner in the past 12 months prior to the survey. Utilisation of IPV services is having used or sought any formal services related to physical or sexual violence perpetrated by intimate partners.

Intimate partner violence services is defined as having used or sought any formal services related to physical or sexual violence perpetrated by a woman's intimate partner. Women were regarded to have sought IPV services if they sought help from medical personnel, police, lawyer, social worker, non-governmental organizations (NGOs) marriage counsellors, the victim support unit or community leaders

Migration is the internal or external movement of people from their usual place of residence or place of origin to another for short term (at least 3 months but less than a year), long term (at least one year) or permanent change of residence with the intention of establishing a new residence [9–11]

Internal migration in this study is the movement of people within the country of birth [9,12].

International migration is the movement of people from one country to another [9,12,13].

Coping strategies in this study refer to remedial actions or alternative solutions used by women who were not able to access and utilise the required sexual and reproductive health services (SRH) from a health facility [14–16].

Availability is sufficient quantity of the required SRH commodities and services at the health facilities [5,17].

Accessibility is explained by four dimensions namely non-discrimination, geographic, economic (affordability) and information accessibility [5,17].

Acceptability is the provision of services and commodities in a culturally appropriate manner and respectful of medical ethics [5,17].

Adequacy is the effectiveness and appropriateness of the services and commodities provided at the health facility [5,17].

CHAPTER 1: INTRODUCTION

1.1: Background

Migration has historical roots globally and in Southern Africa it intensified after the discovery of minerals (gold, copper and diamonds). Migration is a major determinant of development, population change and health. The main factor leading to increased migration is the disparity that exists in the socio-economic development and political stability within and between countries, which results in people moving from less to more favourable areas [10,18–20]. Thus, migration is an imperative livelihood strategy for people from least favourable areas [21]. For instance, in Southern Africa, the main destination of international migrants is South Africa given its more advanced economic development and relatively stable political environment [22]. In addition to being the driver of economic change, migration has been identified as a social determinant of health which plays a significant role in the transmission of communicable diseases mainly tuberculosis (TB) and human immunodeficiency virus (HIV) [5,23,24]. As a result, migration is a public health concern globally as migrants face challenges in exercising their right to health and accessing and utilising health services in the host countries.

As migration increasingly become part of life globally and Southern Africa in particular, the health outcomes as a result of migration and the health of migrants need to be acknowledged as an important issue in immigration and health policy making. Thus, the right to health for migrants should explicitly and formally recognized in national laws in order to eliminate the obstacles encountered during implementation and health service delivery. Most countries in Southern Africa have indicated in their constitution the right to universal access to health services, however, the immigration laws contradict this as they either prohibit entry of migrants with certain diseases or instruct healthcare workers to report migrants without the legal documents [17,25]. As a result, healthcare workers lack a common interpretation of the constitution and immigration policies, and are unclear of the healthcare entitlements of migrants, which may result in discriminatory practices within the health system [17,25].

Historically, migration was male dominated, however recent migration patterns and recent migration patterns and trends have shown an increase in the prevalence of female migration with a global average of 48.1 % in 2020 [26]. Within Africa, the share of international women migration increased from 45.0 % in 2010 to 47.1% in 2020 [26–28]. It has been documented that between 2000 and 2020, the increase in female international migrants in Africa (69.0 %) was slightly higher than the increase in male migrants (68.0 %) [26]. Most of these migrants are in the reproductive age group (15- 49 years) with the average age of international migrants being 39 years [27]. The migration of people of the reproductive age group has important implications for public health and in particular, access to and utilisation of SRH services. Migrants' health and access to and utilisation of sexual and reproductive health (SRH) services is determined by the availability, accessibility, affordability, acceptability and adequacy of health services in the host country [5,17]. However, migrants are usually denied access to public health services or are hesitant to access public health facilities due to fear of being deported especially when they do not possess the legal documents [5,23,24,29–31]. Additionally, migrants are not aware of their entitlement to health care services and availability of health services in the host country thereby hindering their access to and usage of health services, particularly SRH services [5,20,23].

The SRH of migrant women was first acknowledged at the United Nations International Conference on Population and Development (ICPD) in 1994 due to increased reported negative SRH outcomes among migrant women [32–34]. Since then, several international organisations including the International Organization for Migration (IOM) and World Health Organization (WHO) have held regular meetings where all the member states of World Health Assembly (WHA) promote equitable access to health and disease prevention to all citizens irrespective of their migration status [30,35]. In 2009, the Migration Dialogue for Southern Africa (MIDSA) was held to continue discussions on the implementation of the WHA resolutions of ensuring equitable access and service provision to both migrants and non-migrants [30]. The resolutions of the MIDSA dialogue were that:

(1) All the Southern Africa Development Community (SADC) Member States should clearly authorise migrants' access to health in national health policies and implementation plans [36].
(2) Immigration Ministries should incorporate migrants' rights to healthcare in immigration policies [36].

(3) SADC Member States should include migrant health into primary health care reform principles and programmes [36].
(4) SADC Member States should implement existing SADC policies and protocols as well as bilateral agreements that promote migrants' access to health [36].

Recently, various international instruments, treaties and conventions were formed. These include: the Agenda 2030 and the Sustainable Development Goals which advocates for universal and non-discriminatory access to health. The 2019 political declaration on Universal Health Coverage and the Global Compact for Safe, Orderly and Regular Migration (GCM) [37]. The 2019 WHO Global Action Plan: Promoting the health of refugees and migrants 2019-2023. All these are aimed at addressing the health needs of migrants by reducing inequality, discrimination and vulnerabilities through migrants' right to health [37]. However, despite all these efforts, the SADC countries are yet to mainstream migration into health systems in order to have migrant sensitive health systems which is one of the key components of the WHA resolution [25]. Thus, access to health care including SRH services by migrants remains a challenge in Southern Africa.

Literature has shown that there are inequalities in accessing and utilising SRH services between migrants and non-migrants. Being a migrant was associated with reduced access to and utilisation of health care, including SRH services [20,21,46–48,38–45]. The following are examples of this reduced access to and utilisation of SRH services:

(1) While health services including SRH services were provided to citizens for free in Botswana and South Africa, a fee was charged for migrants to access these services [43,46,47,49].
(2) In Botswana, migrants were not provided with referrals to clinics or hospitals to access the required health services including SRH services and they were not entitled to the provision of HIV services [43,46,47,49].
(3) Lack of transfer and referral letters between Lesotho and South Africa for migrants hindered them from accessing SRH and HIV services [44].
(4) Lack of legal documentation (valid passport and permits) resulted in migrants being denied access to health services including SRH and HIV services in South Africa [45].

Previous studies have shown that migrant women experience low contraception use, high maternal morbidity and mortality, high abortion rates and abortion complications and high experience of IPV and high HIV prevalence compared to non-migrant women [22,40,55–62,41,43,44,50–54]. Several obstacles to access and utilisation of SRH services by migrant women were documented. These include religious and cultural beliefs, financial constraints, fear of deportation for migrants who do not possess legal documents, language barriers, lack of SRH information, and negative service provider attitude [1,10,46–48,50,51,54,56,59,63,64,20,65–72,22,40–45]. Further, lower educational level, being unmarried, financial instability and high costs of services for migrants have been identified as factors associated with access to and utilisation of contraceptive methods and HIV services [44,54,56,62,73].

Inaccessibility and therefore underutilisation of SRH services contributes to the decline of the "healthy migrant effect" [5,10]. This is defined as deterioration over time of the health of migrants after they enter a host country due to unfavourable conditions they encounter resulting in loss of the healthy status that allowed them to migrate in the first instance [5]. This results in negative SRH health outcomes including unwanted pregnancies, miscarriages, unsafe abortion complications, low birth weight babies, maternal deaths, stillbirths, neo-natal deaths and contraction of STIs including HIV/AIDS [2,5,33,34,41,65].

The aforementioned findings were mainly collated from studies that focused on qualitative exploration of attitudes, perceptions and experiences of migrants in accessing SRH services [42,43,66,74–76]. In Southern Africa, research has been conducted on migrant commercial farm workers focusing on determinants of condom use in South Africa and unmet need for contraception among internal female migrants in Zambia, [62,77]. Similarly, a few mixed methods studies were conducted which focused on access to HIV care and treatment among migrants in Lesotho and South Africa [44]. Regarding healthcare providers, some studies in Southern Africa explored the perceptions of public healthcare providers on migrant women's access to reproductive health services [43]. Therefore, studies have been conducted in isolation, either looking at barriers to migrant women's access to and utilisation of SRH services which are condom use and HIV services or healthcare provider's perceptions about migrant women's access to SRH services.

Further research is required to determine factors associated with access to and utilisation of SRH services on a broader scale. Research is also required to contextually explore and understand both migrant women's (internal and international) experiences in accessing and utilising SRH services and healthcare workers' experiences in providing SRH services. To broaden understanding of access to SRH services by migrants in all dimensions (availability, affordability, acceptability, accessibility and adequacy), it is vital to contextually explore the factors migrants face in the communities they reside and work. From previous studies, little is known concerning the influence of partner characteristics, SRH decision making power, intimate partner violence (IPV), comprehensive knowledge about HIV and comprehensive knowledge about SRH on migrant women's access to SRH services as they influence health seeking behaviour of women. Similarly, there is a dearth of information on migrant women's access to and utilisation of IPV services and SRH referrals. Therefore, the purpose of this study is to investigate associated factors and explore the experiences of migrant women in accessing and utilising SRH and HIV services and experiences and coping strategies of healthcare workers in providing SRH and HIV services to migrant women. Quantitatively the study focuses on the following SRH and HIV services: modern contraceptive use, SRH referral services, IPV services and HIV testing services. The qualitative component looks at pregnancy related services, IPV, SRH referrals and HIV services.

1.2: Problem statement

The Southern African region is faced with many health challenges which include the deteriorating health system, lack of human resources and unavailability of medication which pose difficulties in accessing health services, including SRH services [78]. Sexual and reproductive health outcomes in Southern Africa are poor with approximately only 54 % of married women using any method of contraception in 2019 [79]. In the Southern African region, about 55 % of pregnancies were reported as unintended [80–83] of which about 30% ended in abortion, mainly unsafe abortion [81,83]. Southern Africa is one of the regions most affected by HIV with approximately 20.7 million people living with HIV in 2019 and about 60% being women aged 15 years and above [84,85]. A significant number of people in the region are not aware of their HIV status with an estimated 87% of people living with HIV (PLHIV) knowing their HIV status [85]. In the region, HIV prevalence is higher among females than among males [84].

Migration has been identified as one of the main drivers of the HIV epidemic [55,86]. Therefore, denying migrants to access and utilise HIV services in the host country negatively impacts on both migrants and non-migrants [45–47]. Intimate partner violence (IPV) is a global social problem. In Southern Africa approximately 47% of women have experienced physical and or sexual violence [87,88]. As a result, migrants pass through, work and reside in these countries with high SRH challenges. In addition, studies conducted in Southern Africa reported inequalities in accessing SRH services between migrants and non-migrants [30,43,71,89,44–47,49,55,60,62].

Owing to inaccessibility of SRH services and discrimination based on migration status, HIV prevalence was found to be higher among migrants (46 %) than non-migrants (34.7 %) in South Africa [55,60]. Some studies on access to and utilisation of SRH services in Southern Africa were conducted among migrant sex workers, migrant adolescent females and migrant commercial farm workers. These studies concentrated on contraceptive method use, maternal health, HIV and condom use among migrants [30,43,44,54,55,60,62,71,89]. There is a dearth of literature on migrant women's utilisation of IPV services and referrals for SRH services in Southern Africa. In addition, emphasis has been on international migrants leaving internal migrants on the periphery whereas, they may also face challenges in access to and utilisation of SRH services [25]. Many studies on SRH of migrant women are qualitative studies and few studies have used mixed methods. Of all the studies conducted, the experiences of migrants (internal and international) and healthcare workers were not interrogated concurrently to understand from the user and provider point of view. Hence, this study is designed to investigate the factors associated with access to and utilisation of SRH by migrant women quantitatively and explores the experiences and coping strategies of migrant women in accessing and utilising SRH and HIV services. Furthermore, it explores healthcare workers experiences in providing SRH and HIV services to migrant women. The use of mixed methods and inclusion of both migrants and healthcare workers provides a broader and balanced understanding of experiences from both the users and providers.

1.3: Aim and objectives of the study

1.3.1: Aim

This study aims to investigate the factors that are associated with access to and utilisation of SRH services, and explore the experiences and coping strategies of women living in high migration communities in the Kingdom of Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia. The experiences and coping strategies of healthcare workers in providing SRH services to migrant women will also be explored.

1.3.2: Specific objectives

i. To examine the level of and differentials in access to and utilisation of SRH and HIV services among women in high migration communities in the Kingdom of Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia.
ii. To identify the factors that are associated with access to and utilisation of SRH and HIV testing services among women in high migration communities of the six Southern African countries.
iii. To explore the experiences and coping strategies of internal and international migrant women in accessing and utilising SRH and HIV services in Ekurhuleni, South Africa.
iv. To explore the experiences of health care workers in providing SRH and HIV services to migrant women in Ekurhuleni, South Africa

1.4: Rationale

Internationally, efforts have been made to improve SRH of women through the implementation of the ICPD Programme of Action, WHA resolutions, the2030 Agenda and sustainable development goals (SDGs) and the Global Compact for Safe, Orderly and Regular Migration. However, access to and utilisation of SRH by migrant women remains a challenge [25,32–34,45,46]. Regional efforts to ensure equitable access and service provision to both migrants and non-migrants through MIDSA failed to yield positive results owing to the absence of country-level migrant sensitive health systems [30]. Without migrant-sensitive health systems, inequalities will persist in the provision of SRH services between migrants and non-migrants. As a result, countries will find it difficult to achieve the SDG targets of ensuring universal access to health including the SRH care

services, elimination of all forms of violence against women and girls in the public and private spheres, achieving a maternal mortality ratio of less than 70 per 100 000 live births and realisation of gender equity and empowerment of all women and girls [90].

In addition, countries have to date (2020) struggled to reach the 90 90 90 targets set by the United Nations Programme on HIV/AIDS (UNAIDS) and partners. These targets include having 90 % of all HIV-positive persons diagnosed, providing antiretroviral therapy (ART) for 90% of those diagnosed, and achieving viral suppression for 90% of those treated by 2020 [84,91,92]**.** Thus, investigating factors that affect access to and utilisation of SRH services by women in high migration communities is crucial in formulation, programming and implementation of immigration and health policies for promoting universal access to healthcare services regardless of migration status. Furthermore, exploring experiences among migrant women in accessing and utilising SRH and HIV services and experiences of healthcare workers in the provision of SRH to migrant women can contribute to health policy amendments and formulation of strategies required to achieve migrant-sensitive health systems and ultimately, positive SRH outcomes among migrant women. This will assist countries to achieve the Global Compact objectives, the SDG targets and provision of health services that are in line with the WHA and Migration Dialogue for Southern Africa resolutions. Thus, this study is crucial in providing a balanced understanding of experiences and coping strategies from the user and provider point of view.

The importance of this study is also in the inclusion of male characteristics, SRH decision making power, comprehensive knowledge about SRH and comprehensive knowledge about HIV in the analysis of access to and utilisation of SRH services by migrant women. SRH decision making power in this study is a woman's ability to decide about timing of sexual intercourse, timing of pregnancy, mode of child delivery and the ability to refuse sex when not in the mood. The inclusion of male characteristics and SRH decision making power variables demonstrates the importance of advancing past studies that viewed men as the sole decision makers yet both male characteristics and women's knowledge and ability to decide about their SRH is vital in influencing women's access to and utilisation of SRH and HIV services. Thus, including male characteristics in the study will provide a platform for policy avenues aimed at targeting changing men's perceptions and attitudes towards women's access to and utilisation of SRH services. In addition, the influence

of SRH knowledge and decision making power can be used to devise strategies that can empower women to overcome the notions of a patriarchal society where men are viewed as the sole decision makers.

1.5: Organisation of the thesis

Chapter 1- Introduction: This chapter introduces the study and summarises the current state of migration research and potential gaps in the existing literature. Subsequent to this brief description, a discussion pertaining to the focus of the study is given. In this discussion, the research is presented by stating the aim and objectives of the study and the rationale for conducting the study.

Chapter 2 – Literature review: Presents the migration statistics and a critical review of the existing literature. It looks at what is known from previous studies regarding the barriers migrants face when accessing and utilising SRH services. It also presents the theoretical frameworks that informed the general approach to the entire study and describes the conceptual framework which operationalised the ideas obtained from the existing theories and literature.

Chapter 3 - Methodology: Presents the research methodology of the study. It describes the study setting, the study design, the study population, the data sources and sampling techniques. In addition, the variables used in the analysis and their definitions are outlined. It also presents the methods of data analysis, ethical considerations and the limitations of the study.

Chapter 4 – Results: Access to SRH and HIV services: Presents the results on access to SRH services. It presents the descriptive statistics and the factors that are associated with access to condoms and HIV testing services. The chapter provides the results for the first and second objectives of the study.

Chapter 5 – Results: Utilisation of SRH services: Presents the results on utilisation of SRH services. It presents the descriptive statistics and the factors that are associated with current non-utilisation of modern contraceptive methods, utilisation of SRH referral services and utilisation of IPV services. The chapter provides the results for the first and second objectives of the study.

Chapter 6 – Qualitative results: Presents the results for the third and fourth objectives of the study. It discusses the five dimensions of access in relation to this study's qualitative findings. It also explores migrant women's experiences in accessing and utilising SRH and HIV services at interpersonal, community and institutional level. In addition, it outlines the experiences of healthcare workers in providing SRH and HIV services to migrant women. The chapter also presents the coping strategies of migrant women in accessing and utilising SRH services and measures aimed at improving migrant women's access to and utilisation of SRH and HIV services.

Chapter 7 - Discussion, conclusion and recommendations: This chapter interprets the results. It discusses converging and diverging findings and use the existing literature to explain the results.

CHAPTER 2: LITERATURE REVIEW

2.1: Introduction

This chapter is comprised of three sections. The first section is a critical review of relevant literature on migration statistics, factors associated with access to and utilisation of SRH services and the consequences that result from inaccessibility of SRH services. The second section discusses the theories and frameworks that guide this study and the third section provides a detailed evaluation of the conceptual framework which is used in this study.

2.2: Global migration trends and levels

Migration within and across countries has increased over the years. Worldwide internal migration was estimated at 740 million in 2009 and increased to 763 million in 2015 [10,26,27,93]. Globally, international migration in the year 2015 was recorded at 244 million and rose to 258 million in 2017 which is an increase of about 69 % since the 1990s and to approximately 280.6 million in 2020 [26–28]. Of the 280.6 million international migrants in 2020, 86.7 million reside in Europe, 85.6 million in Asia, 58.7 million in North America, 25.4 million in Africa, 14.8 million in Latin America and the Caribbean and 9.4 million in Oceania [26].

Previously, migration was dominated by males however recent trends have shown an increase in the proportion of women migrants, with women now constituting about 48.1 % of all international migrants in 2020 [26]. In many regions, females are now either above half or slightly below half of all the international migrants. In Northern America, women constituted 51.8% of international migrants, 51.6 % in Europe, 50.5 % in Oceania, 49.5% in Latin America and the Caribbean, 47.1% in Africa and 41.8% in Asia [26]. The global median age of international migrants in 2020 was 39 years with the youngest international migrants found in Africa with the median age of 30.9 years followed by Asia 35.1 years and Latin America and the Caribbean 35.8 years [26].

2.3: Migration levels and trends in Africa and in Southern Africa

There were approximately 25 million international migrants in Africa in 2017 and 25.4 million in 2020 an increase of about 4 % since the year 2000 [26,28]. Of all international migrants in the African continent, female migration increased steadily from approximately 45 % in 2010 to about

46.9 % in 2015 and 47.1 % in 2020 [26–28]. In 2020 the Southern African region recorded approximately 6.4 million international migrants [26]. The median age of international migrants in Africa was 30.9 years in 2017 and 2020 which is slightly lower than that of Southern Africa (33.7 years) [26,28].

2.3.1: The six Southern African countries

The discovery of minerals in African countries resulted in people moving within the countries and across the countries. For example, in the 1800s, the discovery of Gold in South Africa resulted in migration of men from rural areas and from many African countries namely, Lesotho, Swaziland, Botswana and Zimbabwe to work on the mines [24]. In the contemporary era an increasing trend of international migration in the six countries has been noticed. In the African continent and Southern African region, South Africa is the main host of international migrants, with the number of international migrants estimated to be 4.8 million, of whom the majority (68%) come from SADC countries, with only 32% coming from non-SADC countries [26,28,94,95]. In 2010 there were 32 600 international migrants in Eswatini, and this number increased slightly to 32 900 in 2020 while it almost doubled during the same period in Lesotho from 6 400 to 12 100 [26]. In Malawi, international migrants were 191 400 at mid-year 2020 and a slight increase in international migrants has been documented in Mozambique from 306 500 in 2010 to 338 900 in 2020 [26]. Similarly, international migrants in Zambia increased from 150 000 in 2010 to 188 000 in 2020 [26]. The proportion of female migrants in the six countries is significant and in some countries there are more female migrants than male migrants. The share of female migrants at mid-year 2020 was 48.5% in Eswatini, 45.8% in Lesotho, 51.1% in Malawi, 51.2% in Mozambique, 49.2% in South Africa and 48.1% in Zambia [26].

The use of any method of contraception among currently married women was 48% in Zambia, 58 % in Malawi, 55 % in South Africa, 27 % in Mozambique, while the statistics for Eswatini and Lesotho are not available [7,96–98]. In the six Southern African countries under study, the highest prevalence of HIV was reported in Eswatini with adult prevalence of 27.2 % (also highest in the world) followed by Lesotho (25%), Zambia (21.4%), South Africa (18.9%), Mozambique (12.5%) and Malawi (9.2%) [84,85]. Worldwide, South Africa has the highest HIV burden (number of people living with HIV) with approximately 7.5 million people living with HIV and the highest

distribution of new infections in the region of about 34% in 2020 [84].In the six Southern African countries, lifetime experience of IPV among women aged 15-49 years in 2018 was 41% in Zambia, 40% in Lesotho, 30% in Malawi and Mozambique and 24 % in South Africa. In the same year (2018), the prevalence of IPV among women aged 15-49 years was 28% in Zambia, 18% in Eswatini, 17% in Malawi, 16% in Lesotho and Mozambique and 13% in South Africa. The majority of women who experienced violence did not seek help, close to half the women (49%) in Malawi who experienced physical or sexual violence were reported to have never sought help or told anyone about the violence [96].

In 2018 it was reported that 51.3% of women of reproductive age in Eswatini used any method of contraception [99]. Migration and cultural norms that discourage safe sexual practices for example the use of condoms have been reported to contribute towards high adult HIV prevalence in Eswatini of approximately 27.2 % and 25.7% in Hhohho district [44,84,85,100,101]. Lesotho is one of the countries in Africa facing the devastating impact of the HIV/AIDS epidemic. It has adult (15-49 years) HIV prevalence of about 23%, being higher among women 28% than men 18% [84]. Sexual violence is high in Lesotho with approximately 61% of women reported to have ever experienced sexual violence [102]. [103]. Having the highest number of people living with HIV in the world, South Africa had approximately seven million people living with HIV in 2015. In 2018, HIV prevalence among adults (15–49 years) in South Africa was 20.4% and about 71,000 deaths from AIDS-related illness were recorded.

2.3.2: Initiatives to ensure access to and utilisation of SRH and HIV services in Africa

In Africa, the East and Southern Africa regions are typified by high levels of migration. In addition, these regions are the regions experiencing the highest HIV and tuberculosis (TB) epidemics in the world thereby making migration and health a perilous issue in the region [17,24,93]. As a result, several countries in Africa for example Algeria, Ghana, Mauritius, Nigeria and Uganda are incorporating the principle of non-discrimination in their legal and policy frameworks as a way of ensuring that migrants can exercise their right to access health services in the host country [48]. The draft 2017 health law of Algeria entitles migrants to health protection with the expenses covered by the state. Similarly, there is equal access and entitlements to health facilities between

migrants and non-migrants in Ghana, Uganda, Liberia and Angola while in some countries for example Mauritius, the government mandates employers to provide and fund health insurance schemes for migrant workers in order to ensure access to health services [48].

Southern Africa embarked on several initiatives that were aimed at ensuring equal access to healthcare services regardless of migration status. However, the initiatives mainly focused on HIV and TB, while the increase in female migration requires that, in addition SRH issues should be incorporated and addressed. The initiatives include the International Labour Organization transport corridor initiative which was implemented in Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe. It's aim was to improve access to health services and HIV prevention services for migrant workers and their families in transport corridors in Southern Africa [20]. In addition, the Partnership on Health and Mobility in East and Southern Africa (PHAMESA) program responded to the 61st 2008 World Health Assembly (WHA) Resolution 61.17 which is about the health of migrants from 2010 to 2013 [48].

Furthermore, the Southern Africa Development Community (SADC) draft policy framework on Population Mobility and Communicable Diseases in 2009 focused on three communicable diseases namely, HIV and AIDS, TB and Malaria [9]. Similarly, programs that were implemented in South Africa focused on HIV prevention and treatment for example the Mpilonhle-Mpilonde (quality life-long life in Johannesburg), whilst the Ripfumelo project focused on HIV and TB in commercial agriculture and mining sectors, informal settlements and border towns. Despite all the aforementioned efforts to ensure migrant's access to health services, literature has shown that migrants in Africa face difficulties in accessing health services [23,24,106,25,30,44,46–48,104,105].

2.4: The SRH and HIV services focus of the study

2.4.1: Migrant women's contraceptive behaviour

Globally, several studies have shown that migrant women face difficulties in accessing and therefore utilising contraceptive methods. As a result, they have lower control of pregnancy resulting in a higher rate of unwanted pregnancies compared to non-migrant women [42,50,57,66,73,107,108]. Similarly, a study conducted in Bangladesh showed that internal

migrants were less likely to access and utilise modern contraceptive methods services compared to non-migrants [109,110]. Compromised access to and utilisation of contraceptive methods by migrant women is partly attributed to lack of knowledge of available family planning services and cultural factors. For example, gender roles and gender inequality which may hinder migrant women from accessing and using contraceptive methods as they are not the sole decision makers of their reproductive health [111].

Inequality in accessing and utilising contraceptive methods has been highlighted by several studies. For example, a study conducted among Nepalese female migrants living in Japan found that compared to non-migrants, modern contraceptive use among migrant women was low due to discrimination because of their migration status, language barriers, cultural differences, financial barriers and inadequate knowledge about contraception [112,113]. Studies have also shown that not only older migrant women face difficulties in accessing contraceptive methods. A study conducted among very young migrant adolescents (10-14 years) and young migrant adolescents (15-24 years) living in Thailand and Netherlands found that migrant adolescents could not access and utilise family planning information and services owing to language barriers, age and marital status as healthcare workers perceived them to be too young for the services [59]. However, compared to younger migrant women, older migrant women had better odds of accessing and utilising contraceptive methods. This was illustrated in the results of a study conducted in Nepal where women aged 15-19 were less likely to use contraceptive methods compared to women aged 20-29, 30-39 and 40-49 [110,114].

The majority of studies that were conducted on migrant women's access to and utilisation of contraceptive methods were qualitative studies and only a few cross sectional studies examined the factors of modern contraceptive use among migrant women. A cross sectional study that investigated factors of unmet need for contraception among Chinese migrants found that non-access to and utilisation of contraceptive methods was associated with lower educational level, being unmarried and high costs of services for migrants [69]. Similarly, through the use of the 2016 Nepal DHS, duration of stay, age, education, religion and employment status were found to have a significant effect on the use of modern contraceptive methods among internal migrant women [110]. Internal migrant women who had stayed for five years or less had significantly lower

odds of modern contraceptive use compared with non-migrant women. Regarding employment status and occupation, compared with unemployed women, women who were employed in the non-agricultural sector and in the agricultural sector had higher odds of using modern contraceptive methods [110,114].

2.4.2: Migrant women's utilisation of IPV services

Violence against women is not only a violation of human rights but also a significant public health problem. A cross-sectional study conducted in Spain showed that IPV prevalence was high among migrant women (27.9%) compared to non-migrant women (14.3%) [115,116]. An association between economic circumstances and utilization of IPV services was found. Findings from a study conducted among Vietnamese migrant women showed that educated and employed migrant women were more likely to utilise IPV services compared to their counterparts [117,118]. The result suggests that economically vulnerable migrant women lack resources to effectively utilise available IPV services.

Similar findings that women with higher educational level utilised IPV services more than those with low education have been made by a number of authors in studies in Canada, America, Sweden, Mexico and Korea [117,118,127,119–126]. However, some studies documented different findings regarding the association between education level and utilisation of IPV services [121,122,128]. The differences in the findings may be related to the relationship between education level and type of help sought, with educated women utilising formal IPV services while women with lower education utilise informal IPV services [117,119,123,126,127]. This is because women with high educational level seek more help from formal institutions because they possess knowledge and have deeper understanding of their rights [127,129,130].

A study conducted in China found that married internal migrants with secondary or higher education were less likely to report IPV and utilise IPV services compared to married internal migrants with primary or lower education. This could be attributable to the fact that higher level of education was protective against IPV [131]. Studies vary in their findings on the effect of age on utilisation of IPV services. Some studies have found that age has no effect on women's utilization of IPV services [117,132–134]. Several studies found that younger women utilise IPV

services more than older women and that older age is associated with postponement or delays in seeking IPV services [121,122,127,131]. On the contrary, several studies documented that older women utilise IPV services more than younger women [117,127,131,135,136]. Duration of stay was also found to influence utilization of IPV services among migrant women. A study conducted in Canada showed no differences in the utilisation of IPV services between migrant women who had lived in Canada for 10 or more years and non-migrant women [117,137]. Findings indicated that women who are more acculturated are more likely to seek formal help [117,118,137].

Qualitative studies have documented several barriers to utilization of IPV services encountered by migrant women which are lack of education, limited access to culturally appropriate services, and financial barriers [118,138]. In addition, underutilization of IPV services by migrant women is attributed to lack of knowledge about IPV support programmes and services, cultural differences and language barriers [139–143]. Furthermore, migrant women reported cultural norms that tolerate IPV by encouraging women to stay with their violent partners, isolation from the community for exposing IPV issues, and fear of deportation for migrant women without legal documents to be the factors impeding them from utilising IPV services [140].

In the modern era, traditional norms and values continue to play a crucial role in determining utilisation of IPV services. A qualitative study conducted among African migrant women who were survivors of IPV documented that cultural norms that perpetuate gender inequality and community acceptance or tolerance of IPV were barriers that hindered migrant women from utilising IPV services [141–143]. In addition, a qualitative study conducted among West African migrants documented that migrant women mainly sought help from family and religious leaders as reporting to the police is perceived as the least acceptable way of solving IPV issues [141]. In support of the findings, it is postulated that in most countries globally, less than half of women who experience violence sought help and they mainly sought it from family and friends as opposed to the police and health services [144]. In addition, it has been documented that women feel comfortable to utilize health care services for other health related issues and not IPV related services [145]. While studies have shown the importance of partner's characteristics in experiencing IPV, little is known concerning the influence of partner's characteristics on women's utilization of IPV services [146].

2.4.3: Migrant women's access to and utilisation of HIV and AIDS services

Studies globally have shown that migrants face difficulties and unequal treatment in accessing and utilising HIV services. This is because of lack of trust regarding confidentiality of the results, financial instability, language and discrimination based on migration status [1,40,147,43,44,46,47,49,55,65,70]. Additionally, in a study in the European Union member states and Australia it was found that migrants delay HIV testing, resulting in late entry to HIV treatment owing to lack of knowledge regarding places to get HIV services, financial constraints, language barriers, fear of deportation, confidentiality issues and lack of trained healthcare providers and healthcare workers being unaware of the undocumented migrant's entitlement to HIV testing services [147–150].

Unequal access to and usage of HIV services was documented in Botswana where there was no equitable provision of SRH services between migrant women and non-migrant women with migrants being deprived of Antiretroviral (ARV) treatment and prevention of HIV transmission from the mother to the child (PMTCT) services [43,46,47,49]. Migrants who tested positive for HIV in Botswana were deprived of follow ups and other HIV treatment services namely viral load testing [43,46,47,49]. Similarly, lack of transfer or referral letters between South Africa and Lesotho and lack of legal documentation (valid passport and permit) hindered migrants from accessing SRH and HIV services [44,45]. Although HIV testing in the United Kingdom is provided for free regardless of migration status, a qualitative study of migrants in England revealed that high costs of accessing treatment, fear of deportation among migrants with no legal papers, stigma, lack of privacy, lack of confidentiality and lack of trust were the barriers that hindered migrants from accessing and utilising HIV testing services in England [149,151].

2.4.4: Migrant women's utilisation of referrals for SRH services

One of the gaps that was highlighted in the Policy Framework for Population Mobility and Communicable Diseases in the SADC Region is lack of cross border patient referral. In addition to cross border referrals, referrals for migrants between health facilities in the host country has been a challenge. In a qualitative study conducted in Botswana, migrants did not have referral

rights to clinics or hospitals owing to their migration status [43]. Similarly, in Lesotho, lack of transfer or referral letters for migrants hindered them from utilising SRH services including HIV services [44]. In agreement, a systematic review of healthcare access and utilisation by migrants in the European Union documented that hospital referrals for SRH services were limited for migrants owing to their migration status [61]. Similarly, a study conducted in Chiang Mai, Thailand found that access to and therefore utilisation of referrals for safe abortion were limited among migrant women and factors that facilitated the participation of migrant women in the safe referral abortion programme include lack of costs, friendly programme staff, availability of interpretation services and availability of legal documentation [152]. Few studies have looked at SRH referrals among migrant women mainly in Southern Africa hence little is known about access to and utilisation of SRH referral services [43].

2.5: Health outcomes as a result of inaccessibility and underutilisation of SRH services

The multifaceted barriers faced by migrants in accessing and utilising health services especially SRH services increase their vulnerability to SRH related complications. Globally, it has been documented that inaccessibility and underutilization of SRH services exposed migrant women to negative SRH outcomes including unplanned pregnancy, unsafe abortion complications, maternal death, still births, low birth weight babies, high neonatal and perinatal mortality, high incidence of STIs and HIV infection and many babies being delivered without professional assistance [34,35,41,65,113,152–155]. For example, migrant women in Geneva were found to have more unplanned pregnancies compared to non-migrants [50]. Similarly, HIV prevalence was found to be high among migrants (46%) than non-migrants (34.7%) in a high risk community in South Africa owing to inaccessibility of SRH services and discrimination based on migration status [55,60]. Regarding experience of IPV, it was highlighted that it can reduce the woman's ability to work thereby negatively affecting the family and the society at large [116]. Additionally, women who experienced IPV had higher chances of contracting HIV, have unwanted pregnancy, had 16% chances of having a low-birth weight baby, more likely to experience an abortion and depression compared to women who never experienced IPV [20,116]. To avoid these SRH issues, access to and utilization of SRH services should be enhanced for women to gain control over their sexual and reproductive health.

2.6: Theoretical frameworks guiding the study

Several ecological theories have been used to explain health seeking behaviour including access to health services. The ecological theories have similarities in explaining different environmental factors that influence individual health decisions. The Ecological Psychology Theory developed by Lewin (1951) focuses on the influence of the outside environment on an individual's decisions and determines an individual's adaptation. Similar to Ecological Psychology Theory, Environmental Psychology theory by Barker (1968) argues that human behaviour can be predicted more accurately from the surrounding environments people live in than from their individual characteristics [156]. In addition, Bronfenbrenner's (1979) Social Ecology Theory of human development postulates that interactions at different levels that is at the individual, microsystem, mesosystem, exosystem and macrosystem influence an individual's human behaviour.

The individual level is placed at the centre and comprises of the demographic characteristics for example, age and sex. The microsystem is characterised by individual's human relationships and interpersonal interactions with the immediate surrounding for example, the relationship and interaction between an individual with family, friends and school environment (Bronfenbrenner and Ceci, 1994). The mesosystem encompasses the different interactions between the characters of the microsystem (Bronfenbrenner and Ceci, 1994). An example is the relationship between an individual's family and the individual's school teachers or health workers. The exosystem contains elements of the microsystem which indirectly affects the individual for example if an individual's parent loses a job that will indirectly affect their health seeking behaviour owing to financial constraints (Sallis, Owen and Fisher, 2008). The macrosystem comprises of cultural and societal beliefs that influence individual health behaviour for example gender norms and religious influence (Bronfenbrenner and Ceci, 1994). These ecological theories are congruent in that health seeking behaviour has multiple levels of influences and these influences interact across the different levels [156]. Thus, ecological theories explain the influence of the environment on an individual's health seeking behaviour. However, these ecological theories overlooked the influence of individual characteristics on health seeking behaviour and how individual characteristics influence interactions between individuals and their surrounding environments.

With guidance from Bronfenbrenner's Social Ecological Theory (1979), McLeroy et al (1988) developed the Social Ecological Theory which acknowledges the influence of individual characteristics in health seeking behaviour. In contrast to other ecological theories, McLeroy et al (1988) Social Ecological Theory does not perceive an individual as a passive object but argues that reciprocal interaction between individuals and their surrounding environments shape their health seeking behaviour; hence the theory recognises both individual and environmental influences on health seeking behaviour. The theoretical framework for this study is drawn in part from McLeroy et al's Social Ecological Theory (1988) and the Health Access Livelihood Framework of Obrist et al (2007), which argues that access reached along five dimensions (accessibility, affordability, adequacy, availability and acceptability) depends on the interplay between the health care services and the livelihood assets people can mobilise in particular vulnerable contexts. In addition, resilience or coping mechanisms are incorporated in order to understand an individual's capacity and ability to withstand hardships faced within the undesirable environment. The theory is suitable for this study because it recognises both the individual and the environmental factors that influence health seeking behaviour. In addition, the theory is based on features of the environment which are similar to the settings where the migrant populations reside and have identifiable linkages of access to SRH services. Hence, it provides a background for analysing influential factors at different levels.

2.6.1 The Social Ecological Theory of McLeroy et al. (1988)

The Social Ecological Theory of McLeroy et al. (1988) focuses on both the individual and environmental factors that affect health seeking behaviour. It is premised on two key concepts namely: multiple levels and reciprocal causation. The theory argues that the individual's health seeking behaviour is affected by multiple levels of influence namely, the intrapersonal, interpersonal, institutional, community and public policy factors. Regarding reciprocal causation, it posits that the individual's health seeking behaviour shapes and is also shaped by the social environment [157]. The theory consists of five layers which are described as follows:

Intrapersonal factors: this layer consists of individual characteristics including age, marital status, knowledge, attitudes, behaviour and skills. This includes the developmental history of an individual [157].

Interpersonal factors: Is the second layer which is comprised of an individual's relationship with primary groups which are formal and informal social networks and social support systems which influence an individual's health seeking behaviour. Examples include family, work group, and friendship networks [157].

Institutional factors: Is the third layer which consists of formal and informal rules and regulations of organisations and institutions which governs operation that can impact on health behaviour [157].

Community factors: is the fourth layer which is comprised of the relationships among organisations and institutions and informal networks within defined boundaries [157]. In this study, these will be understood as location of resources within the community for example, geographic accessibility of health facilities and support groups that may enhance or inhibit access and utilisation of SRH services.

Public Policy: The fifth layer which consists of local, state and national laws and policies that impact on health [157]. Similar to previous ecological theories, the Social Ecological Theory of McLeroy et al. (1988) is grounded on the principle that reciprocal interactions between the individual and the environment exist and there are multiple influences on specific health seeking behaviour and these influences of behaviour interact across different levels and assumes that multi-level interventions are the most effective in changing behaviour [156,158].

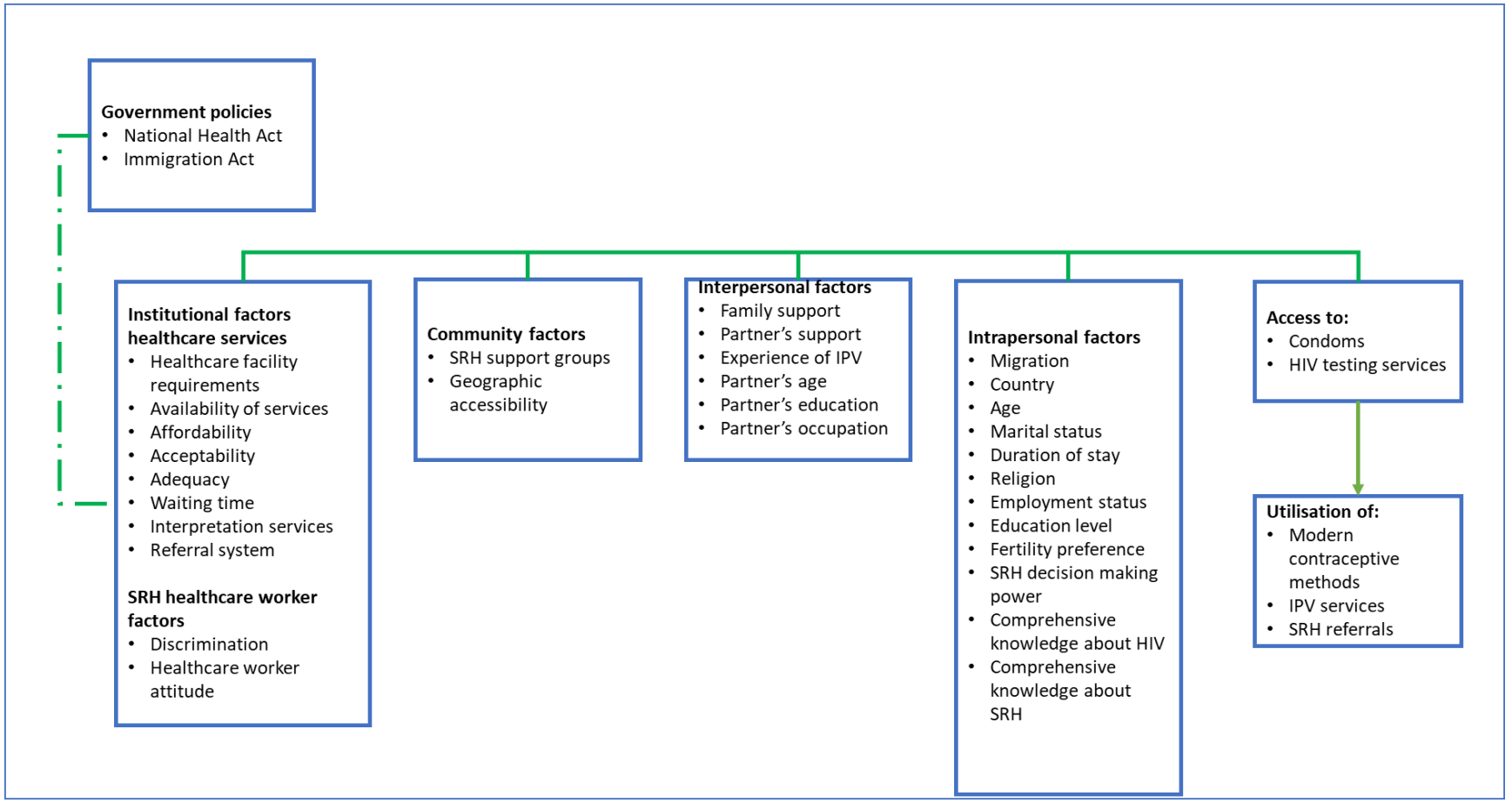
2.6.2 The Health Access Livelihood Framework

The Health Access Livelihood Framework argues that the access reached along five dimensions (accessibility, affordability, adequacy, availability and acceptability) depends on the interplay between the health care services and the livelihood assets people can mobilise in particular vulnerable contexts [4]. Since migrant women are mainly in the reproductive age group, they require SRH services in the host country and accessing SRH services becomes critical. At this point migrant women's health seeking process is influenced by the adaptation strategies at their disposal and the five dimensions of access namely affordability, acceptability, adequacy, availability and accessibility [4]. The level of accessibility and utilisation of SRH services by migrant women as guided by the aforementioned five dimensions is dependent on the relationship between health care services, the processes involved, policies and the available resources that migrants can utilise within their context of vulnerability [4].

