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ORIGINAL RESEARCH ARTICLE

Access to and provision of sexual and reproductive health services in Ekurhuleni, South Africa: Experiences and coping strategies of migrant women and healthcare workers

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Abstract

The importance of universal access to health services including sexual and reproductive health and rights (SRHR) services by migrant populations and the fundamental role of healthcare workers in providing SRHR services, requires a balanced understanding of the experiences of both migrants and healthcare workers. This study explored the experiences of migrant women in accessing and utilising SRHR services and the experiences of healthcare workers in providing SRHR and HIV services in Ekurhuleni, South Africa. In-depth interviews were conducted with five internal migrants, eight international migrant women aged 18-49 years, and four healthcare workers. Migrant women were selected using snowball sampling while healthcare workers were purposively sampled. Migrant women face multifaceted challenges including but not limited to language barriers, discrimination based on migration status, cultural and religious hurdles when accessing and utilising SRHR and HIV services. Similarly, healthcare workers encounter challenges in providing SRHR and HIV services to migrant women which include language barriers and having migrants who seek services without referral documentation and legal migration documents. Training healthcare workers on cultural sensitivity and integration of migrant friendly services in the health policy may improve migrant women's experiences in accessing and utilising as well as healthcare workers' experiences in providing SRHR services. *(Afr J Reprod Health 2024; 28 [8]: 30-47).*

Keywords: Sexual and reproductive health; migration; medical xenophobia; access dimensions

Résumé

L'importance de l'accès universel aux services de santé, y compris les services de santé et de droits sexuels et reproductifs (SDSR) pour les populations migrantes et le rôle fondamental des agents de santé dans la fourniture de services SDSR, nécessitent une compréhension équilibrée des expériences des migrants et des agents de santé. Cette étude a exploré les expériences des femmes migrantes en matière d'accès et d'utilisation des services SDSR et les expériences des agents de santé dans la fourniture de services SDSR et VIH à Ekurhuleni, Afrique du Sud. Des entretiens approfondis ont été menés avec cinq migrants internes, huit femmes migrantes internationales âgées de 18 à 49 ans et quatre agents de santé. Les femmes migrantes ont été sélectionnées à l'aide d'un échantillonnage boule de neige tandis que les travailleurs de la santé ont été échantillonnés à dessein. Les femmes migrantes sont confrontées à des défis multiformes, notamment les barrières linguistiques, la discrimination basée sur le statut migratoire, les obstacles culturels et religieux lors de l'accès et de l'utilisation des services SDSR et VIH. De même, les agents de santé rencontrent des difficultés pour fournir des services SDSR et VIH aux femmes migrantes, notamment des barrières linguistiques et le fait que les migrantes recherchent des services sans documents de référence ni documents de migration légaux. La formation des agents de santé à la sensibilité culturelle et à l'intégration de services adaptés aux migrants dans la politique de santé peut améliorer les expériences des femmes migrantes en matière d'accès et d'utilisation, ainsi que les expériences des agents de santé dans la fourniture de services SDSR. *(Afr J Reprod Health 2024; 28 [8]: 30-47).*

Mots-clés: Santé sexuelle et reproductive ; migration; xénophobie médicale ; dimensions d'accès

Introduction

South Africa is the main host of international migrants in Africa with approximately 4.2 million international migrants at mid-year in 2019[1,2]. Within South Africa, internal migration is rife mainly with people migrating from their province of origin to Gauteng province in search of better

economic opportunities[3]. An increase in female migration has been documented worldwide and in South Africa. The share of international female migrants in the year 2019 was 48% globally and 43% at mid-year in South Africa[4,5]. The majority of the women migrating are of the reproductive age group 15-49 years who require health services, specifically sexual and reproductive health and rights (SRHR) services in the host country[6,7]. Sexual and reproductive health and rights is access to positive and correct information, diagnosis, treatment, and prevention services regarding SRHR in a respectful manner, free of coercion, discrimination, and violence[8–10]. The services include contraception, abortion, pregnancy, maternal health, post-partum services, and sexually transmitted diseases including HIV and AIDS[8–10]. In line with the 2030 Sustainable Development Goals, countries should ensure access to SRHR services for its citizens, regardless of migration status[11].