2.6.3 The conceptual framework

Figure 2.1 shows the conceptual framework for the study adapted from the Social Ecological Theory and the Health Access Livelihood Framework. The conceptual framework shows that factors at different levels influence women's decisions to access and utilise SRH services and that access to SRH is a prerequisite for women's utilisation of SRH services. It is shown that government policies influence institutional level factors in the form of healthcare service factors and healthcare worker factors. However, in this study government policies are not operationalised. Institutional, community, interpersonal and intrapersonal level factors influence an individual's decision to access and therefore utilise SRH services. The cost of SRH service may influence the decision to access and utilise the required SRH services. For example, being a migrant, who is not employed, whose partner is also not employed and does not obtain any form of support from the family may make it difficult to access the required SRH service owing to high costs attached to the service. In this conceptual framework, institutional, community and interpersonal factors are explored qualitatively while intrapersonal factors that influence access to and utilisation of SRH by migrant women are investigated quantitatively. Qualitative findings are used to illustrate, triangulate, expand and complement quantitative findings on access to and utilisation of SRH services.

Figure 2.1: The Conceptual Framework for the study



2.7: Summary of the chapter

Internal and international migration has been increasing with slightly below half of all the migrants being female migrants mainly of the reproductive age group. Migration of people of the reproductive age group worldwide has important implications on public health, access to and utilisation of SRH services in particular. However, despite having international and regional conferences aimed at promoting equitable access to health services to all citizens regardless of their migration status, disparities in accessing and utilising SRH and HIV services between migrants and non-migrants have been documented. Against the background of an increasing number of female migrants of reproductive age, reproductive health is of greater importance. It is necessary to understand the existing picture of access to and utilisation of SRH by migrants in order to develop migrant-sensitive strategies and enhance universal access to healthcare services.

CHAPTER 3: METHODOLOGY

3.1: Introduction

This chapter presents the research methodology of the study, including the study setting, the study design, the study population, the data sources and the sampling techniques. In addition, the variables used in the analysis and their definitions are provided. The methods of data analysis, ethical considerations and the limitations of the study are presented.

3.2: Study Setting

The data used for the quantitative component of this study is from a baseline survey conducted in 10 high migration communities in six Southern African countries, namely Hhohho (Eswatini), Maputsoe (Lesotho), Mwanza and Mchinji (Malawi), Chifunde and Ressano Garcia (Mozambique), Ekurhuleni and Nkomazi (South Africa), Chipata and Katete (Zambia). The rationale for selecting these communities was that they are labour and transport corridors for migrants and they have major inflows of migrants within the countries and from other African countries [18,22,94]. The six countries have a long history of labour migration owing to disparities in socio-economic and political environments [103]. The countries also share similar cultural beliefs regarding safe sexual practices, fertility and polygamy which have an impact on women's access to and utilisation of SRH services [159]. In addition, the countries are in southern Africa, a region with a high HIV prevalence [84]

The Kingdom of Eswatini was formerly known as Swaziland, and it will be referred to as Eswatini in this study. It is a land-locked country which is located to the east of South Africa. The country has a long history of both internal and international migration. It provides labour to South African mines and women participate in international migration through cross border trading [160]. Recently, an increase in women migrating from Eswatini to South Africa has been noticed. These women migrants are mainly employed in the manufacturing sector, agribusiness, tourism and domestic services in both Mpumalanga and Gauteng provinces in South Africa [103,160].

Hhohho is a district in Eswatini. It is located in the north-western part of Eswatini. Hhohho is the most economically advanced district with the largest urbanized population in the country [103,160]. The main economic activities in the district are mining, tourism and forestry [160]. As a result, the district attracts both internal and international migrants mainly from other African countries [103,160].

Geographically, Lesotho is surrounded by South Africa with a total population of 2.1 million at mid-year 2020 [26]. It is one of the countries in Africa facing the devastating impact of the HIV/AIDS epidemic. It has adult (15-49 years) HIV prevalence of about 23%, being higher among women 28% than men 18% [84]. Sexual violence is high in Lesotho with approximately 61% of women reporting having ever experienced sexual violence [102]. Maputsoe is a town in the northern district of Leribe in Lesotho. It is one of the busiest border towns in Lesotho and it shares a border-post with Ficksburg in the eastern Free State, South Africa. Hence, it has the major migration routes for migrant workers [161].

Mwanza and Mchinji are districts in Malawi. Mwanza shares the border with Mozambique while Mchinji is located near the Zambian border. Mwanza is located in the Southern Region of Malawi and it is the main commercial, political and administrative urban centre of Mwanza District. Mwanza lies on the main route from Blantyre to Tete in Mozambique. It is a market town for local produce, and distribution market for commercial products and processed foods. Mwanza also acts as a transhipment point for goods going down the Zambezi River via Tete [162]. In 2007, Ethiopian illegal immigrants on their way to South Africa were found hiding in an oil tanker at Mwanza, Malawi, where it borders with Mozambique [162]. In addition, Mchinji is a town and the capital of the Mchinji District in the Central Region of Malawi. It is located near the Zambian border and is the major hub of government and general business. Mchinji has a main railroad junction which connects to Zambia. Thus both Mwanza and Mchinji are major transport corridors linking Malawi to Mozambique and Zambia.

Mozambique is a country in Southeast Africa bordered by the Indian Ocean to the East, Tanzania to the North, Malawi and Zambia to the Northwest, Zimbabwe to the West, and Swaziland and South Africa to the Southwest. In Mozambique, mining is the major economic activity with

considerable coal reserves in Tete Province [163]. Chifunde, a district of Tete Province in western Mozambique shares the border with Zambia in the north and Malawi in the northeast. Being adjacent to South Africa, Ressano Garcia is a small town in Maputo Province, Mozambique. Ressano Garcia is strategically located on the Maputo Transport Corridor linking South Africa, Zimbabwe, Swaziland and Botswana thereby increasing international migration [163,164]. The Ressano Garcia-Lembobo one-stop border post is one of the busiest border posts in the Southern African Development Community (SADC). Between 2013 and 2014, international migrants from South Africa to Mozambique increased by 15% and significant cross border trading from Mozambique to Swaziland and South Africa has been noticed [103,165].

To the north, South Africa borders with Namibia, Botswana, and Zimbabwe and to the east and northeast with Mozambique and Eswatini and it surrounds Lesotho. South Africa has a mixed economy (agriculture, tourism and mining) which attracts many migrants both internal and international. Approximately 60% of workers in the mining sector in South Africa are from Southern African countries, mainly from Lesotho, Mozambique and Swaziland [103]. Owing to economic and political instability, many people from Southern African countries migrated to South Africa. As a result, an increase in female migration consisting of mainly low-skilled workers to South Africa was noticed, with approximately 30 % of all Basotho migrant workers in South Africa being females [166]. In Africa, South Africa mainly hosts migrants from Angola, Botswana, Democratic Republic of Congo, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, Somalia, Sudan, Tanzania, Zambia and Zimbabwe [26]. Ekurhuleni is a district and a metropolitan municipality in Gauteng province, South Africa [165]. It receives a high influx of both internal and international migrants. In 2011, 37% of the population in Ekurhuleni were internal migrants while 8% (252 865) were international migrants [167]. For the qualitative component of the study, Ekurhuleni district was chosen mainly because it is part of the primary study (SRHR-HIV Knows No Borders Project) sites. The choice of South Africa for the qualitative study is premised on the fact that compared to the other countries and site, it has relatively high migrant inflows from other provinces within South Africa and from other African countries because of its relatively favourable economic conditions [22,95]. In addition, Gauteng province is the economic hub of the country hence it is characterized by high inflow of both internal migrants from other provinces and international migrants mainly from African countries. This would enable

selection of study participants from diverse backgrounds in order to obtain diverse views and experiences.

Zambia lies at the heart of Central-Southern Africa and borders with Angola, Botswana, the Democratic Republic of the Congo, Malawi, Mozambique, Namibia, the United Republic of Tanzania and Zimbabwe [86,168]. Zambia is found on the southern migration route towards South Africa. Zambia is one of the major receiving countries of refugees in the Southern African region [86]. Similarly, significant trade and international migration occurs between Zambia and Malawi through Chipata while Katete is a town located in the Eastern Province of Zambia. Chipata is the administrative centre and provincial capital of the Eastern Province of Zambia and it is the primary transport hub for trade between Zambia and Malawi. The Eastern Province borders with Malawi to the east and Mozambique to the south. Agriculture is the major economic activity in the province. Katete is a medium-sized town in the Eastern Province of Zambia close to the Mozambique border.

3.3: Study design

A mixed methods study design was used to achieve the research objectives. The quantitative component used secondary data while the qualitative component used primary information. The study used the explanatory sequential design which entails quantitative data collection followed by qualitative data collection [169]. Mixed methods were used in this study for three distinct purposes including triangulation, expansion and complementarity. Triangulation in this study was used to determine any converging issues between quantitative and qualitative findings [170]. Expansion and complementarity were used to extend, elaborate, clarify and explain the quantitative findings with qualitative results [169,170].

3.4: Data source and sample size

3.4.1: The SRHR-HIV Knows No Borders Project

The quantitative data used in this study was from a baseline survey conducted as part of the SRHR-HIV Knows No Borders Project was funded by the Government of the Kingdom of Netherlands. The project is a collaboration of three implementing partners; the International Organization for Migration (IOM), Save the Children Netherlands (SCN) and University of the Witwatersrand's

School of Public Health (WSPH) (consortium partners). The broad aim of the SRHR-HIV Knows No Borders Project was to improve sexual and reproductive health and HIV (SRH-HIV) related outcomes among people living in high migration communities. Thus, the baseline data collected was used for program planning and as a benchmark to evaluate the project's progress and impact over the project duration/period and to document SRH-HIV indicators of the study sites.

The Project collected data from 10 high migration communities in the six Southern African countries. Data collection took place in 2018 from 16 April to 4 June in Zambia, 28 May to 15 June in Lesotho, 30 May to 30 August in Eswatini, 11 to 24 June in Malawi, 13 to 31 August in Mozambique and 27 October to 3 December in South Africa. The data was collected using a household questionnaire, an individual men's questionnaire and an individual women's questionnaire. The data collection process involved initial administration of the household questionnaire in order to determine eligible household members and to collect household characteristics. In a household with more than three eligible participants, a maximum of three respondents were randomly selected. The individual women questionnaire collected demographic information, marriage, sexual activity, family planning/contraception, pregnancy and reproduction, fertility preferences, HIV/AIDS and STIs, IPV, gender roles and other health related issues including referrals. The individual men questionnaire collected demographic information, marital status, sexual activity, family planning/contraception, HIV/AIDS and STIs, gender roles and other health related issues. In this study, the individual men's questionnaire was not used.

Eligible participants for the baseline survey were women of reproductive age (15-49 years) and men aged 15-59 years who were regular household members or migrants. Visitors were not eligible, hence, they were excluded from the study. A fixed sample of 300 per study site was used, yielding a pooled sample size of 3000 participants for the six countries. The fixed sample of 300 was stratified as 30 sex workers, 120 female AYPs, 60 male AYPs, 60 female adults aged 25-49 years and 30 male adults aged 25-59 years. In arriving at the sample size, the project accounted for clustering, assumed a moderate design effect (DEFF) of 1.5 and accounted for non-response. Strata for female AYPS, male AYPs, female adults and male adults were further sub-divided into two; settled population (migration affected population) and migrant population. Strata sample size allocations were computed using proportional to size sampling technique. For example, if overall

80% of the population was settled and 20% of the population was mobile, the stratum for settled female AYP will have 96 participants (80%*120) while the stratum for mobile female AYP will have 24 participants (20%*120). However, the number in each sub-stratum varied by country and site. For this study, only the women data is used and the total sample size is 2070 women. This sample size is sufficient to detect an absolute difference of 12% in the rate of access or utilisation to a given SRH service (e.g. access to condoms) between two groups (e.g. international migrants and non-migrants) as being statistically significant at the 5% level with 80% power, based on the following assumptions a) roughly equal numbers of women are in each of the three migration status categories and b) the effect of the clustering of women within sites results in a moderate Design Effect (DEFF) of 1.5.

The population of interest in the primary survey are women, sex workers (SW), adolescent and young people (AYP), and mobile population. Thus, while a fixed sample of 10% of the total population recruited were sex workers, women and AYPs were over sampled to be twice the sample size of men and non-AYPs, respectively. Further, the mobile population size was chosen to reflect the proportion of the mobile population in each of the sites. A combination of snowball and convenience sampling was used to enrol sex workers. To facilitate access to the SWs and the mobile populations, a rapid mapping exercise was carried out at each site to identify hotspots for SWs, truck stops and sleeping places of mobile populations. Within each selected project site, clusters (villages/wards) were randomly selected. In each cluster, listing of buildings and households was performed using a household schedule form. The building and household listing were done sequentially to avoid errors in uniquely numbering each building/household.

3.4.2: Qualitative data

Qualitative data used in this study was collected by the researcher (PhD student) and two research assistants (data collectors) in Ekurhuleni, South Africa. Ekurhuleni district was chosen mainly because it is part of the primary study (SRHR-HIV Knows No Borders Project) sites. The choice of South Africa for the qualitative study is premised on the fact that compared to the other countries and site, it has relatively high migrant inflows from other provinces within South Africa and from other African countries because of its relatively favourable economic conditions [22,95]. In

addition, Gauteng province is the economic hub of the country hence it is characterized by high inflow of both internal migrants from other provinces and international migrants mainly from African countries. This would enable selection of study participants from diverse backgrounds in order to obtain diverse views and experiences.

In-depth interviews (IDIs) with migrant women and healthcare workers were conducted using the open ended interview guides (See Appendices 5 and 6). The interviews were conducted between December 2019 and March 2020. The interviews were conducted in English, Zulu and Xhosa and each interview took between 30 – 60 minutes. The interview guides that were translated into Zulu and Xhosa were back translated with the assistance of professionals to ensure consistency of meaning. The interviews were translated into Zulu and Xhosa because these are the most spoken languages in Ekurhuleni. Owing to the sensitivity of the study topic (sexual and reproductive health including HIV), the interviews were conducted in a private and conducive environment. Hence, to ensure privacy, participants chose the setting or venue with which they were comfortable.

A two day training workshop was conducted for the research assistants to establish their understanding of the study aims, objectives, questions and familiarisation with access to and utilisation of SRH concepts. The interview guides were validated by three qualitative experts. In addition, prior to data collection, a pre-test of the study was conducted among migrant women in Ekurhuleni district. Pre-testing was carried out to check whether the questions were well defined, clearly understood and presented in a consistent manner and to identify potential deficiencies in the research. Furthermore, pre-testing was carried out to ensure that the questionnaire was appropriate and addressed the research questions. Digital recording was used to ensure that all the information provided and discussed was captured. The qualitative sample consist of 13 migrant women (five internal migrant women and eight international migrant women) and four healthcare workers. The participants needed to have accessed and utilised SRH and HIV services in Ekurhuleni. The selection criteria for healthcare workers was that they must be working in the provision of SRH and HIV commodities and services. The participants did not necessarily need to have participated in the primary study (the SRHR-HIV Knows No Borders Project).

To recruit participants for the qualitative component, purposive and snowball sampling methods were used. Purposive sampling was used to recruit healthcare workers while snowball sampling was used for recruiting migrant women. Purposive sampling involves identifying and selecting individuals who have specific knowledge and experience in the subject under study [171–173]. Thus, purposive sampling allows for selection of specific members based on a specific purpose thereby resulting in greater depth of information from suitable members [172,173]. The healthcare workers were purposively sampled and included in the study because they have extensive experience in providing SRH services to migrants and they possess detailed information regarding migrant women's experiences in accessing and utilising SRH services. Snowball sampling was for recruiting migrant women because it allows for identification of study participants with specific characteristics and information required in the study [171]. Given that migrants are difficult to identify, snowball sampling enabled migrant women to recommend or refer other migrant women to be interviewed [172,173].

3.4.3: Study population

For the quantitative component of this study, the study population consists of 2070 women of the reproductive age group 15 to 49 years who resided in the 10 sites of the six Southern African countries in 2018. Owing to ethical issues around people below the age of 18, the study population for the qualitative component comprises of internal and international women aged 18 to 49 years residing in Ekurhuleni (South Africa). In addition, healthcare workers that provide SRH and HIV services in Ekurhuleni form part of the study population. In this study, the quantitative study population was grouped into the three categories of: non-migrants, internal migrants and international migrants.

3.5: Data management

STATA release 15.0 was used to manage and analyse the quantitative data. Data management involved deriving variables to measure comprehensive knowledge about SRH, comprehensive knowledge about HIV, experience of IPV, SRH decision making power and migration status. In addition, a number of variables were recoded, including educational level, employment status,

access to health care facility, access to contraceptive methods, HIV testing, religion, partner's educational level and partner's employment status. To analyse qualitative data, NVivo 12 was used. Interviews were digitally recorded and transcribed verbatim. To ensure that the transcriptions captured everything included in the interviews, the researcher read the transcripts while listening to the audio recordings. For coding and thematic analysis, the transcripts were imported into NVivo 12 and codes were derived using the hybrid approach, that is allowing themes to emerge directly from the data (inductive approach) and having preconceived themes based on the theoretical framework and existing literature (deductive analysis) [174]. Thematic analysis allows for coding of data by identifying and organising the information into themes and analyse patterns which cannot be noticed by listening to the digital recorder or reading the transcript [175]. To ensure inter-coder reliability, two independent coders who are proficient in qualitative research coded four transcripts together with the researcher and an agreement was reached regarding the codes. The recurring codes were developed into themes and ambiguous words for example ""mmm" were deleted from the transcripts.

3.6: Statistical analysis

The analysis performed answers the research questions and therefore addresses the research objectives.

Objective 1: *To examine the level of and differentials in access to and utilisation of SRH services among women in high migration communities in the Kingdom of Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia.*

The objective was achieved by computing descriptive statistics to show the levels of access to and utilisation of SRH services by various explanatory variables. The descriptive statistics used are frequency and percentage distributions and means. the distribution of the explanatory variables was broken down by i) whether or not they had access to condoms ii) whether or not they had access to HIV testing services iii) whether or not they utilised modern contraceptive methods iv) whether or not they utilised SRH referral services v) whether or not they utilised IPV services.

Objective 2: *To identify the factors that are associated with access to and utilisation of SRH services among women in high migration communities in the Kingdom of Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia*. The analysis included:

1. Investigation of the factors associated with access to SRH services among all women in high migrant communities of six Southern African countries.
2. A sub-analysis which investigated the effects of partner's characteristic variables and SRH decision making power was also conducted among partnered women.

Univariable and multivariable logistic regression models were fitted to establish the relationship between the explanatory variables and the binary outcome variables. Migration status is the primary exposure variable and it was included in all the models. Other explanatory variables that were found to be significant in the univariable model at P=0.20 were included in the analysis. In addition, some variables that were found not to be significant but were highlighted to be important/relevant in the literature were also included in the multivariable models (for all women and the sub-analysis restricted to partnered women).The potential explanatory variables are given in section 3.6.1.2 below. The results from the binary logistic regression are interpreted using odds ratio with level of significance set at p<0.05 and confidence intervals of 95%. A likelihood ratio test was carried out to see if there was an association between the outcome variable and explanatory variables.

For the binary logistic regression, the following formula was used:

$$log\frac{\pi_i}{1-\pi_i} = log0_i \ = \alpha + \beta_1(X_1) + \beta_2(X_2) + \beta_3(X_3) \ldots + \beta_n(X_n)$$

Where:

$1-\pi_i$ is the conditional probability of not accessing or utilising SRH services, $\pi_i$is the conditional probability of accessing and utilising SRH services.

0_i is the conditional odds of not accessing and utilising SRH services.

X represent the explanatory variables.

To achieve objective 3 and 4, thematic analysis was used. Quantitative and qualitative findings were integrated and qualitative findings were used to elaborate, expand and complement the quantitative findings.

3.6.1: Variables and Measurement

3.6.1.1: Outcome variables

There are five outcome variables. Two outcome variables measure access to SRH services namely, access to condoms and access to HIV testing services. Three outcome variables measure utilisation of SRH services namely, current use of modern contraceptive methods, utilisation of IPV services, and utilisation of SRH referral services. The reason for analysing non-use of modern contraceptive methods, not being able to access condoms and not having access to HIV testing services in this study is due to the difficulty in interpreting ORs when the prevalence of the outcome is high.

Access to condoms measure a woman's ability to obtain either female or male condoms as a modern contraceptive method and to protect her against HIV and other STIs. It is derived from questions which asked respondents' "if you wanted to, could you get a male condom yourself?" and "if you wanted to, could you get a female condom yourself?" If a woman answered "yes" to being able to get either a male condom or a female condom, she was considered to have access to condoms, while if she answered "no" to both questions she was considered not to have access to condoms.

Access to HIV testing services was derived from asking respondents if they know of a place where people can get tested for HIV and identifying the place. If the respondent reported knowing of a place where one could get tested for HIV and was able to identify the facility or other place, then she was considered to have access to HIV testing services, otherwise she was regarded as not having access to HIV testing services.

Current use of modern contraceptive methods is defined as currently using any modern method to delay or avoid getting pregnant. In this study, the following were considered to be modern contraceptive methods: female sterilisation, male sterilisation, intrauterine device (IUD), injectables, implants, pill, male condom, female condom, diaphragm, foam/jelly, standard days, lactational amenorrhea method (LAM) and emergency contraception.

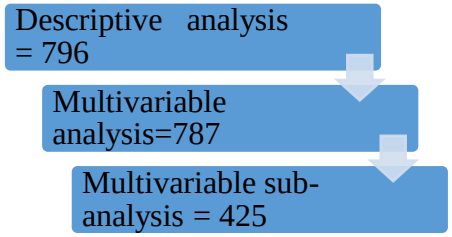
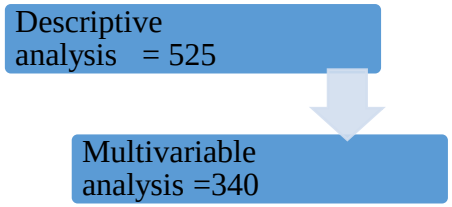
Utilisation of IPV services is defined as having used or sought any formal services related to physical or sexual violence perpetrated by a woman's intimate partner. The variable was derived

from the question “Have you ever told anyone about any of the abuse or sought help? (Yes/No)” and those who responded Yes were further asked from who/where? Women were regarded to have sought help if they sought help from medical personnel, police, lawyer, social worker, non-governmental organizations (NGOs) marriage counsellors, the victim support unit or community leaders and none if they sought help from own family, partner’s family, neighbours or friends. The question was asked to women who reported experiencing physical or sexual violence in the past 12 months.

Utilisation of SRH referral services was derived from the question as to which SRH/HIV services the woman had been referred for since they were not offered at a health facility that she had visited (Facilities in community, facilities outside community). A woman was regarded as having utilised SRH referral services only if a) they were referred to a facility and b) they went for the referred services.

Table 3.1: Outcome variables and respective explanatory variables

Outcome variable	**Sample size**	**Potential explanatory variables**
Access to condoms	Descriptive analysis = 2070 Multivariable analysis =2052 Multivariable sub-analysis = 987	Age, marital status, educational level, employment status, country, duration of stay in the community, religion, partner's age, partner's educational level, partner's occupation, comprehensive knowledge about SRH, comprehensive knowledge about HIV, SRH decision making power.
Access to HIV testing services	Descriptive analysis = 2070 Multivariable analysis =2052 Multivariable sub-analysis = 987	Age, marital status, educational level, employment status, country, duration of stay in the community, religion, partner's age, partner's educational level, partner's occupation, comprehensive knowledge about SRH, comprehensive knowledge about HIV, SRH decision making power.
Utilisation of modern contraceptive methods	Descriptive analysis = 1677 Multivariable analysis=1665 Multivariable sub-analysis = 952	Age, marital status, educational level, employment status, country, duration of stay in the community, religion, desire for another child, partner's age, partner's educational level, partner's occupation, , experience of IPV, comprehensive knowledge about SRH, comprehensive knowledge about HIV, SRH decision making power.

Utilisation of SRH referral services		Age, marital status, educational level, employment status, country, duration of stay in the community, religion, partner's age, partner's educational level, partner's occupation, access to healthcare facility, experience of IPV, comprehensive knowledge about SRH, comprehensive knowledge about HIV, SRH decision making power.
Utilisation of IPV services		Age, marital status, educational level, employment status, country, duration of stay in the community, religion, partner's age, partner's educational level, partner's occupation, parental violence, attitude towards wife beating, comprehensive knowledge about SRH, comprehensive knowledge about HIV, SRH decision making power.

3.6.1.2: Explanatory variables

The main explanatory variable is migration status, categorised as non-migrants, internal migrants and international migrants. In addition, a number of other explanatory variables were derived and these are explained here. Comprehensive knowledge about SRH is a discrete quantitative variable taking integer values between 0 and 2 inclusive, and is derived from questions about effective ways of preventing pregnancy, misconceptions about pregnancy and knowing fertile days.
A score of zero is awarded for either an incorrect answer or "don't know" on each question, and a score of one is awarded for a correct answer.

Comprehensive knowledge about HIV is a discrete quantitative variable taking integer values between 0 and 3 inclusive, which is defined as respondents having knowledge about HIV transmission, rejecting two or more HIV myths and knowing that a healthy looking person can be HIV positive. It is derived from a set of questions and a correct answer on each question is scored one and incorrect answer/don't know is scored zero.

SRH decision making power is a discrete quantitative variable which takes integer values between 0 and 5 and is derived from the responses to five questions which measure a women's ability to decide about timing of sexual intercourse, ability to refuse sex when not in the mood, timing of pregnancy and mode of child delivery. Women who responded that they have the power to decide for all five questions were given a score of five while those who reported that they did not have the power to decide any of the five questions were given a score of zero.

Experience of IPV refers to encountering physical or sexual violence from an intimate partner in the past 12 months. It is derived from the following questions: did your (last) intimate partner ever do any of the following things to you in the last 12 months: for physical violence- push you, shake you or throw something at you, slap you, twist your arm or pull your hair, punch you with his fist or something that could hurt you, kick, drag you or beat you up, try to choke you or burn you on purpose and threaten or attack you with a knife. For sexual violence, physically force you to have sexual intercourse with him when you did not want to, and physically force you to perform any other sexual acts you did not want to. A respondent was regarded as experiencing IPV if they

experienced any of the instances of physical or sexual violence and as not experiencing IPV if they did not experience any physical violence nor any sexual violence.

Table 3.2a: Outcome variables definition and operationalisation

Variable	Variable Definition/explanation	Operationalisation
Access to condoms	Measures whether a woman is able to access either a male or a female condom as a modern contraceptive method and to protect herself against HIV and other STIs and is coded as 0 – able to access a condom 1 – not able to access a condom	The variable is derived from the questions "If you wanted to, could you get a male condom yourself" and "If you wanted to could you get a female condom yourself". If the woman responds "yes" to either question, then she is able to access a condom and the variable takes the value 0, while if she answers "no" or "don't know" to both questions, then she is unable to access a condom and the variable takes the value 1.
Access to HIV testing services	Measures whether a woman has knowledge about HIV testing places and her ability to identify places where one can get tested for HIV. The variable is coded as: 0 – able to access HIV testing services 1 – not able to access HIV testing services	The variable is derived from questions "Do you know of a place where people can get tested for HIV? And Where is that place? If a woman responds "yes" to the first question and was able to name at least one place, then she is able to access HIV testing services and the variable takes the value 0, while if she answers "no" to the first question then she is unable to access HIV testing services and the variable takes the value 1
Utilisation of modern contraceptive methods	Measures whether a woman is currently using any modern method of contraception to delay or avoid pregnancy. The variables are coded as: 0 – currently using modern contraceptive methods 1 – not currently using modern contraceptive methods	The variable is derived from the question "Have you ever used/are currently using any method to delay or avoid pregnancy?" If the woman responds "yes" to currently using a method and stating the method she is using then she is currently using a modern contraceptive method and the variable takes the value 0, while if she answers "no" or says she was using traditional methods then she is not currently using any modern contraceptive methods and the variable takes the value 1.
Utilisation of IPV services	A variable that measures a woman's: 1. Experience of physical and sexual violence 2. Utilisation of IPV services	The variable is derived from the following questions on physical violence and sexual violence in the past 12 months and whether they sought help and where they sought help: **Experience of physical violence:**

	3. The places where they went for services In the data set the variables are coded as : 1. Yes 2. No 3. No response	Did your (last) partner ever do any of the following things to you in the last 12 months: 8. Push you, shake you or throw something at you? 9. Slap you? 10. Twist your arm or pull your hair? 11. Punch you with his fist or something that could hurt you? 12. Kick, drag you or beat you up? 13. Try to choke you or burn you on purpose? 14. Threaten or attack you with a knife? **Experience of sexual violence** 15. Physically force you to have sexual intercourse with him when you did not want to? 16. Physically force you to perform any other sexual acts you did not want to? **Sought help** Have you ever told anyone about any of the abuse or sought help? From who/where? If a woman reported to have experienced physical or sexual violence, and sought help from formal channels (for example, Police, marriage counsellor, medical personnel) she is regarded as having utilised IPV services and the variable takes the value 1 while women who experienced physical and sexual violence and reported not seeking help or sought from informal sources (for example parents, friends, neighbours) were regarded as not having utilised IPV services and the variable takes the value 0.

		The variable is coded as: 0 – not utilised IPV services 1 – Utilised IPV services
Utilisation of SRH/HIV referral services	Measures a woman's uptake of SRH referral services. Coded as: 0. Unchecked (No) 1. Checked (Yes)	The variable is derived from the questions "Which of the following SRH-HIV services have you been referred out for because they are not offered at a health facility that you visited? Facilities in community, facilities outside community and went for referral? Respondents who were referred to facilities inside the community or facilities outside community and went for the SRH referral were regarded as having utilised SRH referral services and the variable takes the value 1 while respondents who were referred to facilities inside the community or facilities outside community and did not go for SRH referral were regarded as not having utilised SRH referral services and the variable takes the value 0.

Table 3.2b: Explanatory variables definition and operationalisation

Variable	Variable Definition/explanation	Operationalisation
Migration status	Measures the migration status of a respondent and takes one of three values namely: 1 – non-migrant - if the woman was from both the country and the province / district where the survey took place 2 – internal migrant – if the woman was from the country where the survey took place but from a different province / district 3 – international migrant – if the woman was from a different country to the country where the survey took place	
Age	Measures the age of respondents on their last birthday. A continuous variable listing the age of the respondents from 15 to 49.	The variable is derived from the question "How old were you on your last birthday?" This is a continuous variable showing the age of the respondent on their last birthday in years.
Educational level	Measures the highest educational level of the responded. Coded as: 0. None 1. Primary 2. Secondary 3. Higher	Respondents were asked if they ever attended school and the highest educational level they attended. Owing to low frequencies, the variable is recorded as: 1. Primary/lower 2. Secondary/ higher education.
Country	Refers to country of origin for the citizens and destination for migrants. The country were the participants were interviewed from. 1. Lesotho 2. Malawi	

	3. Mozambique 4. South Africa 5. Swaziland 6. Zambia	
Duration of stay in the community	Length of stay in the community. Ranging from 0 to 49 years	Operationalised as a continuous variable in years.
Religion	A categorical variable coded as: 1. Catholic 2. Protestant 3. Orthodox 4. Other Christian 5. Islam 6. Traditionalist 7. Other	The variable is derived from the question "What is your religion?" A categorical variable recorded as: 1. Catholic 2. Other Christians (Protestant, Orthodox and other Christians) 3. Others (Muslims, No religion and traditionalists)
Employment status	Measures the respondent's work done in the past 12 months. Coded as: 1. Yes 2.No	A categorical variable recoded and renamed to employment status, Respondents who reported 'Yes', that is to have been working in the past 12 months were regarded as employed while those who reported 'No' as unemployed. Recoded as: 2 (no) =0. Unemployed 1(yes) =1. Employed.
Marital status	Measures the current marital status of the respondents. A categorical variable coded as: 1. Never married 2. Married 3. Living with partner 4. Widowed 5. Divorced 6. Separated.	In this study, married and living with partner are grouped together as married; separated, divorced and widowed are grouped together as formerly married. It is recoded as: 1. Never married 2. Married 3. Formerly married

Ever denied access to a public healthcare facility	Measures if the responded was ever denied access to public healthcare facility. Coded as: 1. Yes 2. No	Derived from the question, Have you ever been denied access to any public health care facility? A binary variable recoded as 0. Denied 1. Not denied
Comprehensive knowledge about SRH	Comprehensive knowledge about SRH is defined as (1) the knowledge that consistent and correct use of condom is an effective method of preventing pregnancy; and knowledge that from one menstrual period to the next, there are certain days when a woman is more likely to become pregnant and (2) rejection of two misconceptions about pregnancy prevention from the following list (a) Douching/cleaning vagina after sexual intercourse can prevent pregnancy, (b) When sexual intercourse takes place in certain positions, the woman will not get pregnant, (c) If the man pulls his penis from the vagina before ejaculation, there is no risk of getting pregnant, (d) A person cannot become pregnant by having sex only once and (e) A woman who is breastfeeding a baby cannot become pregnant.	Operationalised as a discrete quantitative variable taking integer values between 0 and 2 inclusive. A 0 score is awarded for incorrect answers and don't know on each question and 1 is awarded for a correct answer on each question. Participants who get all the answers wrongly are awarded a 0 score and those who get all answers correctly are awarded 2 scores. Estimation of comprehensive knowledge about SRH was based on: **1. Effective method** Knowing that consistent and correct use of condom is an effective method to prevent pregnancy and **Fertile days** Knowing the days and that from one menstrual period to the next there are certain days when a woman is more likely to become pregnant. **2. Misconceptions** 2. Knowing that douching/cleaning vagina after sexual intercourse does not prevent pregnancy. 3. Knowing that when sexual intercourse takes place in certain positions the woman can still get pregnant. 4. Knowing that if a man practice withdrawal method there is risk of getting pregnant. 5. Knowing that a breastfeeding woman can become pregnant.

		6. Knowing that a person can become pregnant by having sex only once.
Comprehensive knowledge about HIV	Comprehensive knowledge about HIV is defined as correct knowledge of ways to prevent HIV transmission, knowledge that a healthy-looking person can have HIV and rejection of two misconceptions about HIV transmission.	Comprehensive knowledge about HIV was derived from correct answers to HIV transmission modes and HIV prevention methods. The indicator is defined as: (1) correct knowledge of two ways to prevent HIV, (2) knowledge that a healthy-looking person can have HIV and (3) rejection of two misconceptions about HIV transmission. Operationalised as a discrete quantitative variable taking integer values between 0 and 3 inclusive, a correct answer on each question is scored 1 and incorrect answer/don't know is scored 0. The questions used are: **1. HIV transmission** Knowing that people can reduce their chance of getting HIV/AIDS by having just one uninfected sex partner who has no other sexual partners and Knowing that consistent and correct using of condoms is an effective method to prevent HIV and other STIs. **2. HIV myths/misconceptions** Knowing that people cannot get HIV from mosquito bites. Knowing that people cannot get HIV virus by sharing food with a person who has HIV/AIDS. Knowing that people cannot get HIV through witchcraft or other supernatural means. **3. Healthy looking person** Being aware that a healthy looking person can have HIV.

Experience of Intimate partner violence (IPV)	Measures a woman's experience of physical or sexual violence from an intimate partner in the past 12 months. Coded as: 1. Yes 2. No 3. No response	No response is treated as missing values. A 'yes' response to the questions on physical or sexual violence was regarded as a "yes" and a 'no' response to the questions on physical and sexual violence was treated as a "no". Coded as: 1. Yes 2. No The questions used are: **Experience of physical violence:** Did your (last) partner ever do any of the following things to you in the last 12 months: 1. Push you, shake you or throw something at you? 2. Slap you? 3. Twist your arm or pull your hair? 4. Punch you with his fist or something that could hurt you? 5. Kick, drag you or beat you up? 6. Try to choke you or burn you on purpose? 7. Threaten or attack you with a knife? **Experience of sexual violence** 8. Physically force you to have sexual intercourse with him when you did not want to? 9. Physically force you to perform any other sexual acts you did not want to?
SRH decision making power	Decision about timing of sexual intercourse, ability to refuse sex when not in the mood,	A discrete quantitative variable which takes integer values between 0 and 5. A 0 score is awarded for a "no" on each question and 1 is awarded for a "yes" on each question

	timing of pregnancy and mode of child delivery	The following questions are used to derive the variable: Can you decide when you want to have sex with your partner? Can you refuse to have sex if you are not in the mood? Who decides whether you should get pregnant? Who decides when you should get pregnant? For child delivery, can you decide the mode of delivery that you wish?
Partner's age	Measures the age of the respondent's current/last partner on his last birthday. Coded as: 1. No partner 2. Don't know 3. Age in years (specify) (ranging from 12 years to 71 years)	The variable is restricted to women who reported to have a partner. It is operationalised as: 1. <=24 2. 25-34 3. >=35 4. Don't know
Partner's educational level	Measures the highest educational level attained by the respondent's last or current partner. Coded as: 0. None 1. Primary 2. Secondary 3. Higher	The variable is operationalised as: 1. Primary/lower (None or primary education) 2. Secondary/higher (secondary or higher education)
Partner's employment status	Measures the respondent's current or last partner's occupation. Coded as: 1. Technical/managerial 2. Clerical 3. Sales 4. Agricultural-self employed 5. Agricultural-employee	Recoded as: 0. No occupation (Other specify- none, nothing) 1. Technical/managerial (technical/managerial, clerical and sales) 2. Agriculture (agricultural self-employed and agricultural employee) 3. Skilled manual

	6. Household and domestic services 7. Skilled manual 8. Unskilled manual 9. Other specify	4. Unskilled manual (unskilled manual and household and domestic services)
Parental violence	The respondent witnessing violence from either the father or the mother. The variable is coded as: 1. Yes 2. No 3. No response	Respondents who reported witnessing violence perpetrated by any of their parents were coded as (1), Yes and (0), No if they never witnessed it from either parent. No response was treated as missing.
Desire for another child	Willingness to have a child or another child and the timing of having the child. Coded as: 1. Have another child 2. No, no more 3. She cannot get pregnant 4. Undecided/unsure For timing it is coded as: 1. Less than 2 years 2. 2 years or more 3. Don't know/undecided 4. Other specify	Recoded as: 1. Have a child <2yrs 2. Have a child >=2yrs 3. No more and cannot get pregnant 4. Unsure 5. No partner 6. Missing
Attitude towards wife beating	Attitude/opinion towards wife beating. Coded as: 1. Yes 2. No 3. Don't know	Respondents were asked if they agree that a husband is justified in hitting or beating his wife under each of the following five circumstances: she burns the food, she argues with him, she goes out without telling him, she neglects the children, and she refuses to have sex with him. If respondents answer 'yes' in at least one circumstance, they are considered to have attitudes that justify wife beating and if respondents answer 'no' in all the circumstances they are considered

		not having attitudes that justify wife beating. The don't know category was regarded as missing data. Recoded as: 0. No ; 1. Yes

Table 3.3: Quantitative data analysis

Objective	**Study population**	**Data collection tool**	**Method**	**Analysis process**
1. To examine the level of and differentials in access to and utilisation of SRH services among women in six Southern African countries.	Migrant women aged 15 to 49 years	Individual women questionnaire	Quantitative methods. Descriptive statistics	Descriptive statistics using frequency and percentage distributions to show levels and differentials in accessing and utilising SRH services by various characteristics.
2. To identify factors associated with access to and utilisation of SRH services among women in six Southern African countries.	Migrant women aged 15 to 49 years	Individual women questionnaire	Quantitative Methods: Multivariable logistic regression model.	Outcome variables are analysed using multivariable logistic regression model to identify factors associated with access to and utilisation of SRH services. A sub-analysis is performed on partnered women to show the effect of partner characteristics on women's utilisation of SRH services.

Table 3.4: Qualitative data analysis

objective	Study population	Sample size	Data collection tool	Analysis process
3. To explore and document the factors, experiences and coping strategies of migrant women in accessing and utilising SRH services in South Africa.	Internal and international migrant women aged 18 to 49	13	In-depth interview guide (see Appendix 5)	Thematic analysis is used. Thematic analysis involved drawing themes related to the five dimensions of access, experiences in accessing and utilising SRH and HIV services, coping strategies and suggested recommendations.
4. To explore and document factors and experiences of healthcare workers in providing SRH services to migrant women.	Health care workers who provide SRH services	4	In-depth interview guide (see appendix 6)	Thematic analysis is used. Themes explored include: experiences in providing SRH and HIV services to migrant women, coping strategies and suggested recommendation

3.7: Ethical considerations

The study observed the established ethical considerations to ensure safety of the participants whilst participating in the study. Ethical clearance for the study was obtained from the Human Research Ethics Committee-Medical of the University of Witwatersrand (Clearance Certificate Number M190601). Permission to use the data was obtained from the SRHR-HIV Knows No Borders Project consortium. In addition, permission was obtained from the Ekurhuleni Health District Research Committee (GP_201909_037). See Appendices 8, 9,10,11,12,13,14 and 15 for ethical clearance documents. All the qualitative study participants were provided with information sheets stating the details of the study and that their participation was voluntary. The right of the participants to withdraw from the study if they were no longer comfortable with participating was clearly explained. Willingness to participate was shown by either signing or thumb printing the consent form and the audio recording form (see Appendix 3). Some of the participants were not comfortable with being audio recorded hence, for those participants notes were written down. To maintain confidentiality, all the information that contained the participant's identity was removed from the transcripts and labelled with codes. Participants were informed that there are no risks that are associated with participating in the study. The benefits of participating will be formulation of favourable policies and programmes that will improve migrant women's access to and therefore utilisation of SRH services.