Since 1994, xenophobia has been a major recurring issue in South Africa targeting African migrants with the most recent notable xenophobic attacks being Operation Dudula in 2021 where members of Operation Dudula restricted undocumented migrants from accessing healthcare in Pretoria[12]. Xenophobia is not only a violent phenomenon but can be practiced through exclusion and discrimination of foreigners in various institutions including health service providers. In health service provision, migrants experience medical xenophobia by being denied the required treatment and denigrated verbally by healthcare workers precisely because they are foreigners[13–15]. As such, medical xenophobia' refers to the negative attitudes and practices of health sector professionals and employees towards migrants[15,16]. In addition to medical xenophobia, it has been documented that migrants in South Africa fail to access public health care when they fail to produce evidence of their legal right to be in South Africa (the legal documents) and because they cannot speak local languages[15,17–19]. As a result, migrants without all the required documents change their health-seeking behaviours as they fear being arrested or deported[19]. However, the practice of medical xenophobia contradicts Section 27 of the South African constitution which includes the provision that everyone has a right to health care[13,15,20]. Discrimination and medical xenophobia were mirrored and worsened during South Africa's response to the COVID-19 pandemic where migrants particularly, undocumented migrants were denied COVID-19 vaccination[21–23]. Consequently, discrimination and medical xenophobia in healthcare settings are major barriers to the achievement of the Sustainable Development Goals (SDGs).

Although SRHR has been recognised as an important aspect of women's quality of life, several studies worldwide have documented limited access to and utilisation of SRHR services by migrant women [24–34]. Extant literature has shown that factors that hinder migrant women from accessing and utilising SRHR services are language or communication barriers, negative health care worker attitude, lack of financial resources, lack of proper documentation, being a migrant, institutional barriers, cultural and religious barriers[6,28–30,33,35–40]. In addition, it has been documented that the contraceptive methods used by migrant women, may not be available in the host country leading to interrupted access and use of the services[10].

Studies on migrant women's access to SRHR services have been conducted in isolation, either exploring the barriers faced by migrant women or from the perspective of healthcare workers[25,27,28,30,41]. There is a dearth of literature on the experiences and coping strategies of healthcare workers in providing SRHR services to migrant women with few studies conducted in Australia and Botswana[28,42]. 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 SRHR services[43]. As such, research is required to contextually explore and understand both migrant women's (internal and international) experiences in accessing and utilising SRHR services and healthcare workers' experiences in providing SRHR services. Against this backdrop, this study aims to concurrently explore the experiences and coping strategies of female migrants in accessing and utilising SRHR services and that of healthcare workers in providing SRHR services to migrant women.

The Health Access Livelihood framework[44], was used to guide the study. It 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[44,45]. Since migrant women are mainly in the reproductive age group, they require SRHR services in the host country, and accessing SRHR 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[44]. The level of accessibility and utilisation of SRHR services by migrant women as guided by the 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[44–46].

Methods

Study setting

The study was conducted in Ekurhuleni district in Gauteng province, South Africa. Gauteng province is the economic hub of the country hence it is characterized by a high inflow of both internal migrants from other provinces and international migrants mainly from African countries. Approximately 47.5% of the international migrants in South Africa reside in Gauteng province[2]. Despite having a diverse population and being a signatory to several international and regional treaties that promote universal access to healthcare, access to healthcare services in South Africa remains a challenge for migrants[27,43,47].

Study design and study participants

This qualitative study used a phenomenological approach to understand the lived experiences and coping strategies of migrant women in accessing and utilising SRHR services and of healthcare workers in providing SRHR services to migrant women. Due to the sensitivity around migration status and to ensure recruitment of participants within the legal age of consent, the study participants comprised of women aged 18 to 49 years who are not South African citizens (International migrants) and South African women who migrated from their provinces of origin to Ekurhuleni District- (Internal migrants). In addition, healthcare workers that provide SRHR and HIV services in Ekurhuleni form part of the study population. Given that migrant women are difficult to identify, snowball sampling was used to recruit them as it enables migrant women to recommend or refer other migrant women to be interviewed [48]. Healthcare workers were purposively sampled because they have extensive experience in providing SRHR services to migrants and they possess detailed information regarding their experiences in providing SRHR services to migrant women[49,50]. The healthcare workers who participated in this study included a lead facilitator, professional nurse, a student nurse, and an HIV counsellor. Recruitment of participants was done with the assistance of change agents and data collectors of the SRHR-HIV Knows No Borders Project as they were familiar with the area.

Data collection

Data was collected using in-depth interviews between December 2019 and March 2020. Through an extensive literature review on barriers and experiences faced by migrant women in accessing SRHR services, the interview guides were developed. The open-ended interview guides explored the participants' experiences in accessing and utilising SRHR and HIV services, the five dimensions of access, (affordability, availability, accessibility, adequacy, and acceptability of SRHR services), coping strategies and suggested measures to ease access to, utilisation and provision of SRHR and HIV services. The interview guides that were translated into Zulu and Xhosa were back-translated with the assistance of professionals to ensure consistency of meaning. To validate the interview guides and to reach a consensus on the content of the instruments, the Delphi method was used by three purposively selected qualitative experts. Pre-testing was carried out to identify problems/challenges with the questions. Three research assistants who had experience in conducting qualitative research interviews were recruited to ensure coverage of the different languages spoken in Ekurhuleni. A two-day training was conducted with the research assistants to establish their understanding and familiarisation with access to and utilisation of SRHR concepts. The interviews were conducted in English, Zulu,

and Xhosa by the research assistants and each interview, on average took about 30 to 60 minutes. Considering the potentially invasive nature of discussions about SRHR and HIV, the participants selected private interview venues where they were most comfortable.

Data management and analysis

Interviews were digitally recorded and transcribed verbatim. To ensure that the transcriptions captured everything included in the interviews, the first author 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, a combination of deductive and inductive thematic analysis. The recurring codes were developed into themes and ambiguous words for example "mhm", 'errr" and "uhhhh" were deleted from the transcripts. To ensure inter-coder reliability, two independent coders (who are not co-authors) who are proficient in qualitative research coded four transcripts together with the first author, and an agreement was reached regarding the codes.

Ethical considerations

Ethical clearance for the study was obtained from the University of Witwatersrand Human Research Ethics Committee (Medical) [Clearance Certificate Number M190601]. In addition, permission was obtained from the Ekurhuleni Health District Research Committee. All participants were provided with information sheets stating the details of the study and that their participation was voluntary. Willingness to participate was shown by either signing or thumb-printing the consent and audio recording forms. To maintain confidentiality, all the transcripts were de-identified and labelled with codes.

Limitations of the study

The study is subject to social desirability bias from both migrants and healthcare workers. In addition, it is subject to under-reporting by migrants regarding their experiences of intimate partner violence and experiences in accessing and utilising SRHR and HIV services.

Results

Participant characteristics

The participants comprised of five internal migrants, eight international migrants, and four healthcare workers from municipal and provincial clinics in Ekurhuleni. The healthcare workers had tertiary education and possessed more than five years of working experience in the health sector. The participants' ages ranged from 20 to 54 years and had been in South Africa for three to more than ten years. The majority of the migrant participants were living with a partner, had secondary/tertiary education, and were employed. International migrants were from the Democratic Republic of Congo (DRC), Malawi, Mozambique, Uganda, Zambia, and Zimbabwe.

Five dimensions of access

Geographic accessibility to services

There were mixed responses regarding the geographic accessibility of healthcare facilities. Some participants reported being within walking distance to the health facility from their place of residence or work while others reported being far from the facility. Migrants who reported not being in close proximity to the healthcare facilities found accessing the healthcare facility expensive as they faced transportation costs which they reported as not being affordable at times. Regarding geographic accessibility of healthcare facilities participants reported that:

"It (healthcare facility) is not far, it is a walking distance from both my work and home". (Internal migrant woman 1).

"The health facility is far; I walk for about 30 minutes or more and imagine if you are sick ... it is too far, and I can't afford the transport costs..." (International migrant woman 2).

Affordability of services

The majority of the participants described obtaining SRHR and HIV services from the clinics as affordable as there are no administrative costs or

service-related payments. 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. However, some participants reported being referred to the hospital mainly for child delivery where they are required to pay high hospital fees which they could not afford. They further highlighted that the services at the hospital were higher for those without legal documents to stay in South Africa.

*"Both HIV and SRHR services are free, and you do not have to pay for you to get the services and there are no administration costs that need to be paid at the clinics." (*International migrant woman 3).

*"...So, what happens is for those who deliver at the hospital and do not have the proper legal documents, they are forced to 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." (*International migrant woman 4).

Availability of services

The majority of participants stated that some SRHR services are not always available in public health facilities. These are mainly pregnancy-related services including Depo Provera (contraceptive), pregnancy testing kits and abortion services. Unavailability of the services resulted in migrant women resorting to private facilities and pharmacies where the SRHR services are expensive hence, unaffordable. The experience was different for HIV services as they were reported to always be available.

"At times healthcare workers tell you that they do not have the services especially the injection, Depo Provera and you must come after a certain time..." (Internal migrant woman 1)

"...I went for abortion services at the clinic, and they told me that they do not offer abortion services in the surrounding clinics, but HIV services are always available". (International migrant woman 5).

"At first I went to the private clinic and bought the Depo Provera but buying became expensive for me because most of the time it was not available". (International migrant woman 6).