3.8: Summary

The chapter highlighted the methods used in the PhD research. The study uses mixed methods to achieve the research objectives. The baseline survey data used for the quantitative component of this study was conducted in 10 high migration communities in six Southern African countries, namely Hhohho (Eswatini), Maputsoe (Lesotho), Mwanza and Mchinji (Malawi), Chifunde and Ressano Garcia (Mozambique), Ekurhuleni and Nkomazi (South Africa), Chipata and Katete (Zambia). Qualitative data was collected from Ekurhuleni, South Africa. STATA release 15.0 was used to manage and analyse the quantitative data while NVivo 12 was used to analyse qualitative data.

CHAPTER 4: RESULTS: ACCESS TO SRH SERVICES

4.1: Introduction

This chapter presents the results of the analyses on factors associated with access to sexual and reproductive health (SRH) services. The access to SRH services outcome variables are access to condoms and access to HIV testing services. As such, the chapter presents the distribution of selected characteristics of the respondents broken down by whether or not they accessed SRH services. This chapter provides the results for the first and second objectives of the study as they apply to access to SRH services. The first objective being to examine the level of and differentials in access to SRH services among women in high migration communities in the Kingdom of Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia. The second objective is to identify the factors that are associated with access to SRH services among women in high migration communities in the six countries.

4.2: Access to SRH services

4.2.1: Access to condoms

Table 4.1 shows the percentage distribution of access to condoms among women in high migration communities of the six Southern African countries. It shows that 32.0% of women had no access to condoms. Overall 68.2% of women were non-migrants, with 18.8% being internal migrants and 13.0% being international migrants. Among women who did not have access to condoms, the proportions for non-migrants (66.7%) and internal migrants (17.8%) were lower than the population overall, while for international migrants the proportion was higher (15.5%) than overall. On average women who did not have access to condoms stayed in the community for fewer years (17.0 years; SD 11.0) compared to women who had access to condoms (19.9 years; SD 12.5). This shows that access to condoms was higher among women who stayed longer in the community compared to women who did not stay long in the community.

Overall, 10.9% of women were from Lesotho, 23.2% from Malawi, 18.4% from Mozambique, 18.7% from South Africa, 8.9% from Eswatini and 20.0% from Zambia. Among women who did not have access to condoms, the proportions for women in Lesotho (10.0%), Malawi (20.4%), South Africa (9.1%) and Eswatini (8.6%) were lower than for the overall population while for

women in Mozambique (24.0%) and Zambia (28.1) the proportions were higher than overall. Thus, women in Mozambique and Zambia had a proportionately higher representation among those with no access to condoms, showing that access to condoms was lower among women in Mozambique and Zambia compared to women in Eswatini, Lesotho, Malawi and South Africa. Overall, the average age of women was 25.2 years. Among women who did not have access to condoms, the average age was 22.9 years which is lower than the overall. Thus, access to condoms was lower among younger women compared to the overall.

Overall 53.5% women were never married while 32.2% were married and 14.1% were formerly married. Among women who did not have access to condoms, the proportion was higher (61.8%) for never married women than the population overall while lower for married (26.7%) and formerly married women (11.2%) than the overall. This shows that access to condoms was lower among never married women compared to married and formerly married women. Overall, 39.8% women had primary/lower education while 60.2% had secondary/higher education. Among women who did not have access to condoms, the proportion of women with primary/lower education was higher (48.1%) than the population overall while lower among women with secondary/higher education (51.9%) than the overall. Thus, women with primary/lower education had a proportionately higher representation among those with no access to condoms, showing that access to condoms was lower among women with primary/lower education compared to women with secondary/higher education.

Overall, 53.9% women were unemployed, 46.0% were employed and 0.1% missing. Among women who did not have access to condoms, the proportion was higher among unemployed women (59.7%) than the population overall while lower among employed (40.1%) women than the overall. This shows that unemployed women had a proportionately higher representation among those with no access to condoms, meaning that access to condoms was lower among unemployed women compared to employed women. Regarding religion, overall, Catholic women were 33.3%, Other Christians 56.7% and Other Religion 10.0%. Among those who did not have access to condoms, the proportion was higher among Catholics (35.1%) and Other Christians (57.9%) than the population overall while lower among Other Religion (6.9%). This shows that access to condoms was lower among Catholics and Other Christians compared to women of Other Religion.

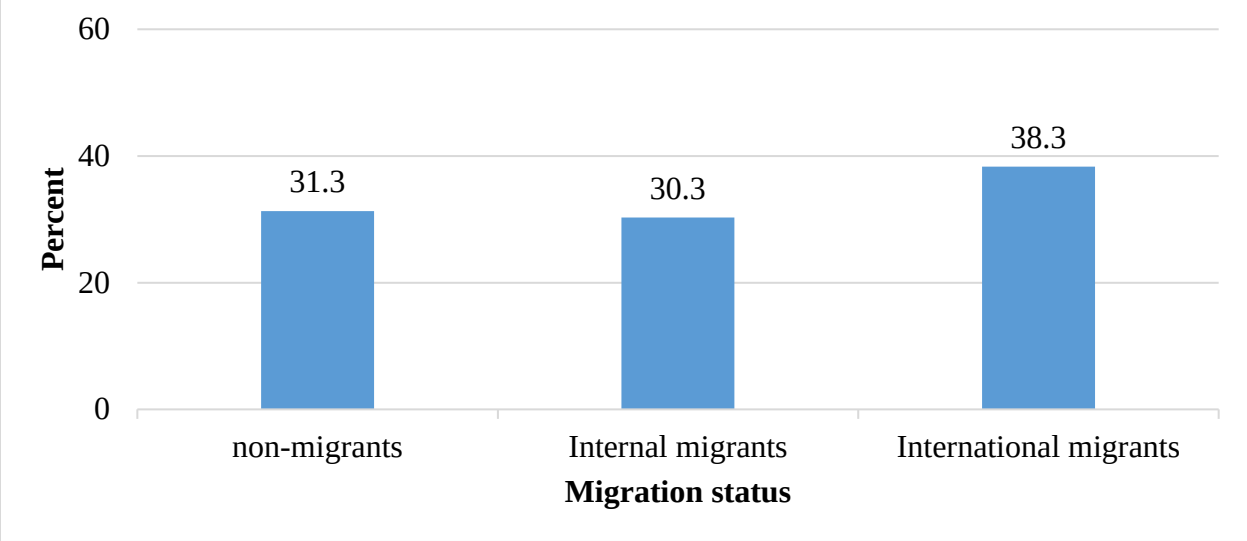
On average, the overall score on comprehensive knowledge about SRH was 0.85(SD 0.48). Among women who do not have access to condoms, the score was lower on average (0.73; SD 0.54) than the overall. Thus, women who did not have access to condoms had a lower score on comprehensive knowledge about SRH on average. Similarly, on average, the overall score on comprehensive knowledge about HIV was 2.28(SD 0.92). Among women who do not have access to condoms, the score was lower on average 2.02(SD 1.09) than the overall. Thus, women who did not have access to condoms had a lower score on comprehensive knowledge about HIV on average. Overall, 14.9% women had partners with primary/lower education, 48.1% had secondary/higher education and 10.0% were missing. Among women who did not have access to condoms, the proportion was higher among women who had partners with primary/lower education (57.6%) than the overall proportion. This shows that access to condom was lower among women who had partners with primary/lower education compared to women who had partners with secondary/higher education. On average, the overall score on SRH decision making power was 3.2(SD 1.6). Among women who did not have access to condoms, the score was lower on average (2.7; SD 1.7) than the overall. Thus, women who did not have access to condoms had a lower score on SRH decision making power SRH on average.

Table 4.1: Distribution of participants' characteristics by access to condoms in high migration communities of six Southern African countries.

Variable	Level	Total (%)	Access to condoms n (%)	No access to condoms n (%)
		2070(100.0)	1407 (68.0)	663(32.0)
Migration status	Non-migrants	1411(68.2)	969(68.9)	442(66.7)
	Internal migrants	390(18.8)	272(19.3)	118(17.8)
	International migrants	269(13.0)	166(11.8)	103(15.5)
Duration of stay in community	Mean (SD)	19.0(12.1)	19.9(12.5)	17.0(11.0)
Country	Lesotho	226(10.9)	160(11.4)	66(10.0)
	Malawi	480(23.2)	345(24.5)	135(20.4)
	Mozambique	381(18.4)	222(15.8)	159(24.0)
	South Africa	387(18.7)	327(23.2)	60(9.1)
	Eswatini	185(8.9)	128(9.1)	57(8.6)
	Zambia	411(20.0)	225(16.0)	186(28.1)
Age	Mean (SD)	25.2(8.5)	26.2(8.4)	22.9(8.1)
Marital status	Never married	1108(53.5)	698(49.6)	410(61.8)
	Married	666(32.2)	489(34.8)	177(26.7)
	Formerly married	292(14.1)	218(15.5)	74(11.2)
	Missing	4(0.2)	2(0.1)	2(0.3)
Educational level	Primary/lower	824(39.8)	505(35.9)	319(48.1)
	Secondary/higher	1246(60.2)	902(64.1)	34(51.9)
Employment status	Unemployed	1115(53.9)	719(51.1)	396(59.7)
	Employed	953(46.0)	687(48.8)	266(40.1)
	Missing	2(0.1)	1(0.1)	1(0.2)
Religion	Catholic	689(33.3)	456(32.4)	233(35.1)
	Other Christians	1174(56.7)	790(56.2)	384(57.9)
	Other religion	207(10.0)	161(11.4)	46(6.9)
Comprehensive knowledge about SRH	Mean (SD)	0.85(0.48)	0.90(0.43)	0.73(0.54)
Comprehensive knowledge about HIV	Mean (SD)	2.28(0.92)	2.40(0.80)	2.02(1.09)
Partner's age	<=24	412(19.9)	288(20.5)	124(18.7)
	25-34	491(23.7)	375(26.7)	116(17.5)
	>=35	341(16.5)	283(20.1)	58(8.8)
	Don't know	353(17.1)	225(16.0)	128(19.3)
	Missing	473(22.9)	236(16.8)	237(35.8)
Partner's educational level	Primary/lower	868(41.9)	486(34.5)	382(57.6)
	Secondary/higher	994(48.1)	786(56.0)	208(31.4)
	Missing	208(10.0)	135(9.6)	73(11.0)
Partner's occupation	No occupation	125(6.0)	94(6.7)	31(4.7)
	Agriculture	188(9.1)	125(8.9)	63(9.5)
	Technical/managerial	269(13)	222(15.8)	47(7.1)
	Skilled manual	362(17.5)	279(19.8)	83(12.5)
	Unskilled manual	595(28.7)	425(30.2)	170(25.6)
	Missing	531(25.7))	262((18.6)	269(40.5)
SRH decision making power	Mean (SD)	3.2(1.6)	3.4(1.5)	2.7(1.7)
Experience of intimate Partner Violence (IPV)	No	1130(54.6)	823(58.6)	307(46.3)
	Yes	503(24.4)	360(25.6)	143(21.6)
	Missing	437(21.0)	224(15.8)	213(32.1)

Figure 4.1: shows the prevalence of non-access to condoms by migration status. The prevalence was highest among international migrant women (38.3%) followed by non-migrant women (31.3%) and lowest among internal migrant women (30.3%).

Figure 4.1: The prevalence of non-access to condoms among women in high migration communities in six Southern African countries, 2018



Prevalence of access to condoms

Table 4.2 shows the prevalence of access to condoms by women in high migration communities. The prevalence of not having access to condoms was higher (45.3%) for women in Zambia and lower (15.5%) for women in South Africa. As expected, the prevalence of not having access to condoms was high among women with primary/lower education 38.7% and low among women with secondary/higher education 27.6%. The prevalence of not accessing condoms was highest among never married women 37.0% and lowest among formerly married women 25.3%. The prevalence of non-access to condoms was also high among unemployed women 35.5% and low among employed women 27.9%. In terms of religion, the prevalence of non-access to condoms was highest among Catholics (33.8%), followed by Other Christians (32.7%) and lowest among Other Religion (22.2%).

The prevalence of non-access to condoms was highest among women who did not know their partner's age (36.3%) followed by women who had partners aged 24 years or below (30.1%) and lowest among women who had partners aged 35 years and above (17.0%). Non-access to condoms was high among women with partners who had primary/lower education (44.0%) and low among women with partners who had secondary/higher education (20.9%). Regarding partner's occupation, non-access to condoms was higher among women with partners in Agriculture (33.5%) and lower among women with partners in technical/managerial (17.5%).

Table 4.2: Prevalence of access to condoms among women in high migration communities of six Southern African countries.

Variable	Level	Total	Have access to condoms	No access to condoms
			1407(68.0)	663(32.0)
Migration status	Non-migrant	1411	969(68.7)	442(31.3)
	Internal Migrant	390	272(69.7)	118(30.3)
	International migrant	269	166(61.7)	103(38.3)
Country	Lesotho	226	160(70.8)	66(29.2)
	Malawi	480	345(71.9)	135(28.1)
	Mozambique	381	222(58.3)	159(41.7)
	South Africa	387	327(84.5)	60(15.5)
	Swaziland	185	128(69.2)	57(30.8)
	Zambia	411	225(54.7)	186(45.3)
Educational level	Primary/lower	810	498(61.5)	312(38.5)
	Secondary/higher	1246	902(72.4)	344(27.6)
Marital status	Never married	1108	698(63.0)	410(37.0)
	Married	666	489(73.0)	177(26.6)
	Formerly married	292	218(74.7)	74(25.3)
Religion	Catholic	689	456(66.2)	233(33.8)
	Other Christians	1174	790(67.3)	384(32.7)
	Other religion	207	161(77.8)	46(22.2)
Employment status	Employed	953	687(72.1)	266(27.9)
	Unemployed	1115	719(64.5)	396(35.5)
Partner's age	<=24	412	288(69.9)	124(30.1)
	25-34	491	375(76.4)	116(23.6)
	>=35	341	283(83.0)	58(17.0)
	Don't know	353	225(63.7)	128(36.3)
Partner's education	Primary/lower	868	486(56.0)	382(44.0)
	Secondary/higher	994	786(79.1)	208(20.9)
Partner's occupation	No occupation	125	94(75.2)	31(24.8)
	Agriculture	188	125(66.5)	63(33.5)
	Technical/managerial	269	222(82.5)	47(17.5)
	Skilled manual	362	279(77.1)	83(22.9)
	Unskilled manual	595	425(71.4)	170(28.6)
Experience of IPV	Yes	503	360(71.6)	143(28.4)
	No	1130	823(72.8)	307(27.2)

Factors associated with non-access to condoms

Table 4.3 shows the factors associated with not being able to access to condoms by all women in high migration communities. The results show no significant association between migration status and non-access to condoms (P=0.153). Country was significantly associated with not being able to access condoms (P<0.001). After adjusting for other factors, women from Lesotho (aOR=3.24; 95% CI 2.06-5.11), Malawi (aOR=3.13; 95% CI 2.10-4.66), Mozambique (aOR=2.95; 95% CI 1.99-4.36), Swaziland (aOR=3.41; 95% CI 2.17-5.35) and Zambia (aOR=5.10; 95% CI 3.46-7.52) had higher odds of not being able to access condoms compared to women from South Africa. Age was strongly associated with non-access to condoms (P<0.001). The odds of not being able to access condoms decreased by 19 % with a five year increase in age (aOR=0.81; 95% CI 0.73-0.90). There was a significant association between educational level and non-access to condoms (P=0.018). In the adjusted model, compared to women with primary/lower education, the odds of not accessing condoms were 26% lower among women with secondary/higher education (aOR=0.74; 95% CI 0.59-0.93). Lack of comprehensive knowledge about SRH was strongly associated with non-access to condoms (P<0.001). The odds of not being able to access condoms decreased by 36 % with a unit increase in comprehensive knowledge about SRH (aOR=0.64; 95% CI 0.51-0.80). Similarly, Comprehensive knowledge about HIV was strongly associated with non-access to condoms (P<0.001). The odds of not accessing condoms decreased by 32% with a unit increase in comprehensive knowledge about HIV (aOR=0.68; 95% CI 0.60-0.77).

The association between marital status and non-access to condoms was marginally significant (P=0.09). After controlling for other factors, married and formerly married women had 24 % and 28% lower odds of not accessing condoms compared to never married women (aOR=0.76; 95% CI 0.58-0.99) and (aOR=0.72; 95% CI 0.50-1.03) respectively. Employment status was marginally associated with non-access to condoms (P=0.066). Similarly, religion was marginally associated with non-access to condoms (P=0.050).

Table 4.3: Factors associated with non-access to condoms among all women in high migrant communities of six Southern African countries.

Variable	Level	Unadjusted OR (95% CI)	Adjusted OR (95% CI)	LR P-value
			N=2052	
Migration status	Non-migrant	1.00	1.00	0.153
	Internal	0.95(0.75-1.21)	1.06(0.69-1.63)	
	International	1.36(1.04-1.78)	1.47(0.93-2.34)	
Duration of stay in community	Per 5 year increase	1.00(1.00-1.00)	0.99(0.91-1.09)	0.934
Country	South Africa	1.00	1.00	P<0.001
	Lesotho	2.25(1.51-3.35)	3.24(2.06-5.11)	
	Malawi	2.13(1.52-3.00)	3.13(2.10-4.66)	
	Mozambique	3.90(2.77-5.50)	2.95(1.99-4.36)	
	Eswatini	2.43 (1.60-3.68)	3.41(2.17-5.35)	
	Zambia	4.51(3.22-6.31)	5.10(3.46-7.52)	
Age	Per 5 year increase	0.95(0.94-0.96)	0.81(0.73-0.90)	P<0.001
Marital status	Never married	1.00	1.00	0.09
	Married	0.62(0.50-0.76)	0.76(0.58-0.99)	
	Formerly married	0.58(0.43-0.77)	0.72(0.50-1.03)	
Educational level	Primary/lower	1.00	1.00	0.018
	Secondary/higher	0.60(0.50-0734)	0.74(0.59-0.93)	
Employment status	Employed	1.00	1.00	0.067
	Unemployed	1.42(1.18-1.72)	1.21(0.97-1.50)	
Religion	Catholic	1.00	1.00	0.050
	Other Christians	0.95(0.78-1.16)	1.10(0.88-1.37)	
	Other religion	0.56(0.39-0.80)	0.68(0.45-1.04)	
Comprehensive knowledge about SRH	Per unit increase	0.48(0.39-0.58)	0.64(0.51-0.80)	P<0.001
Comprehensive knowledge about HIV	Per unit increase	0.65(0.59-0.72)	0.68(0.60-0.77)	P<0.001

*CI=Confidence interval; LR =Likelihood test ratio

Factors associated with non-access to condoms among partnered women

Table 4.4 shows the factors associated with non-access to condoms in a sub-analysis restricted to women who were partnered. After controlling for other factors, there was no evidence of an association between migration status and non-access to condoms (P=0.553). There was a strong association between country and non-access to condoms (P<0.001). Compared to women in South Africa, women in Lesotho (aOR=6.28; 95% CI 2.37-16.59), Malawi (aOR=4.47; 95 % CI 1.72-11.60), Mozambique (AOR=3.57; 95% CI 1.38-9.27), Eswatini (aOR=6.43; 95% CI 2.38-17.36) and Zambia (aOR=4.56; 95% CI 1.71-12.17) had higher odds of non-access to condoms. Comprehensive knowledge about SRH was significantly associated with non-access to condoms (P=0.002). The odds of not being able to access condoms decreased by 45% with a unit increase

in comprehensive knowledge about SRH (aOR=0.55; 95% CI 0.38-0.80). Similarly, comprehensive knowledge about HIV was significantly associated with non-access to condoms (P=0.002). With a unit increase in comprehensive knowledge about HIV the odds of non-access to condoms decreased by 18% (aOR=0.82; 95% CI 0.72-0.93). There was a strong association between SRH decision making power and non-access to condoms (P=0.001). The odds of not being able to access condoms decreased by 28% with a unit increase in SRH decision making power (aOR=0.72; 95% CI 0.59-0.89).

Partner's age was significantly associated with non-access to condoms (P=0.05). Compared to women whose partners were aged 24 years and below, women with partners aged 35 years and above had 46% lower odds of not being able to access condoms (aOR=0.54; 95% CI 0.31-0.97). Partner's educational level was significantly associated with non-access to condoms (P=0.011). Compared to women who had partners with primary or lower education, women who had partners with secondary/higher education had 40% lower odds of not being able to access condoms (aOR=0.60; 95% CI 0.41-0.89). Experience of IPV in the last 12 months was marginally associated with non-access to condoms (P=0.057).

Table 4.4: Factors associated with non-access to condoms among partnered women in high migration communities of six Southern African countries

Variable	Level	Unadjusted OR(95% CI)	Adjusted OR(95% CI)	LR P-value
			N= 987	
Migration status	Non-migrant	1.00	1.00	0.553
	Internal	0.97(0.73-1.29)	0.90(0.43-1.87)	
	International	1.25(0.90-1.72)	1.26(0.57-2.80)	
Duration of stay in the community	Per 5 year increase	0.94(0.90-0.98)	0.89(0.77-1.04)	0.111
Country	South Africa	1.00	1.00	P<0.001
	Lesotho	4.07(2.38-6.97)	6.28(2.37-16.59)	
	Malawi	3.10(1.87-5.15)	4.47(1.72-11.60)	
	Mozambique	5.62(3.38-9.33)	3.57(1.38-9.27)	
	Eswatini	4.19(2.40-7.29)	6.43(2.38-17.36)	
	Zambia	5.66(3.40-9.42)	4.56(1.71-12.17)	
Age	Per 5 year increase	0.86(0.80-0.93)	0.95(0.81-1.13)	0.458
Marital status	Never married	1.00	1.00	0.392
	married	0.99(0.78-1.26)	1.32(0.87-1.99)	
	Formerly married	0.94(0.68-1.29)	1.10(0.63-1.92)	
Educational level	Primary/lower	1.00	1.00	0.396
	Secondary/higher	0.62 (0.49-0.77)	0.82(0.57-1.19)	
Employment status	Employed	1.00	1.00	0.748
	Unemployed	1.18(0.94-1.47)	1.08(0.77-1.51)	
Religion	Catholic	1.00	1.00	0.190
	Other Christians	1.08(0.67-1.76)	1.39(0.97-2.00)	
	Other religion	2.11(0.73-6.14)	0.98(0.48-2.01)	
Comprehensive knowledge about SRH	Per unit increase	0.51(0.40-0.65)	0.55(0.38-0.80)	0.002
Comprehensive knowledge about HIV	Per unit increase	0.63(0.56-0.71)	0.72(0.59-0.89)	0.002
SRH decision making power	Per unit increase	0.83(0.81-1.05)	0.82(0.73-0.93)	0.001
Partner's age	<=24	1.00	1.00	0.051
	25-34	0.72(0.53-0.97)	0.86(0.57-1.29)	
	>=35	0.48(0.33-0.68)	0.54(0.31-0.97)	
	Don't know	1.32(0.98-1.79)	1.16(0.68-1.96)	
Partner's educational level	Primary/lower	1.00	1.00	0.011
	Secondary/higher	0.46(0.37-0.582)	0.60(0.41-0.89)	
Partner's occupation	No occupation	1.00	1.00	0.417
	Agriculture	1.40(0.84-2.34)	1.39(0.70-2.77)	
	Technical/managerial	0.58(0.34-0.98)	1.34(0.66-2.73)	
	Skilled manual	0.83(0.51-1.34)	1.29(0.67-2.46)	
	Unskilled manual	1.10(0.70-1.73)	0.92(0.51-1.69)	
Experience of IPV	Yes	1.00	1.00	0.057
	No	0.97(0.75-1.25)	1.44(0.98-2.11)	

4.2.2: Access to HIV testing services

Table 4.5 shows that 9.8 % women reported not having access to HIV testing services while 90.2% had access to HIV testing services. Overall, 68.2% were non-migrants, 18.8% were internal migrants and 13.0% were international migrants. Among women who did not have access to HIV testing services, the proportions for non-migrants (67.3%) and internal migrants (10.4%) were lower than for the population overall, while for international migrants the proportion was higher (22.3%) than overall. Thus international migrants had a proportionately higher representation among those with no access to HIV testing services, showing that access to HIV testing services was lower among the international migrants compared to non-migrants and internal migrants. Overall, the average duration of stay in the community was 18.9 years (SD 12.1). Among women who did not have access to HIV testing services, the average duration of stay was 17.7 years (SD 11.5) lower than the overall duration of stay. Thus, women who stayed for shorter years in the community had a proportionately lower representation among those with no access to HIV testing services, showing that access to HIV testing services was higher among women who stayed in the community for few years on average.

Overall, 10.9% women were in Lesotho, 23.2% in Malawi, 18.4% in Mozambique, 18.7% in South Africa, 8.9% in Eswatini and 20.0% in Zambia. Among women who did not have access to HIV testing services, the proportions for women in Lesotho (5.9%), Malawi (2.5%), Eswatini (1.5%) and Zambia (17.8%) were lower than the population overall, while for women in Mozambique (53.5%) and South Africa (18.8%) the proportion was higher than the overall. Thus, women in Mozambique and South Africa had a proportionately higher representation among women with no access to HIV testing services, showing that access to HIV testing services was lower among women in Mozambique and South Africa compared to women in Lesotho, Malawi, Eswatini and Zambia. Overall the average age of women was 25.1 years (SD 8.5). Among women who did not have access to HIV testing services, the average age (23.7; SD 8.9) was lower than the overall, implying that access to HIV testing services was lower among younger women compared to the overall.

Overall, 53.5% of women were never married, 32.2% were married and 14.1% were formerly married. Among women who did not have access to HIV testing services, the proportions for married women (23.3%) and formerly married women (11.9%) were lower than the population

overall, while for never married women the proportion was higher (63.9%) than overall. Thus never married women had had a proportionately higher representation among those with no access to HIV testing services. This shows that access to HIV testing services was lower among never married women compared to married and formerly married women. Overall, 39.3% women had primary/lower education and 60.2% had secondary/higher education. Among women who did not have access to HIV testing services, the proportion for women with primary/lower education was higher (66.0%) than the population overall, while for women with secondary/higher education the proportion was lower (33.7%) than overall. Thus women with primary/lower education had a proportionately higher representation among those with no access to HIV testing services, showing that access to HIV testing services was lower among women with primary/lower education.

Concerning employment status, overall 53.9% women were unemployed while 46.0% were employed. Among women who did not have access to HIV testing services, the proportion for unemployed women was higher (57.9%) than the population overall, while for employed women the proportion was lower (46.0%) than overall. Thus unemployed women had a proportionately higher representation among those with no access to HIV testing services, showing that access to HIV testing services was lower among unemployed women compared to employed women. Regarding religion, overall, 33.3% women were Catholics, 56.7% were Other Christians and 10.0% belonged to other religion. Among women who did not have access to HIV testing services, the proportion for Catholic women (33.3%) was the same as the population overall, for Other Christians the proportion was lower (52.2%) than overall while, for Other Religion the proportion was higher (14.4%) than the population overall. Thus women who belonged to Other Religion had a proportionately higher representation among those with no access to HIV testing services, showing that access to HIV testing services was lower among women who belonged to Other Religion compared to Catholics and other Christians.

As expected, women who did not have access to HIV testing services had a lower score on comprehensive knowledge about SRH (0.45; SD 0.51) on average compared to women who had access to HIV testing services (0.89; SD 0.45). Similarly, women who did not have access to HIV testing services had a lower score on comprehensive knowledge about HIV (0.80; SD 1.11) on average compared to women who had access to HIV testing services (2.44; SD 0.73). Regarding partner characteristics, although the overall proportion of women whose partners had

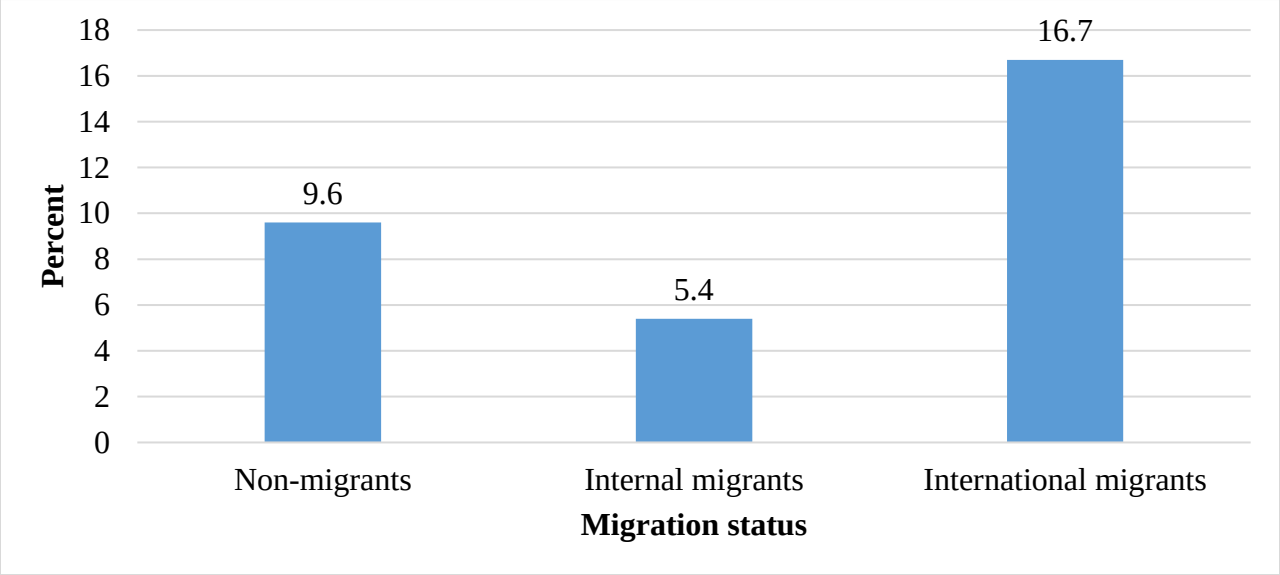
secondary/higher education was higher (48.1%) than those whose partners had primary/lower education, among those who did not have access to HIV testing services, the proportion was much higher (71.6%) for women whose partners had primary/lower education and proportionately lower for women whose partners had secondary/higher education (18.9%). Overall, 6.1% women had partners with no occupation, 9.1% with partners in agriculture, 13.0% with partners in technical/managerial, 17.5% with partners in skilled manual and 28.8% with partners in unskilled manual. Among women who did not have access to HIV testing services, the proportions were lower for women with partners with no occupation (2.5%), in agriculture (6.0%), in technical/managerial (6.0%), in skilled manual (10.0%) and in unskilled manual (17.9%), while higher among the missing category (57.7%). The missing category consists of women who reported not having a partner at the time of the survey and women who reported having a partner but did not provide any information regarding the partner's occupation.

Table 4.5: Distribution of respondents' characteristics by access to HIV testing services in high migration communities of six Southern African countries.

Variable	Level	Total (%)	Access to HIV testing	No access to HIV testing
		N=2070	n=1868(90.2)	n=202(9.8)
Migration status	Non-migrants	1411(68.2)	1275(68.2)	136(67.3)
	Internal migrants	390(18.8)	369(19.8)	21(10.4)
	International migrants	269(13.0)	224(12.0)	45(22.3)
Duration of stay in the community	Mean (SD)	18.9(12.1)	19.1(12.2)	17.7(11.5)
Country	Lesotho	226(10.9)	214(11.5)	12(5.9)
	Malawi	480(23.2)	475(25.4)	5(2.5)
	Mozambique	381(18.4)	273(14.6)	108(53.5)
	South Africa	387(18.7)	349(18.7)	38(18.8)
	Eswatini	185(8.9)	183(9.7)	3(1.5)
	Zambia	411(20.0)	375(20.1)	36(17.8)
Age	Mean (SD)	25.1(8.5)	25.3(8.4)	23.7(8.9)
Marital status	Never married	1108(53.5)	979(52.4)	129(63.9)
	Married	666(32.2)	619(33.1)	47(23.3)
	Formerly married	292(14.1)	268(14.4)	24(11.9)
Educational level	Primary/lower	807(39.3)	677(36.5)	130(66.0)
	Secondary/higher	1246(60.2)	1178(63.2)	68(33.7)
	Missing	14(0.7)	10(0.5)	4(2.0)
Employment status	Unemployed	1115(53.9)	998(53.4)	117(57.9)
	Employed	953(46.0)	868(46.5)	85(42.1)
	Missing	2(0.1)	2(0.1)	0(0.0)
Religion	Catholic	687(33.3)	620(33.2)	67(33.3)
	Other Christians	1172(56.7)	1067(57.2)	105(52.2)
	Other	207(10.0)	178(9.5)	29(14.4)
Comprehensive knowledge about SRH	Mean (SD)	0.85(0.48)	0.89(0.45)	0.45(0.51)
Comprehensive knowledge about HIV	Mean (SD)	2.28(0.92)	2.44(0.73)	0.80(1.11)
Partner's age	<=24	412(19.9)	390(20.9)	22(10.9)
	25-34	491(23.7)	470(25.2)	21(10.4)
	>=35	341(16.5)	318(17.0)	23(11.4)
	Don't know	353(17.1)	304(16.3)	49(24.3)
	Missing	473(22.9)	386(20.7)	87(43.1)
Partner's educational level	Primary/lower	865(41.9)	721(38.7)	144(71.6)
	Secondary/higher	994(48.1)	956(51.3)	38(18.9)
	Missing	207(10.0)	188(10.1)	19(9.4)
Partner's occupation	No occupation	125(6.1)	120(6.4)	5(2.5)
	Agriculture	187(9.1)	175(9.4)	12(6.0)
	Technical/managerial	269(13.0)	257(13.8)	12(6.0)
	Skilled manual	362(17.5)	342(18.3)	20(10.0)
	Unskilled manual	595(28.8)	559(30.0)	36(17.9)
	Missing	528(22.1)	412(22.1)	116(57.7)
SRH decision making power	Mean (SD)	3.2(1.6)	3.1(1.5)	3.4(1.4)

Figure 4.2 shows the prevalence of non-access to HIV testing services by migration status. The prevalence of non-access to HIV testing services was highest among international migrant women (16.7%) followed by non-migrant women (9.6%) and lowest among internal migrant women (5.4%).

Figure 4.2: The prevalence of non-access to HIV testing services among women in high migration communities in six Southern African countries, 2018



Prevalence of non-access to HIV testing services among women

Table 4.6 shows the prevalence of access to HIV testing services among women in high migration communities. In the six countries, the prevalence of not being able to access HIV testing services was higher among women in Mozambique (28.4%) and lower among women in Malawi (1.1%). The prevalence of non-access to HIV testing services was highest among never married women (11.6%) and lowest among married women (7.1%). As expected, the prevalence of non-access to HIV testing services was high among women with primary/lower education (16.1%) and low among women with secondary/higher education (5.5%). It was also high among unemployed women (10.5%) and low among employed women (8.9%).The prevalence of non-access to HIV testing services was highest among Other Religion (14.0%) and lowest among Other Christians (9.0%).

Regarding partner's characteristics, the prevalence of non-access to HIV testing services was highest among women who did not know their partner's age (13.9%) and lowest among women who had partners aged 25-34 years (4.3%). Non-access to HIV testing services was high among women with partners who had primary/lower education (16.6%) and low among women with partners who had secondary/higher education (3.8%). The prevalence of non-access to HIV testing services was higher among women with partners in unskilled manual (6.0%) and lower among women with partners who had no occupation (4.0%).

Table 4.6: Prevalence of non-access to HIV testing services among women in high migration communities of six Southern African countries.

Variable	Level	Total	Access to HIV testing	No access to HIV testing
		2070	**1868(90.2)**	**202(9.8)**
Migration status	Non-migrants	1411	1275(90.4)	136(9.6)
	Internal migrants	390	369(94.6)	21(5.4)
	International migrants	269	224(83.3)	45(16.7)
Country	Lesotho	226	214(94.7)	12(5.3)
	Malawi	480	475(99.0)	5(1.0)
	Mozambique	381	273(71.7)	108(28.4)
	South Africa	387	349(90.2)	38(9.8)
	Swaziland	185	182(98.4)	3(1.6)
	Zambia	411	375(91.2)	36(8.8)
Educational level	Primary/lower	810	680(84.0)	130(16.0)
	Secondary/higher	1246	1178(94.5)	68(5.5)
Marital status	Never married	1108	979(88.4)	129(11.6)
	Married	666	619(92.9)	47(7.1)
	Formerly married	292	268(91.8)	24(8.2)
Employment status	Employed	953	868(91.1)	85(8.9)
	Unemployed	1115	998(89.5)	117(10.5)
Religion	Catholic	689	622(90.3)	67(9.7)
	Other Christians	1174	1068(91.0)	106(9.0)
	Other religion	207	178(86.0)	29(14.0)
Partner's age	<=24	412	390(94.7)	22(5.3)
	25-34	491	470(95.7)	21(4.3)
	>=35	341	318(93.3)	23(6.7)
	Don't know	353	304(86.1)	49(13.9)
Partner's educational level	Primary/lower	868	724(83.4)	144(16.6)
	Secondary/higher	994	956(96.2)	38(3.8)
Partner's occupation	No occupation	125	120(96.0)	5(4.0)
	Agriculture	188	176(93.6)	12(4.5)
	Technical/managerial	269	257(95.5)	12(4.5)
	Skilled manual	362	342(94.5)	20(5.5)
	Unskilled manual	595	559(94.0)	36(6.0)

Factors associated with non-access to HIV testing services

Table 4.7 shows the factors associated with non-access to HIV testing services among women in high migration communities. In the adjusted model, migration status was significantly associated with non-access to HIV testing services (P=0.046). The odds of not having access to HIV testing services among international migrants were higher compared to non-migrant women (aOR=2.31; 95% CI 0.95-5.43). There was a strong association between country and non-access to HIV testing

services (P<0.001). After controlling for other factors, women in Malawi (aOR=0.24; 95% CI 0.08-0.73) and women in Eswatini (aOR=0.19; 95% CI 0.05-0.74) had lower odds of not having access to HIV testing services compared to women in South Africa. Educational level was significantly associated with non-access to HIV testing services (P=0.004). Women with secondary/higher education had 51% lower odds of not having access to HIV testing services compared to women with primary/lower education after controlling for other factors (aOR=0.49; 95% CI 0.30-0.79). There was a significant association between comprehensive knowledge about SRH and non-access to HIV testing services (P=0.005). After adjusting for other factors, with a unit increase in comprehensive knowledge about SRH, the odds of not having access to HIV testing services decreased by 44% (aOR=0.56; 95% CI 0.38-0.84). Similarly, comprehensive knowledge about HIV was strongly associated with non-access to HIV testing services (P<0.001). A unit increase in comprehensive knowledge about HIV decreased the odds of not having access to HIV testing services by 76% (aOR=0.24; 95% CI 0.19-0.29).

In addition, marital status was marginally associated with non-access to HIV testing services in the adjusted model (P=0.05). Compared to never-married women, the odds of not having access to HIV testing services were 45% lower for married women (aOR=0.55; 95% CI 0.31-0.97) and 54% lower for formerly married women (aOR=0.46; 95% CI 0.22-0.97). Although the importance of age, religion, employment status and duration of stay in the community is documented in the literature, these factors were not significantly associated with non-access to HIV testing services.

Table 4.7: Factors associated with non-access to HIV testing services among all women in high migrant communities of six Southern African countries

Variable	Level	Unadjusted OR (95% CI)	Adjusted OR (95% CI)	LR P-value
			N=2052	
Migration status	Non-migrant	1.00	1.00	0.046
	Internal migrants	0.53(0.33-0.86)	0.81(0.35-1.89)	
	International migrants	1.88(1.31-2.72)	2.17(0.93-5.06)	
Duration of stay in days	Per 5 year increase	0.96(0.90-1.02)	1.13(0.94-1.35)	0.19
Country	South Africa	1.00	1.00	P<0.001
	Lesotho	0.53(0.27-1.04)	0.88(0.37-2.09)	
	Malawi	0.10(0.04-0.26)	0.24(0.08-0.73)	
	Mozambique	3.73(2.49-5.60)	1.60(0.84-306)	
	Eswatini	0.16(0.05-0.51)	0.19(0.05-0.74)	
	Zambia	0.91(0.56-1.47)	0.89(0.44-1.79)	
Age	Per 5 year increase	0.88(0.80-0.97)	0.91(0.75-1.11)	0.34
Marital status	Never married	1.00	1.00	0.05
	Married	0.58(0.41-0.82)	0.55(0.31-0.97)	
	Formerly married	0.68(0.43-1.07)	0.46(0.22-0.97)	
Educational level	Primary/lower	1.00	1.00	0.004
	Secondary/higher	0.09(0.06-0.14)	0.49(0.30-0.79)	
Employment status	Employed	1.00	1.00	0.61
	Unemployed	1.20(0.89-1.61)	1.11(0.72-1.73)	
Religion	Catholic	1.00	1.00	0.93
	Other Christians	0.91(0.66-1.26)	1.07(0.68-1.70)	
	Other religion	1.51(0.95-2.40)	0.99(0.49-2.00)	
Comprehensive knowledge about SRH	Per unit increase	0.16(0.12-0.22)	0.56(0.38-0.84)	0.005
Comprehensive knowledge about HIV	Per unit increase	0.18(0.15-0.22)	0.24(0.19-0.29)	P<0.001

Factors associated with non-access to HIV testing services

Table 4.8 shows the factors associated with non-access to HIV testing services in a sub-analysis restricted to women who were partnered. There was a marginal association between migration status and non-access to HIV testing services after adjusting for other factors (P=0.09). After controlling for other factors country was strongly associated with non-access to HIV testing services (P<0.001). Compared to women in South Africa, women in Malawi (aOR=0.06; 95% CI 0.01-0.56) and Zambia (aOR=0.11; 95% CI 0.02-0.72) had lower odds of not being able to access HIV testing services.