Adequacy of services

Migrant women felt that the service provision was not adequate as some procedures were not followed and they were not involved or given a chance to make appropriate decisions about their pregnancy-related services. Migrant women reiterated that:

"...when I tested positive to 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 7).

"... 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. ...They were supposed to provide me with a variety of options so that I can choose what I want". (International migrant woman 8).

Acceptability of services

The majority of migrant women 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 as it was deemed unacceptable according to their religious and cultural morals. Migrant women reported that:

"My religion is Islam and with Islam, it is always female to female when requiring SRHR services, even your partner must not be there. ...I would find a male nurse and you know being in a foreign land its difficult, worse if most of the staff are not Islamic also." (International migrant woman 7).

"...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 2).

Migrant women's experiences in accessing and utilising SRHR and HIV services

The majority of migrant women described their challenges in accessing SRHR and HIV services in Ekurhuleni, South Africa. The challenges highlighted were at the individual level, interpersonal, and institutional levels.

Individual level

At the individual level, migrant women reported experiencing challenges in accessing and utilising SRHR and HIV services owing to their migration status and language barriers.

Discrimination (medical xenophobia) from healthcare workers

Migrant women encountered multiple forms of medical xenophobia which hindered them from accessing SRHR and HIV-related services and these are; migration status, language, age, and HIV status. Although internal migrants did not experience medical xenophobia based on migration status, they faced it based on age, language, and HIV status. As a result, migrants were reluctant to contest the way they were treated. A feasible option is to encourage migrants to be accompanied by someone who is fluent in English and understands the local languages.

"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 must do things their way as we do not have a say because we are not from here" (internal migrant woman 3).

"…They were discriminating against us foreigners because of where we come from, they call us names, "amakwerekwere" you come here to trouble us" (International migrant woman 2).

"...I was discriminated against because I couldn't speak any other language except for Sepedi and because I am from Limpopo. (Internal migrant woman 4).

"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 (the healthcare worker) not a White person talk to us in Zulu, yet we do not know how to speak in Zulu." (International migrant woman 3).

"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 5).

Interpersonal factors

Migrant women acknowledged the importance of family in accessing and utilising SRHR and HIV services. They reported receiving support from family, friends, and partners (spouses) in the form of financial and emotional support. International migrant women who do not have their families in South Africa either obtained support from their friends or their families sent a relative to look after them. However, migrant women reported mixed experiences regarding partner support as it was not reliable.

Family and partner/spousal support

"My family supported me financially when accessing and utilising SRHR and HIV services and emotionally when I experienced violence from my partner." (Internal migrant woman 3).

"My family is in Zimbabwe, but my friends were very supportive emotionally and in assisting with doing some house chores as well as lending me money when I did not have." (International migrant woman 2).

"Only when it suits him, sometimes he gives me money for transport…" (Internal migrant woman 1).

Institutional factors

Migrant women described several factors that are related to the healthcare facility and healthcare workers that hinder them from accessing and utilising SRHR and HIV services.

Healthcare facility requirements/standard operating procedures

One of the requirements of the public health facilities is for the patients to produce identification documents (national identity document for South Africans, a valid passport or proof of asylum for foreigners) and proof of residence. The major obstacle for migrants in accessing public healthcare in South Africa is the denial of treatment when they fail to produce the required documentation.

Migrant women reported that failure to produce the valid required documents resulted in being denied access to healthcare services.

"…They require passport, ID, or asylum. If you don't have, they do not help you…." (International migrant woman 1).

"…They denied me access to health services 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 1).

Healthcare worker's attitude

The majority of participants expressed dissatisfaction when accessing and utilising SRHR and HIV services because of insults, judgemental sentiments, and being shouted at by healthcare workers.

"*… Here they have a bad attitude, and they shout at you… I once went for abortion here in South Africa and they judged me, they made me feel uncomfortable like they were reminding me how sinful it is and blaming me for not preventing.* (International migrant woman 4).

"… Especially if you are a migrant, they have a tendency of saying we are dirty, we do not bathe … (Internal migrant woman 5)

Waiting time

Both international and internal migrant women described the waiting time to obtain the SRHR related services as too long whereas they do not wait for prolonged hours to obtain HIV services. This could be attributed to high workload as healthcare workers perform several tasks outside their scope. As such, some migrant women indicated resorting to obtaining their services from the women's clinic where they pay a fee and obtain the required services timeously. Majority of participants reported waiting for more than 3 hours to obtain SRHR related services.

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

"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, the waiting period is very long because sometimes you can even wait for about 4 to 5 hours." (International migrant woman 4)

"… For HIV testing and other HIV services, 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)

Lack of Interpretation services

Migrant women stated lack of provision of interpretation services in the healthcare facilities is the main factor behind experiencing language and communication challenges, hence a barrier in accessing and utilising SRHR and HIV services.

"They do not have interpretation services they just call someone who speaks the same language as you. But language is a problem." (International migrant woman 7)

"… they do not have interpretation services making it difficult for us to communicate with the nurses." (Internal migrant woman 4)

Informal SRHR referrals

When the required SRHR and HIV services were not available, participants were verbally referred to other clinics or hospitals. Thus, participants were not provided with referral letters, and this was highlighted to be the reason for not utilising referral services unless the condition was life-threatening.

"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 5).

"…For HIV and TB, they referred me but they did not give me a referral letter…" (International migrant woman 7).

"…In clinics they do not do abortions, so they refer you to a hospital. I wasn't given a referral letter, so I did not go." (International migrant woman 2).

Migrant women's coping strategies in accessing and utilising SRHR and HIV services

For migrant women to cope in the community where there are challenges in accessing and therefore utilising SRHR and HIV services, they resorted to several strategies described below.

Private healthcare facilities as alternatives

Majority of migrant women highlighted that they resort 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.

"Whenever they do not have the SRHR 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 4).

Unauthorised SRHR service providers

The majority of international migrant women highlighted that when they do not have the legal documents to stay in South Africa, when the required services are not available, or when the healthcare facility do not have the same contraceptive methods they use, for example, the pills, they resort to purchasing them from individuals who sell them illegally.

"…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 5).

"My passport was overstayed 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).

Borrowing the required documents and money

Migrant women stated that to access and utilise SRHR and HIV services, healthcare facility requires an identity document (ID) or passport and proof of residence. Failure to produce the required documents resulted in denied access to healthcare facilities and services. As a result, migrant women mentioned borrowing mainly the proof of residence from other patients. This shows that while it is a routine procedure for patients to produce proof of residence, healthcare workers do not pay attention to the details as migrants are able to use other people's proof of residence. In addition, migrant women reported borrowing money from family or friends for transport to the healthcare facility or when they needed to access and utilise the required SRHR and HIV services from private facilities. Another migrant woman reported diverting the child social grant to obtain SRHR-related services.

"*… An old woman overheard that I did not have proof of residence hence they could no 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 SRHR services I needed.*" (Internal migrant woman 2).

"When Depo Provera was not available, I borrowed the money from my friends and bought it from the surgeries which are along the road…" (International migrant woman 7).

"… 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 SRHR related services." (Internal migrant woman 5).

Support systems

The migrant women reported the absence of support groups within their communities.

This may be attributed to migrants not being aware of the available support services in the communities as they usually isolate themselves due to fear of being labelled or being attacked during the recurrent xenophobic attacks. On the other hand, the lack of support groups in the communities that focus on SRHR could be attributed to health facilities focusing mainly on communicable diseases leaving behind sexual and reproductive issues. Participants reported that:

"…there are no support groups in this community, I have never heard of any and we would appreciate if there were any initiatives to have such groups in this community." (International migrant woman 3)

"We used to see health workers moving around looking for those on TB medication, but I do not know of any support groups for SRHR services, we do not have those groups in this community." (Internal migrant woman 1)

Women who experienced emotional distress due to discriminatory attitudes of the health workers presented their cases on social media where they found some respite by relating their experiences with those of other people who experienced similar situations.

"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 to other people's experiences through the comments on my post." (Internal migrant woman 3).

Silence

The majority of migrant women reported not taking any action or remained 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 fear of being reported to the police when they did not have the legal documents.

"*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 4).

Healthcare workers' experiences in providing SRHR and HIV services.

Healthcare workers reported experiencing several challenges in providing SRHR and HIV services. Apart from language barriers and lack of transfer letters, healthcare workers have highlighted that non-migrant women also experience a shortage of SRHR services and long waiting time. However, healthcare workers did not experience any challenges with migrants failing to pay hospital fees because all the services are provided free of charge.

Language barriers

Healthcare workers reported experiencing language/communication challenges in providing SRHR and HIV services. While migrant women reported being discriminated against based on language, healthcare workers highlighted that language challenges made it difficult for them to understand the required services as migrant women failed to express themselves clearly.

"… We experience language problems, sometimes it is difficult for migrants to express themselves and that makes our job difficult because we may misunderstand them." (Healthcare worker 1).