Comprehensive knowledge about SRH was significantly associated with non-access to HIV testing services (P=0.045). A unit increase in comprehensive knowledge about SRH decreased the odds of non-access to HIV testing services by 56% (aOR=0.44; 95% CI 0.20-0.97). There was a strong association between comprehensive knowledge about HIV and non-access to HIV testing services (P<0.001). The odds of not being able to access HIV testing services decreased by 61% with a unit increase in comprehensive knowledge about HIV (aOR=0.39; 95% CI 0.27-0.56). None of the partner characteristic variables was significantly associated with non-access to HIV testing services. Similarly neither SRH decision making power nor experience of IPV in the last 12 months were significantly associated with non-access to HIV testing services.

Table 4.8: Factors associated with non-access to HIV testing services among partnered women in high migration communities of six Southern African countries

Variable	Level	Unadjusted OR (95% CI)	Adjusted OR (95% CI)	LR P-value
			N=987	
Migration status	Non-migrant	1.00	1.00	0.09
	Internal	0.47(0.25-0.90)	1.44(0.28-7.38)	
	International migrants	2.29(1.47-3.59)	4.58(0.83-25.1)	
Duration of stay in community	Per 5 year increase	1.00(0.93-1.08)	1.32(0.97-1.80)	0.09
Country	South Africa	1.00	1.00	P<0.001
	Lesotho	0.63(0.29-1.36)	0.38(0.08-1.68)	
	Malawi	0.06(0.01-0.26)	0.06(0.01-0.56)	
	Mozambique	3.41(1.98-5.86)	1.33(0.39-4.51)	
	Eswatini	0.20(0.06-0.70)	0.31(0.05-1.96)	
	Zambia	0.55(0.26-1.13)	0.11(0.02-0.72)	
Age	Per 5 year increase	1.02(0.92-1.14)	0.77(0.53-1.12)	0.17
Marital status	Never married	1.00	1.00	0.27
	Married	1.01(0.66-1.54)	1.92(0.70-5.29)	
	Formerly married	1.12(0.66-1.90)	0.91(0.22-3.74)	
Educational level	Primary/lower	1.00	1.00	0.32
	Secondary/higher	0.32(0.21-0.47)	0.61(0.23-1.61)	
Employment status	Employed	1.00	1.00	0.84
	Unemployed	0.94(0.64-1.37)	0.92(0.41-2.08)	
Religion	Catholic	1.00	1.00	0.45
	Other Christians	0.60(0.25-1.46)	0.61(0.25-1.53)	
	Other religion	0.81(0.10-6.59)	0.45(0.10-1.92)	
Comprehensive knowledge about SRH	Per unit increase	0.17(0.11-0.24)	0.44(0.20-0.97)	0.045
Comprehensive knowledge about HIV	Per unit increase	0.17(0.14-0.22)	0.39(0.27-0.56)	P<0.001
SRH decision making power	Per unit increase	1.19(0.99-1.43)	1.16(0.82-1.64)	0.41
Partner's characteristics				
Partner's age	<=24	1.00	1.00	0.61
	25-34	0.79(0.43-1.46)	1.24(0.39-3.96)	
	>=35	1.28(0.70-2.34)	0.93(0.25-3.42)	
	Don't know	2.861.69-4.83)	2.05(0.60-6.10)	
Partner's educational level	Primary/lower	1.00	1.00	0.12
	Secondary/higher	0.28(0.18-0.41)	0.45(0.16-1.27)	
Partner's occupation	No occupation	1.00	1.00	0.36
	Agriculture	1.13(0.26-4.94)	0.99(0.13-7.49)	
	Technical/managerial		4.92(0.66-36.76)	
	Skilled manual		2.93(0.43-20.04)	
	Unskilled manual		1.85(0.31-11.06)	
Experience of IPV	Yes	1.00	1.00	0.14
	No	1.31(0.81-2.11)	0.51(0.21-1.26)	

4.3: Summary of chapter

This chapter presented the level of and differentials in access to SRH services among women in high migration communities in six Southern African countries. In addition, it highlighted the prevalence and the factors that are associated with access to SRH services specifically access to condoms and access to HIV testing services.

4.3.1: Access to condoms

The prevalence of non-access to condoms was highest among international migrant women and lowest among internal migrant women. It is also shown that on average, women who have stayed for a shorter period of time in the community had reduced access to condoms. Regarding age, younger women were found not to have access to condoms compared to older women. The proportion of women who did not have access to condoms was higher for never married women compared to married and formerly married women. It is shown that the highest proportion of women who did not have access to condoms were unemployed. On average, women who did not have access to condoms had a relatively lower score on comprehensive knowledge about SRH and comprehensive knowledge about HIV.

In the adjusted models, the findings show no significant association between migration status and access to condoms. The results show country differences in accessing condoms with women from Lesotho, Malawi, Mozambique, Swaziland and Zambia having higher odds of not being able to access condoms compared to women from South Africa. Findings of this study shows that the odds of accessing condoms was lower for younger women and never married women compared to older, married and formerly married women. The study identified a significant negative association between educational level and not having access to condoms. Comprehensive knowledge about SRH and comprehensive knowledge about HIV were found to be significant factors for not having access to condoms. Regarding partner's characteristics, partner's age and partner's educational level were found to be significantly associated with non-access to condoms.

4.3.2: Access to HIV testing services

The prevalence of non-access to HIV testing services was highest among international migrant women and lowest among internal migrant women. It is also shown that on average, women who have stayed for a shorter period of time in the community had reduced access to HIV testing services. Compared to the other countries, the proportion of women who did not have access to HIV testing services was higher for Mozambique while the least proportion was in Eswatini. Younger women were found not to have access to HIV testing services compared to older women. The proportion of women who did not have access HIV testing services was higher for never married women compared to married and formerly married women. It is shown that the highest proportion of women who did not have access to HIV testing services were unemployed. On average, women who did not have access to HIV testing services had a relatively lower score on comprehensive knowledge about SRH and comprehensive knowledge about HIV.

In the adjusted models, the findings suggest that being an international migrant is associated with limited access to HIV testing services. This study identified a significant association between educational level and not having access to HIV testing services. Comprehensive knowledge about SRH and comprehensive knowledge about HIV were found to be significantly associated with access to HIV testing services. The results show that partner characteristic variables were not significantly associated with non-access to HIV testing services.

CHAPTER 5: RESULTS: UTILISATION OF SRH SERVICES

5.1: Introduction

This chapter presents the results for utilisation of sexual and reproductive health (SRH) services. The results are comprised of descriptive statistics in the form of percentage distribution and the factors that are associated with utilisation of SRH services. The utilisation of SRH services outcome variables are utilisation of modern contraceptive methods, utilisation of sexual and reproductive health (SRH) referral services and utilisation of intimate partner violence (IPV) services. The chapter provides the results for the first and second objectives of the study. The first objective being to examine the level of and differentials in utilising SRH services among women in high migration communities in Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia. The second objective is to identify the factors that are associated with utilisation of SRH services among women in high migration communities of the six countries.

5.2: Utilisation of SRH services

5.2.1: Utilisation of modern contraceptive methods

Table 5.1a shows the distribution of selected characteristics of the respondents broken down by whether or not they used modern contraceptive methods. Overall, 61.0% women were currently using modern contraceptive methods while 39.0% were not currently using modern contraceptive methods. Duration of stay in the community differed between women who used modern contraceptive methods and women who did not. On average, women who used modern contraceptive methods had stayed fewer years in the community than women who did not use modern contraceptive methods. There are country differences between women who used modern contraceptive methods and women who did not. Compared to women who did not use modern contraceptive methods, a higher proportion of women who used modern contraceptive methods were from Malawi while a lower proportion were from Lesotho. Regarding age, on average, women who used modern contraceptive methods were slightly younger than women who did not use modern contraceptive methods. Educational level differed between women who used modern contraceptive methods and women who did not. A higher proportion of women who used modern

contraceptive methods had secondary/higher education than among women who did not use modern contraceptive methods.

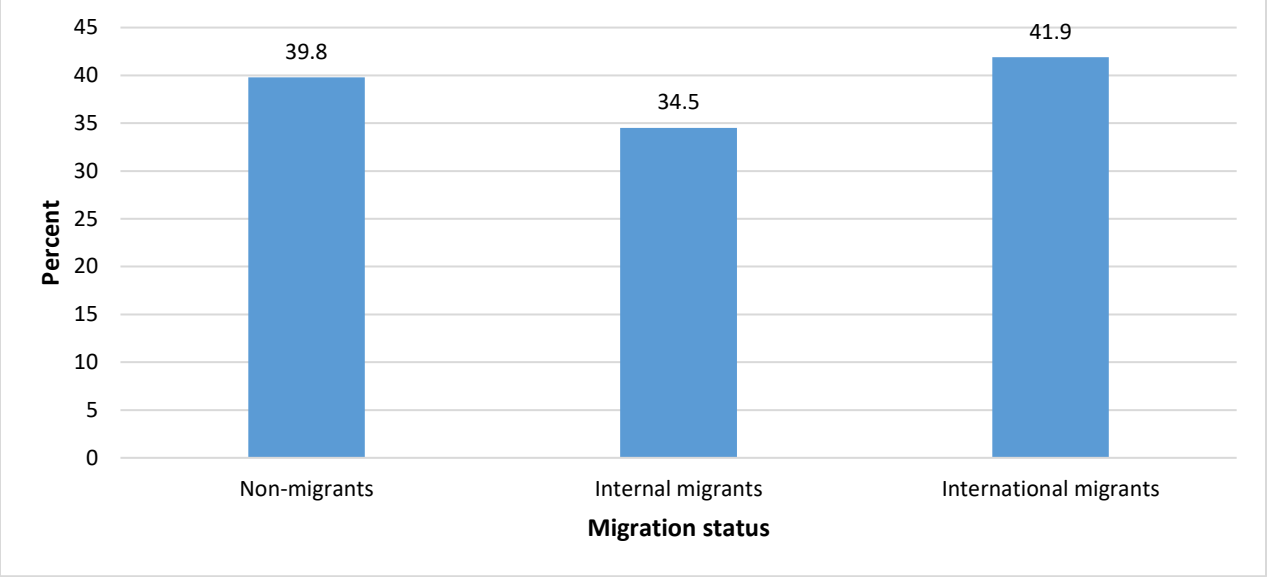
Similarly, employment status differed between women who used modern contraceptive methods and women who did not. Women who used modern contraceptive methods were more likely to be employed than women who did not use modern contraceptive methods. Desire for another child differed between women who used modern contraceptive methods and women who did not. A higher proportion of women who used modern contraceptive methods no longer want to have children while a lower proportion were women who did not have a partner. There are differences regarding comprehensive knowledge about SRH between women who used modern contraceptive methods and women who did not. Women who used modern contraceptive methods had higher comprehensive knowledge about SRH on average than women who did not use modern contraceptive methods. Similarly, comprehensive knowledge about HIV differed between women who used modern contraceptive methods and women who did not. On average, women who used modern contraceptive methods had higher comprehensive knowledge about HIV than women who did not use modern contraceptive methods.

Table 5.1a: Distribution of respondents' selected characteristics by utilisation and non-utilisation of modern contraceptive methods in high migration communities of six Southern African countries.

Variable	Level	Total	Utilised	Not utilised
		N=1677 (%)	**n=1023(61.0)**	**n=654(39.0)**
Migration status	Non-migrant	1129 (67.3)	680 (66.5)	449(68.6)
	Internal migrants	333(19.9)	218 (21.3)	115(17.6)
	International migrants	215(12.8)	125(12.2)	90(13.8)
Duration of stay in community	Mean duration (SD)	20.1(12.8)	19.6(12.5)	20.8 (13.2)
Country	Lesotho	209(12.5)	115(11.2)	94(14.4)
	Malawi	411(24.5)	280(27.3)	131(20.0)
	Mozambique	304(18.1)	179(17.5)	125(19.1)
	South Africa	265(15.8)	157(15.4)	108(16.5)
	Eswatini	156(9.3)	94(9.2)	62(9.5)
	Zambia	332(19.8)	198(19.4)	134(20.5)
Age	Mean (SD)	26.9(8.3)	26.6(7.7)	27.4(9.3)
Marital status	Never married	716(42.0)	441(43.1)	275(42.1)
	Married	666(38.4)	415(40.6)	251(38.4)
	Formerly married	292(19.1)	167(16.3)	125(19.1)
	Missing	3(0.5)	0(0.0)	3(0.5)
Educational level	Primary/lower	686(40.9)	399(39.0)	287(43.9)
	Secondary/higher	982(58.6)	620(60.6)	362(55.4)
	Missing	9(0.5)	4(0.4)	5(0.7)
Employment status	Unemployed	804 (48.0)	465(45.5)	339(51.8)
	Employed	872(52.0)	558(55.5)	314(48.0)
	Missing	1(0.0)	0(0.0)	1(0.2)
Religion	Catholic	556(33.1)	321(31.4)	235(35.9)
	Other Christians	957(57.1)	605(59.1)	352(53.8)
	Other religion	36(2.2)	97(9.5)	67(10.2)
Desire for another child	Have a child <2 years	75(4.5)	51(5.0)	24(3.7)
	Have a child >=2 years	261(15.6)	181(17.7)	80(12.2)
	No more	607(36.2)	388(37.9)	219(33.5)
	Unsure	37(2.2)	23(2.3)	14(2.1)
	Don't have a partner	137(8.2)	76(7.4)	61(9.3)
	Missing	560(33.4)	304(29.7)	256(39.1)
Comprehensive knowledge about SRH	Mean (SD)	0.90(0.45)	0.93(0.43)	0.84(0.46)
Comprehensive knowledge about HIV	Mean (SD)	2.32(0.88)	2.39(0.81)	2.21(0.97)

Figure 5.1 presents the prevalence of current non-use of modern contraceptive methods by migration status. The prevalence of non-use of modern contraceptive methods was highest among international migrants (41.9%) followed by non-migrants (39.8%) and lowest among internal migrants (34.5%).

Figure 5.1: The prevalence of non-use of modern contraceptive methods among women in high migration communities in six Southern African countries, 2018



The prevalence of utilisation of modern contraceptive methods

Table 5.1b presents the prevalence of utilisation of modern contraceptive methods by all women in high migration communities of the six countries. Non-use of modern contraceptive methods was higher among women in Lesotho (45.0%) and lower among women in Malawi (31.9%). Regarding marital status, non-use of modern contraceptive methods was highest among formerly married women (42.8%) followed by never married women (38.4%) and lowest among married women (37.7%). The prevalence of non-use of modern contraceptive methods was 41.8% for women with primary/lower education and 36.9% for women with secondary/higher education. With regards to employment status, non-use of modern contraceptive methods was 42.2% among unemployed women and 36.0% among employed women. As expected, the prevalence of non-use of modern contraceptive methods was highest among Catholic women (42.3%) and lowest among other Christians (36.8%). The prevalence of non-use of modern contraceptive methods was 44.5%

among women with no partners, 37.8% among women who were not sure if they still want to have another child, 36.1% among women who no longer want to have another child, 32.0% among women who wanted to have a child in less than two years and 30.7% among women who wanted to have a child after two years.

The prevalence of non-use of modern contraceptive methods was higher among women who did not know the age of their partners (43.0%), followed by women whose partners were aged 24 years and below (40.1%), women who had partners aged 35 years and above (35.2%) and lower among women who had partners aged 25-34 years (34.6%). Non-use of modern contraceptive methods was high among women who had partners with primary/lower education (42.7%) and low among women who had partners with secondary/higher education (35.7%). The prevalence of non-use of modern contraceptive methods was higher among women who had partners with no occupation (44.7%) and lower among women who had partners in technical/managerial (35.4%).

Table 5.1b: Prevalence of utilisation of modern contraceptive methods by respondents' selected characteristics in high migration communities of six Southern African countries.

Variable	Level	Total	Utilised	Not utilised
		2070	1023(61.0)	654 (39.0)
Migration status	Non-migrant	1129	680(60.2)	449(39.8)
	Internal migrants	333	218(65.5)	115(34.5)
	International migrants	215	125(58.1)	90(41.9)
Country	Lesotho	209	115(55.0)	94(45.0)
	Malawi	411	280(68.1)	131(31.9)
	Mozambique	304	179(58.9)	125(41.1)
	South Africa	265	157(59.3)	108(40.7)
	Swaziland	156	94(60.3)	62(39.7)
	Zambia	332	198(59.6)	134(40.4)
Educational level	Primary/lower	686	399(58.2)	287(41.8)
	Secondary/higher	982	620(63.1)	362(36.9)
Marital status	Never married	716	441(61.6)	275(38.4)
	Married	666	415(62.3)	251(37.7)
	Formerly married	292	167(57.2)	125(42.8)
Employment status	Employed	872	558(64.0)	314(36.0)
	Unemployed	804	465(57.8)	339(42.2)
Religion	Catholic	556	235(42.3)	321(57.7)
	Other Christians	957	605(63.2)	352(36.8)
	Other religion	164	97(59.1)	67(40.90
Desire for another child	Have a child < 2 years	75	51(68.0)	24(32.0)
	Have a child >= 2 years	261	181(69.4)	80(30.6)
	No more	607	388(63.9)	219(36.1)
	Unsure	37	23(62.2)	14(37.8)
	No partner	137	76(55.5)	61(44.5)
	Missing	560	304(54.3)	256(45.7)
Partner's age	<=24	359	215(59.9)	144(40.1)
	25-34	485	317(65.4)	168(34.6)
	>=35	341	221(64.8)	120(35.2)
	Don't know	312	178(57.0)	134(43.0)
Partner's educational level	Primary/lower	676	387(57.3)	289(42.7)
	Secondary/higher	934	601(64.3)	333(35.7)
Partner's occupation	No occupation	103	57(55.3)	46(44.7)
	Agriculture	180	108(60.0)	72(40.0)
	Technical/managerial	257	166(64.6)	91(35.4)
	Skilled manual	346	217(62.7)	129(37.3)
	Unskilled manual	571	359(62.9)	212(37.1)

Factors associated with modern contraceptive non-use

Table 5.1c presents the factors associated with non-use of modern contraceptive methods by all women found by fitting multiple logistic regression models. In the adjusted model, the results show no significant association between migration status and non-use of modern contraceptive methods (P=0.401). Country was significantly associated with non-use of modern contraceptive methods (P=0.028). Women in Malawi (aOR=0.73, 95% CI 0.50-1.07), Mozambique (aOR= 0.85, 95% CI 0.58-1.26) and Zambia (aOR=0.87, 95% CI 0.59-1.28) had lower odds of modern contraceptive non-use than women in South Africa. Compared to women in South Africa, women in Lesotho (aOR=1.42; 95% CI 0.93-2.15) and Eswatini (aOR=1.08; 95% CI 0.70-1.65) had higher odds of non-use of modern contraceptive methods.

Employment status was significantly associated with non-use of modern contraceptive methods after controlling for other factors (P=0.006). Unemployed women had 34% higher odds of not using modern contraceptive methods compared to employed women (aOR=1.34, 95% CI 1.09-1.67). After adjusting for other factors, desire for another child was significantly associated with non-use of modern contraceptive methods. Compared to women who want to have a child in less than two years, women who did not have a partner had higher odds of non-use of modern contraceptive methods (aOR=2.19; 95% CI 1.16-4.12). There was a significant association between comprehensive knowledge about SRH and non-use of modern contraceptive methods (P=0.010). In the multivariable model, for each unit increase in comprehensive knowledge about SRH, the odds of non-use of modern contraceptive methods decreased by 27% (aOR=0.73, 5% CI 0.57-0.93). Similarly, comprehensive knowledge about HIV was significantly associated with non-use of modern contraceptive methods (P=0.023). A unit increase in comprehensive knowledge about HIV decreased the odds of non-use of modern contraceptive methods by 13% (aOR=0.87; 95% CI 0.77-0.98).

There was a marginal association between age and non-use of modern contraceptive methods (P=0.06). The adjusted result shows that with a five year increase in age, the odds of non-use of modern contraceptive methods increased by 10% (aOR=1.10, 95% CI (1.01-1.22). After adjusting for other factors, marital status became marginally associated with modern contraceptive non-use

(P=0.05). Compared to never married women, formerly married women had higher odds of non-use of modern contraceptive methods (aOR=1.51, 95% CI 1.08-2.14). Duration of stay in the community and religion were not significantly associated with non-use of modern contraceptive methods.

Table 5.1c: Factors associated with non-use of modern contraceptive methods among women in high migration communities of six Southern African countries.

		Unadjusted OR (95% CI)	Adjusted OR OR (95% CI)	LR P-value
Variable	**Level**		**n=1665**	
Migration status	Non-migrant	1.00	1.00	0.40
	Internal migrants	0.79(0.62-1.03)	0.87(0.55-1.36)	
	International migrants	1.09(0.81-1.47)	1.13 (0.7-1.83)	
Duration of stay in community	Per 5 year increase	1.04(1.00-1.08)	1.03(0.95-1.13)	0.46
Country	South Africa	1.00	1.00	0.028
	Lesotho	1.19(0.82-1.71)	1.42(0.93-2.15)	
	Malawi	0.68 (0.49-0.94)	0.73(0.50-1.07)	
	Mozambique	1.02(0.73-1.42)	0.85(0.58-1.26)	
	Eswatini	0.96(0.64-1.44)	1.08(0.70-1.65)	
	Zambia	0.98(0.71-1.37)	0.87(0.59-1.28)	
Age	Per 5 year increase	1.06(1.01-1.13)	1.10(1.01-1.22)	0.06
Marital status	Never married	1.00	1.00	0.05
	Married	0.97 (0.78-1.21)	1.20(0.90-1.58)	
	Formerly married	1.20 (0.91-1.58)	1.51(1.08-2.14)	
Educational level	Primary/lower	1.00	1.00	0.045
	Secondary/higher	0.81(0.66-0.99)	0.79(0.63-0.99)	
Employment status	Employed	1.00	1.00	0.006
	Unemployed	1.30 (1.06-1.58)	1.34(1.09-1.67)	
Religion	Other Christians	1.00	1.00	0.23
	Catholics	1.26(1.02-1.56)	1.22(1.03-1.53)	
	Other religion	1.19(0.85-1.66)	1.04(0.72-1.50)	
Desire for another child	Have a child <2years	1.00	1.00	P<0.001
	Have a child >2years	0.94(0.54-1.63)	1.03(0.58-1.81)	
	No more	1.20(0.72-2.00)	0.98(0.58-1.67)	
	Unsure	1.29(0.57-2.94)	1.33(0.57-3.09)	
	No partner	1.71(0.94-3.08)	2.19(1.16-4.12)	
	Missing	1.79(1.07-2.99)	2.07(1.21-3.53)	
Comprehensive knowledge about SRH	Per unit increase	0.62 (0.50-0.78)	0.73(0.57-0.93)	0.010
Comprehensive knowledge about HIV	Per unit increase	0.80(0.72-0.89)	0.87(0.77-0.98)	0.023

Table 5.1d shows the factors associated with non-utilisation of modern contraceptive methods in a sub-analysis restricted to women who were partnered. Similar to the results in table 5.1a, there was no evidence of an association between migration status and non-use of modern contraceptive methods after adjusting for other factors (P=0.81). There was a significant association between country and non-use of modern contraceptive methods (P=0.002). Compared to women in South Africa, the odds of non-use of modern contraceptive methods were high among women in Lesotho

(aOR=1.92; 95% CI 1.04-3.56). Age was significantly associated with non-use of modern contraceptive methods (P=0.027). After controlling for other factors, a five year increase in age increased the odds of currently not using modern contraceptive methods by 19% (aOR=1.19, 95% CI 1.02-1.39). There was a significant association between employment status and non-use of modern contraceptive methods (P<0.001). After controlling for other factors, unemployed women had 65% higher odds of not using modern contraceptive methods compared to employed women (aOR=1.65, 95% CI 1.22-2.24).

Desire for another child was strongly associated with non-use of modern contraceptive methods (P<0.001). Compared to women who preferred to have a child within two years, women who preferred to have a child after two years (aOR=1.08; 95% CI 0.53-2.19) and those who were unsure (aOR=1.70; 95% CI 0.59-4.91) had higher odds of non-use of modern contraceptive methods. Furthermore, women who no longer wanted to have another child had lower odds of non-use of modern contraceptive methods compared to women who wanted to have a child within two years (aOR=0.96; 95% CI 0.49-1.86). Comprehensive knowledge about SRH was strongly associated with non-use of modern contraceptive methods P<0.001. A unit increase in comprehensive knowledge about SRH decreased the odds of non-use of modern contraceptive methods by 46% (aOR=0.54, 95% CI 0.38-0.76). Regarding partner's characteristic variables, partner's age was significantly associated with non-use of modern contraceptive methods (P=0.013). Compared to women with partners aged 24 years and below, women with partners aged 35 years and above (aOR=0.54, 95% CI 0.33-0.90) had lower odds of non-use of modern contraceptive methods. In addition, partner's education was significantly associated with non-use of modern contraceptive methods (P=0.05). Compared to women whose partners had primary or lower education, women whose partners had secondary/higher education had 28% lower odds of non-use of modern contraceptive methods (aOR=0.72, 95% CI 0.50-0.99). Factors that were not significantly associated with non-use of modern contraceptive methods are migration status, duration of stay, marital status, educational level, religion, comprehensive knowledge about HIV, partner's occupation, experience of IPV in the last 12 months and SRH decision making power.

Table 5.1d: Factors associated with modern contraceptive non-use among partnered women in high migration communities of six Southern African countries.

		Unadjusted OR (95% CI)	Adjusted OR (95% CI)	LR P-value
Variable	**Level**		**N=952**	
Migration status	Non-migrant	1.00	1.00	0.81
	Internal migrants	0.79(0.60-1.03)	0.84(0.44-1.58)	
	International migrants	1.03(0.75-1.41)	0.97(0.49-1.93)	
Duration of stay in community	Per 5 year increase	1.05(1.01-1.09)	1.04(0.92-1.17)	0.51
Country	South Africa	1.00	1.00	0.002
	Lesotho	1.51(1.01-2.24)	1.92(1.04-3.56)	
	Malawi	0.80(0.56-1.14)	0.84(0.47-1.52)	
	Mozambique	1.34(0.93-1.93)	0.66(0.36-1.21)	
	Eswatini	1.22(0.80-1.87)	1.50(0.78-2.88)	
	Zambia	1.15(0.79-1.66)	0.83(0.45-1.56)	
Age	Per 5 year increase	1.10(1.04-1.17)	1.19(1.02-1.39)	0.027
Marital status	Never married	1.00	1.00	0.15
	Married	1.07(0.84-1.35)	1.31(0.88-1.94)	
	Formerly married	1.34(1.00-1.80)	1.63(0.99-2.69)	
Educational level	Primary/lower	1.00	1.00	0.22
	Secondary/higher	0.79(0.64-0.98)	0.8(0.58-1.14)	
Employment status	Employed	1.00	1.00	P<0.001
	unemployed	1.27(1.03-1.56)	165(1.22-2.24)	
Religion	Catholic	1.00	1.00	0.41
	Other Christians	0.82(0.66-1.03)	0.97(0.70-1.34)	
	Other religion	1.00(0.68-1.46)	1.40(0.78-2.51)	
Desire for another child	Have a child <2 years	1.00	1.00	P<0.001
	Have a child >=2 years	0.98(0.56-1.72)	1.08(0.53-2.19)	
	No more	1.18(0.70-1.99)	0.96(0.49-1.86)	
	Unsure	1.32(0.58-3.03)	1.70(0.59-4.91)	
	Missing	1.76(1.04-2.96)	2.38(1.22-4.68)	
Comprehensive knowledge about SRH	Per unit increase	0.57(0.45-0.72)	0.54(0.38-0.76)	P<0.001
Comprehensive knowledge about HIV	Per unit increase	0.76(0.68-0.86)	0.90(0.75-1.09)	0.29
Partner's age	<=24 years	1.00	1.00	0.01
	25-34	0.79(0.60-1.05)	0.74(0.49-1.10)	
	>=35	0.81(0.60-1.10)	0.54(0.33-0.90)	
	Don't know	1.12(0.83-1.53)	0.66(0.40-1.10)	
Partner's educational level	Primary/lower	1.00	1.00	0.05
	Secondary/higher	0.72(0.58-0.90)	0.72(0.50-0.99)	
Partner's occupation	Agriculture	1.00	1.00	0.73
	None	1.16(0.70-1.92)	1.19(0.61-2.31)	
	Technical/managerial	0.79(0.53-1.19)	0.99(0.55-178)	
	Skilled manual	0.86(0.59-1.25)	1.23(0.72-2.09)	
	Unskilled manual	0.87(0.61-1.23)	0.95(0.59-1.52)	
Experience of IPV	Yes	1.00	1.00	0.42
	No	1.38(1.09-1.76)	1.14(0.82-1.62)	
SRH decision making power	Per unit increase	0.96(0.89-1.04)	0.97(0.87-1.09)	0.66

5.2.2: Utilisation of SRH referral services

Table 5.2a shows the distribution of selected characteristics of the respondents broken down by whether or not they have utilised SRH referral services. Overall, 45.6% of women who reported being referred for SRH services utilised the SRH referral services while 54.4% did not utilise the SRH referral services. Migration status differed between women who utilised SRH referral services and women who did not. Women who utilised SRH referral services were more likely to be international migrants or internal migrants while those who did not were more likely to be non-migrants. Ever denied access to a public healthcare facility differed between women who utilised SRH referral services and women who did not. Women who utilised SRH referral services were more likely to have been denied access to a healthcare facility than women who did not utilise a healthcare referral. There are country differences between women who utilised SRH referral services and women who did not. Women who utilised SRH referral services were more likely to be in Eswatini, South Africa and Zambia while those who did not utilise SRH referral services were more likely to be in Lesotho, Malawi and Mozambique.

Women who utilised SRH referral services were older on average than women who did not utilise SRH referral services. Comprehensive knowledge about SRH differed between women who utilised SRH referral services and women who did not. Women who utilised SRH referral services had higher comprehensive knowledge about SRH on average than women who did not. Similarly, comprehensive knowledge about HIV differed between women who utilised SRH referral services and women who did not. Women who utilised SRH referral services had higher comprehensive knowledge about HIV on average than women who did not utilise SRH referral services.

Table 5.2a: Distribution of respondents' selected characteristics by utilisation and non-utilisation of SRH referral services in high migration communities of six Southern African countries.

Variable	level	Total	Utilised	Not utilised
		N=796 (%)	**n=363(45.6)**	**n=433 (54.4)**
Migration status	Non-migrant	539(67.7)	231(63.6)	308(71.1)
	Internal migrants	109(13.7)	54(14.9)	55(12.7)
	International migrants	148(18.6)	78(21.5)	70(16.2)
Duration of stay	Mean duration of stay in years (SD)	19.8(12.4)	19.7(12.8)	19.9(12.1)
Ever denied access to a public healthcare facility	Yes	239(30.0)	135(37.2)	104(24.0)
	No	557(70.0)	228(62.8)	329(76.0)
Country	Lesotho	7(0.89)	0(0.0)	7(1.6)
	Malawi	198(24.9)	82(22.6)	116(26.8)
	Mozambique	176(22.1)	60(16.5)	116(26.8)
	South Africa	130(16.3)	75(20.7)	55(12.7)
	Eswatini	156(19.6)	81(22.3)	75(17.3)
	Zambia	129(16.2)	65(17.9)	64(14.8)
Age	Mean age (SD)	25.9(19;30)	27(8.2)	24.9(8.4)
Marital status	Never married	409(51.5)	167(46.0)	242(55.9)
	Married	274(34.5)	136(37.5)	138(31.9)
	Formerly married	112(14.0)	60(16.5)	52(12.0)
	Missing	1(0.0)	0(0.0)	1(0.2)
Educational level	Primary/lower	338(42.5)	143(39.5)	195(45.0)
	Secondary/higher	457(57.5)	219(60.5)	238(55.0)
Employment status	Unemployed	360(45.3)	159(43.8)	201(46.4)
	Employed	435(54.7)	204(56.2)	231(53.4)
	Missing	1(0.0)	0(0.0)	1(0.2)
Religion	Catholics	243(30.5)	102(28.1)	141(32.6)
	Other Christians	472(59.3)	220(60.6)	252(58.2)
	Other religion	81(10.2)	41(11.3)	40(9.2)
Comprehensive knowledge about SRH	Mean (SD)	0.85(0.47)	0.88(0.48)	0.82(0.46)
Comprehensive knowledge about HIV	Mean(SD)	2.29(0.93)	2.39(0.85)	2.21(0.99)

Figure 5.2 shows the prevalence of utilisation of SRH referral services by migration status. The prevalence of utilisation of SRH referral services was 52.7% among international migrants, 49.5% among internal migrants and 42.8% among non-migrants.

Figure 5.2: The prevalence of utilisation of SRH referral services among women in high migration communities in six Southern African countries, 2018

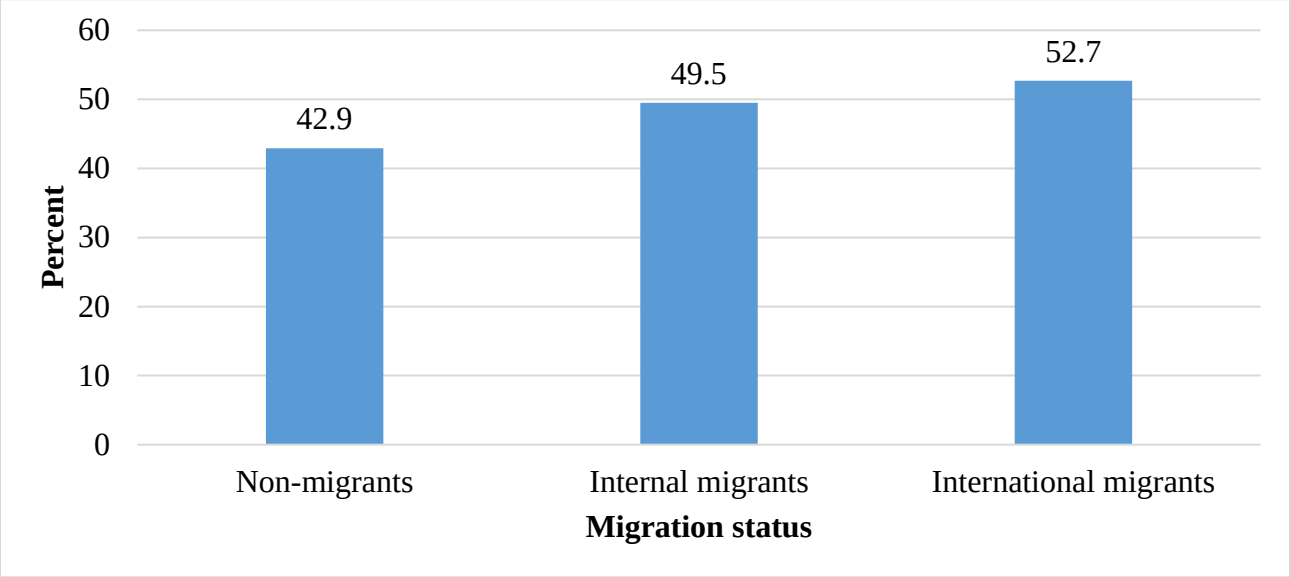


Table 5.2b shows the prevalence of utilisation of SRH referral services by all women in high migration communities of six Southern African countries. The prevalence of utilisation of SRH referral services was 56.5% among women who were denied access to a healthcare facility and 40.9% among women who were never denied access to a health facility. The prevalence of utilisation of SRH referral services was 53.5% among formerly married women, 49.5% among married women and 40.8% among never married women. In addition, the prevalence of utilisation of SRH referral services was 47.9% among women with secondary/higher education and 42.3% among women with primary/lower education. The prevalence of utilisation of SRH referral services was 46.9% among unemployed women and 44.0% among employed women. The prevalence of utilisation of SRH referral services was 50.6% among other religion, 46.6% among other Christians and 42.0% among Catholics.

The prevalence of utilisation of SRH referral services was higher among women who had partners aged 35 years and above (57.2%) and lower among women who did not know the age of their partners (37.1%). The prevalence of utilisation of SRH referral services was high among women who had partners with secondary/higher education (50.0%) and low among women who had partners with primary/lower education (42.5%). The prevalence of utilisation of SRH referral

serviced was higher among women whose partners were into technical/managerial (59.8%) and lower among women who had partners with no occupation (41.7%).

Table 5.2b: Prevalence of utilisation of SRH referral services by respondents' selected characteristics in high migration communities of six Southern African countries N=796.

Variable	Level	Total	Utilised	Not utilised
			363(45.6)	433(54.4)
Migration status	Non-migrant	539	231(42.9)	308(57.1)
	Internal migrants	109	54(49.5)	55(50.5)
	International migrants	148	78(52.7)	70(47.3)
Country	Lesotho	7	0(0.0)	7(100.0)
	Malawi	198	82(41.4)	116(58.6)
	Mozambique	176	60(34.1)	116(65.9)
	South Africa	130	75(57.7)	55(42.3)
	Swaziland	156	81(51.9)	75(48.1)
	Zambia	129	65(50.4)	64(49.60
Ever denied access to a public healthcare facility	Yes	239	135(56.5)	104(43.5)
	No	557	228(40.9)	329(59.1)
Educational level	Primary/lower	338	143(42.3)	195(57.7)
	Secondary/higher	457	219(47.9)	238(52.1)
Marital status	Never married	409	167(40.8)	242(59.2)
	Married	274	136(49.6)	138(50.4)
	Formerly married	112	60(53.6)	52(46.4)
Employment status	Employed	360	159(44.2)	201(55.8)
	Unemployed	435	204(46.9)	231(53.1)
Religion	Catholic	243	102(42.0)	141(58.0)
	Other Christians	472	220(46.6)	252(53.4)
	Other religion	81	41(50.6)	40(49.4)
Partner's age	<=24	163	75(46.0)	88(54.0)
	25-34	192	101(52.6)	91(47.4)
	>=35	145	83(57.2)	62(42.8)
	Don't know	159	59(37.1)	100(62.9)
Partner's educational level	Primary/lower	379	161(42.5)	218(57.5)
	Secondary/higher	382	191(50.0)	191(50.0)
Partner's occupation	No occupation	48	20(41.7)	28(58.3)
	Agriculture	91	40(44.0)	51(56.0)
	Technical/managerial	112	67(59.8)	45(40.2)
	Skilled manual	146	68(46.6)	78(53.4)
	Unskilled manual	246	115(46.8)	131(53.3)

Table 5.2c shows the factors associated with utilisation of SRH referral services by all women found by fitting logistic regression models. Controlling for other factors, there was no evidence of an association between migration status and utilisation of SRH referral services (P=0.95). Ever denied access to a public healthcare facility was associated with utilisation of SRH referral services (P<0.001). Women who reported to have been denied access to a healthcare facility had higher odds of utilising SRH referral services compared to women who were never denied access to healthcare facility (aOR=2.49; 95% CI 1.66-3.73). Country was significantly associated with utilisation of SRH referral services (P<0.001). Women in Malawi (aOR=0.23; 95% CI 0.13-0.42), Mozambique (aOR=0.38; 95% CI 0.22-0.65), Eswatini (aOR=0.60; 95% CI 0.36-0.99) and Zambia (aOR=0.58, 95% CI 033-1.03) had lower odds of utilising SRH referral services compared to women in South Africa.

Marital status was associated with utilisation of SRH referral services (P=0.006). Compared to never married women, married women (aOR=1.61, 95% CI 1.09-2.36) and formerly married women (aOR=2.14, 95% CI 1.29-3.55) had higher odds of utilising SRH referral services. The association between utilisation of SRH referral services and age was marginally significant (P=0.083). Similarly, there was a marginal association between comprehensive knowledge about HIV and utilisation of SRH referral services (P=0.064).

Table 5.2c: Factors associated with utilisation of SRH referral services among all women in high migration communities of six Southern African countries.

		Unadjusted OR (95% CI)	**Adjusted OR (95% CI)**	**LR P-value**
Variable	**Level**		**N=787**	
Migration status	Non-migrant	1.00	1.00	0.95
	Internal migrants	1.31(0.87-1.98)	1.08(0.57-2.07)	
	International migrants	1.49 (1.03-2.14)	1.11(0.58-2.12)	
Duration of stay	Per 5 year increase	0.99(0.94-1.05)	0.93(0.81-1.07)	0.31
Ever denied access to a public healthcare facility	No	1.00	1.00	P<0.001
	Yes	1.87(1.38-2.54)	2.49(1.66-3.73)	
Country	South Africa	1.00	1.00	P<0.001
	Lesotho	Empty	Empty	
	Malawi	0.52(0.33-0.81)	0.23(0.13-0.42)	
	Mozambique	0.38(0.24-0.61)	0.38(0.22-0.65)	
	Eswatini	0.79(0.50-1.27)	0.60(0.36-0.99)	
	Zambia	0.74(0.46-1.22)	0.58(0.33-1.03)	
Age	Per 5 year increase	1.15(1.06-1.26)	1.14(0.98-1.32)	0.08
Marital status	Never married	1.00	1.00	0.006
	Married	1.43 (1.05-1.94)	1.61 (1.09-2.36)	
	Formerly married	1.67 (1.10-2.55)	2.14(1.29-3.55)	
Educational level	Primary/lower	1.00	1.00	0.78
	Secondary/higher	1.25(0.95-1.67)	1.05(0.74-1.48)	
Employment status	Unemployed	1.00	1.00	0.43
	Employed	0.90(0.68-1.19)	0.88(0.65-1.21)	
Religion	Catholic	1.00	1.00	0.80
	Other Christians	1.21(0.88-1.65)	1.09(0.77-1.54)	
	Other religion	1.42(0.86-2.45)	1.19(0.68-2.08)	
Comprehensive knowledge about SRH	Per unit increase	1.32(0.98-1.78)	1.14(0.81-1.61)	0.44
Comprehensive knowledge about HIV	Per unit increase	1.24(1.06-1.44)	1.18(0.99-1.42)	0.06

Table 5.2d shows the factors associated with utilisation of SRH referral services in a sub-analysis restricted to women who were partnered. The results show that access to healthcare facility is associated with utilisation of SRH referral services (P<0.001). Women who reported having been denied access to a healthcare facility had higher odds of utilising SRH referral services compared to women who were never denied access to healthcare facility (aOR=3.12; 95 % CI 1.69-5.77). Country was found to be associated with utilisation of SRH referral services (P<0.001). Compared to women in South Africa, women in Malawi (aOR=0.22; 95% CI 0.09-0.56), Mozambique

(aOR=0.36; 95% CI 0.14-0.92) and Eswatini (aOR=0.45; 95% CI 0.19-1.05) had lower odds of utilising SRH referral services.