Unavailability of SRHR services

While shortage of SRHR services was reported to be a challenge for both migrants and non-migrants, healthcare workers reported being blamed by migrant women for the unwanted pregnancies owing to shortages/stock outs of some SRHR services mainly the injection, intrauterine devices and abortion services. Unavailability of medication is one of the structural challenges being faced by South Africa's healthcare system. Healthcare workers reiterated that:

"The challenge is that we mainly experience shortage of the injection so most women default because of shortage of the injection so we usually have challenges with those who default because

they fall pregnant and think that it is our fault." (Healthcare worker 2).

Waiting time

Healthcare workers reported receiving complaints of patients who waited for long hours without obtaining the required SRHR related services. Studies have shown that long waiting hours and poor quality of care is a result of the conditions under which healthcare workers work. Healthcare workers reiterated that:

"We serve a broad population here, so sometimes I see patients for SRHR services around 2 or 3pm and they will complain that they have been here since 6am. So, the waiting time is very lengthy." (Healthcare worker 3).

"Sometimes service provision is quick and sometimes it is not depending on how many nurses are on duty. Waiting also depends on whether the patient understands the language being used if not it also takes more time." (Healthcare worker 4).

"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." (Healthcare worker 3).

Healthcare facility requirements

Healthcare workers described that for migrants to obtain SRHR and HIV services they ought to have their ID, passport, and proof of residence. In addition, for HIV services healthcare workers reported that migrant women lacked proper documentation in the form of a transfer or referral letter making it difficult for them to provide correct medication. However, there are some inconsistencies regarding what happens when the patients do not possess the required documents. While migrants (both internal and international) reported being denied the required health services, the healthcare workers, though they acknowledged that patients should have the documents they reported providing health services to everyone including those without the required documents. Healthcare workers reported that:

"...Migrants should have an ID, passport, and proof of residence and if they were on HIV treatment, we require a transfer letter. However, our experience with HIV positive migrant women is that they usually come without the transfer, so we ask them to bring the container of the tablets they are taking to show that they are taking treatment. At times they don't bring the container ..." (Healthcare worker 1).

"They should produce all the required documents. However, we do not refuse them treatment if they do not have the documents..." (Healthcare worker 3)

Religious challenges

Migrant women's religious beliefs were identified by healthcare workers as a barrier when providing HIV services to migrant women. They reported migrant women not adhering to their medication as they believed that healing and cure comes solely from God and taking medication was against their faith and religious beliefs. Healthcare workers reiterated:

"...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." (Healthcare worker 2).

Recurring sickness

For HIV-related sickness, 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." (Healthcare worker 1).

Administrative costs and hospital fees

Similar to the responses of migrant women, healthcare workers highlighted that they did not

encounter patients who failed to pay for the required SRHR or HIV services because the services are provided free of charge.
"…we did not experience any payment challenges because they don't have to pay anything, it is free. Everything at this clinic, all services are for free" (Healthcare worker 3).

Healthcare worker's coping strategies

Patients as interpreters

The useful strategies used by healthcare workers whenever they encounter language challenges include the use of other patients as interpreters, pictures, or getting the migrants to write down what they require.

"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." (Healthcare worker 4).

Patient indexing

To ensure that the partner of the migrant woman who gets treated for the same sickness repeatedly is also treated, healthcare workers described a process they referred to as 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 phone numbers, 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. 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. 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. 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."* (Healthcare worker 2).

The use of medication containers

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

"… If the person is positive and does 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." (Healthcare worker 4).

Community outreach programs

Healthcare workers indicated that there are migrant women who fear accessing and utilising services from health facilities because of lack of legal documents. As a result, they reported having community outreach programs that target all women regardless of migration status. The program is aimed at providing information, medication, and follow-up, especially to the elderly and the disabled.

"… 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." (Healthcare worker 2).

Discussion

This study documents the experiences and coping strategies of migrant women in accessing and utilising SRHR 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. Compared to internal migrants, majority of international

migrants reported not being near to the healthcare facilities found accessing the healthcare facility expensive as they faced transportation costs which they reported as not being affordable at times. While this is a new finding in South Africa, similar results were documented in a study conducted among migrants in England and Ethiopia where the costs associated with accessing the health facilities (transportation costs) hindered migrants from accessing and utilising the required services[25,27,29,33,39,51]. 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 SRHR services[24,26,28,29,52]. The results could be attributed to migrants residing in remote areas where accommodation rentals are affordable and places where the police rarely patrol. In addition, the findings could be attributed to international migrants' financial instability and lack of legal documents which forces them to look for cheaper accommodation usually in the outskirts where the police rarely patrol in the communities.