Marital status was significantly associated with utilisation of SRH referral services (P=0.04). Compared to never married women, formerly married women (aOR=2.68, 95% CI 1.22-5.90) had higher odds of utilising SRH referral services. There was a marginal association between utilisation of SRH referral services and employment status (P=0.06). Although the overall partner's occupation variable was not significantly associated with utilisation of SRH referral services overall, women whose partners were into technical/managerial occupation (aOR=3.15, 95% CI 1.16-8.57) had higher odds of utilising SRH referral services compared to women with partners who had no occupation.

Table 5.2d: Factors associated with utilisation of SRH referral services among partnered women in high migration communities of six Southern African countries.

		Unadjusted OR (95% CI)	Adjusted OR (95% CI)	LR P-value
Variable	**Level**		**N= 425**	
Migration status	Non-migrant	1.00	1.00	0.54
	Internal migrants	1.49(0.94-2.35)	1.29(0.49-3.42)	
	International migrants	1.47(0.99-2.18)	0.80(0.30-2.18)	
Duration of stay	Per 5 year increase	0.96(0.91-1.02)	0.88(0.73-1.07)	0.22
Ever denied access to a healthcare facility	No	1.00	1.00	P<0.001
	Yes	2.15(1.53-3.02)	3.15(1.69-5.77)	
Country	South Africa	1.00	1.00	P<0.001
	Lesotho	empty	Empty	
	Malawi	0.45(0.26-0.75)	0.22(0.09-0.56)	
	Mozambique	0.30(0.17-0.51)	0.36(0.14-0.92)	
	Eswatini	0.60(0.35-1.03)	0.45(0.19-1.05)	
	Zambia	0.61(0.34-1.09)	1.58(0.58-4.78)	
Age	Per 5 year increase	1.09(0.99-1.20)	1.19(0.94-1.51)	0.14
Marital status	Never married	1.00	1.00	0.04
	Married	1.18(0.84-1.65)	1.26(0.71-2.23)	
	Formerly married	1.37(0.88-2.12)	2.68(1.22-5.90)	
Educational level	Primary/lower	1.00	1.00	0.29
	Secondary/higher	1.43(1.05-1.95)	1.32(0.79-2.20)	
Employment status	Unemployed	1.00	1.00	0.06
	Employed	0.87(0.64-1.18)	0.65 (0.41-1.03)	
Religion	Catholics	1.00	1.00	0.30
	Other Christians	1.10(0.78-1.55)	0.82(0.49-1.36)	
	Other religion	1.23(0.71-2.12)	1.42(0.62-3.24)	
Comprehensive knowledge about SRH	Per unit increase	1.30(0.94-1.80)	1.15(0.69-1.91)	0.90
Comprehensive knowledge about HIV	Per unit increase	1.22(1.02-1.45)	1.25(0.92-1.68)	0.19
Partner's Age	<=24	1.00	1.00	0.75
	25-34	1.30(0.86-1.98)	1.17(0.64-2.11)	
	>=35	1.57(1.00-2.47)	1.04(0.49-2.19)	
	Don't know	0.69(0.44-1.08)	0.80(0.38-1.68)	
Partner's educational level	Primary/lower	1.00	1.00	0.84
	Secondary/higher	1.25(0.92-1.70)	1.05(0.62-1.78)	0.84
Partner's occupation	None	1.00	1.00	0.10
	Agriculture	1.22(0.59-2.51)	1.46(0.53-4.04)	
	Technical/managerial	2.51(1.23-5.10)	3.11(1.14-8.45)	
	Skilled manual	1.27(0.65-2.50)	1.31(0.52-3.28)	
	Unskilled manual	1.44(0.76-2.72)	1.91(0.81-4.50)	
SRH decision making power	Per unit increase	0.90(0.81-0.99)	0.95(0.81-1.12)	0.54
Experience of IPV	No	1.00	1.00	0.26
	Yes	1.65(1.19-2.29)	1.35(0.81-2.27)	

5.2.3: Utilisation of IPV services

Table 5.3a shows the distribution of selected characteristics of the respondents broken down by whether or not they have utilised IPV services. It shows that, 38.9% of women who reported experiencing IPV utilised IPV services while 61.1% did not utilise the services. Overall 68.8% of women who had experienced IPV were non-migrants, with 19.0% being internal migrants and 12.2% being international migrants. Among women who utilised IPV services, the proportions for non-migrants (70.6%) and internal migrants (19.1%) were higher than for the population overall, while for international migrants the proportion was lower (10.3%) than overall. Thus international migrants had a proportionately lower representation among those who utilised IPV services, showing that utilisation of IPV services was lower among the international migrants compared to non-migrants and internal migrants. Duration of stay in the community differed between women who utilised IPV services and women who did not. Women who utilised IPV services had stayed longer in the community on average than women who did not utilise IPV services. Country differences were noted between women who utilised IPV services and women who did not. Overall 32.8% of women who experienced IPV were from Malawi, while amongst those who did not utilise IPV services this dropped to 29.9% - hence women from Malawi were less likely to not utilise IPV services.

Age differed between women who utilised IPV services and women who did not. Women who utilised IPV services were older on average than those who did not utilise IPV services. There were differences in the distribution of marital status between women who utilised IPV services and those who did not. A higher proportion of women who utilised IPV services were married while those did not were more likely to be never married. Employment status differed between women who utilised IPV services and women who did not, with women who utilised IPV services more likely to be employed than women who did not utilise IPV services. Comprehensive knowledge about HIV differed between women who utilised IPV services and women who did not, with women who utilised IPV services having higher comprehensive knowledge about HIV on average than women who did not utilise IPV services. Attitude towards wife beating differed between women who utilised IPV services and women who did not. A higher proportion of women who utilised IPV services were not in favour of wife beating compared to the proportion amongst women who did not utilise IPV services.

The influence of partner's educational level differed between women who utilised IPV services and women who did not. A higher proportion of women who utilised IPV services had partners with secondary/higher education than women who did not utilise IPV services. Sexual and reproductive health (SRH) decision making power differed between women who utilised IPV services and women who did not. Women who utilised IPV services had more SRH decision making power on average compared to women who did not utilise IPV services.

Table 5.3a: Distribution of utilisation of IPV services by respondents' selected characteristics in high migration communities of six Southern African countries N=525

Variable	Level	Total	Utilised	Not utilised
		N=525	**n=204 (38.9)**	**n=321 (61.1)**
Migration status	Non-migrant	361(68.8)	144(70.6)	217(67.6)
	Internal migrants	100(19.0)	39(19.1)	61(19.0)
	International migrants	64(12.2)	21(10.3)	43(13.4)
Duration of stay in community	Mean duration (SD)	20(12.5)	21.1(13.3)	19.3(11.9)
Country	Lesotho	24(4.6)	11(5.4)	13(4.1)
	Malawi	172(32.8)	76(37.2)	96(29.9)
	Mozambique	59(11.2)	15(7.4)	44(13.7)
	South Africa	46(8.8)	18(8.8)	28(8.7)
	Eswatini	101(19.2)	28(13.7)	73(22.7)
	Zambia	123(23.4)	56(27.5)	67(20.9)
Age	Mean age (SD)	26.2(7.9)	27.9(8.1)	25.2(7.7)
Marital status	Never married	218(41.5)	60(29.4)	158(49.2)
	Married	201(38.3)	87(42.7)	114(35.5)
	Formerly married	106(20.2)	57(27.9)	49(15.3)
Educational level	No education	48(9.1)	16(7.9)	32(10.0)
	Primary	190(36.2)	80(39.2)	110(34.3)
	Secondary/higher	287(54.7)	108(52.9)	179(55.8)
Employment status	Unemployed	274(52.2)	80(39.2)	171(53.3)
	Employed	251(47.8)	124(60.8)	150(46.7)
Religion	Catholic	151(28.8)	52(25.4)	99(30.8)
	Other Christians	329(62.7)	135(66.2)	194(60.4)
	Other religion	45(8.6)	17(8.3)	28(8.7)
Comprehensive knowledge about SRH	Mean(SD)	0.91(0.45)	0.92(0.41)	0.90(0.47)
Comprehensive knowledge about HIV	Mean (SD)	2.36(0.84)	2.5(0.71)	2.26(0.91)
Witnessing family violence	No	199(37.9)	76(37.3)	123(38.3)
	Yes	326(62.1)	128(62.7)	198(61.7)
Attitude towards wife beating	No	249(47.4)	119(58.3)	130(40.5)
	Yes	276(52.6)	85(41.7)	191(59.5)
Partner's age	<=24	112(23.4)	41(20.9)	71(25.1)
	25-34	164(34.2)	62(31.6)	102(36.0)
	>=35	110(23.0)	54(27.6)	56(19.8)
	Don't know	93(19.4)	39(19.9)	54(19.1)
Partner's educational level	No education	122(25.1)	39(19.2)	83(25.9)
	Primary	101(20.8)	51(25.0)	50(15.6)
	Secondary/higher	263(54.1)	108(52.9)	155(48.3)
	Missing	39(7.0)	6.0(2.9)	33(10.3)
Partner's occupation	None	30(6.3)	11(5.7)	19(6.7)
	Agriculture	59(12.4)	20(10.4)	39(13.7)
	Technical/managerial	61(12.8)	17(8.8)	44(15.5)
	Skilled manual	112(23.5)	47(24.4)	65(22.9)
	Unskilled manual	215(45.1)	98(50.8)	11(41.2)
SRH decision making power	Mean (SD)	2.4(1.8)	2.9(1.7)	2.1(1.9)

Figure 5.3 shows the prevalence of utilisation of IPV services by migration status. The prevalence of utilisation of IPV services was highest among non-migrants (39.9%) followed by internal migrants (39.0%) and lowest among international migrants (32.8%).

Figure 5.3: The prevalence of utilisation of IPV services among women in high migration communities in six Southern African countries, 2018

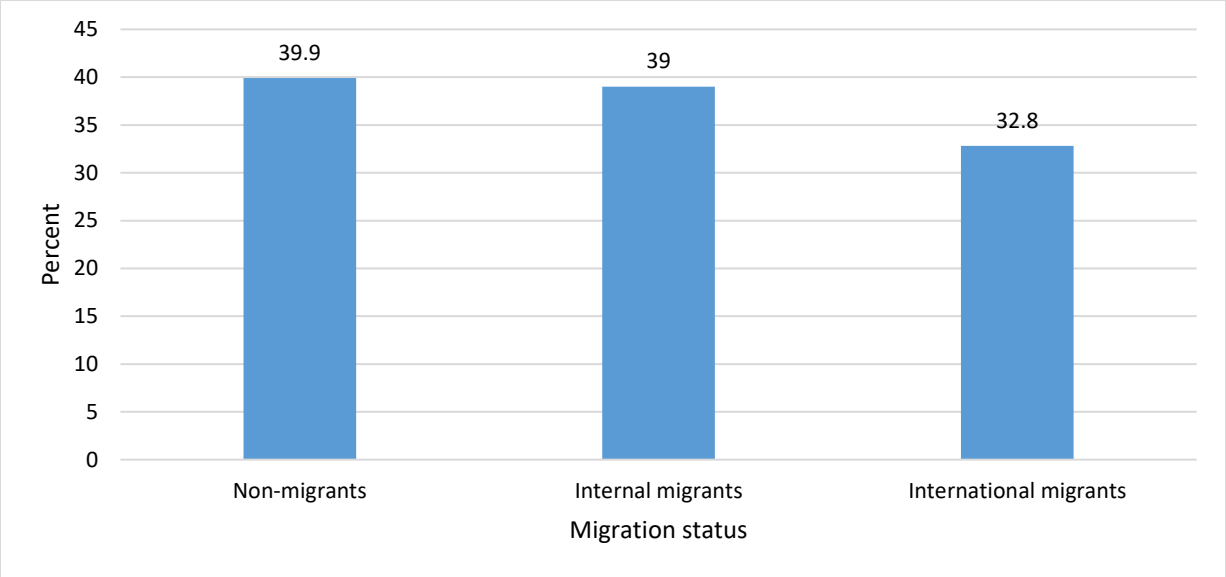


Table 5.3b shows the prevalence of utilisation of IPV services among partnered women in high migration communities in six Southern African countries. Utilisation of IPV services was 45.8% among women in Lesotho, 45.5% among women in Zambia, 44.2% among women in Malawi, 39.1% among women in South Africa, 27.7% among women in Eswatini and 25.4% among women in Mozambique. The prevalence of utilisation of IPV services was 53.8% among formerly married women, 43.3% among married women and 27.5% among never married women. The prevalence of utilisation of IPV services was 42.1% among women with primary education, 37.6% among women with secondary/higher education and 33.3% among women with no education. Utilisation of IPV services was 60.8% among employed women and 39.2% among unemployed women.

The prevalence of utilisation of IPV services was 41.0% among other Christians, 37.8% among other religion and 34.4% among Catholics. It was 39.0% among women who did not witness

parental violence and 38.0% among women who witnessed parental violence. The prevalence of utilisation of IPV services was 48.0% among women who do not justify beating of wives by their husbands and 31.0% among women who justify wife beating. The prevalence of utilisation of IPV services was 49.1% among women who had partners aged 35 years and above, 41.9% among women who did not know their partner's age, 37.8% among women who had partners aged 25-34 years and 36.6% among women who had partners aged 24 years and below. The prevalence of utilisation of IPV services was 50.5% among women who had partners with primary education, 41.1% among women who had partners with secondary/higher and 32.0% among women who had partners with no education. It was 45.6% among women whose partners were in unskilled labour, 42.0% unskilled manual, 36.7% with no occupation, 33.9% in agriculture and 27.9% in technical/managerial.

Table 5.3b: Prevalence of utilisation of intimate partner violence by respondents' selected characteristics in high migration communities of six Southern African countries N=525.

Variable	Level	Total	Utilised	Not Utilised
		525	204(38.9)	321(61.1)
Migration status	Non-migrant	361	144(39.9)	217(60.1)
	Internal migrants	100	39(39.0)	61(61.0)
	International migrants	64	21(32.8)	43(67.2)
Country	Lesotho	24	11(45.8)	13(54.2)
	Malawi	172	76(44.2)	96(55.8)
	Mozambique	59	15(25.4)	44(74.6)
	South Africa	46	18(39.1)	28(60.9)
	Swaziland	101	28(27.7)	73(72.3)
	Zambia	123	56(45.5)	67(54.5)
Educational attainment	No education	48	16(33.3)	32(66.7)
	Primary	190	80(42.1)	110(57.9)
	Secondary/higher	287	108(37.6)	179(62.4)
Marital status	Never married	218	60(27.5)	158(72.5)
	Married	201	87(43.3)	114(56.7)
	Formerly married	106	57(53.8)	49(46.2)
Employment status	Employed	274	124(45.3)	150(54.7)
	Unemployed	251	80(31.9)	171(68.1)
Religion	Catholic	151	52(34.4)	99(65.6)
	Other Christians	329	135(41.0)	194(59.0)
	Other religion	45	17(37.8)	28(62.2)
Partner's age	<=24	112	41(36.6)	71(63.4)
	25-34	164	62(37.8)	102(62.2)
	>=35	110	54(49.1)	56(50.9)
	Don't know	93	39(41.9)	54(58.1)
Partner's educational level	No education	122	39(32.0)	83(68.0)
	Primary	101	51(50.5)	50(49.5)
	Secondary/higher	263	108(41.1)	155(58.9)
Partner's occupation	No occupation	30	11(36.7)	19(63.3)
	Agriculture	59	20(33.9)	39(66.1)
	Technical/Managerial	61	17(27.9)	44(72.1)
	Skilled manual	112	47(42.0)	65(58.0)
	Unskilled manual	215	117(54.4)	98(45.6)
Parental violence	No	299	123(41.1)	176(58.9)
	Yes	199	76(38.2)	123(61.8)
Attitude towards wife beating	No	226	112(49.6)	114(50.4)
	Yes	276	85(30.8)	191(69.2)

Table 5.3c shows the factors associated with utilisation of IPV services among partnered women in high migration communities of six Southern African countries. The results in Table 5.3c show that migration status was significantly associated with utilization of IPV services (P=0.045). Compared to non-migrants, both internal migrants (aOR=0.25; 95% CI 0.06-0.95) and international migrant women (aOR=0.25; 95% CI 0.05-1.21) had lower odds of utilising IPV services. Age was significantly associated with utilisation of IPV services (P=0.025). After controlling for other factors, a five year increase in age increased the odds of utilising IPV services by 34% (aOR=1.34, 95% CI 1.04-1.74). In the adjusted model, there is a significant association between attitude towards wife beating and utilisation of IPV services (P=0.001). Women who justified beating of a woman by her husband had 61% lower odds of utilising IPV services compared to women who condemn husbands beating their wives (aOR=0.39, 95% CI 0.22-0.70).

After controlling for other factors, some variables that were significant in the univariable model showed no significant association with utilisation of IPV services. The variables are country, marital status, employment status, comprehensive knowledge about HIV, partner's educational level and SRH decision making power.

Table 5.3c: Factors associated with current utilisation of IPV services among partnered women in high migration communities of six Southern African countries.

		Unadjusted OR(95% CI)	Adjusted OR (95% CI)	LR P-value
Variable	**Level**		**N=340**	
Migration status	Non-migrant	1.00	1.00	0.045
	Internal migrants	0.96(0.61-1.52)	0.53(0.18-0.95)	
	International migrant	0.74(0.42-1.29)	0.34(0.10-1.12)	
Duration of stay in community	Per 5 year increase	1.06(0.99-1.14)	0.90(0.73-1.11)	0.32
Country	South Africa	1.00	1.00	0.30
	Lesotho	0.94(0.40-2.21)	1.72(0.39-7.51)	
	Malawi	0.40(0.15-1.09)	2.28(0.73-7.13)	
	Mozambique	0.76(0.28-2.06)	1.53(0.40-5.82)	
	Eswatini	0.45(0.18-1.13)	1.53(0.45-5.27)	
	Zambia	0.99(0.41-2.38)	3.32(1.07-10.30)	
Age	Per 5 year increase	1.24(1.11-1.39)	1.34(1.04-1.74)	0.025
Marital status	Never married	1.00	1.00	0.84
	Married	2.01(1.34-3.02)	0.81(0.41-1.60)	
	Formerly married	3.06(1.89-4.97)	0.83(0.38-1.84)	
Educational level	No education	1.00	1.00	0.76
	Primary	1.45(0.75-2.83)	0.96(0.33-2.78)	
	Secondary/higher	1.21(0.63-2.30)	1.19(0.41-3.51)	
Employment status	Unemployed	1.00	1.00	0.67
	Employed	1.78(1.24-2.52)	1.12(0.67-1.87)	
Religion	Catholic	1.00	1.00	0.05
	Other Christians	1.32(0.89-1.98)	1.52(0.85-2.72)	
	Other religion	1.16(0.58-2.30)	1.46(0.51-4.24)	
Comprehensive knowledge about SRH	Per unit increase	1.06(0.72-1.56)	0.82(0.44-1.52)	0.89
Comprehensive knowledge about HIV	Per unit increase	1.43(1.14-1.79)	1.41(0.99-2.01)	0.13
Witnessing parental violence	No	1.00	1.00	0.46
	Yes	0.96(0.66-1.37)	0.83(0.50-1.37)	
Attitude towards wife beating	No	1.00	1.00	0.001
	Yes	0.49(0.34-0.69)	0.39(0.22-0.70)	
Partner's age	<=24	1.00	1.00	0.90
	24-34	1.05(0.64-1.73)	1.18(0.60-2.32)	
	>=35	1.67(0.98-2.85)	1.40(0.58-3.35)	
	Don't know	1.25(0.71-2.20)	1.20(0.52-2.78)	
Partner's educational level	No education	1.00	1.00	0.69
	Primary	2.17(1.26-3.74)	1.44(0.60-3.44)	
	Secondary/higher	1.48(0.94-2.33)	1.29(0.61-2.73)	
Partner's occupation	None	1.00	1.00	0.20
	Agriculture	0.89(0.35-2.22)	0.74(0.22-2.51)	
	Technical/managerial	0.67(0.26-1.69)	0.36(0.10-1.25)	
	Skilled manual	1.25(0.54-2.87)	0.90(0.31-2.65)	
	Unskilled manual	1.45(0.66-3.19)	1.03(0.36-2.90)	
SRH decision making power	Per unit increase	1.25(1.12-1.40)	1.13(0.95-1.34)	0.15

5.3: Summary of chapter

This chapter presented the level of and differentials in utilisation of SRH services among women in high migration communities in six Southern African countries. In addition, it presented the factors that are associated with utilisation of modern contraceptive methods, SRH referral services and IPV services among women in high migration communities.

5.3.1: Utilisation of modern contraceptive methods

Controlling for other factors, the results show no significant association between migration status and current non-use of modern contraceptive methods. Women who used modern contraceptive methods were slightly younger on average than women who did not use modern contraceptive methods. Employment status and comprehensive knowledge about SRH came out as important factors that determine utilisation of modern contraceptive methods. The odds of modern contraceptive non-use were higher among unemployed women and women with a lower score on comprehensive knowledge about SRH. Other factors that were found to be important are country, marital status, religion. In addition, regarding partner characteristic variables, partner's age and partner's educational level were found to be important factors that influence women's utilisation of modern contraceptive methods.

5.3.2: Utilisation of SRH referral services

It is shown that migration status differed marginally between women who utilised SRH referral services and women who did not. Women who utilised referrals were more likely to be non-migrants while those who did not were more likely to be internal or international migrants. In the adjusted model, the results show no significant association between migration status and utilisation of SRH referral services. In the adjusted model, the factors that were found to be important are ever denied access to a public healthcare facility, country, age, marital status and employment status. Partner characteristic variables were not found to be significantly associated with utilisation of SRH referral services.

5.3.4: Utilisation of IPV services

The results show that duration of stay in the study site differed between women who utilised IPV services and women who did not. Women who utilised IPV services had stayed longer in the community on average than women who did not utilise IPV services. In addition, country differences were noted between women who utilised IPV services and women who did not. After controlling for other factors, migration status was significantly associated with utilization of IPV services. Compared to non-migrants, both internal and international migrant women had lower odds of utilising IPV services. Age was significantly associated with utilisation of IPV services, a five year increase in age increased the odds of utilising IPV services by 34%. In addition, the findings show that attitude towards wife beating is a crucial determinant of women's utilisation of IPV services. Women who justified beating of a woman by her partner or husband had lower odds of utilising IPV services compared to their counterparts. Partner characteristic variables were not found to be important predictors of women's utilisation of IPV services.

CHAPTER 6: QUALITATIVE RESULTS

6.1: Introduction

This chapter explores the five dimensions of access, namely geographic accessibility, affordability, availability, adequacy and acceptability in migrant women's access and utilisation of SRH and HIV services. The chapter also presents the experiences and coping strategies of migrant women in accessing and utilising SRH and HIV services. In addition, the experiences of healthcare workers (HCW) in providing SRH and HIV services to migrant women are highlighted. The experiences/factors are categorised into three levels namely; interpersonal, community and institutional level.

6.2: Characteristics of the participants

The participants were five internal migrants, eight international migrants and four healthcare workers from municipal and provincial clinics in Ekurhuleni. The majority of the participants are between the ages 20 and 49 years. The majority of the participants had stayed for 6 to 10 years and were living together with their partners as if they were married. In addition, the majority of the participants had secondary/higher education and were employed.

Table 6.1: Socio-demographic characteristics of the participants

Socio-demographic characteristics		**Migrant women (N=13)**	**Healthcare workers (N=4)**
Age	20-29	4	1
	30-39	5	1
	40-49	4	1
	50^{+}		1
Duration of stay (years)	1-5	3	-
	6-10	7	-
	>10	3	-
Marital status	Single	3	-
	Married	2	-
	Living with a partner	8	-
Educational level	No formal education	1	-
	Primary	2	-
	Secondary/higher	10	4
Employment status	Unemployed	5	-
	Employed	8	4

Table 6.2: Themes derived from the data

Themes	**Sub-themes**
Five dimensions of access	Geographic accessibility Affordability Availability Adequacy Acceptability
Experiences in accessing and utilising SRH and HIV services	Individual level factors • Migration status • Language barriers Interpersonal factors • Family and friends support • Partner/spousal support • Utilisation of IPV services Institutional factors • Healthcare facility requirements or standard operating procedures • Discrimination from health workers

	• Healthcare worker's attitude • Waiting time • Interpretation services • SRH referral Community factors • Support groups
Experiences in providing SRH and HIV services	• Language barriers • Unavailability of SRH services • Administration costs and hospital fees • Waiting time • Lack of documentation • Recurring sickness • Religious challenges
Coping strategies in accessing, utilising and providing SRH and HIV services	Migrant women coping strategies • Private healthcare facilities as alternatives • Unauthorised SRH providers • Borrowing the required documents • Use of social media as support system • Silence • Borrowing from family and friends Healthcare worker's coping strategies • Patients as interpreters • Patient indexing • The use of medication containers • Community outreach programs
Suggested recommendations	Migrant women • Training of healthcare workers Provision of migrant friendly services. • Provision of interpretation services • Recruiting foreign healthcare workers • The required documents and action on complaints Healthcare workers • Collaboration with NGOs • Provision of interpretation services

6.3: The five dimensions of access

According to the Health Access Livelihood framework, access to healthcare is influenced by five dimensions of access which are geographic accessibility, affordability, availability, adequacy and acceptability [4].

6.3.1: Geographic accessibility of healthcare facility

The geographic accessibility of the healthcare facility has been recognised as a vital factor that determines women's access to and utilisation of health services including SRH and HIV services. Participants reported mixed responses regarding accessibility of healthcare facilities. Some participants, mainly internal migrant women reported being close to the health facility hence they usually walk from the place of residence or work to the healthcare facilities whenever they require SRH and HIV related services. However majority of international migrant women reported being far from the health facility hence inaccessible and costly as they could not afford the transportation costs every time they visit the health facility for SRH and HIV related services. Participants noted:

> *"The healthcare facilities are not far, I walk, and it is about 10 minutes away from this house."* (Internal migrant woman).
>
> *"It is not far, it is a walking distance from both my work and home."* (International migrant woman)
>
> *The healthcare facilities are not far, I walk, and it is about 10 minutes away from this house."* (Internal migrant woman).
>
> "*I am not that far from the health facility, I am 20 minutes away and I don't use transport, I walk because it is not far.*" (Internal migrant woman)
>
> International migrant women who found the healthcare facility to be inaccessible and therefore unaffordable reported that:
>
> *"Yes it is far, I walk for about 30 minutes or more and imagine if you are not feeling well it is too far and I do not afford the transport costs that is why I walk there*." (International migrant woman)
>
> *"I am far from the health facilities because I need to use transport to get there and it costs me R40 to get to the clinic which I cannot afford at times."* (International migrant woman)
>
> *"It is 20 to 30 minutes and since I work in the same area where I stay the time is almost the same and for me it is far and I use a taxi"* (International migrant woman).

6.3.2: Affordability of SRH and HIV services

The majority of the participants highlighted that SRH and HIV services are provided free of charge in the public healthcare facilities. As a result, obtaining the required SRH and HIV services from the public healthcare facilities is perceived as affordable as there are no administrative costs or service-related payments prior to accessing the required SRH and HIV services. Compared to internal migrant women, international migrant women reported being referred to the hospital for child delivery where they had to pay high hospital fees. They further highlighted that the services at the hospital were higher for child delivery and if you do not have valid or legal documents to stay in South Africa.

> *"Both HIV and SRH services are provided for free, you do not have to pay for you to get the services and there are no administration costs that need to be paid." (*International migrant woman)
>
> *"All the SRH and HIV services at the government clinics are provided free of charge and therefore affordable."* (International migrant woman)
>
> *"…You don't pay for the SRH and HIV services they are provided free of charge."* (Internal migrant woman)
>
> *"….I did not pay anything to obtain the SRH and HIV services."* (Internal migrant woman)
>
> *"…So what happens is for child delivery at the hospital if you do not have the proper documents you pay R 5000 for registration and R 15000 for delivery so all in all they pay R 20 000 and they do not assist you if you have not paid anything. They want you to pay at least half of the money. So it is unaffordable and difficult for us foreigners." (*International migrant woman).

6.3.3: Availability of SRH and HIV services

Internal and international migrant women reported similar experiences regarding availability of SRH and HIV services. The majority of the participants reported that some SRH services are not always available in the public health facilities, however, HIV services were reported to be always available. The services that are not always available are mainly pregnancy related which are the injection (depo Provera), pregnancy testing kits and abortion services. The participants highlighted that:

"At times they tell you that they do not have the services especially the injection and depo and you must come after a certain time, when you go back they still tell you stories." (Internal migrant woman)

"I went for abortion services at the clinic and they told me that they do not offer abortion services in the surrounding clinics." (International migrant woman).

"There is another time when I went to the health facility I wasn't well, I had pregnancy symptoms and the nurse who attended to me told me that I was supposed to bring my own pregnancy testing kit for them to test me not knowing if they did not have the pregnant testing kits or maybe since I am an outsider they wanted me to bring my own. Also when I wanted to try the injection they did not have it." (International migrant woman).

"Yes especially in clinics they do not do abortions so they refer you to a hospital." (International migrant woman).

6.3.4: Adequacy of SRH and HIV services

International migrant women explained inadequacy of SRH and HIV services in relation to unavailability of some contraceptive methods and procedural loopholes. Following unavailability of SRH and HIV services, international migrant women expressed that they could not take the alternative contraceptive method options as they are different from what they have been using hence regarded as inadequate by participants. In addition, international migrant women felt that service provision was not adequate as some crucial procedures were not followed and they were not involved or given a chance to make appropriate decisions about their pregnancy and HIV related services.

"…In 2016 when I tested positive for HIV they were supposed to test me for TB because I had the signs and symptoms of TB and I was continuously coughing but they did not test me, to me the service was not adequate." (International migrant woman).

"… For contraception they said we are going to inject you with this and they didn't give me a choice to decide that time it was immediate. So they only told me about the injection and that is what they wanted to provide me with, of which they were supposed to provide

me with variety of options so that I can choose what I want." (International migrant woman).

6.3.5: Acceptability

Regarding acceptability, majority of participants explained it in relation to their religion and culture. Participants raised some religious and cultural concerns when being examined or assisted by male healthcare workers. Cultural influence was highlighted in the form of discomfort in being examined and communicating about sexual health with male healthcare workers. Thus, women expressed that having a male healthcare worker assisting them with pregnancy related services is deemed unacceptable according to their religious and cultural morals. Participants reported:

"My religion is Islam and with Islam it is always female to female when requiring SRH and HIV services, even your partner must not be there. There is not so much of a male and a female mixing. So I broke the rules because I didn't have an option, sometimes I would find a male nurse and you know being in a foreign land it is difficult especially when the staff are not Islamic." (International migrant woman).

"…Sometimes I was attended to by a male nurse and I did not feel comfortable around male nurses because it goes against my culture" (Internal migrant woman).

"…I was transferred to the big hospital, and when I was there pregnancy dilation was checked by a male health worker. I was not comfortable with that and it is not acceptable according to my religious and cultural norms but I did not have an option" (International migrant woman).

"I can say abortion is against my religion so in as much as I went for it, my religion and the laws of where I come from does not allow it. It is unacceptable and regarded as murder. In addition, for SRH and HIV services there were male nurses and I did not feel comfortable explaining to them in detail my sexual issues as some words cannot be said to a male person in my culture, and I did not feel comfortable when they examined me during labour." (International migrant woman).

"My religion is against abortion, it's a sin to God and I know I have sinned because it is not acceptable." (International migrant woman).

6.4: Migrant women's experiences in accessing and utilising SRH and HIV services

Both internal and international migrant women highlighted experiencing several challenges in accessing SRH and HIV services in Ekurhuleni, South Africa. The challenges experienced in accessing and utilising SRH and HIV services stem from different levels namely; the individual, interpersonal, institutional and community level.

6.4.1: Individual level factors

6.4.1.1: Migration status

Migration status strongly influenced migrant women's access to and utilisation of health services including SRH and HIV services. Some participants have highlighted that the challenges they face which include discrimination and ill treatment from the healthcare workers is attributed to their migration status, as a result, they fear to contest maltreatment from the healthcare workers. Discrimination based on migration status was perceived to be more pronounced among international migrant women compared to internal migrant women.

Participants mentioned, *"The healthcare workers are full of discrimination. It is very hard for us as migrants because they take advantage of us they have this tendency of saying we have to do things their way as we do not have a say because we are not from here"* (internal migrant woman).

"… Especially if you are a migrant, they have a tendency of saying we are dirty and we do not bath" (Internal migrant woman).

"They were discriminating us foreigners because of where we come from" (International migrant woman)

6.4.1.2: Language barriers

It is inevitable to experience language barriers in South Africa because it is the main host of both international and internal migrants who speak different languages. All internal and international migrant women indicated that language is the major challenge they experience when accessing and utilising SRH and HIV services. However, the mostly affected women were international

migrant women from Malawi and Mozambique. As a result, it hinders migrant women from accessing and utilising the required services.

> Participants have reported that, *"… I was discriminated because I couldn't speak any other language except for Sepedi and because I am from Limpopo. The treatment was bad at first because of the language I speak…* (Internal migrant woman).
>
> *"What I saw is that language is the main problem so that is why many people do not like going to the hospital. When you talk to the nurses in English they tell you that I am not a White person talk to us in Zulu yet we do not know how to speak Zulu.*" (International migrant woman).
>
> *"When it comes to language it's a very big problem, because health workers mostly expect you to speak their local language yet you do not know it. That is the most problem in clinics because usually people coming from outside of the country in terms of language there is discrimination because they expect you to speak their language so how can you speak their language yet you don't even know it, maybe you have been in the country for only a week and you are being expected to speak the local language how is that possible when you have just arrived. So usually they give priority to those who speak the same language with them."* (International migrant woman).

6.4.2: Interpersonal factors

The majority of the respondents highlighted their families as the main source of support when accessing and utilising SRH and HIV services and intimate partner violence (IPV) services. The support they obtained from their family was in the form of financial and emotional support especially when they experience IPV. Families of international migrant women are in their countries of origin, as such, they mainly receive support from their friends. However, migrant women reported mixed experiences regarding partner (spousal) support.

6.4.2.1: Family and friends support

Participants reported obtaining financial and emotional support from family and friends when accessing and utilising SRH and HIV services and when dealing with intimate partner violence. Participants highlighted:

> *"My family supported me financially when accessing and utilising SRH and HIV services and emotionally when I experience violence from my partner."* (Internal migrant woman)

> *"They do not stay here they are in Zimbabwe but they supported me because when I gave birth I had complications. I was not feeling well and they sent my sister in law to help me with house chores and other things"* (International migrant woman)

> *"My family and friends provided me with money when I did not have it and with emotional support too. They convinced me to get him arrested but I didn't."* (Internal migrant woman)

6.4.2.2: Partner/spousal support

Although some participants highlighted that their partners were not supportive enough, they did not prohibit them from accessing and utilising the required SRH and HIV services. Some participants also highlighted that their partners provided social, emotional and financial support. Participants reported that:

> *"Sometimes he would escort me to the clinic but sometimes he would not. Yes he would assist me financially, he is the one who borrowed the money for transport."* (International migrant woman).

> *"He was very supportive. He would remind me of the dates, and also the time for taking the contraceptive tablets, he is the one who sets the alarm and reminds me every day. When the Depo Provera gave me some complications he encouraged me to go to the clinic and most of the time we went together to the clinic even when I was pregnant. Yes he gives me money when I do not have especially transport money."* (International migrant woman).

> *"…both emotionally and financially and he would also look after the baby and remind me about my injection (contraception) dates."* (Internal migrant woman).

> *"… When I always tell him that I am going to the clinic for family planning he does not have a problem with that, he assists financially*....(International migrant woman)

"Although he did not forbid me to access and utilise SRH and HIV services, he didn't care about anything, he really didn't play his part of being supportive in any way." (Internal migrant woman)

"*Yes he was supportive he would even wake me up early to go to the hospital for SRH services but he was also disappointed because I would come back without being attended to."* (International migrant).

"Only when it suits him, sometimes he gives me money for transport…" (Internal migrant woman)

"Yes, he supported me by encouraging me to go for SRH and HIV services and he financially support me" (International migrant woman)

"Yes he played his role of supporting me in every possible way, financially and emotionally when I accessed and utilised SRH and HIV services." (Internal migrant woman)

"Yes he was and is very supportive. Like he always reminds me when my contraceptive pills are almost finishing he always asks me if I still have them. Regarding financial support, you know life is so difficult, here and there he gives me money for transport." (International migrant woman)

"He would always make sure that I do not forget the dates they gave me an appointment to go to the clinic and to the hospital and he would make sure he goes with me, waits with me and comes back with me. Even on the day of giving birth he was there in the room." (International migrant woman)

6.4.2.3: Utilisation of formal IPV services

Although the majority of the participants highlighted that they obtained support from their partners, they also reported experiencing violence in the form of physical, sexual and emotional violence from their intimate partners. However, the majority of the participants who experienced IPV did not utilise formal IPV services, instead they shared their experiences with families and

friends. Some participants highlighted discomfort in sharing with family, hence they shared their experiences with strangers or with friends. The reasons highlighted for not utilising formal IPV services are fear of deportation as they do not have proper migration documents, cultural reasons, the partner being the breadwinner so they will not have anyone to take care of them if he gets arrested and fear of being judged by relatives.

Participants reported that:

> *"I experienced all sorts of violence from my partner. I did not get any form of help, I wanted to report him to the police but I did not. I saw that if I report him since he is the breadwinner I will have no one to look after me. Also I do not have enough papers so if I went there to report they were going to deport me"* (international migrant woman)

> *I just shared with my friends. I didn't tell my family because they are far. They are not here and you know if I tell them tension will always be there between my husband and my family so it's better if they do not know. I wish I could report him to the police but you know it only happens when he is drunk otherwise he is a loving and caring partner. Even if I wanted to report him to the police we were going to be deported together because we do not have valid documents. Otherwise when he is not drunk he is a loving person he takes good care of us so imagine if I report him who will take care of us. We are working towards him stopping alcohol and he is willing to stop it* (International migrant woman).

> *"I did not report him, I only shared with my family. You know I do not have proper documents, I overstayed so if I report him the police will deport me. In my culture it's also difficult to report to the police the father of your children. I didn't want to involve other people in my marriage, it is okay when it's only me and my family who knew about what I was going through."* (International migrant woman)

> *"…Even after pregnancy, the father of my children is the one who has been abusing me emotionally and spiritually. He would come home very late and drunk, he would even say hurtful things and that breaks my heart at all times"* (International migrant woman)

"Yes I have experienced physical, emotional and sexual violence from my partner. I have always reported him to the police. Sometimes they arrest him and he gets out, sometimes when I call them again they don't come and that is why I no longer report him " (Internal migrant woman).

". … I used to talk about my experience of IPV to people I didn't know. So that really helped me because they did not judge me since they did not know me. These people supported me by reminding me of my worth, telling me that everything will be fine and reminded me of my children. I didn't report him to police because they were his friends so I knew they wouldn't open a case against him" (Internal migrant woman)

"At first I wasn't comfortable with telling my family but as time went by I started to be comfortable because they saw that I was being abused. I didn't report to the police. I was scared of him and I thought that he may hurt me more." (Internal migrant woman)

6.4.3: Institutional factors

6.4.3.1: Healthcare facility requirements/standard operating procedures

As part of the standard operating procedures (SOP) patients are required to produce identification documents whenever they access health services. The majority of the participants mentioned documents that are required to obtain the required health services. The documents highlighted for international migrant women are passport or asylum and proof of residence and for internal migrants the national identity document and proof of residence. For HIV services, in addition to identity documents and proof of residence, they require a transfer letter. Failure to produce the documents (passport or ID and proof of residence) resulted in being denied access to healthcare services. However, there are some inconsistencies regarding service provision and the required documents as some international migrants indicated using their national identity documents instead of passports to obtain the required services. Furthermore, some participants reported being denied access to the healthcare facilities which are outside their residential community. Participants highlighted that:

*"They require passport, ID or asylum. If you don't have they do not help you at all. The hospital in this community is very strict but if you go to other clinics they can help you using the ID from your home country." (*International migrant woman).

"…But when I reached there they could not assist me they turned me away because I did not have my proof of residence. They told me that they cannot assist me because I am not from that community and I should go to the clinic in my community. So from there I don't bother them anymore, I go to women's clinic." (International migrant women).

"Yes they denied me access at the clinic because I didn't have my ID with me, I left it at home and I didn't have proof of residence." (Internal migrant woman).

6.4.3.2: Discrimination from healthcare workers

The majority of participants reported experiencing discrimination mainly based on their migration status, the language they speak, age and HIV status when accessing and utilising SRH and HIV services. Participants have expressed that:

"They discriminate a lot because we are foreigners. The way that they treat us sometimes is not good and it is not the same as the way they treat South Africans." (International migrant woman).

"They discriminate a lot. I was always insulted about being pregnant at a very young age and I was left unattended because of pregnancy and being HIV positive, they said they want to teach me a lesson that I will never forget and I always remember that every time I think of falling pregnant again." (Internal migrant woman).

"… Yes, a lot even. Especially if you are a migrant, they discriminate based on the language you speak and where you come from." (Internal migrant woman).

6.4.3.3: Healthcare workers attitude

The majority of participants expressed dissatisfaction highlighting that the healthcare workers insult, judge and shout at them when they seek SRH and HIV services.

"They shout at us even when you are in the queue saying you don't know what you are doing, Zimbabweans you are troublesome you give birth to so many children and these are some of the things that we are not satisfied with." (International migrant woman).

"*Here they have a bad attitude because we can't speak the same language as them and they shout at you sometimes…. I once went for abortion here in South Africa and you know they judged me, they made me feel uncomfortable like they were reminding me how sinful it is and blaming me for not preventing. So I did not like the way they treated me."* (International migrant woman).

"…they have a tendency of saying we are dirty, we do not bath..." (Internal migrant woman).

6.4.3.4: Waiting time

Despite having the health facilities opening for 24 hours from Monday to Friday for SRH services, participants wait for many hours before being attended to. Both internal and international migrant women described the waiting time to obtain the SRH related services as too long whereas they do not wait for prolonged hours to obtain HIV services. The majority of participants reported waiting for more than 3 hours to obtain SRH services. Some participants reported that:

"*The problem is that they tell you to get there (health facility) early in the morning but you will get attended after a very long time about 3 hours depending on the SRH services that you went for* (Internal migrant woman).

"We wait for long because they prioritise other patients and for us who sometimes will be going for family planning related issues we have to wait until they finish with other patients. So even if you go in the morning, you may get assisted late in the afternoon and when you go there in the afternoon they tell you that you should have come in the morning, there is always an excuse. So the waiting period is very long because sometimes you can even wait for about 4 to 5 hours." (International migrant woman).