Regarding affordability of SRHR services, all participants reported that SRHR services are provided free 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 as well as section 27 of the of the South African constitution[13]. However, regarding availability of SRHR services, healthcare workers concurred with the responses from migrant women highlighting SRHR services which are not always available in the health facilities. Owing to unavailability of some SRHR services which are injections (Depo Provera), pregnancy testing kits and abortion services, migrant women resorted to purchasing them from pharmacies and private surgeries where the services are costly. In agreement with the previous findings, some contraceptive methods especially the pill and HIV treatment in South Africa was reported to be different from the ones provided in the country of origin, therefore, migrants purchase them from unauthorised individuals in the communities[10]. It has been documented that when migrants move, they cross both geographical Borders and health facilities[53], yet a gap exists in policy, standardized guidelines, and systems of patient referral to harmonize and better coordinate health services in the SADC region[54–57]. As such, it is recommended to standardise mainly HIV treatment, family planning and the referral system in the SADC region.

Similar to previous findings on acceptability of SRHR and HIV services, the results show that cultural and religious beliefs are crucial in determining migrant women's access to and utilisation of SRHR services as provision of SRHR services by male healthcare workers was deemed unacceptable by some migrant women[29,30,33,37–39,58]. Migrant women and healthcare workers highlighted multiple forms of discrimination/ medical xenophobia which include age, language or communication challenges, HIV status and migration status and these act as the major barriers in accessing SRHR and HIV related services. Multiple and interlocking forms of discrimination impacts negatively on the self-esteem of the migrants resulting in migrants withdrawing and isolating themselves and being reluctant to access the required healthcare services. Similar findings were documented in studies conducted in Southern African countries namely Lesotho, Malawi, Mozambique, South Africa, The Kingdom of Eswatini, and Zambia, and in Geneva where discrimination based on language, migration status, age, and HIV status hindered migrants from accessing SRHR services including HIV services[26,27,29–33,35,37,38,59,60]. Language and communication barriers were exacerbated by the unavailability of interpretation services in public healthcare facilities. To curb language issues, migrant women highlighted the need for interpretation services. However, South Africa's health care system mirrors the health challenges being faced by many Southern African countries which include high disease burden, lack of resources, shortage of human resources and lack of infrastructure and medication[61]. As such, the South African health system is overburdened and may not be able to support interpretation services. As a coping mechanism, the healthcare workers identified other patients to provide interpretation services. The health policies should promote a diverse health workforce by recruiting foreign health workers who are willing to communicate in English. It is also critical to devise strategies and interventions that respond to multiple forms of discrimination (medical xenophobia). To facilitate

this, it is recommended to routinely measure and report experiences of medical xenophobia/multiple discrimination in South Africa in national surveys and official statistics. In addition, there is a need for research that has a more specific and in-depth focus on experiences and health outcomes of multiple and interlocking forms of discrimination among migrants.

Some studies have shown that show that healthcare workers unconsciously exhibit negative attitudes and stereotypes against minorities including migrants when providing health services [62]. While some authors argue that the poor working conditions and workplace stress partly explain the negative behaviour of healthcare workers and poor treatment rendered to the patients [63]. However, this results in migrants having lower trust in healthcare, lower satisfaction with care, and negative perception of quality of care[62]. Similar to previous findings from systematic reviews on access to and utilisation of abortion services, this study shows that migrant women face stigmatisation and judgmental sentiments from healthcare workers[64–66]. In addition, judgmental and stigmatisation sentiments based on age from health care workers act as a barrier to access and utilisation of SRHR services by adolescence and young women[25,67].

The majority of migrant women described waiting for long hours to obtain the required pregnancy-related services as compared to waiting time for HIV services. This could be attributed to high workload as healthcare workers perform several tasks outside their scope [61,63]. Healthcare workers in South Africa are stressed and have high workload resulting in exhibition of very low levels of job satisfaction, hence the delay in providing health services to the patients irrespective of migration status[62,63]. However, for migrants, the waiting time may be worsened by other factors including language barriers, required documentation and healthcare worker attitude. The lengthy waiting time was attributed to healthcare workers being involved in other tasks which are outside their daily responsibilities thereby increasing their workload[15,61,63]. As such, migrant women obtained their services from the women's clinic where they pay a fee and obtain the required services timeously. There is a need for health facilities to collaborate with non-governmental organizations (NGOs) to reduce the waiting time to obtain SRHR services, this reduces the workload of healthcare workers. Lessons can be drawn from the existing collaborations between health facilities and Aurum Institute in the provision of HIV services.