"It takes a very long time to obtain the SRH services you want because they are very slow and they start working late so you have to wait for about 3- 4 hours." (Internal migrant woman)

"… For HIV testing and other HIV services the, it didn't even take long like most of the time I go there I don't wait for too long." (International migrant woman)

6.3.3.5: Interpretation services

Unavailability of interpretation services in the healthcare facilities could be the main factor behind migrant women experiencing language and communication barriers in accessing and utilising SRH and HIV services. Migrant women reported non-existence of interpretation services. Participants highlighted that:

"No there are no interpretation services…." (International migrant woman).

"No, interpretation services were not provided…" (International migrant woman).

"They do not have interpretation services they just call someone who speaks the same language like you. But language is a problem." (International migrant woman)

6.4.3.6: SRH referral

When the required SRH and HIV services were not available, participants were told to either come again after some time to check if the services are available or verbally referred to other clinics or hospital especially for child delivery, abortion and HIV related services. Thus, participants were not provided with referral letters and this was highlighted to be the reason for not utilising referral services unless if the condition is life threatening. Participants mentioned:

"No they didn't give us letters. They just tell you that in all the clinics they don't have the 3 months injection, it's finished" (International migrant woman).

"Well they tell you to come at a certain date or you can go to a private doctor if you can afford" (Internal migrant woman).

"No they do not refer, they just tell you to come next time or to choose from available methods" (International migrant woman).

"I was referred to give birth at the hospital as you cannot give birth at a clinic but they did not give me a letter, but because it's a life and death situation I had to go to the hospital." (Internal migrant woman).

"Yes for HIV and TB they referred me, they did not give me a letter…" (International migrant woman).

"…Especially in clinic they do not do abortions so they refer you to a hospital. You know I wasn't given a referral letter so I did not go." (International migrant woman).

6.4.4: Community factors

6.4.4.1: Support groups

The majority of the participants reported not being aware of any support groups that promote women's access to and utilisation of SRH and HIV services. However, one participant mentioned obtaining support from a group on social platform (Facebook) which she found to be very useful and helpful. Participants reported:

"No I don't belong to any group, I have never heard of any" (International migrant woman)

"No there are no support groups. I once looked for these groups after I heard another lady who told me that there are people from the health facilities who were walking in the community providing check-up services to those who cannot or are not able to go to the hospital but I did not see them I just heard about them" (International migrant woman).

"Yes there was one on Facebook. It was okay, they really supported me emotionally after I went through abortion and it helped me a lot. Yes it did but I forgot the name" (International migrant woman).

6.5: Coping strategies of migrant women to access and utilise SRH and HIV services

Migrant women resorted to several strategies in order to cope in the community where there are challenges in accessing and utilising SRH and HIV services. The strategies highlighted by migrant women are, going to private healthcare facilities, buying from unauthorized foreign individuals, borrowing the required documents from other patients, resorting to social media for support, remaining silent when they are discriminated against and borrowing money from family and friends.

6.5.1: Private healthcare facilities as alternatives

The majority of migrant women resorted to private healthcare facilities or pharmacies whenever the required services were not available or when they were denied access to the healthcare facility due to lack of the required documents. Participants reported:

> *"Whenever they do not have the SRH services I need or when they tell me that no you don't have the necessary documents, I go to the private hospital or the pharmacy."* (Internal migrant woman).

> *"When the Depo was not available I borrowed money and I went to buy it from the surgeries which are along the roads."* (Internal migrant woman).

6.5.2: Unauthorised SRH service providers

When international migrant women did not have the legal documents to stay in South Africa and when the required services were not available for example the pills, they purchased them from people who sell them illegally. Participants mentioned that:

> *"I noticed that they do not have the same contraceptive pills (control) found in my country and those are the ones I use so there are people from my country who sell them here and that is where I usually buy them."* (International migrant woman).

> *"My passport was over stayed so I ended up not giving it to them and I went to buy family planning tablets from other Zimbabweans who sell them by the road."* (International migrant woman).

6.5.3: Borrowing the required documents

Migrant women expressed that to access and utilise SRH and HIV services, one needs to be in possession of an ID or passport and proof of residence and failure to produce the required documents resulted in being denied access to healthcare facility and services. To access the required services, migrant women borrowed mainly the proof of residence from other patients.

> "*… An old woman overheard that I did not have proof of residence hence they could not assist me at the facility, she gave me hers, fortunately we were coming from the same area.*

So I used her proof of residence to obtain the SRH services I needed." (Internal migrant woman).

6.5.4: Use of social media as support system

Social media was used to gain emotional support when migrant women experienced discrimination and negative healthcare worker attitude. Emotional support and comfort was obtained from relating the migrant women's' experiences with experiences of other women who were in the similar situation.

"I was not happy with the way they treated me because of my HIV status and age, so I posted about it on my social networks and I received a lot of support from strangers and all of that made me feel better as I was able to relate other people's experiences through the comments on my post." (Internal migrant woman).

6.5.5: Silence

The majority of migrant women reported not taking any action or remaining silent when they were mistreated or discriminated against by healthcare workers. Silence was regarded as a solution for them to obtain the required services and also fear of being reported to the police when they do not possess the legal documents. Owing to ill-treatment, some migrant women chose to obtain the required services from facilities from other communities.

"*I did not do anything because I needed their help and I was in a foreign land. Even if maybe you want to tell her that you are not happy with the way they are treating you, you fear that they might even report you to the police that you do not have papers and that fear that you are not in your country, so I just kept quiet but it pained me a lot."* (International migrant woman).

"The bad treatment and discrimination I experienced didn't sit well with me to an extent that I even stopped going to the clinic I used to and went to another one in a different area." (Internal migrant woman).

6.5.6: Borrowing from family and friends

Migrant women reported borrowing money from family or friends for transport to the healthcare facility or to access and utilise the required SRH and HIV services from private facilities. Another migrant woman reported diverting the child social grant to obtain the required SRH services.

> *"When Depo was not available I went to buy it from the surgeries which are along the road. I did not have enough money because it was expensive so I ended up borrowing because I did not have a choice."* (International migrant woman).

> *"I went back and I just asked my friend she helped me with the money and I bought the testing kit and I did it by myself…."* (International migrant woman).

> *"… I have other kids, therefore I took their money for social grant and saved it so I can get to the hospital to obtain the SRH related services."* (Internal migrant woman).

6.6: Migrant women's suggested recommendations to ensure access to SRH services

Several measures have been proposed by both migrant women and healthcare workers to ensure access to and utilisation of SRH and HIV related services. The measures include training healthcare workers on the provision of equitable health service provision, on diverse cultural sensitive issues and healthcare worker behaviour change towards migrants. In addition, migrant women recommended the provision of interpretation services in health facilities, ensuring stock of commodities does not run out, employ healthcare workers who are multilingual or employing foreign healthcare workers and taking corrective action of the complaints in the suggestion boxes.

6.6.1: Training of healthcare workers and provision of migrant friendly services

Migrant women suggested training of healthcare workers and provision of migrant friendly services to ensure equal provision of SRH and HIV services. They reported that training especially on cultural sensitivity and behaviour change would improve the way healthcare workers treat and provide services to migrant women.

> *"It is better to train healthcare workers to be multilingual and also to train them on diverse cultural and religious beliefs so that they are aware and know how to handle women with special needs."* (International migrant woman).

"Healthcare workers needs specialized training for them to be friendly and supportive so that everyone could feel welcomed and ensure equality regardless of migration status. I believe that everyone has the right to be granted all the services which they need therefore their job as healthcare workers is not to check where people are from but to deliver the services so they need to understand that first. We need provision of services that are friendly to migrants." (Internal migrant woman).

"…training will enforce that equality is practiced everywhere because we are all human and we all deserve the same respect." (Internal migrant woman).

6.6.2: Provision of interpretation services and recruiting foreign healthcare workers

Migrant women believed that interpretation services and recruitment of foreign healthcare workers would minimise language challenges being faced by migrant women when accessing and utilising SRH and HIV services.

"…they need to employ interpreters or to employ nurses from other countries or to ensure that they don't give an attitude when someone speaks in English." (International migrant woman).

"They should hire healthcare workers from outside that is from other countries so that if you go to the clinic there is someone who is willing to speak in English and assist those who cannot speak South African languages." (International migrant woman).

"… As for language they need to employ interpreters (Internal migrant woman).

6.6.3: Provision of services to people without the required documents, action on complaints and stock outs

Migrant women suggested that SRH and HIV services should be provided to people even when they do not possess the required documents. In addition, the women suggested that their complaints

should be considered and commodities should always be available in order to improve migrant women's access to and utilisation of SRH and HIV services.

> *"They always say they need passports, proof of residence and permits when we go to the clinic so many people don't go to hospitals or clinics because of that. They die in their houses/homes. So they should help those without permits or passports, they should help them all …"* (International migrant woman)

> *"The government must do something about their workers because the clinics and hospitals are not rendering good services. They should not turn people away but rather find possible ways to assist even when we do not have the documents. Commodities should always be available they should make sure that they have enough stock of commodities."* (Internal migrant woman).

> *"I think complaints that we put in suggestion boxes should be taken seriously. With or without proper papers people should get treatment or any other service they want."* (International migrant woman).

6.7: Experiences of healthcare workers in providing SRH and HIV services to migrant women

Healthcare workers reported experiencing language/communication challenges in providing SRH and HIV services. In addition, they experience shortages/stock outs and complaints concerning long waiting hours when providing SRH services resulting in insults from the patients. Regarding HIV services healthcare workers highlighted lack of proper documentation in the form of a transfer letter for HIV positive patients. Furthermore, they have encountered patients who refuse to initiate HIV medication because of religious reasons. However, besides language barriers and lack of transfer letters, healthcare workers highlighted that non-migrant women also experience long waiting hours and shortage of SRH services.

6.7.1: Language barriers

Language was reported to be the main challenge experienced by healthcare workers in providing SRH and HIV services especially when providing the services to Malawian and Mozambican women. As a result, healthcare workers find it difficult to understand the required services as migrant women fail to express themselves. Healthcare workers reported that:

> *" ... Language is the major barrier. People from Mozambique cannot speak English, write their names and surnames, let alone speak English so it is hard for us to know what they want and because of communication barriers they sometimes fear to come to the clinic they think they will be mistreated because they cannot explain their problems clearly."* (HCW 1).

> *"The majority of migrant women that I have assisted were from Mozambique, Zimbabwe, Malawi and Limpopo. With the people from Mozambique some speak Tsonga and I am not able to speak Tsonga…. The same happened with those from Limpopo they were speaking Venda yet I don't understand it…With the Zimbabweans, the ones I came across were fluent in English so I never had a problem. The Malawian ladies could not speak English. So Language is the main barrier that I have experienced when providing STI/HIV services to migrants but not only STI/HIV, this applies to all the services they might need, language will always be a problem."* (HCW 2).

> *"... We experience language problems, sometimes it is difficult for migrants to express themselves and that makes our job difficult because we may misunderstand them."* (HCW 3).

6.7.2: Unavailability of SRH and HIV services

Healthcare workers highlighted experiencing shortages/stock outs of some SRH services resulting in insults and blaming as women default and have unplanned pregnancies. However, healthcare workers highlighted that they do not experience shortages when providing the services to migrant women only but to women in general.

> *"The challenge is that we mainly experience shortage of the injection. So most women default because of shortage of the injection and we usually have challenges with those who default because they fall pregnant and think that it is our fault." (HCW 1).*

"We do not provide termination of pregnancy services here and not only migrants but all women question us because they come thinking that we provide it." (HCW 2).

"We provide all the SRH services except for abortion and loop and sometimes the injection is not always available. So usually for the unavailable services they ask for referral letters but we don't give them, we just tell them to go somewhere else where they do TOP and we can see that they are not satisfied with the response." (HCW 3).

6.7.3: Administration costs and hospital fees

Healthcare workers highlighted that they did not encounter patients who failed to pay for the required SRH or HIV services because the services are provided free of charge. Healthcare workers reported that:

"No we did not experience any payment challenges because they don't have to pay anything, everything is provided at no cost. Everything at this clinic, all services are provided free of charge" (HCW 1)

"Everything is for free, they don't pay anything here so we have never encountered any hardships regarding payments". (HCW 2)

"No everything here is for free. They do not pay anything hence we did not experience any challenges." (HCW 3)

6.7.4: Waiting time

Healthcare workers reported receiving complaints of patients who wait for long hours without obtaining the required SRH related services. They lengthy waiting time was attributed to healthcare workers being involved in other tasks which are outside their daily responsibilities thereby increasing their workload. In addition, long waiting hours were due to language challenges as patients struggle to explain and understand the language used. Healthcare workers reported that:

"Sometimes they wait for too long. Our waiting time should be 45 minutes from the reception to provision of the service but there are so many things that can be involved and delay the process which makes them to wait a bit longer and they complain a lot. Like today people are protesting and we have closed the clinic too." (HCW 1).

"We serve a broad population here, so sometimes I see patients for SRH services around 2pm or 3pm and they complain that they have been here since 6am. So the waiting time is very lengthy. And most of the patients do not like or enjoy waiting for too long as they continue to talk about how long they have been waiting." HCW 2)

"Sometimes service provision is quick and sometimes it is not depending on how many nurses are on duty. But it should be 45 minutes according to the facility but in most cases it exceeds so they wait a bit longer and most of them do not have the patience they start complaining. Waiting also depends on whether the patient understands the language being used if not it also takes more time." (HCW 3)

"In as much as I provide family planning services I do other things in other departments for example emergency room or school health promotion hence they wait for too long" (HCW 4)

"So besides counselling which is my role, I also assist with opening files and it is not part of my job description which in a way increases my workload." (HCW 5)

"Besides pregnancy services, I also do health education, nutritional diet and malnutrition education." (HCW 6)

6.7.5: Lack of documentation

Healthcare workers highlighted the required documents for migrants to obtain SRH and HIV services. The documents are the identity document (ID), passport and proof of residence. In addition, for HIV services healthcare workers reported that migrant women lack proper documentation in the form of a transfer or referral letter making it difficult for them to provide correct medication. Healthcare workers reported that:

"They should come with their ID or passport and proof of residence, but most of the ones (migrants) who come do not have." (HCW 1)

"…they should have an ID, passport, and proof of residence and if they were on HIV treatment we require a transfer letter…." (HCW 2).

"I know that they are asked of their IDs even if you are not a migrant." (HCW 3)

"We have encountered situations whereby migrants feel bad and sometimes fear to come to the clinics…. Especially those without proper documents they fear to come thinking that they won't get assisted or they will be reported to the police, yet we don't do that because there are no rules and regulations that say we should report them. (HCW 4)

6.7.6: Recurring sickness

For sexually transmitted infections, healthcare workers reported having migrant women coming for the same treatment several times because their partners refused to seek treatment.

"…we have issues with migrant women coming back with the same sickness because their partners did not agree to come for treatment…" (HCW).

6.7.7: Religious challenges

Religious beliefs were highlighted by healthcare workers as a barrier they experience when providing HIV services to migrant women. They explained that migrant women refused to take medication as they believed that healing and cure comes solely from God and taking medication was against their faith and religious beliefs. It was reported:

"… Yes I have had some experiences with migrant women who refuse to take their medication because of religious beliefs. There was a lady who tested positive so she was sent to me for assessment and treatment initiation. She said to me I don't believe in this medication, I believe in God, he is the only person who can cure me. I am not going to take the medication. So I started counselling her and in the end she said, I am taking this medication just to please you because it is against my faith and religion. I am going to be on fasting and prayer and I will come back for you to test me negative next time because God would have healed me." (HCW).

6.8: Healthcare workers' coping strategies

6.8.1: Patients as interpreters

The use of other patients as interpreters, pictures or to get them to write down what they require whenever they encounter language challenges were reported by the healthcare workers to be useful strategies.

> *"I went out and looked for someone who can understand both languages to interpret for them and that assisted very well. In some cases where we could not find an interpreter we use pictures especially with migrants who cannot write or speak English. I have also noticed that with the Mozambicans they are normally accompanied by someone who interprets for them the person can be their husband or friends, they normally do that."* (HCW 1)

> *"… I had to look for a colleague who speaks Tsonga to interpret and translate…But if they can write we let them write so that we can read and understand what they want." (HWC 2)*

> *"… We look for other patients who can speak Portuguese and English to interpret for them." (HCW 3)*

6.8.2: Patient indexing

To ensure treatment of the partner of the migrant woman who gets treated for the same sickness, healthcare workers highlighted resorting to patient indexing.

> "*… For partners who do not want to come for HIV and STI treatment we do patient indexing, this is whereby we take the details of their partners that is the phone number(s), name and surname, age, so their partner would have told us not to tell him that she went to the hospital and that she gave them his number. So when we call him we would tell him that we are having a healthy week promotion where we are testing for BMI, Blood pressure, sugar etc. and even tell them when we have our big promotions where we give them airtime. So this will in a way make them feel like coming for those tests and we tell them when you come look for the person called so and so. So when they come the person knows this is a partner to this lady. So they will do the normal tests and eventually ask them for STI/HIV tests and normally they consent. That's how we get to ensure that they get treated."* (HCW)

6.8.3: The use of medication containers

For HIV services, healthcare workers highlighted asking the migrant women to bring the containers of their medication if they did not have the transfer or referral letter. This was reported as a way of confirming being on treatment.

> *"... If the person is positive and do not have a transfer letter, we ask them to bring the container of the tablets they are taking to show that they are taking treatment, if they do not have then we open a new file for them and start with them as a new patient."* (HCW)

6.8.4: Community outreach programs

Healthcare workers explained that there are migrant women who fear to access and utilise services from the health facilities because they do not possess the required legal documents. As a result, they highlighted having community outreach programs which target all women regardless of migration status. The program is aimed at educating and providing information, medication especially to the elderly and the disabled and follow-ups.

> *"... So in terms of them fearing to come to the hospital, we have people who provide them with information in the communities, and these people at times provide medication to elders and disabled people in the community. They are called WBOT- Ward Based Outreach Team. So when they provide them with information and encourage them to come, they end up not fearing to come. These people also do follow ups to check who is defaulting their tablets and they educate them on the dangers."* (HCW)

6.9: Healthcare workers' suggested recommendations to ensure access to SRH services for migrant women

6.9.1: Collaboration with non-governmental organizations (NGOs)

Healthcare workers believed that collaborating with NGOs would reduce patient waiting time to obtain SRH services and availability of SRH and HIV services. They gave an example of the reduced waiting time due to the facility's collaboration with the Aurum Institute in the provision of HIV services.

"…clinics should collaborate with NGOs in providing SRH services like what the Aurum Institute does in providing STI/HIV services thereby reducing the waiting time." (HCW)

6.9.2: Provision of interpretation services

Healthcare workers recommended the provision of interpretation services in healthcare facilities to minimize language challenges.

"…health facilities should have interpreters who will be able to assist when someone does not speak the local language and also migrants should be taught English and how to write." (HCW 1)

"… There is also need for interpretation services." (HCW 2).

6.9.3 English language to be compulsory

Healthcare workers highlighted facing language challenges mainly with migrant women from Mozambique, as a result, they recommended that Mozambique should enforce English language in the country.

"…Mozambique should make English compulsory." (HCW)

6.10 Summary of the chapter

This chapter presented the experiences and coping strategies of migrant women in accessing and utilising SRH and HIV services and the experiences of healthcare workers in providing these services to migrant women. Both internal and international migrant women highlighted mixed perceptions regarding geographic accessibility of healthcare facilities in Ekurhuleni. Participants who reported not being in close proximity to the healthcare facilities found accessing the healthcare facility to be expensive as they face transportation costs which they cannot afford at times. Regarding affordability of SRH services, all participants reported that SRH services are provided free of charge in all public facilities and there are no administration costs incurred. The provision of free basic health services in public health facilities in South Africa is in line with the 2030 Sustainable Development Goals of ensuring universal access to healthcare.

Owing to unavailability of some SRH services which include injections (Depo Provera), pregnancy testing kits and abortion services, migrants resorted to pharmacies and private surgeries where the

services are not affordable. In addition, some contraceptive methods especially the pill in South Africa were reported to be different from the ones provided in the country of origin, therefore, migrants purchase them from unauthorised individuals in the communities. The results show that cultural and religious beliefs are crucial in determining migrant women's access to and utilisation of SRH services. This is because reporting of IPV, abortion and provision of SRH services by male healthcare workers was deemed unacceptable by some migrant women. In addition to cultural reasons, some of the reasons for not accessing formal IPV services were fear of deportation, the partner being the breadwinner of the family and fear of being judged by relatives.

Language or communication challenges were highlighted as major barriers in accessing SRH and HIV services by migrant women and healthcare workers. Language and communication barriers were exacerbated by unavailability of interpretation services in the public healthcare facilities. As a coping mechanism, the healthcare workers identify other patients to perform interpretation services. Owing to language challenges, migrants encountered discrimination and negative healthcare worker attitude. Furthermore, discrimination and negative healthcare worker attitude was experienced in healthcare facilities owing to their migration status, falling pregnant at a younger age and being HIV positive.

The majority of migrant women expressed that they waited for long hours to obtain the required SRH services as compared to waiting time for HIV services which could be attributed to high workload as healthcare workers perform several tasks outside their scope. Regarding long waiting hours, some migrant women indicated that they resorted to obtaining their services from the women's clinic where they pay a fee and obtain the required services timeously. At every healthcare facility, the participants together with the healthcare workers highlighted that for administration purposes, national identity documents or passport and proof of residence are required and failure to produce the documents resulted in being denied access to the healthcare facility and therefore to the required SRH and HIV services. As a survival strategy, migrant women borrow documents, mainly proof of residence from other patients in order to have access to the healthcare facility and to obtain the required SRH and HIV services. The study shows that migrant women face stigmatisation and judgmental sentiments from healthcare workers when accessing and utilising abortion services. In addition, judgmental and stigmatisation sentiments from health

care workers act as a barrier to access and utilisation of SRH services by adolescents and young women.

CHAPTER 7: DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

7.1: Introduction

To address the objectives of the study, the research employed mixed methods. The aim of this research was to investigate the factors associated with access to and utilisation of SRH services among women living in high migration communities in the Kingdom of Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia. The experiences and coping strategies of migrant women in accessing and utilising SRH services and of healthcare workers in providing SRH services to migrant women were also explored. The socio-ecological model and the health access framework were used to guide the study. To investigate the influence of male partners in accessing and utilising SRH services, some male variables were incorporated into the analysis of partnered women's access to condoms, access to HIV testing services, current utilisation of modern contraceptive methods, utilisation of SRH referral services and utilisation of IPV services. This chapter discusses points of convergence and divergence with the existing literature in explaining the results.

7.2: Discussion of results

7.2.1: Access to SRH services

In this study, international migrants experienced limited access to HIV services. This limited access may be explained by the findings of the qualitative component of this study where discrimination against migrants restricted their access to and use of SRH services. Similar results have been documented globally and in specific countries in Southern Africa namely Angola, Lesotho, Malawi, South Africa, Mozambique, Eswatini, Botswana, Zambia and Zimbabwe [40,42–44,66,72,147,149–151]. The results show that access to both condoms and HIV testing services differed significantly across countries. Compared to women in South Africa, women in Lesotho, Malawi, Mozambique, Swaziland and Zambia had higher odds of not being able to access condoms. Although South African women had better access to condoms than the other countries in the study, literature has shown that South Africa has the highest number of unwanted pregnancies among AYPs and people living with HIV. Previous literature has attributed demand for condoms to the desire to prevent unwanted pregnancy and HIV infection [176]. In addition, the country differences in accessing condoms and HIV testing services could be attributed to

different beliefs, perceptions and acceptance levels as condom use and HIV testing in many African countries is linked to promiscuous behaviour, hence the negative connotations act as barriers to accessing condoms and HIV testing services.

In addition, differences in accessing condoms could be attributed to policies which differ between countries in the way in which they promote access to condoms and emphasise dissemination of HIV information and promotion of HIV testing. For example, the education policy in South Africa permits condom distribution in schools whereas in Zambia and Malawi the policy prohibits distribution of condoms in schools [177]. Although there are country differentials, the results of this study are encouraging and positive as the majority (68%) of the participants reported having access to condoms. This suggests that although people have concerns about condoms, they are gaining acceptance in all the countries.

Findings of the quantitative study shows that the odds of accessing condoms were lower for younger women and never married women compared to older, married and formerly married women. Similarly, the qualitative component of this study showed that younger women faced challenges in accessing and utilising SRH and HIV services, this was attributed to discrimination because of age and negative healthcare worker attitude. These results are similar to those of another study in Ghana where age and marital status were found to be inhibitors of access to SRH services for adolescents and never married women. Similar to the findings of this study, in Ghana this was attributed to negative health worker attitude and shared norms which discourage access and use of contraception by teenagers and never married women [178]. However, the finding of this study that married women had higher odds of accessing condoms and HIV testing contradicts the findings of studies conducted in South Africa and Malawi where married women were found to have lower odds of accessing condoms [62,179].

This study identified a significant association between educational level and not having access to both condoms and HIV testing services, women with higher education were less likely not to have access to HIV testing services. Similarly, findings from the literature have shown that women with higher education are more likely to access SRH services than women with lower or no education [180–184]. A possible explanation of the findings could be that education empowers and provides

women with autonomy to make informed decisions regarding their sexual and reproductive health as it improves women's knowledge and attitude towards the use of HIV testing services [181,185]. This study found that women who had comprehensive knowledge about SRH and comprehensive knowledge about HIV had lower odds of not accessing condoms. A possible explanation can be obtained from existing studies which show that women who possess accurate knowledge about SRH and HIV can dismiss misconceptions and inaccurate information about condoms which normally hinder women from accessing SRH services [184,186]. It is therefore important to ensure that correct information is imparted to women regardless of their migration status, age, educational level and marital status.

In this study, religion plays a crucial role in women's access to SRH services. Similar to previous findings of studies conducted in Norway and Tanzania, Catholic women were found to have lower odds of accessing condoms compared to non-religious women [187,188]. A possible explanation could be the Catholic religious teachings which prohibit the use of hormonal methods and condoms [187,188]. Although the legal status of the migrants was beyond the scope of this study, it is crucial in determining access to SRH services. It is expected that illegal migrants face more challenges compared to legal migrants, however, in this study, the qualitative results showed that all migrants including internal migrants face similar challenges in accessing SRH services.

7.2.2: Utilisation of SRH services

7.2.2.1: Utilisation of modern contraceptive methods

The findings show no significant association between migration status and current non-use of modern contraceptive methods. This study found that women who used modern contraceptive methods were slightly younger, employed and have comprehensive knowledge about SRH. An explanation to the study finding could be because of postponement of marriage by younger women hence they use modern contraceptive methods to prevent getting pregnant. The results are consistent with previous research which showed the importance of age in utilising SRH services including modern contraceptive methods [189].

Similar results were documented in the previous studies that found employment status to be an important factor that determine utilisation of modern contraceptive methods [69,189]. The results

of this study could be attributed to the fact that knowledge and employment act as empowerment tools that encourage women to make appropriate decisions concerning their reproductive health and well as enforcing their reproductive health rights. In addition, employed women are financially less dependent on their partners hence they are less likely to face financial challenges that may hinder them from not utilising the required modern contraceptive methods. The results show country differentials in non-use of modern contraceptive methods. Compared to women from South Africa, women from Malawi and Eswatini had lower odds of modern contraceptive methods non-use.

This study found marital status to be an important factor that determines women's use of contraception. Compared to never married women, married and formerly married women had higher odds of not utilising modern contraceptive methods. The results could be attributed to the fact that in African societies, childbearing is more pronounced in marriages and contraception is used for child spacing while never married women consistently use modern contraceptive methods to avoid pregnancy [62,189]. Consistent with previous findings, Catholic women were found to have higher odds of modern contraceptive non-use compared to other Christians. An explanation could be the Catholic doctrine that prohibits women from using modern contraceptive methods [189]. Regarding partner characteristic variables, partner's age and partner's educational level were associated with women's utilisation of modern contraceptive methods. Women with older and educated partners had higher odds of utilising modern contraceptive methods. A possible explanation could be that older and educated partners are aware of the consequences of not utilising modern contraceptive methods. As such, they may encourage their partners to use modern contraceptive methods in order to avoid unwanted and unplanned pregnancies.

7.2.2.2: Utilisation of SRH referral services

The results show that migration status differed between women who utilised SRH referral services and women who did not. Women who utilised SRH referrals were more likely to be non-migrants while those who did not were more likely to be internal or international migrants. A previous study found similar results where migrants were found to have compromised access to SRH referral services [61]. The results maybe be explained by the qualitative findings of this study which showed that SRH referrals were provided verbally, hence lack of written referrals resulted in non-utilisation of SRH referral services by migrant women. In Africa, and southern Africa in particular,

it is difficult to be provided with a referral letter that you can use in another country and health facilities do not have specific regional transfer letters that can be used in the destination country [9,190]. The results of this study are similar to findings of a mixed methods study that was conducted among migrants in Lesotho and South Africa, where lack of transfer or referral letters was found to hinder access to SRH services including HIV services among migrants [44]. In addition, an explanation of the results could be that migrants may fear to go for referrals in the destination country due to lack of proper documents and being unable to locate the health facility to which they have been referred.

Unexpectedly, women who reported having been denied access to a healthcare facility were found to have higher odds of utilising SRH referral services compared to women who were never denied access to healthcare facility. The unexpected results could be because the question on referrals was self-reported and participants could have been informally referred by other community members after being denied access at a certain health facility. There were differences in utilisation of SRH services across the six countries. Women in Malawi, Mozambique, Eswatini and Zambia had lower odds of utilising SRH referral services compared to women in South Africa. A possible explanation of country differences could be attributed to different socio-economic, cultural norms and beliefs as well as different levels of women economic empowerment with South Africa being the main destination for migrants because of its relatively advanced economic development. The study found that married women and formerly married women had higher odds of utilising SRH referral services. A possible explanation could be the finding of the qualitative component of this study which showed that married women utilised SRH referral services when they have a life threatening condition for example, delivery of babies. Partner characteristic variables were not found to be significantly associated with utilisation of SRH referral services.

7.2.2.3: Utilisation of IPV services

The results show that migration status is associated with utilisation of IPV services. Compared to non-migrants, internal and international migrant women had lower odds of utilising IPV services. Similar results were highlighted in the qualitative component of this study and other previous studies and the reasons provided as barriers for not utilising IPV services are fear of deportation, dependency on the partner, injustice by the police, fear of being judged by relatives and cultural

reasons [127,140,191–194]. This study shows the importance of age as a determinant for utilisation of IPV services.

Women who utilised IPV services were older on average than those who did not utilise IPV services. The findings are in line with previous findings where older women were found to utilise IPV services more than younger women [195–197]. A possible explanation could be attributed to younger women being afraid of reporting their partners owing to their age differences because in the African context, in an ideal relationship, men are usually older than women which gives them the leverage to manipulate their younger partners. Contrary to the finding, some studies globally found that younger women had higher odds of utilising IPV services than older women [117,124,127,129,131,135,136,198]. Furthermore, in other studies age was found to have no effect on women's utilization of IPV services [132–134].

This study found attitude towards wife beating to be a crucial determinants of women's utilisation of IPV services [127,140,192,194,199]. Women who justify beating from their partners were less likely to utilise IPV services. A possible explanation could be the patriarchal norms and values and gender-role socialization which normalizes perpetration of violence between couples and marriages [127,140,192,194,199]. Partner characteristic variables were not associated with utilisation of IPV services.

7.3: The dimensions of access

The Health Access Framework of Obrist et al (2007) acknowledges the influence of the dimensions of access in women's access to and utilisation of SRH services. While internal migrant women reported to be in close proximity to the public health facilities, international migrant women reported the public health facilities to be far from where they stay and work. In line with the Health access framework, this study found that although participants reported having SRH services free of charge, costs associated with geographic accessibility of healthcare facilities act as barriers to access and utilisation of SRH services. Many international migrants are employed in unskilled low paying jobs, hence they find accommodation close to the health facilities expensive. As a result, they reside far from the health facilities where they have to use transport making it costly for them to access the health facilities. The findings corroborate studies conducted among migrants in

England, South Africa, Lesotho and Ethiopia which found that despite SRH services being provided free of charge, the costs associated with accessing the facilities (transportation costs) hindered migrants from accessing and utilising the required services [44,67,71,75,106,149,151].

In support of the findings, a study conducted among sub-Saharan migrants living in Australia, United Kingdom, Netherlands and Botswana found that financial challenges acted as a barrier to accessing SRH services [43,67,72,147,150]. Similarly, previous findings show that within the healthcare system the barriers were unavailability of services, and cost of services [66]. Although SRH services are provided free of charge in all public health facilities, unavailability of some SRH services rendered the services unaffordable as migrants purchase them from pharmacies and private surgeries where they are expensive. The results could be attributed to the fact that many public health facilities in southern Africa lack funding. As a result of financial constraints, healthcare facilities fall short of some crucial commodities rendering some services and commodities unavailable.

The results show that cultural and religious beliefs determine migrant women's access to and utilisation of SRH services. Owing to culture and religion, some women found it unacceptable to have conversations on sexual and reproductive health with male health workers. Similar to the findings of this study, qualitative studies of migrants in Australia and Canada found that socio-cultural factors and lack of trust regarding the confidentiality of the HIV results hindered migrants from accessing and utilising SRH services [42,147,151].Other studies globally have similarly reported that, utilisation of IPV services and provision of SRH services by male healthcare workers was deemed culturally unacceptable by some migrant women [67,74,201,202,75,106,140–143,194,200].

7.4: Experiences of migrant women in accessing and utilising SRH services

The conceptual framework for this study which was partly drawn from the Socio-Ecological Model of McLeroy et al. (1988) shows that factors at different levels influence women's access to and utilisation of SRH services. In line with the conceptual framework, at the intrapersonal level, language or communication challenges were highlighted as the major barriers in accessing and providing SRH related services. Similar findings were documented in studies conducted in

Lesotho, South Africa and Geneva where language, discrimination and being a migrant hindered migrants from accessing SRH services including HIV services [30,44,67,70,106,151,201,202]. This study revealed that women from Malawi and Mozambique were the most affected with language challenges as they could not speak English. As a result, from the qualitative component of this study, migrant women suggested that healthcare facilities should provide interpretation services. However, given the financial situation of the health sector, and unavailability or stock out of essential services, employing a language interpreter is unrealistic and costly, more so, the interpreter may not be able to know all the languages spoken by migrant women [78]. A possible solution could be a behaviour change training for healthcare workers that encourages them to communicate in English with anyone who seems not to understand the local language. Language and communication barriers were exacerbated by unavailability of interpretation services in the health facilities. Furthermore, findings from this study and previous studies showed that owing to language challenges, migrants encountered discrimination and negative healthcare worker attitude [44,67,74,148,201]. In addition, this study and previous studies found that migration status, falling pregnant at a younger age and being HIV positive were some of the factors that led to discrimination and negative healthcare worker attitude [147,201].

At institutional level, the prolonged waiting time to obtain SRH related services reported in this study could be attributed to high workload as healthcare workers perform several tasks outside their scope. This study and previous studies in Africa found that being denied access to the healthcare facility and therefore to the required SRH services was experienced when migrants did not have either the national identity documents/ passport or proof of residence [30,43,44,71,106]. In this study, denied access due to lack of the required documents was more pronounced among international migrant women compared to internal migrant women. However, as a standard operating procedure, migrants are obliged to produce their identification documents hence, the suggestion that services should be provided to everyone irrespective of legal status is difficult to apply. As a result, the current situation of borrowing the required documents reported by migrant women in this study is likely to continue as migrant women require health services including SRH and HIV services in the host country. Similar to previous findings on access to and utilisation of abortion services, the study shows that migrant women face stigmatisation and judgmental sentiments from healthcare workers [51,71,203]. Similarly, negative attitude and stigmatisation

from health care workers hindered access to and utilisation of SRH services by adolescents and young women [71,204].

In the quantitative component, women were asked if they were ever denied access to any public healthcare facility and the reasons for being denied access, 294 women reported ever having been denied access to a public healthcare facility. Similar to the qualitative findings of this study, the reasons that were provided for being denied access in the quantitative questionnaire were; that they did not have the identity documents (6.1%), their permit had expired (5.1%), language problems (16.0%), they did not have money (67%), they did not have the referral letter (37%), unavailability of medication mainly contraceptives (7.5%) and because of age restrictions (7.1%) as they were told to bring their parents in order to obtain contraceptive methods.

7.5: Experiences of healthcare workers in providing SRH and HIV services to migrant women

The findings show that healthcare workers experience language barriers when providing SRH and HIV services to migrant women. To cope with the language barriers, other patients provide interpretation services. In addition, healthcare workers experience shortage or stock-outs of SRH services and this could be due to shortage or lack of funding in the health sector. Similar results were documented in a study conducted in Australia were unavailability of services, time constraints and cost of services were found to be barriers in the healthcare system [66]. Furthermore, healthcare workers reported patients waiting for prolonged time owing to shortage of healthcare workers which result in healthcare workers working in other tasks which are outside their daily responsibilities. It has been documented that one of the health challenges faced in Southern Africa is of shortage of healthcare workers which negatively impacts on service provision [78].

In this study, healthcare workers highlighted lack of referral or transfer letters as a challenge they face. Similar results were documented in Lesotho and South Africa where lack of referral or transfer letters posed challenges in providing HIV services to migrants [44]. When providing STI services, healthcare workers experienced having migrant women with recurring sickness as a result they resort to patient indexing (taking contact details of a partner and encourage them to go for

treatment) in order to be able to treat the partner. The recurring sickness is a result of migrant women not disclosing the sickness to their partners and encourage them to be treated as they fear to be blamed for bringing the sickness even if they were not promiscuous.

7.6: Strengths and limitations of the study

The study has a number of strengths:

1. This is the first study in Southern Africa to attempt to provide a balanced view of the factors and experiences in accessing, utilising and proving SRH and HIV services from both migrant women (internal and international) and healthcare workers.
2. The study also utilised different types of data sources, that is, the SRHR-HIV Knows No Borders data and the primary data collected in Ekurhuleni. In addition, it was conducted in six southern African countries thereby depicting the current status of migrant women's access to SRH and HIV services in the countries.
3. It is one of the few studies that used the socio-ecological model to explore the factors/experiences that influence access to and utilisation of SRH and HIV services by migrant women and experiences of healthcare workers in providing SRH and HIV services to migrant women.
4. The study used appropriate and relevant methods (mixed methods) to perform statistical and thematic analysis. These methods adequately provide an analysis of the factors behind migrant women's access to and utilisation of SRH and HIV services and provides detailed experiences of both migrant women and healthcare workers.
5. Fourth, the study has reaffirmed the socio-ecological theory that several factors/ecological level factors equally matter in influencing migrant women's access to and utilisation of SRH and HIV in southern Africa as in developed countries as shown by the previous studies.

The study has shown the importance of socio-cultural norms and religion in migrant women's access to and utilisation of SRH and HIV services. Cultural norms, values and practices specific to ethnic groups play an important role in determining health behaviours. The limitations of this study include: The cross-sectional design, which makes it difficult to conclude that there was a causal relationship between the explanatory variables and outcome variables.

The data collected was self-reported hence it may be subject to recall bias for example recalling information about their partners' age, educational level and occupation. In addition, the study is subject to social desirability bias and under-reporting especially regarding experience of intimate partner violence and experiences in accessing and utilising SRH and HIV services. The baseline survey was conducted primarily in selected migration and transport corridors which may not be representative of all the migration/transport corridors in the countries. As such, the results may not be generalizable to the countries. Regarding the measurement of access outcome variables, measurement of access to other modern contraceptive methods was not possible as the questions on access were limited to condoms. Similarly, measurement of access to other HIV services (especially access to PMTCT services) was not possible as the questions were restricted to HIV testing services.

The quantitative component of the study covers all six countries while the qualitative component was limited to one site (Ekurhuleni) in South Africa. As a result, exploration and documentation of experiences and coping strategies of migrant women is restricted to South Africa. Another limitation lies with the selection of participants for the qualitative study. Selection of qualitative participants was not premised on their participation in the quantitative component. This might result in divergent findings between quantitative and qualitative findings.

7.6: Conclusion

In Southern Africa, despite efforts at ensuring universal access to healthcare, this study confirmed that access to and utilisation of SRH services is a major challenge for women in general and migrant women in particular. In addition, the qualitative findings have shown that both internal and international migrant women experience similar challenges in accessing and utilising SRH and HIV services. This is attributed to several factors at intrapersonal, interpersonal and institutional levels which hinder migrant women from accessing and utilising SRH services. However, the challenges faced are more pronounced for international migrant women compared to internal migrant women. Similarly, healthcare workers encounter several changes when providing SRH and HIV services. As such, it is important to understand and evaluate the existing experiences of migrant women when accessing and utilising health services and SRH services in order to develop migrant-sensitive strategies aimed at improving access to and utilisation of SRH

services. This can be achieved by harmonizing migration and health policies at all levels and raising awareness among healthcare workers regarding the policies and their implementation. In order to bridge the gap between health policies and immigration policies, countries in Southern Africa can draw lessons from Thailand. In Thailand, the Ministry of Public Health successfully introduced the concept of migrant-friendliness in health service delivery with an overarching theme of "Healthy migrants, Healthy Thailand", aimed at improving migrants' information, knowledge and awareness of health entitlements and access to health services[5]. This is crucial in curbing the negative consequences that arise from lack of information or awareness about migrants' rights to health services and availability of health services including SRH services in the host country. Thus, there is need for countries in Southern Africa to ensure that the immigration policies are in tandem with the national health policies in emphasising universal access to healthcare regardless of migration status and health service provision to be consistent with the principle of non-discrimination. In addition, healthcare workers can be trained on behaviour change and culturally sensitive issues in order to minimize discrimination, stigmatization and enhance service acceptance by migrant women.

7.7: Contribution of the study

Owing to the unavailability of migration data, this study has contributed by providing recent statistics and data on internal migrant women, international migrant women, non-migrants and healthcare workers thereby fulfilling one of the objectives of the Global Compact. The similarities and differences revealed by the study in terms of access to and utilisation of SRH and HIV services by internal migrant women, international migrant women and healthcare workers contributes to the ongoing migration debates and migration policies. The use of mixed methods is one of the contributions as the few studies conducted in Southern Africa were mainly qualitative owing to unavailability of migration data. Furthermore, the study focused on both migrants and healthcare workers thereby providing balanced views from both the user and the provider which has not been previously done in southern Africa. In addition, the study applied the socio-ecological model together with the health access framework to investigate and explore the factors associated with access to and utilisation of SRH services. The study is unique in that it looked at the factors that are associated with SRH referral services and IPV services thereby contributing immensely to the

available literature. The study controlled for the influence of partner characteristics and qualitatively explored factors at multiple levels that can affect women's access to and utilisation of SRH services. Owing to scanty research on migration and access to and utilisation of SRH services (public health) in Africa and southern Africa in particular, the study has made a notable contribution to the existing literature. The knowledge and findings from this study has contributed immensely to understanding of migration and access to and utilisation of SRH services in sub-Saharan Africa. Thus, the findings of the study are valuable in health policy formulation, alteration and programme planning and implementation.

7.8: Recommendations

7.8.1: Research recommendations

Although this study explored the socio-ecological factors qualitatively, it could not do so quantitatively. This was due to an error in data collection as village identifiers were not collected and hence multilevel models could not be fitted. As such, it is recommended for future studies to investigate multilevel factors using both quantitative and qualitative methods in order to have a comprehensive understanding of the factors that influence access and utilisation of SRH services. Most societies in Africa including southern Africa, are patriarchal. Issues of access to and utilisation of SRH services especially contraception, IPV services and HIV services come from the social structures and gender-role socialization. These patriarchal societies are characterised by unequal division of power and decision-making which have an influence on women's access to and utilisation of healthcare services, SRH services in particular. It is therefore recommended that research on access and utilisation of SRH services should incorporate community level variables that are reflective of the wider societal social organization.

In addition, some variables which were not analysed in this study could be included in future research. For instance, household characteristics and pooled couple characteristics. This study explored factors and experiences of migrant women and healthcare workers. Further exploration is required that includes other stakeholders for example, male partners, community leaders and policy makers.

Although this study investigated the factors that are associated with access to and utilisation of SRH services among non-migrants, internal migrants and international migrants, the study did not go further to examine the different categories of international migrants which include the illegal migrants, the legal migrants, the refugees and the asylum seekers as they may encounter different experiences in accessing and utilising SRH services. As such, it is recommended for future research to look at the different categories of international migrants taking into account the reasons that led them to migrate.

7.8.2: Programme recommendations

It is recommended that programmes and interventions aimed at improving women's access to and utilisation of SRH services should involve their partners. Furthermore, churches can be used as information dissemination platforms aimed at influencing women's access to and utilisation of SRH services by supporting efforts to ensure universal access to health services.

7.8.3: Policy recommendations

This study found that collaboration of healthcare facilities with other parties could improve the provision of health services in terms of quality and waiting time. As such, it is recommended for governments to find ways of collaborating with NGOs to ensure that services and commodities are always available and source funding to finance the introduction of interpretation services in healthcare facilities. The study confirms that despite having regional efforts to ensure universal access to health services, migrants face challenges in accessing and utilising SRH services. Therefore, at regional, national, provincial and district level, governments should recognise migration as a public health issue and mainstream it in the migration and health policy frameworks and development agendas. Only when the migration and health policies are harmonised will programmes and interventions aimed at ensuring universal access to health services be a success in promoting access and utilisation of services by migrants.

Furthermore, the continued challenges being faced by migrants after the inclusion of migration and health in the immigration policies, universal access to health in the SDGs and the global compact for Safe, Orderly and Regular Migration indicates the absence of policy implementation

at health facility level. It is crucial to ensure that all the healthcare workers are cognisant of the immigration policies and enforce implementation through regular monitoring and performance evaluations. In addition, enhancing access to and utilisation of SRH services for migrants requires training of healthcare workers on behaviour change and equitable provision of services regardless of migration status. Healthcare facilities should thrive to have migrant-sensitive services and interpretation services. At regional level, the SADC Policy Framework for Population Mobility and Communicable Diseases focuses on HIV and AIDS, TB and Malaria. It is recommended that SRH related issues should be incorporated in the framework as reproductive health is of significant importance.

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Appendices

Information sheets
Appendix 1: Information sheet – Migrant women

UNIVERSITY OF THE WITWATERSRAND

FACULTY OF HEALTH SCIENCES, SCHOOL OF PUBLIC HEALTH

Site name: ……... Date……..

Category …….. Participant number……

INFORMATION SHEET

Study title: Access to and utilisation of sexual and reproductive health services: A study of migrant women in six Southern African countries.

Good day Madam

My name is Christine Chawhanda, a PhD student in the School of Public Health, University of Witwatersrand in Johannesburg, South Africa. I am conducting a research on the factors, experiences and coping strategies that are associated with access to and utilization of Sexual and Reproductive Health services by migrant women living in Ekurhuleni and Nkomazi districts. Research is a process used in seeking new knowledge. In this study, I want to learn about migrant women's experiences and coping strategies in accessing and utilising sexual and reproductive health services. The research is a requirement in fulfilment of my PhD degree.

I am inviting you to participate in this research study. Please take your time to decide if you are willing to take part in this study.

This is a qualitative study involving adult migrant women in Ekurhuleni and Nkomazi districts. I will be conducting face to face discussions with those who are willing to participate in the study. The information provided will be confidential and your name will be kept anonymous with only codes assigned on the questionnaire for each category of migrants and the questionnaires will be kept safely in a locked office. Digital recorders will be used, and the information provided will only be accessed by people involved in the study (supervisor, student and the research assistants). The main purpose of recording is to ensure that all the information provided and discussed is captured. The summary of findings from this study will be shared in presentations and publications.

Participation in this study will require about one hour of your time and it is voluntary and does not involve any risks. If you do not feel comfortable to participate or continue answering during the interview or if there are questions you would rather not answer, let me know and your decision will be respected. You have the right to withdraw from participating at any time and there will be no form of prejudice or penalty as a result of your withdrawal. This is to reinforce that participation is voluntary and there are no consequences for refusing to participate or withdrawing your participation. There are no costs to the participant that are associated with participating in this study There are no direct benefits or remuneration associated with participating in this study, but the information provided might assist in informing policy makers to ensure that Sexual and Reproductive Health Services become accessible to everyone regardless of migration status.

If you agree to participate, I will require you to sign or have your thumb print on the consent form which only serves the purpose that the study has been well explained to you and you agree to participate. Please feel free to ask any questions that you may have regarding the study.

For further information and clarification, you can contact:

Student researcher:

Name: Christine Chawhanda

Phone number: 0027627404028

Email: 1502472 @students.wits.ac.za or cchawhanda@gmail.com

University of Witwatersrand Human Research Ethics Committee

Ms Zanele Ndlovu, or Mr Rhulani Mkansi, Faculty of Health Sciences, Phillip Tobias Building, Offices 301,302 and 304, 3rd Floor, 29 Princess of Wales Terrace, Parktown, 2193, Email: HREC-Medical.ResearchOffice@wits.ac.za ; Zanele.Ndlovu@wits.ac.za ; Rhulani.Mkansi@wits.ac.za ,Tel 011 717 1234 / 1252 / 2656 / 2700.

Appendix 2: Information sheet – Healthcare workers

UNIVERSITY OF THE WITWATERSRAND

FACULTY OF HEALTH SCIENCES, SCHOOL OF PUBLIC HEALTH

Site name: ……... Date……..

Category …….. Participant number……

INFORMATION SHEET

Study title: Access to and utilisation of sexual and reproductive health services: A study of migrant women in six Southern African countries.

Good day Sir/Madam

My name is Christine Chawhanda, a PhD student in the School of Public Health, University of Witwatersrand in Johannesburg, South Africa. I am conducting a research on the factors, experiences and coping strategies that are associated with access to and utilization of Sexual and Reproductive Health services by migrant women living in Ekurhuleni and Nkomazi districts. Research is a process used in seeking new knowledge. In this study, I want to learn about health care workers experiences in providing sexual and reproductive health services to migrant women. The research is a requirement in fulfilment of my PhD degree.

I am inviting you to participate in this research study. Please take your time to decide if you are willing to take part in this study.

This is a qualitative study involving adult men and women health care workers who provide sexual and reproductive health services in Ekurhuleni and Nkomazi districts. I will be conducting face to face discussions with those who are willing to participate in the study. The information provided will be confidential and your name will be kept anonymous with only codes assigned on the

questionnaire for each category of migrants and the questionnaires will be kept safely in a locked office. Digital recorders will be used, and the information provided will only be accessed by people involved in the study (supervisor, student and the research assistants). The main purpose of recording is to ensure that all the information provided and discussed is captured. The summary of findings from this study will be shared in presentations and publications.

Participation in this study will require about one hour of your time and it is voluntary and does not involve any risks. If you do not feel comfortable to participate or continue answering during the interview or if there are questions you would rather not answer, let me know and your decision will be respected. You have the right to withdraw from participating at any time and there will be no form of prejudice or penalty as a result of your withdrawal. This is to reinforce that participation is voluntary and there are no consequences for refusing to participate or withdrawing your participation. There are no costs to the participant that are associated with participating in this study. There are no direct benefits or remuneration associated with participating in this study, but the information provided might assist in informing policy makers to ensure that Sexual and Reproductive Health Services become accessible to everyone regardless of migration status.

If you agree to participate, I will require you to sign or have your thumb print on the consent form which only serves the purpose that the study has been well explained to you and you agree to participate. Please feel free to ask any questions that you may have regarding the study.

For further information and clarification, you can contact:

Student researcher:

Name: Christine Chawhanda

Phone number: 0027627404028

Email: 1502472 @students.wits.ac.za or cchawhanda@gmail.com

University of Witwatersrand Human Research Ethics Committee

Ms Zanele Ndlovu, or Mr Rhulani Mkansi, Faculty of Health Sciences, Phillip Tobias Building, Offices 301,302 and 304, 3rd Floor, 29 Princess of Wales Terrace, Parktown, 2193, Email: HREC-Medical.ResearchOffice@wits.ac.za; Zanele.Ndlovu@wits.ac.za ; Rhulani.Mkansi@wits.ac.za ,Tel 011 717 1234 / 1252 / 2656 / 2700.

Consent form
Appendix 3: Consent form for IDIs

Study title: Access to and utilisation of sexual and reproductive health services: A study of migrant women in six Southern African countries.

Interviewer's Declaration

I…… Date: …….

Hereby declare that I have explained clearly to the participant the purpose of this study and I have received participant's consent.

Interviewee's Declaration

I have read/have been read the information sheet about access to and utilisation of Sexual and Reproductive Health services by migrant women. I have been given the opportunity to ask any questions and the questions have been answered to my satisfaction I have understood and voluntarily consent to participate in the interview I have been informed orally and in writing of the contact person in case I have further questions. I hereby agree to participant in this study.

Name of Respondent: …….....

Signature /thumb print of Respondent: …… Date: .....

Name of Interviewer: …….....

Signature of Interviewer: ……...Date: ……...

Appendix 4: Consent form for digital recording

Title: Access to and utilisation of sexual and reproductive health services: A study of migrant women in six Southern African countries.

I would like to seek your kind permission to record the proceedings of the interview on tape. The recording is to ensure that all that is discussed and explained during the interview session is

captured. The tape will be kept strictly confidential and will be destroyed immediately after transcription. Do you agree to be tape recorded during the course of the interview?

Yes…….. No…….

Interviewer's Declaration

I…… Date: …….

Hereby declare that I have explained clearly the purpose of tape recording and I have received participant's consent to be tape recorded.

Interviewee's Declaration

I hereby agree to be tape recorded during the course of the interview.

Name of Respondent: …….....

Signature of Respondent: …… Date: .....

Name of Interviewer: …….....

Signature of Interviewer: ……...Date: ……...

Interview guides
Appendix 5: Interview guide - Migrant women

Interviewer:

Thank you once again for agreeing to take part in this interview. My name is Christine Chawhanda, a PhD student conducting a research on access to and utilisation of pregnancy and STI/HIV services by migrant women. I would like to ask you questions about your experience and coping strategies in accessing pregnancy or STI/HIV related services. The information provided will help to identify strategies that will improve migrant women's access to and utilisation of pregnancy or STI/HIV related services.

Participant background information

SN	Socio demographic information	Response
1.	Site	a. Ekurhuleni b. Nkomazi
2.	Age at last birthday	
3.	Marital status	a. Single b. Married c. Living with partner c. Separated d. Divorced e. Widowed

4.	Highest educational level	
5.	Country of origin	
6.	Province of origin (if question 4 is South Africa)	
7.	Length of stay in this community	
8.	Current employment status	a. Employed b. Unemployed c. Looking for employment
9.	Type of work if employed	
10.	Usual place of residence	

Factors, experiences in accessing and utilising SRH services

1. There are various ways or methods people use to prevent or avoid getting pregnant. Please tell me the ways or methods you have used to avoid or prevent pregnancy. Probe: where did you obtain them?

2. May you tell me your experience in obtaining these ways and methods of preventing or avoiding pregnancy? If not mentioned,

    a. Probe: availability of the services cost of services, distance (mode of transport, estimated time from home; how about from work), discrimination, language issues, administration requirements, waiting time, information about side effects.

    b. Probe: After experiencing what you have mentioned, what did you do to ensure that you obtain the required pregnancy related services?

c. If services were not available, Probe: May you tell me what the health care workers provided you with when the service was not available. If not mentioned Probe for referral letter.

d. Did you manage to go for the referred services? If no, Probe: Kindly explain why you did not go for the referred services?

3. Was/were the method(s) you were provided your preferred choice for preventing or avoiding pregnancy or would you have preferred other methods?

4. Kindly explain what you were satisfied with when you were obtaining pregnancy related services that you received the last time you visited a health facility? How about what you were not satisfied with?

5. Apart from pregnancy, may you tell me what can happen as a result of having unprotected s ex? If not mentioned, Probe: STI/HIV.

Probe: May you tell me the STI or HIV services you have obtained in this country/community?

Probe: where did you obtain them?

b. Kindly explain your experience in obtaining these services. If not mentioned, Probe: availability of the services, cost of the service, distance, discrimination, language issues, administrative requirements, waiting time, information about side effects.

c. Probe: After experiencing what you have mentioned, what did you do to ensure that you obtain the required STI/HIV related services?

d. If services were not available, Probe: what did the health care workers provide when the service was not available? If not mentioned probe: referral letter.

e. Did you manage to go for the referred services? If no, Probe: Kindly tell me why you did not go for the referred services?

7. May you explain your experience with using the services you obtained? Probe: side effect(s). How about your experience with obtaining the referred STI/HIV services?

    a. Tell me what you were satisfied with when you were obtaining STI/HIV services that you received the last time you visited a health facility? How about what you were not satisfied with?

Access to SRH services and coping strategies

8. Do you usually obtain pregnancy or STI/HIV services from a formal health facilities for example government health facilities?
    a. If no, explain to me why you do not to go to formal health facilities for pregnancy or STI/HIV services.
    b. If not mentioned Probe: Explore fear of deportation, rejection, discrimination, poor service delivery, cost, health care worker attitude.
9. In your opinion, how do the health care workers who provide pregnancy or STI/HIV services relate with migrant women when providing pregnancy or STI/HIV services?
    a. Explain the similarities with obtaining pregnancy or STI/HIV services from your place of origin?

    b. Explain the differences with obtaining pregnancy or STI/HIV services from your place of origin?

10. Have you ever been turned away or denied access to a health facility in this community?
    a. If yes, kindly explain the reasons why you were turned away. If not mentioned, Probe: ID documents, administration fee, discrimination.
    b. If yes, may you tell me what you did to obtain the required services after being turned away?

Experiences in accessing and using SRH services

12. Have you ever felt discriminated against or stigmatised when seeking pregnancy or STI/HIV services at any facility in this community? If yes, Probe: Explain what happened for you to feel that way.

    a. Tell me how you managed to deal with the discrimination?

    b. In your opinion, what can be done to stop discrimination at health care facilities?

13. In your opinion, what would you say about the ability of international migrant women in obtaining pregnancy or STI/HIV services in this community?

    a. How about the ability of internal migrant women?

14. What would you say about the way pregnancy or STI/HIV services are provided and your religion or beliefs? For example, are the processes involved acceptable to you? Kindly explain.

15. Explain any form of violence you experienced in this community? If not mentioned probe:

    a. Sexual violence from your partner or anyone

    b. Physical violence - any harm or damage caused to your body

    c. Emotional violence/ your partner humiliating you or making you feel bad in front of people.

    e. Kindly tell me how you dealt with it? If not mentioned, Probe: Did you report to the police, hospital, family or friends and what type of assistance did you get?

The role of the Community

16. May you explain the role of your partner in accessing and utilising your pregnancy or STI/HIV services? If not mentioned probe financial assistance, social support, does he allow you to access and use these services?

    a. Explain the role of family (your family and partner's family) in influencing the way you access and utilise pregnancy or STI/HIV services.

b. Tell me the support groups you belong to in this community?

c. How do the support groups assist you in this community in terms of obtaining/accessing and utilising pregnancy or STI/HIV services?

Now we are coming to the end of the session, do you have anything you want to share concerning access to and utilisation of pregnancy or STI/HIV related services?

Thank you for your input and time.

Appendix 6: Interview guide – Healthcare workers

Interviewer:
Thank you once again for agreeing to take part in this interview. My name is Christine Chawhanda, a PhD student conducting a research on access to and utilisation of pregnancy and STI/HIV services by migrant women. I would like to ask you questions about your experience in providing pregnancy and STI/HIV services to migrant women and availability of these services at this facility. The information provided will help to identify strategies that will improve migrant women's access to and utilisation of pregnancy or STI/HIV related services.

Checklist

SN	Socio-demographic information	Response
1	Site	
2	Type of facility	
3	Gender	
4	Opening days per week and time	a. Days

		b. Time	
5	Closing time		
6	Age at last birthday		
7	Highest educational level		
8	Highest qualification		
9	Position in the health facility		
10	Years of service in providing SRH services		
11	Number of health care workers trained to provide SRH services		
12	Number of health care workers available to provide SRH services		
13	Number of health care workers trained to provide SRH services to migrants		
	Are these SRH methods available?	**Yes**	**NO**
	Family planning counselling and services		
	Condom provision		
	HIV testing and counselling?		
	HIV/STI health promotion talks		
	Pre-termination of pregnancy counselling (TOP)		
	Termination of pregnancy		
	Post-termination of pregnancy counselling		
	Prevention of gender based violence (GBV)		
	Management of GBV		
	Referrals for SRH services		

Roles, experiences and availability of SRH services

1. Let us start by you telling me your main roles and responsibilities at this facility?

    a. Aside from providing pregnancy or STI/HIV services, what other duties or work do you perform at this facility? Probe: How long have you been providing pregnancy or STI/HIV related services? What are your experiences in providing the services to migrant women?

2. Can you explain to me the various ways or methods that people use to prevent pregnancy and your experiences in providing the services?

a. Probe: From the methods/services you have mentioned, tell me the methods/services that are not always available at this facility? If no, Probe: How about the methods/services that are always available?

Probe: Explain to me how you assist the client if the required service is not available? If not mentioned, Probe: Do you provide referral letters?

b. Can you explain to me the pregnancy or STI/HIV related referral system or process followed at this facility? Kindly explain to me how you do follow-ups on the referrals that are provided by this facility?

Standard operating procedures

3. Explain to me the rules and regulations of the health facility that guides you in providing pregnancy or STI/HIV related services to migrants

4. Please tell me what is required from internal migrants for them to be attended to at this facility? Probe referral letter?

5. Tell me what is required from international migrants for them to be attended to or provided with SRH and HIV related services at this facility? Probe: Identity documents, administration fee, referral letter

a. Can you tell me your experiences and what happens if a migrant woman does not have the required items e.g. ID, administration fee

b. May you explain to me the process of providing pregnancy or STI/HIV related services to an international migrant who does not possess legal papers?

c. How about to an international migrant who has the legal permission to stay in South Africa?

d. How about a woman who is not from this province/internal migrants?

6. Can you tell me the pregnancy or STI/HIV services which are not provided to international migrant women? Probe: How about internal migrant women?

7. Explain the requirements and the process of providing abortion services to international migrant women at this facility? Probe: How about to internal migrant women?

    a. Tell me the abortion services that you provide to international migrant women?

    b. Tell me the abortion services that you provide to internal migrant women?

    c. Describe the waiting period from the day migrant women seek abortion to the day the abortion process is done?

    d. May you tell me your experience in providing abortion services to international migrant women? How about internal migrant women? If there are negative experiences, probe: How did you manage to deal with the negative experience? How do you think these can be prevented or avoided?

Experiences in providing SRH to migrant women

8. Can you describe your experience in providing pregnancy or STI/HIV related services to international migrant women? How about internal migrant women?

    a. If there are negative experiences Probe: May you explain how you managed the negative experiences?

9. Please tell me the language that you use when providing pregnancy or STI/HIV related services to international migrant women? How about internal migrant women?

    a. Can you explain your experience in communicating using this language with migrant women? If there are negative experiences probe, how do you deal with the negative experiences?

    b. In your opinion what do you think can be done to avoid the negative experiences in communicating with this language? Probe for interpreters?

10. Tell me how do you ensure that migrant women have the correct information about the available services and side effects of methods of preventing or avoiding pregnancy? If not mentioned probe for Pamphlets, leaflets?

11. In your opinion and from your experience what challenges do you encounter in providing pregnancy or STI/HIV related services to international migrant women? Probe: What about people from elsewhere in this country that now live/are settled here?

    a. In your opinion, what can be done to address these challenges?

12. In your opinion and from your experience what challenges do international migrant women face in obtaining pregnancy or STI/HIV information and services at this health facility and in general? Probe: What about people from elsewhere in this country that now live/are settled here?

    a. Tell me the initiatives that are in place to address challenges migrant women face in accessing and utilising these services?

    b. From your experience, what can be done to improve access to and utilisation of pregnancy or STI/HIV related services by migrant women?

Now we are coming to the end of the session, do you have anything you want to share concerning providing pregnancy or STI/HIV related services to migrants?

Thank you for your input and time.

Appendix 7: Distress protocol for the study

Study title: Access to and utilisation of sexual and reproductive health services. A study of migrant women in six Southern African countries.

The following is provided as a means of preparation should a participant become distressed during the interview phase of this study: Prior to the commencement of any interview, information regarding the counselling available at Emthonjeni Centre, Psychological services through should it be required will be provided to all prospective and actual study participants. This information will be provided prior to a participant consenting to take part in the study and prior to the commencement of the interview. In addition, the information and referral letters will also be provided to those participants should they become uncomfortable or distressed during the actual interview. The participants will be referred to Emthonjeni Centre, Psychological services through Dr Sharon Moonsamy
Email: sharon.moonsamy@wits.ac.za
Tel: 011 717-4583. Confirmation letter from Emthonjeni Centre, Psychological services is attached

Should the participant become uncomfortable or distressed while discussing their experiences in accessing and utilising sexual and reproductive health services, the following actions will be taken by the interviewer:

a) The interviewer will suggest that it is appropriate that the interview be terminated.
b) If the participant wishes this to happen, the interview will be completed.
c) Time will be spent with the participant and assistance provided, within the scope of interviewer's ability, to discuss their concerns and support them, if appropriate.
d) The participant will be recommended and will be referred to speak to a health professional to discuss their concerns. All costs involved will be covered by the study.
e) A follow-up phone call will be made by the interviewer the following day to ensure that the participant is alright. During this time, the information previously provided regarding counselling services at health care facilities will be provided.

Appendix 8: Codebook for data analysis

Introduction

This study explored the experiences and coping strategies of migrant women in accessing and utilising SRH and HIV services and of healthcare workers in providing SRH and HIV services to migrant women in Ekurhuleni, South Africa. In-depth interviews were used to collect data from migrant women and healthcare workers who provide SRH and HIV services. The data was transcribed and after reading the data, recurrent themes were identified and a codebook also known as the coding scheme was developed. A codebook is a list of codes and their description. [205,206]. For coding and thematic analysis, the transcripts were imported into NVIVO 12 and codes were derived deductively based on the theory and existing knowledge.

Codebook development

Two independent coders and the principal investigator were involved in developing the codebook. Steps were followed in the development of a codebook which are 1) familiarisation with the data- this involved randomly selecting few transcripts for reading in order to be familiar with the data. 2) Developing codes. This involved highlighting short phrases and coming up with labels to describe the content. This was done independently and once everyone was done, a meeting was scheduled to discuss and agree on the codes to ensure inter-coder agreement. 3) Generating themes. This involved looking at the codes and identify patterns among them, and generate themes. 4). Reviewing themes. At this stage, themes were checked for accuracy and representation of the data, 5) Defining and naming themes. At this stage themes were given a description. 6). Writing up

Codebook

Five main themes were developed for the study. The themes and their descriptions are shown in Table 7.1. These themes were applied to the transcripts. During the coding process, new themes emerged that were added to the existing ones while modifications and adjustments were made along the line, as necessary.

Table 7.1: Study themes and their description

Theme	Description

Five dimensions of access	• When the respondents talk about the distance from their home or workplace to the healthcare facility • When the respondents mention about hospital fees or administration fees. And when they mention transportation costs • When the respondents talk about shortages or stock-outs or unavailability of the SRH and HIV services • Appears when the respondents talk about the effectiveness and appropriateness of the procedures, services, and inclusion in decision making about the services provided at the health facility • When the respondents link provision of service to their religious and cultural beliefs
Experiences in accessing and utilising SRH and HIV services	• Occurs when respondents explain what they go through because of where they come from or being a foreigner or not from the same area, different languages spoken, borrowing money, having people assisting them, encountering abuse from an intimate partner and reporting of abuse, being scolded or shouted at by healthcare workers, time they spent waiting to obtain the services, referral of services, discrimination and the requirements from the health facility
Experiences in providing SRH and HIV services	This is when the respondents describe what they encounter which can be negative or positive when providing the required services for example: • When the respondents talk about not understanding the patient because of communication challenges • What happens when they do not have the services required • When they mention of hospital fees and administration costs

	• Occurs when the respondents mention about the waiting time, the requirements to obtain the needed services • When respondents mention of same sickness and rigid partners who refuse treatment • Occurs when they mention encountering hurdles because of religious beliefs
Coping strategies in accessing, utilising and providing SRH and HIV services	• When the respondents describe or explain actions they take or what they do to obtain the services whenever they are denied access to health facility or when there are shortages and are unable to obtain the required SRH or HIV services. • When the respondents explain what they resort to in order to ensure that they provide the required services
Suggested recommendations	This includes what respondents highlight as measures or actions that can be taken to ensure that both migrant women and healthcare workers do not face challenges in accessing, utilising and providing SRH and HIV services

Ethical clearance

Appendix 9: Ethical clearance – Eswatini

Research Protocol clearance certificate

Type of review	Expedited	X		Full Board			
Name of Organization	SRHR-HIV Knows No Borders"						
Title of study	Improving SRHR–HIV Outcomes for Migrants, Adolescents and Young People and Sex Workers in Migration-Affected Communities in Southern Africa - 2016 – 2020						
Protocol version	1.0						
Nature of protocol	New	X		Amendment		Renewal	
List of study sites	SEE ATTACHED LIST						
Name of Principal Investigator	DR. THANDEKA DLAMINI-SIMELANE, DR. LATIFAT OBISOMI						
Names of Co- investigators	N/A						
Names of steering committee members in the case of clinical trials	N/A						
Names of Data and Safety Committee members in the case of clinical trials	N/A						
Level of risk (Tick appropriate box)	Minimal			High			
	X						
Clearance status (Tick appropriate box)	Approved	X		Disapproved			
Clearance validity period	Start date	09/04/2018					
Signature of Chairperson							
Date of signing	09/04/2018						
Secretariat Contact Details	Name of contact officers		Ms Simangele Madlela				
	Email address		[redacted]				
	Telephone no.		(00268) 24042866/24044935				

10 APR 2018
HEALTH RESEARCH REVIEW BOARD
SWAZILAND

Page 1 of 2

APPROVAL CONDITIONS

Ref.	Conditions	Indication of conditions (tick appropriate box)				
1.	Implementation of approved version of protocol	✓				
2	Reporting of adverse events within 5 days of occurrence	✓				
3	Submission of progress reporting for multi-year studies	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
		N/A	N/A	N/A	N/A	N/A
4	Submission of end of project report (Hard copy)	✓				
5	Submission of end of project report (Soft copy)	✓				
6	Submission of data sets	✓				

List of reviewed documents

Ref.	Documents	Reviewed documents (tick appropriate box)
1.	Completed application form	✓
2.	Cover letter	✓
3	Evidence of administrative permission to conduct the research by involved institutions/sites (where applicable)	✓
4	Detailed current resume or curriculum vitae of Principal Investigator/s including Principal Investigators declaration	✓
5	Summary resume or biography for other investigator(s)	✓
6	Evidence of approval/rejection by other Ethics Committees, including comments and requested alterations to the protocol, where appropriate.	
7	Research protocol (see outline in Annex 1)	✓
8	Questionnaires and interview guides (with back-translated versions where applicable)	✓
9	Case report forms (CRFs), abstraction forms and other data collection tools	✓
10	Participant/subjects Information Statement(s) (where applicable)	✓
11	Informed consent form(s) including photographic and electronic media consent statements.	✓
12	Advertisements relevant to the study (where applicable)	
13	Source of funding and detailed budget breakdown including material and incentives to participants if applicable	
14	Notification form for adverse effects/events.	
15	Proof of payment	✓
16	Proof of insurance cover for research subjects in clinical trials or where applicable	
17	Any other special requirements should be stated, if applicable	None

Targeted schools and health facilities

Series	Name of School
1	Phophonyane Primary
2	Ntfonjeni High
3	Mshingishingini Primary
4	Mswati II High
5	Gobolondlo Primary
6	Nhlanhleni Primary
7	Sidvwashini Primary
8	Mbasheni Primary
9	Vusweni Nazarene Primary
10	Enkonjaneni Primary

Health facilities

Name of Clinic
Ntfonjeni Clinic
Mshingishingini Nazarene Clinic
Vusweni Clinic

Chiefdoms

Ntfonjeni Chiefdoms	
1	Mvembili
2	Lomshiyo
3	Vusweni
4	Mshingishingini
5	Hhohho
6	Hhelehhele
7	Ndwandwe

*NB – this is where the community respondents will be selected/identified from

Appendix 10: Ethical clearance – Lesotho



Ministry of Health
PO Box 174
Maseru 100

REF: ID07-2018

Date: 26 March 2018

Category of Review:
[x] Initial Review
[ ] Continuing Annual Review
[ ] Amendment/Modification
[ ] Reactivation
[ ] Serious Adverse Event
[ ] Other _____

To
John Takwoingwgire
Executive Director and PI
Skillshare, Lesotho

Dear Mr. John,

RE: A Baseline Study on SRH-HIV Knows no border in Lesotho

This to inform you that on 20 March 2018 the Ministry of Health Research and Ethics Committee reviewed and **APPROVED** the above named protocol and hereby authorises you to conduct the study according to the activities and population specified in the protocol. Departure from the approved protocol will constitute a breach of this permission.

This approval includes review of the following attachments:
[x] Protocol dated 21 November 2017
[x] Informed consent forms English & Sesotho
[x] Data collection tools in English & Sesotho
[ ] Participant information sheets in English & Sesotho
[x] Other materials: Referral form & CVs of Mr. N. Dickson, Lasiffat O. O. Ibironi & Mampoteso C. Kobo
This approval is **VALID** until 25 March 2019.

Please note that an annual report and request for renewal, if applicable, must be submitted at least 6 weeks before the expiry date.

All serious adverse events associated with this study must be reported promptly to the MOH Research and Ethics Committee. Any modifications to the approved protocol or consent forms must be submitted to the committee prior to implementation of any changes.

We look forward to receiving your progress reports and a final report at the end of the study. If you have any questions, please contact the Research and Ethics Committee at rec.moh@gmail.com (or) 22226317.

Sincerely,

Dr. Nyane Letsie
Director General Health Services

Dr. Jill Sanders
CO-chairperson NH-REC

THE KINGDOM OF LESOTHO
MINISTRY OF EDUCATION AND TRAINING

14th February 2018

REF: ED/G/44

IOM-Head of Office
International Organisation on Migration - Lesotho
5rd Floor, UN House
18 UN Road
Maseru 100

Dear Ms Eriko Nishimura

RE: REQUEST TO CONDUCT SRHR-HIV NEEDS ASSESSMENT IN THE MAPUTSOE PRIMARY AND SECONDARY SCHOOLS, LERIBE DISTRICT

Your letter to the Principal Secretary of the Ministry of Education and Training, dated 15th January 2018, on the above subject refers.

The Ministry of Education and Training grants permission to IOM-Lesotho, through Skillshare-Lesotho, in liaison with the Leribe District Education Office, to enter schools to conduct Sexual Reproductive Health and Rights (SRHR) needs assessment in primary and secondary schools in the Maputsoe area. This permission is given under the following conditions:

1. That you will consult with the District Education Manager on the details of your programme;

P.O. BOX 47 MASERU 100 LESOTHO TEL.: (+266) 22 322862 Fax (+266) 22 310206 eso2.moet@gtwil.com

2. That under no circumstances should your programme interfere with regular teaching and learning in any school.
3. That you seek the consent and permission of school principals to secure a slot in each school.
4. That for any intrusive procedure or information that you may require from minor learners, you will get prior, express consent from their parents.

We wish you the best of luck in your programme.

Yours sincerely

Paramente Phamotse (Mr.)
Chief Education Officer – Secondary

Cc.
Regional Inspector North
District Education Managers - Leribe

Appendix 11: Ethical clearance – Malawi

NATIONAL COMMISSION FOR SCIENCE & TECHNOLOGY
Lingadzi House
Robert Mugabe Crescent
P/Bag B303
City Centre
Lilongwe
Tel: +265 1 771 550
+265 1 774 189
+265 1 774 868
Fax: +265 1772 431
Email:directorgeneral@ncst.mw
Website:http://www.ncst.mw

REF.NO.NCST/RTT/2/6 **8th May, 2018**

Mr Mtafu Manda
Principal Investigator
Department of Land Management
Mzuzu University
Planning Unit
Private Bag 201,
Luwinga,
Mzuzu 2

E-mail: manda.ma@mzuni.ac.mw or mtafu.manda@gmail.com

Dear Mr Manda,

RESEARCH ETHICS AND REGULATORY APPROVAL AND PERMIT FOR PROTOCOL NO. P.12/17/240: SRHR-HIV OUTCOMES FOR MIGRANTS, ADOLESCENTS AND YOUNG PEOPLE AND SEX WORKERS IN MIGRATION-AFFECTED COMMUNITIES IN SOUTHERN AFRICA: THE CASE OF MALAWI

Having satisfied all the relevant ethical and regulatory requirements, I am pleased to inform you that the above referred research protocol has officially been approved. You are now permitted to proceed with its implementation. Should there be any amendments to the approved protocol in the course of implementing it, you shall be required to seek approval of such amendments before implementation of the same.

This approval is valid for one year from the date of issuance of this approval. If the study goes beyond one year, an annual approval for continuation shall be required to be sought from the National Committee on Research Ethics in the Social Sciences and Humanities (NCRSH) in a format that is available at the Secretariat. Once the study is finalised, you are required to furnish the Committee and the Commission with a final report of the study. The committee reserves the right to carry out compliance inspection of this approved protocol at any time as may be deemed by it. As such, you are expected to properly maintain all study documents including consent forms.

Wishing you a successful implementation of your study.

Yours Sincerely,

Mike Kachedwa
HEAD OF NCRSH SECRETARIAT
For: CHAIRMAN OF NCRSH

Appendix 12: Ethical clearance – Mozambique

REPÚBLICA DE MOÇAMBIQUE

MINISTÉRIO DA SAÚDE

Gabinete da Ministra

Exmo Senhor
Augusto Bartolomeu Sixpense
Director Executive
Maputo

Nota n.º 159/GMS/002/2018 Maputo, 24 de Julho 2018

Assunto: Solicitação de Autorização para Realização de Estudo

Incumbe-me S.Excia Ministra da Saúde Dra Nazira Karimo Vali Abdula, de acusar a recepção da vossa nota com a referência nº07 de 07 de Julho de 2018, na qual solicitam autorização para realização de um estudo intitulado: " **Estudo dee Base do Projecto: Exercícios dos direitos Sexuais Reprodutivos e HIV entre migrantes, adolescentes e jovens, nas zonas fronteiriças da África Austral: o caso de Ressano Gracia (Maputo) e Chifunfde (Tete)/ 2016-2020"** , e tenho a informar o despacho recaido cujo o teor é o seguinte:

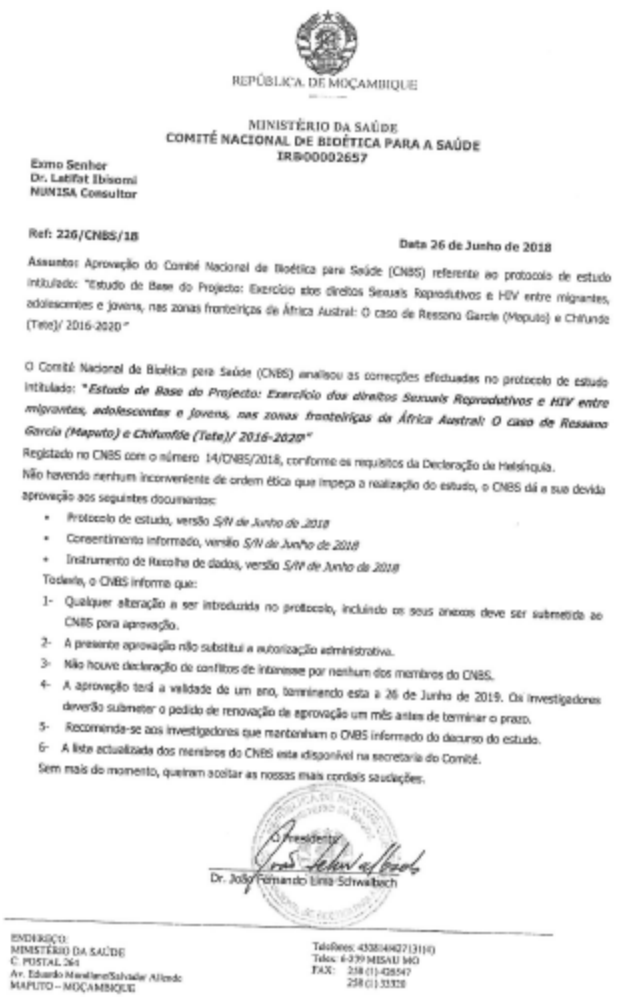
"Autorizo"
Deve manter informando do decorrer do Estudo ao CNBS, Instituto Nacional de Saúde Direcção Nacional de Saúde Pública, Direcção Provincial de Saúde e a Direcção Provincial de Saúde de Tete
Assinado: Dra. Nazira Karimo Vali Abdula
(25/07/2018)

Cumprimentos

A Chefe do Gabinete

Fátima Souto

CC: CNBS
INS
DNSP
DPS-Maputo
DPS-TETe



REPÚBLICA DE MOÇAMBIQUE

MINISTÉRIO DA SAÚDE
COMITÉ NACIONAL DE BIOÉTICA PARA A SAÚDE
IRB00002657

Exmo Senhor
Dr. Latifat Ibisomi
NUNISA Consultor

Ref: 226/CNBS/18

Data 26 de Junho de 2018

Assunto: Aprovação do Comité Nacional de Bioética para Saúde (CNBS) referente ao protocolo de estudo intitulado: "Estudo de Base do Projecto: Exercício dos direitos Sexuais Reprodutivos e HIV entre migrantes, adolescentes e jovens, nas zonas fronteiriças da África Austral: O caso de Ressano Garcia (Maputo) e Chifunfe (Tete)/ 2016-2020"

O Comité Nacional de Bioética para Saúde (CNBS) analisou as correcções efectuadas no protocolo de estudo intitulado: "*Estudo de Base do Projecto: Exercício dos direitos Sexuais Reprodutivos e HIV entre migrantes, adolescentes e jovens, nas zonas fronteiriças da África Austral: O caso de Ressano Garcia (Maputo) e Chifunfe (Tete)/ 2016-2020*"

Registado no CNBS com o número 14/CNBS/2018, conforme os requisitos da Declaração de Helsínquia.

Não havendo nenhum inconveniente de ordem ética que impeça a realização do estudo, o CNBS dá a sua devida aprovação aos seguintes documentos:

- Protocolo de estudo, versão *S/N de Junho de 2018*
- Consentimento informado, versão *S/N de Junho de 2018*
- Instrumento de Recolha de dados, versão *S/N de Junho de 2018*

Todavia, o CNBS informa que:

1- Qualquer alteração a ser introduzida no protocolo, incluindo os seus anexos deve ser submetida ao CNBS para aprovação.
2- A presente aprovação não substitui a autorização administrativa.
3- Não houve declaração de conflitos de interesse por nenhum dos membros do CNBS.
4- A aprovação terá a validade de um ano, terminando esta a 26 de Junho de 2019. Os investigadores deverão submeter o pedido de renovação de aprovação um mês antes de terminar o prazo.
5- Recomenda-se aos investigadores que mantenham o CNBS informado do decurso do estudo.
6- A lista actualizada dos membros do CNBS esta disponível na secretaria do Comité.

Sem mais do momento, queiram aceitar as nossas mais cordiais saudações.

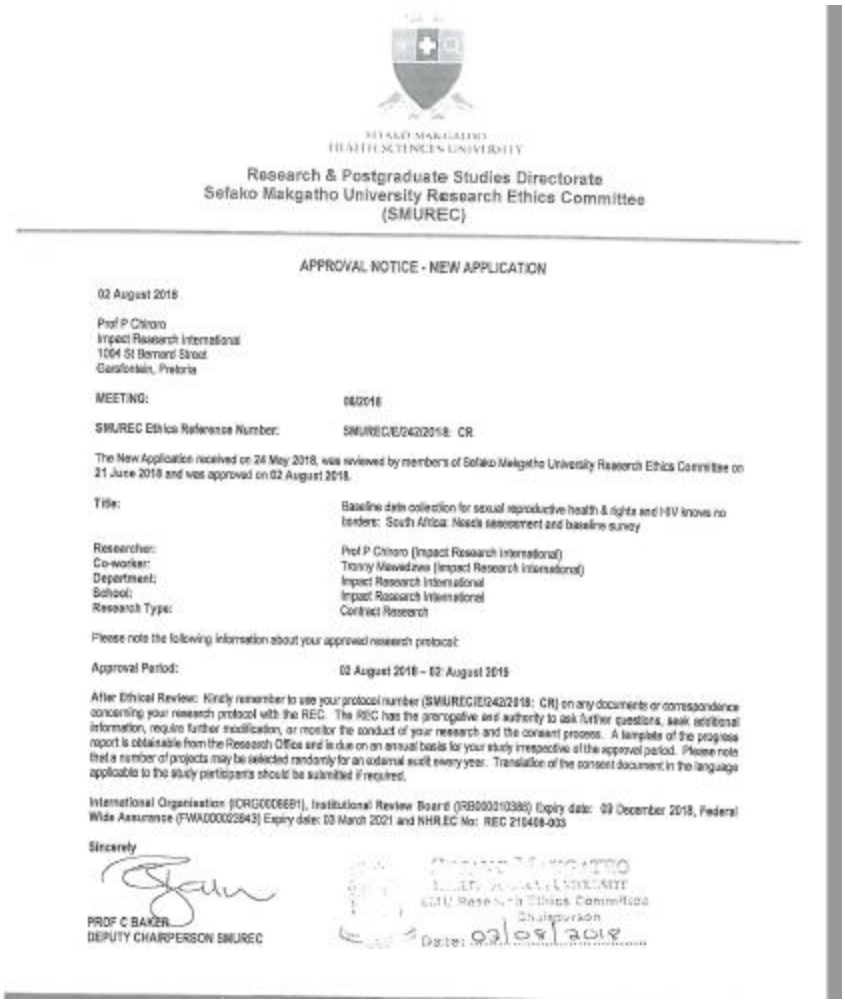
O Presidente

Dr. João Fernando Lima Schwalbach

ENDEREÇO:
MINISTÉRIO DA SAÚDE
C. POSTAL 264
Av. Eduardo Mondlane/Salvador Allende
MAPUTO – MOÇAMBIQUE

Telefones: 4308400/27/3110
Telex: 6-379 MISAU MO
FAX: 258 (1)-428547
258 (1) 33328

Appendix 13: Ethical clearance – South Africa



SEFAKO MAKGATHO
HEALTH SCIENCES UNIVERSITY

Research & Postgraduate Studies Directorate
Sefako Makgatho University Research Ethics Committee
(SMUREC)

APPROVAL NOTICE - NEW APPLICATION

02 August 2018

Prof P Chiro
Impact Research International
1064 St Bernard Street
Garsfontein, Pretoria

MEETING: 06/2018

SMUREC Ethics Reference Number: SMUREC/E/242/2018: CR

The New Application received on 24 May 2018, was reviewed by members of Sefako Makgatho University Research Ethics Committee on 21 June 2018 and was approved on 02 August 2018.

Title: Baseline data collection for sexual reproductive health & rights and HIV knows no borders: South Africa: Needs assessment and baseline survey

Researcher: Prof P Chiro (Impact Research International)
Co-worker: Tronny Mawadzwa (Impact Research International)
Department: Impact Research International
School: Impact Research International
Research Type: Contract Research

Please note the following information about your approved research protocol:

Approval Period: 02 August 2018 – 02 August 2019

After Ethical Review: Kindly remember to use your protocol number (SMUREC/E/242/2018: CR) on any documents or correspondence concerning your research protocol with the REC. The REC has the prerogative and authority to ask further questions, seek additional information, require further modification, or monitor the conduct of your research and the consent process. A template of the progress report is obtainable from the Research Office and is due on an annual basis for your study irrespective of the approval period. Please note that a number of projects may be selected randomly for an external audit every year. Translation of the consent document in the language applicable to the study participants should be submitted if required.

International Organisation (IORG0006691), Institutional Review Board (IRB0003103B) Expiry date: 09 December 2018, Federal Wide Assurance (FWA00002843) Expiry date: 03 March 2021 and NHREC No: REC 210408-033

Sincerely

PROF C BAKER
DEPUTY CHAIRPERSON SMUREC

SMU Research Ethics Committee
Chairperson
Date: 02/08/2018

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

No 3, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province
Private Bag X11285, Mbombela, 1200, Mpumalanga Province
Tel: +27 (13) 766 3429, Fax: +27 (13) 766 3458

Lefapha la Temphedi | Departement van Gesondheid | UmNyango WezeMpilo

Enquiries: Thembi Madonsela 013 766 3511

Prof Patrick Chiroro
1004 St Bernard Drive
Garsfontain
Pretoria East
0081

Dear Prof Patrick Chiroro

APPLICATION FOR RESEARCH & ETHICS APPROVAL: BASELINE DATA COLLECTION: SEXUAL REPRODUCTIVE HEALTH & RIGHTS AND HIV KNOWS NO BORDERS; SOUTH AFRICA: NEEDS ASSESSMENT AND BASELINE SURVEY

The provincial health research committee has approved your research proposal in the latest format you sent.

- Approval Ref Number: **MP_201809_003**
- ***Period: 30/09/2018 to 31/08/2019***
- Facilities: Komatipoort Clinic Naas CHC, Tonga Block B Clinic and Tonga Block C Clinic

Kindly ensure that the study is conducted with minimal disruption and impact on our staff, and also ensure that you provide us with the soft or hard copy of the report once your research project has been completed.

Kind regards

MS. T.Z MADONSELA
MPUMALANGA PHRC

2018/9/25
DATE

MPUMALANGA
THE PLACE OF THE RISING SUN

City of Ekurhuleni

GAUTENG PROVINCE

EKURHULENI HEALTH DISTRICT
RESEARCH PERMISSION

Research Project Title: Sexual Reproductive Health & Rights and HIV Knows No Borders; South Africa: Needs Assessment and Baseline Survey

NHRD No: GP_201809_028

Research Project Number: 11/10/2018-01

Name of Researcher(s): Prof Patrick Chiroro

Division/Institution/Company: Sefako Makgatho University

Date of review by the EHDRC: 11 October 2018

DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT RESEARCH COMMITTEE (EHDRC)

- This document certifies that the above research project has been reviewed by the EHDRC and permission is granted for the researcher(s) to commence with the intended research project.

Facilities approved for the research: Daveton East Clinic, Daveton Ext Clinic, Daveton Main clinic, Tsakane Ext 10 Clinic Offices. The researcher will report to the relevant manager/facility manager before initiating the study.

- Participants' rights and confidentiality must be maintained throughout the study period and when disseminating the findings.
- No resources (financial, material and human resources) from the health facilities will be used for the study. Neither the district nor the health facilities will incur any additional cost for the study.
- The study will comply with Publicly Financed Research and Development Act 2008 (Act 51 of 2008) and its related regulations.
- The EHDRC must be informed in writing before publication or presentation of research findings and a copy of the report/publications/presentation must be submitted to the EHDRC
- The district must be acknowledged in all the reports/publications generated from the research.
- The researcher will be expected to provide the EHDRC with
  - Six monthly progress updates including any adverse events
  - The final study report in electronic format
  - Present the final research findings at the annual Ekurhuleni research conference if possible.
- The EDHRC reserves the right to withdraw the approval, if any of the conditions mentioned above have being breached
- The research committee wishes the researcher(s) the best of success.

DR JOSEPH SEPWYA

DEPUTY CHAIRPERSON: CITY OF EKURHULENI

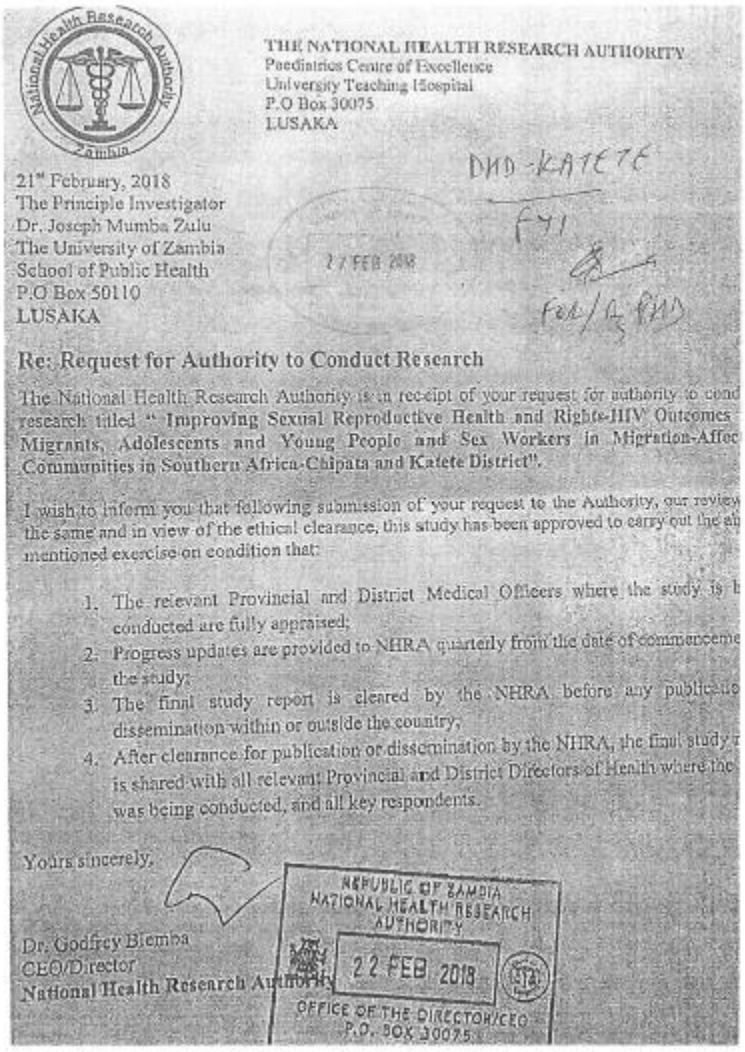
Dated: 11/10/2018

Dr R Kellerman

CHAIRPERSON: GAUTENG DEPARTMENT OF HEALTH (EKURHULENI HEALTH DISTRICT)

Dated: 11/10/2018

Appendix 14: Ethical clearance – Zambia



THE NATIONAL HEALTH RESEARCH AUTHORITY
Paediatrics Centre of Excellence
University Teaching Hospital
P.O Box 30075
LUSAKA

DHD - KATETE
FYI
22 FEB 2018
For/A PHD

21st February, 2018
The Principle Investigator
Dr. Joseph Mumba Zulu
The University of Zambia
School of Public Health
P.O Box 50110
LUSAKA

Re: Request for Authority to Conduct Research

The National Health Research Authority is in receipt of your request for authority to cond
research titled " **Improving Sexual Reproductive Health and Rights-HIV Outcomes**
Migrants, Adolescents and Young People and Sex Workers in Migration-Affec
Communities in Southern Africa-Chipata and Katete District".

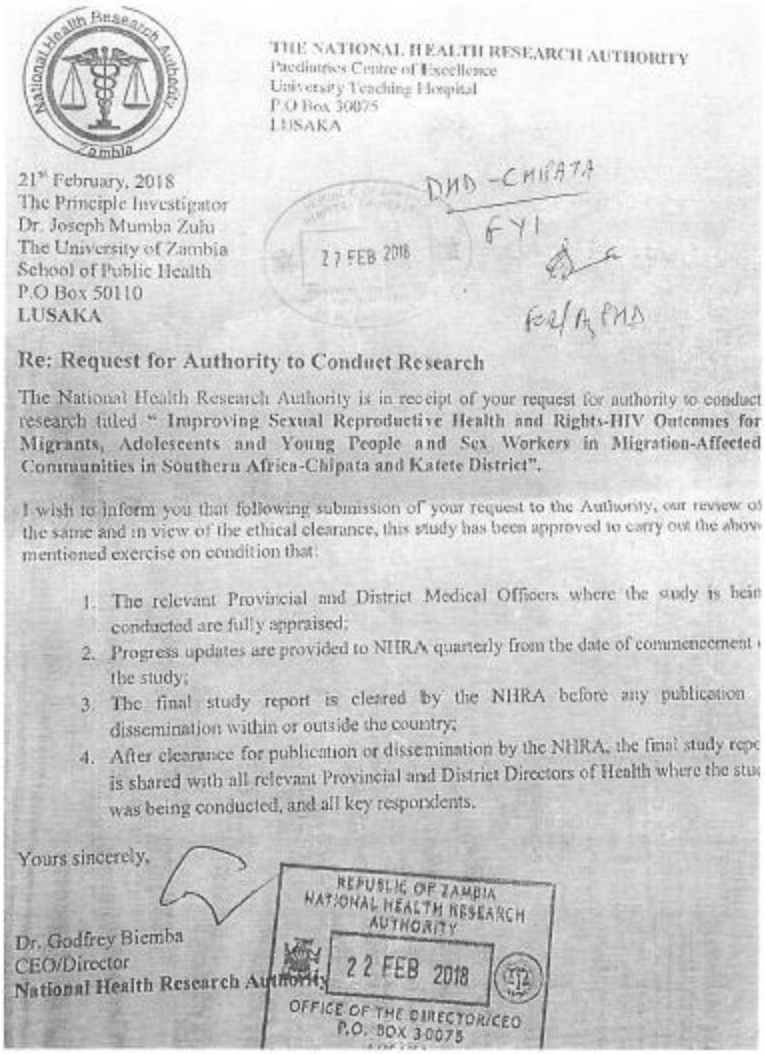
I wish to inform you that following submission of your request to the Authority, our review
the same and in view of the ethical clearance, this study has been approved to carry out the ab
mentioned exercise on condition that:

1. The relevant Provincial and District Medical Officers where the study is b
conducted are fully appraised;
2. Progress updates are provided to NHRA quarterly from the date of commenceme
the study;
3. The final study report is cleared by the NHRA before any publication
dissemination within or outside the country;
4. After clearance for publication or dissemination by the NHRA, the final study r
is shared with all relevant Provincial and District Directors of Health where the
was being conducted, and all key respondents.

Yours sincerely,

Dr. Godfrey Biemba
CEO/Director
National Health Research Authority

REPUBLIC OF ZAMBIA
NATIONAL HEALTH RESEARCH AUTHORITY
22 FEB 2018
OFFICE OF THE DIRECTOR/CEO
P.O. BOX 30075



THE NATIONAL HEALTH RESEARCH AUTHORITY
Paediatrics Centre of Excellence
University Teaching Hospital
P.O Box 30075
LUSAKA

DMD - CHIPATA
FYI

27 FEB 2018

21st February, 2018
The Principle Investigator
Dr. Joseph Mumba Zulu
The University of Zambia
School of Public Health
P.O Box 50110
LUSAKA

Re: Request for Authority to Conduct Research

The National Health Research Authority is in receipt of your request for authority to conduct research titled " **Improving Sexual Reproductive Health and Rights-HIV Outcomes for Migrants, Adolescents and Young People and Sex Workers in Migration-Affected Communities in Southern Africa-Chipata and Katete District".**

I wish to inform you that following submission of your request to the Authority, our review of the same and in view of the ethical clearance, this study has been approved to carry out the above mentioned exercise on condition that:

1. The relevant Provincial and District Medical Officers where the study is bein conducted are fully appraised;
2. Progress updates are provided to NHRA quarterly from the date of commencement the study;
3. The final study report is cleared by the NHRA before any publication dissemination within or outside the country;
4. After clearance for publication or dissemination by the NHRA, the final study repo is shared with all relevant Provincial and District Directors of Health where the stu was being conducted, and all key resporndents.

Yours sincerely,

REPUBLIC OF ZAMBIA
NATIONAL HEALTH RESEARCH AUTHORITY
22 FEB 2018
OFFICE OF THE DIRECTOR/CEO
P.O. BOX 30075

Dr. Godfrey Biemba
CEO/Director
National Health Research Authority

Appendix 15: Ethical clearance - Wits HREC

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

R14/48 Miss Christine Chawhanda

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M190601

NAME: (Principal Investigator)	Miss Christine Chawhanda
DEPARTMENT:	Epidemiology and Biostatistics Ekurhuleni and Nkomazi
PROJECT TITLE:	Access to and utilisation of sexual and reproductive health services. A study of migrant women in six Southern African countries
DATE CONSIDERED:	28/06/2019
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Latifat Ibisomi and Jonathan Levin
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	17/09/2019

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the Third Floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in June and will therefore be due in the month of June each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature

Date 18/09/2019

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix 16: Ethical clearance - Ekurhuleni

City of Ekurhuleni

GAUTENG PROVINCE
REPUBLIC OF SOUTH AFRICA

EKURHULENI HEALTH DISTRICT
RESEARCH PERMISSION

Research Project Title: Access to and utilisation of sexual and reproductive health services: A study of migrant women in six Southern African countries

NHRD No: GP_201909_037

Research Project Number: 10/10/2019-05

Name of Researcher(s): Ms Christine Chawhanda

Division/Institution/Company: University of Witwatersrand

Date of review by the EHDRC: 10 October 2019

DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT RESEARCH COMMITTEE (EHDRC)

- This document certifies that the above research project has been reviewed by the EHDRC and permission is granted for the researcher(s) to commence with the intended research project.
  - Facilities approved for the research: Daveyton Main Clinic; Joy Clinic; Phillip Moyo CHC ; Tembisa Hospital and Bertha Gxowa Hospital.
- Participants' rights and confidentiality must be maintained throughout the study period and when disseminating the findings.
- No resources (financial, material and human resources) from the health facilities will be used for the study. Neither the district nor the health facilities will incur any additional cost for the study.
- The study will comply with Publicly Financed Research and Development Act 2008 (Act 51 of 2008) and its related regulations.

Title : Access to and utilisation of sexual and reproductive health services: A study of migrant women in six Southern African countries

- The EHDRC must be informed in writing before publication or presentation of research findings and a copy of the report/publications/presentation must be submitted to the EHDRC
- The district must be acknowledged in all the reports/publications generated from the research.
- The researcher will be expected to provide the EHDRC with
  - Six monthly progress updates including any adverse events
  - The final study report in electronic format
  - Present the final research findings at the annual Ekurhuleni research conference if possible.
- The EDHRC reserves the right to withdraw the approval, if any of the conditions mentioned above have being breached
- The research committee wishes the researcher(s) the best of success.

DR. J. SEPHIA

DEPUTY CHAIRPERSON: CITY OF EKURHULENI

Dated: 10/10/2019.

Dr. R. Kellerman

CHAIRPERSON: GAUTENG DEPARTMENT OF HEALTH (EKURHULENI HEALTH DISTRICT)

Dated: 14/10/2019.

Appendix 17: Policy brief

Introduction

Migrant health including sexual and reproductive health (SRH) has been recognized as a global public health concern and universal access to SRH services is one of the key milestones towards fulfilling the sustainable development goals. This policy brief looks at the factors that influence access to and utilisation of SRH and HIV services focusing on the six Southern African countries which are the Kingdom of Eswatini which will be referred to as Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia. The aim is to highlight policy gaps that can be exploited to ensure universal access and utilisation of SRH services.

Context

There are many health challenges in the Southern Africa region which pose difficulties in accessing health services, including SRH services. The challenges are the deteriorating health system, lack of human and financial resources and unavailability of medication. Partly attributable to the health challenges, there are adverse sexual and reproductive health (SRH) outcomes in Southern Africa with approximately 54 % of married women using a method of contraception in 2019 [79], 55 % unintended pregnancies [80–83] of which about 30% ended in abortion, mainly unsafe abortion [81,83].

Southern Africa is one of the regions mostly affected by HIV with approximately 20.7 million people living with HIV in 2019 and about 60% being women aged 15 years and above [84,85]. A significant number of people in the region are not aware of their HIV status with an estimated 87% of people living with HIV (PLHIV) knowing their HIV status [85]. In the region, HIV is high amongst females compared to males [84]. Furthermore, approximately 47% of women have experienced physical or sexual violence in the region [87,88]. In addition to the poor health outcomes, inequalities in accessing health services, including SRH and HIV services between non-migrants and migrants were reported in Botswana, Lesotho and South Africa [43–47,49].

Specific findings

With the exception of utilisation of SRH referral services, the findings (Figure 1,2,3,4 and 5) show that the prevalence of access to and utilisation of SRH and HIV services was low for international migrant women.

Figure 2: The prevalence of non-access to condoms among women in high migration communities in six Southern African countries, 2018

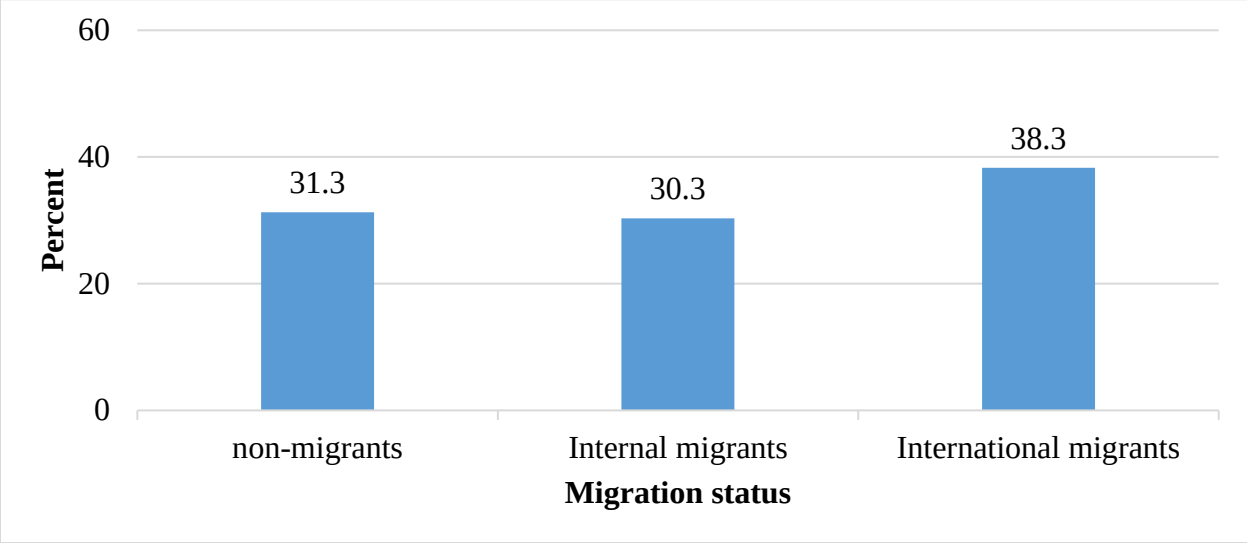


Figure 3: The prevalence of non-access to HIV testing services among women in high migration communities in six Southern African countries, 2018

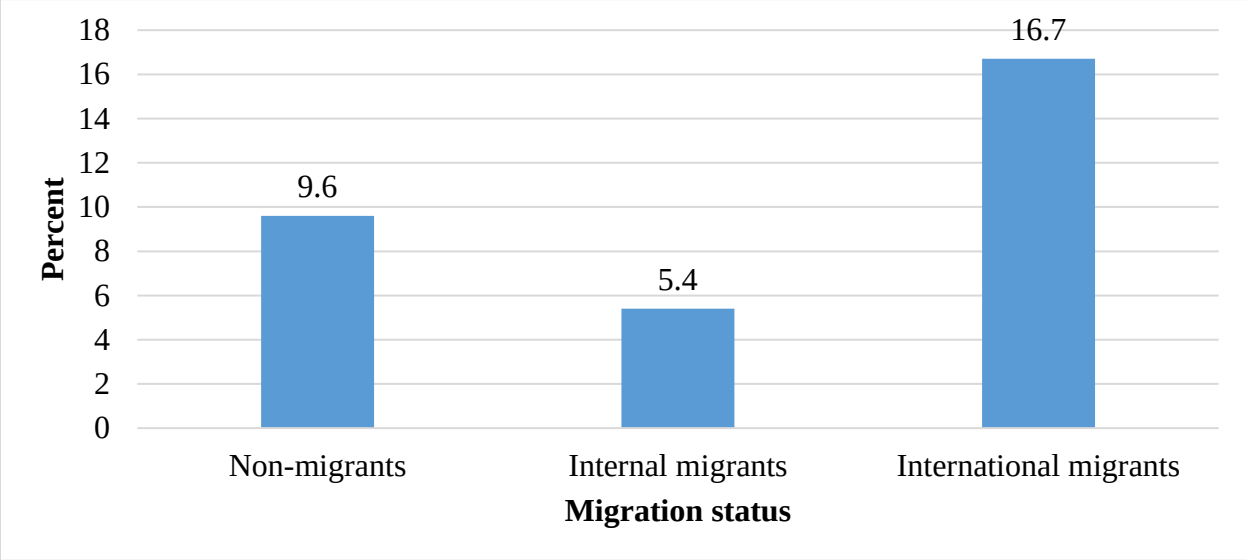


Figure 4: The prevalence of non-use of modern contraceptive methods among women in high migration communities in six Southern African countries, 2018

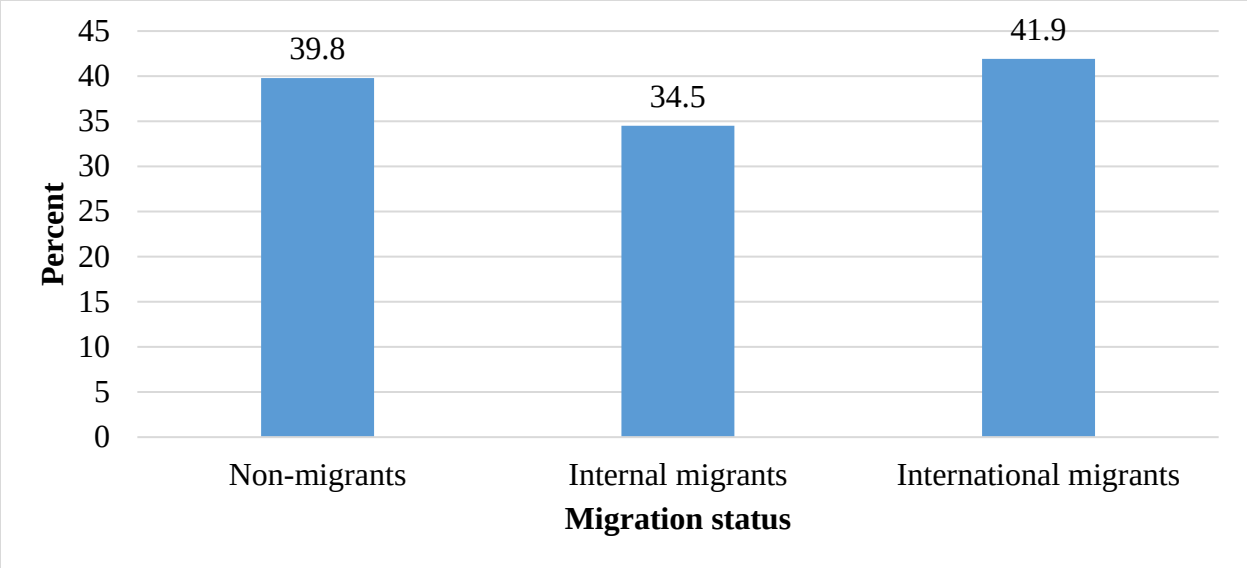


Figure 5: The prevalence of utilisation of SRH referral services among women in high migration communities in six Southern African countries, 2018

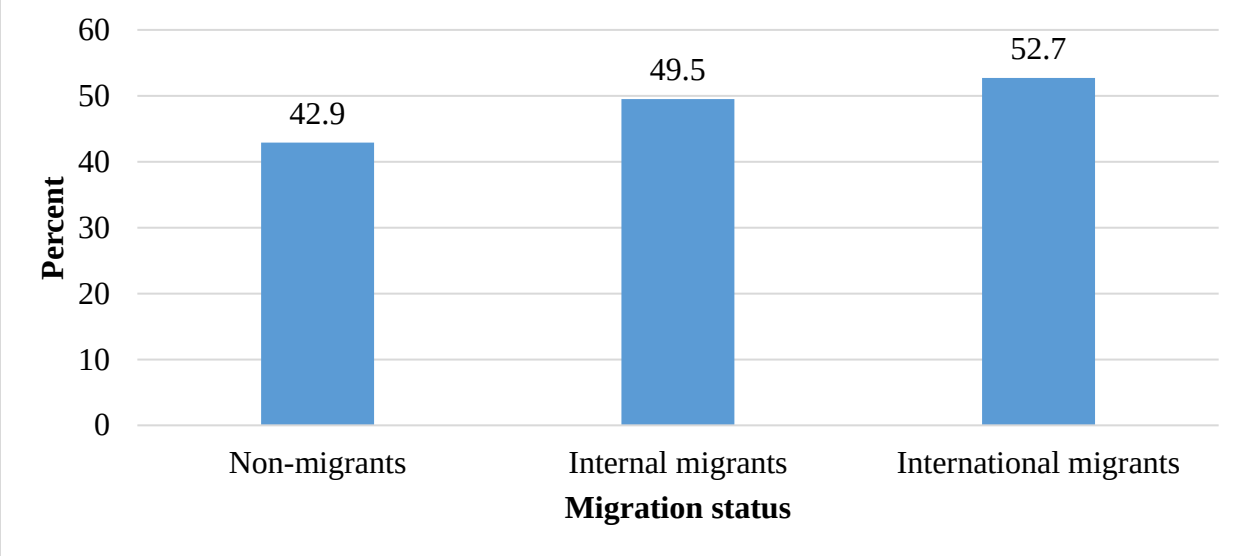
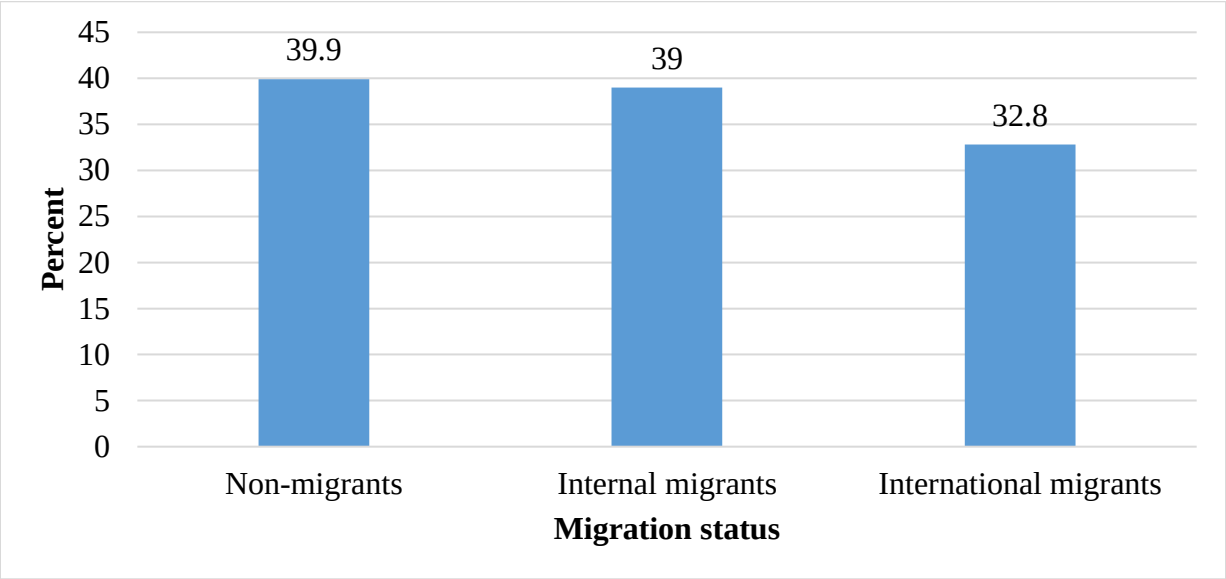


Figure 6: The prevalence of utilisation of IPV services among women in high migration communities in six Southern African countries, 2018



In addition to migration status, the results show significant country differentials in accessing and utilising SRH and HIV services highlighting important national policy avenues that can be explored. Older and married women accessed and utilised SRH and HIV services more than younger and never married women. In addition, having secondary/higher education, comprehensive knowledge about SRH, comprehensive knowledge about HIV and SRH decision making power were found to be enablers of access to and utilisation of SRH and HIV services.

Regarding partner characteristics, partner's age was significantly associated with non-access to condoms, with women who had older partners having lower odds of not being able to access condoms compared to women with younger partners. Partner's educational level was significantly associated with non-access to condoms. Women who had partners with secondary/higher education had lower odds of not being able to access condoms compared to women who had partners with primary/lower education. Experience of IPV in the last 12 months was significantly associated with non-access to condoms (P=0.057). Compared to women who experienced IPV in the last 12 months, women who did not experience IPV in the last 12 months had higher odds of not being able to access condoms.

After controlling for other factors, migration status was associated with non-access to HIV testing services, with international migrants having higher odds of not accessing HIV testing services compared to non-migrant women. In addition, women in Malawi and Eswatini had lower odds of not having access to HIV testing services compared to women in South Africa. Compared to never-married women, the odds of not having access to HIV testing services were lower for married women and formerly married women. Educational level was an important factor that was associated with non-access to HIV testing services. Women with secondary/higher education had lower odds of not having access to HIV testing services compared to women with primary/lower education. Other important factors are comprehensive knowledge about SRH and comprehensive knowledge about HIV. A unit increase in comprehensive knowledge about SRH and comprehensive knowledge about HIV reduced the odds of not having access to HIV testing services.

In the multivariable analysis, although migration status was not significantly associated with current non-use of modern contraceptive methods, significant factors were found to be study country, marital status, employment status, fertility preference, comprehensive knowledge about SRH, comprehensive knowledge about HIV, partner's age and partner's educational level. Women in Malawi, Mozambique and Zambia had lower odds of current non-use of modern contraceptive methods compared to women in South Africa.

Controlling for other factors, there was no evidence of an association between migration status and utilisation of SRH referral services. Factors that were found to be significantly associated with utilisation of SRH referral services are access to healthcare facility, study country, and marital status. Age and comprehensive knowledge about HIV were marginally associated with utilisation of SRH referral services. Women in Malawi, Mozambique, Eswatini and Zambia had lower odds of utilising SRH referral services compared to women in South Africa. Compared to never married women, married women and formerly married women higher odds of utilising SRH referral services.

Migration status was significantly associated with utilisation of IPV services with international migrants having lower odds of utilising IPV services. Age was significantly associated with

utilisation of IPV services, a five year increase in age increased the odds of utilising IPV services by 34% (aOR=1.34, 95% CI 1.04-1.74). Attitude towards wife beating was significantly associated with utilisation of IPV services. Women who justified beating of a woman by her husband had 61% lower odds of utilising IPV services compared to women who condemn husbands beating their wives (aOR=0.39, 95% CI 0.22-0.70).

Policy recommendations

The results show that although migration status was not significantly associated with some outcome variables, migrants continue to experience challenges in accessing and utilising SRH and HIV services. As such, the six countries and probably Southern Africa as a whole need to urgently revisit and harmonise the immigration and health policies to ensure successful implementation of universal access to healthcare for migrants regardless of their legal status. In addition, the health sector should mainstream migrant sensitive health policies health care policies and plans at all levels (regional, national, provincial and district level) and also incorporate IPV services within the health sector. The countries can encourage the health facilities that are situated in high migration communities to collect data and map the barriers to health services including SRH services from non-migrants and migrants (internal and international). This will enable the government to distinguish sociocultural from structural barriers thereby enabling a more effective adaptation of the universal health coverage.

There is also a need for strengthening partnerships between and within countries regarding referral and transfer letters to improve migrant women's utilisation of referral services. Similarly, training of healthcare workers cultural diverse issues, behaviour change can ensure that the services provided culturally tailored and also reduce stigma and discrimination (individual racism).this can be achieved by providing cultural mediation and having migrant friendly health corners. To ensure availability of services the healthcare sector need to collaborate with civil society organizations and non-governmental organizations. For country differences in terms of women's access to and utilisation of SRH services, countries should create regional networks of good practice and disseminate good practice within the country and between countries.

Employment creation and increasing tertiary education opportunities would empower women and enhance transformation of contraceptive use practices, accessing and utilising other SRH and HIV services mainly among married women. Similarly, there is great need for SRH and HIV programs that involve men in order to improve women's access to and utilisation of SRH and HIV services. In addition, there is a need to address cultural norms and religious teachings that discourage access to and utilisation of SRH and HIV services. This involves including various stakeholders for example traditional leaders and religious leaders to disseminate information and have educational platforms aimed at influencing women's access to and utilisation of SRH and HIV services.

Appendix 18: The comprehensive sexuality education paper:
Link to the article: https://ajrh.info/index.php/ajrh/issue/view/110.

ORIGINAL RESEARCH ARTICLE

Comprehensive sexuality education in six Southern African Countries: Perspectives from learners and teachers

DOI: 10.29063/ajrh2021/v25i3.7

Christine Chawhanda[1], Temitope Ogunlela[1], Relebogile Mapuroma[1], Oludoyinmola Ojifinni[1], Mulekya F Bwambale[2], Jonathan Levin[1], and Latifat Ibisomi[1,3]*

School of Public Health, University of the Witwatersrand, Johannesburg[1]; International Organization for Migration (IOM), Pretoria[2]; Nigerian Institute of Medical Research, Lagos[3]

***For Correspondence:** Email: *cchawhanda@gmail.com*; Phone: +263 71 914 9120

Abstract

Comprehensive sexuality education (CSE) promotes young people's healthy sexual decisions. This study assessed the level of provision of CSE in schools in ten sites in six Southern African countries from the perspectives of learners and teachers. The data was from a needs assessment preceding the baseline evaluation of the SRHR-HIV Knows no Borders Project conducted in ten sites in six Southern African countries. A total of 161 learners from 10 schools and 96 teachers from 96 schools were interviewed. Among the teachers, 82.3% reported CSE was part of the school curriculum. Although basic education policies in Southern African countries are in tandem with international, regional and national policies, complete implementation of the policies remains unfulfilled owing to conflicting policies and socio-cultural values of diverse stakeholders. Awareness campaigns and trainings may help to promote positive perceptions among stakeholders about sensitive CSE topics and the distribution of SRH commodities in schools. *(Afr J Reprod Health 2021; 25[3]: 60-71).*

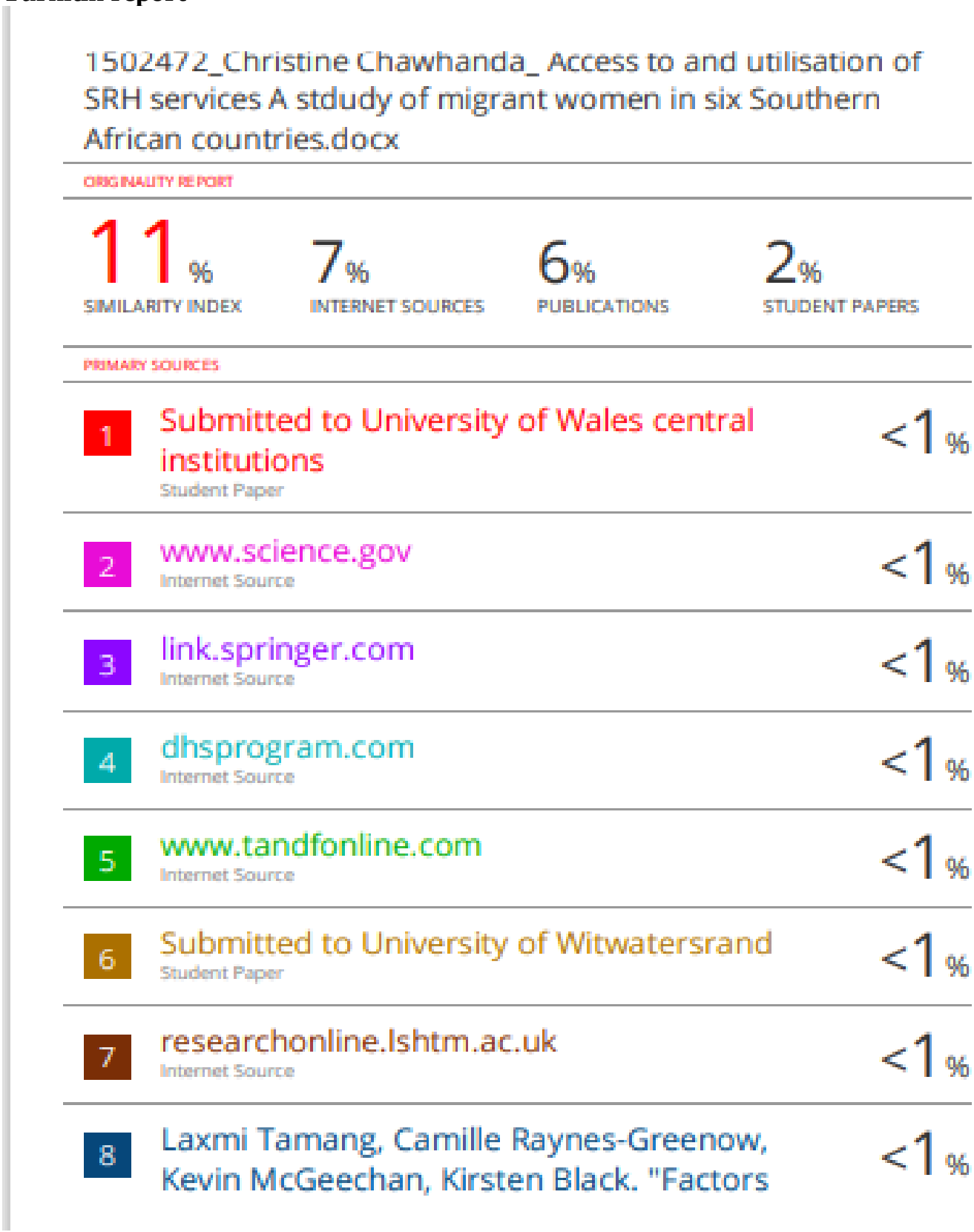
Keywords: Adolescent health, sexual health, reproductive health commodities, school health

Résumé

L'éducation sexuelle complète (CSE) encourage les jeunes à prendre des décisions sexuelles saines. Cette étude a évalué le niveau de fourniture d'ESI dans les écoles de dix sites dans six pays d'Afrique australe du point de vue des apprenants et des enseignants. Les données provenaient d'une évaluation des besoins précédant l'évaluation de base du projet SRHR-HIV Knows no Borders mené dans dix sites dans six pays d'Afrique australe. Au total, 161 apprenants de 10 écoles et 96 enseignants de 96 écoles ont été interrogés. Parmi les enseignants, 82,3% ont déclaré que l'ESC faisait partie du programme scolaire. Bien que les politiques d'éducation de base dans les pays d'Afrique australe soient en tandem avec les politiques internationales, régionales et nationales, la mise en œuvre complète des politiques reste inachevée en raison des politiques contradictoires et des valeurs socioculturelles des diverses parties prenantes. Les campagnes de sensibilisation et les formations peuvent aider à promouvoir des perceptions positives parmi les parties prenantes sur les sujets sensibles de l'ESC et la distribution de produits de SSR dans les écoles. *(Afr J Reprod Health 2021; 25[3]: 60-71).*

Mots-clés: Santé des adolescents, sante sexuelle, produits de sante reproductive, sante scolaire

Turnitin report



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