As part of the standard operating procedures at every healthcare facility, national identity documents or passport and proof of residence are required. Migrants were asked to provide proof of South African residence in the form of a bank statement or other documentation that indicates their residential address. The majority of migrants were unable to secure proper accommodation with lease agreements or to open a bank account, hence they were unable to produce proof of residence. While some authors believe that identification documents are used beyond verifying the name of the patient; by assessing the origins, legal status, and identity in order to erect barriers to accessing health services[15], the findings of this study show that the issue of documents is not targeted solely at foreign migrants as South African nationals are facing similar predicaments.

While migrant women reiterated that failure to produce the documents resulted in denied access to the healthcare facility and therefore to the required SRHR services, healthcare workers reported assisting people everyone including those without the documents. The results corroborate findings of previous studies conducted in South Africa, Lesotho, and Botswana where lack of legal documents hindered migrants from accessing SRHR services[25,27,28,32,33,68,69]. As a survival strategy, migrant women borrow documents, mainly proof of residence from other patients to have access to the healthcare facility and to obtain the required SRHR services. The divergence in reporting regarding the required documents by migrant women and healthcare workers could be attributed to inconsistencies between the constitution and the health policies whereby healthcare workers are aware of the standard operating procedures while being ignorant of the right to healthcare. Therefore, empowering migrants is recommended so that they become aware of their rights and be bold to demand them. This can be achieved through community educational campaigns, peer education and distribution of rights-based pamphlets. This will enable migrants to report and hold perpetrators accountable with the aim of achieving discrimination-free healthcare settings through rights literacy, patient charters, social

accountability monitoring, community support to improve the relationship between migrants and healthcare workers.

Similar to previous findings from systematic reviews on access to and utilisation of abortion services, the study shows that migrant women face stigmatisation and judgmental sentiments from healthcare workers[64–66]. In addition, judgmental and stigmatisation sentiments from health care workers act as a barrier to access and utilisation of SRHR services by adolescents and young women[25,67]. Providing training to healthcare workers on their roles and responsibilities, cultural sensitivity and behaviour change related to addressing discrimination in the healthcare settings, and provision of migrant-friendly services may improve the way healthcare workers treat and provide services to migrant women.

Although cross-border referral was highlighted as a challenge that required attention in 2009[70], the findings of this study reinforced the previous findings as both migrants and healthcare workers mentioned poor referral systems within South Africa and across SADC countries. Within South Africa, referrals from clinics were mainly verbal thereby discouraging migrant women from utilising the referred services. Healthcare workers encountered HIV-positive migrants who seek treatment without the referral documents from their country of origin and to avoid re-starting of treatment, drug resistance, and sub-optimal outcomes, they checked the medication containers of the patients. Poor referral system could be attributed to insufficient coordination between clinics and hospitals and insufficient knowledge of the referral system[71].

It is important to acknowledge that while previous research has documented language, medical xenophobia, the issue of documentation, similar findings were revealed in this study. The perpetuity of the challenges could be due to a lack of policy enforcement as the role models continue to practice medical xenophobia which lower-level healthcare workers tend to imitate. This is depicted by the recent scenario where the health minister for South Africa's Limpopo province berated a Zimbabwean woman for crossing the border to access healthcare in South Africa[12]. It is crucial to support accountability and compliance with the principle of non-discrimination in healthcare settings by devising constructive systems of accountability and strengthening reporting, monitoring and evaluation of discrimination and taking corrective action on complaints. In addition, inconsistencies between the immigration policies, the constitution and the health policies confuse healthcare workers. For instance, the immigration laws call for the deportation of illegal migrants whereas the constitution echoes the right to health services for everyone including the illegal migrants and as standard procedures health facilities require legal documents[54,63]. While the inconsistencies confuse the health workers, they also hinder illegal migrants from accessing and utilising health services.

In addition, the Gauteng Department of Health Annual Report (2013–2014) highlights cross-border utilisation of health services and high rates of migration into the provinces to have a negative impact on service delivery including health service delivery thus, migrants are perceived to be a burden to the health system[54]. There is a high need for the implementation of the United Nations Shared Framework for Action and conducting awareness campaigns and sensitisations on combating inequalities and discrimination aimed at leaving no one behind and changing public perceptions including that of healthcare workers so that migrants are not viewed as problematic but by the important contributions they make in the host country.

Conclusion

This study explores the experiences and coping strategies of migrant women in accessing and utilising SRHR services and the experiences of healthcare workers in providing SRHR services to migrant women. The findings have shown that both internal and international migrant women experience similar challenges in accessing and utilising SRHR and HIV services. Regarding the five dimensions of access, although obtaining SRHR services in South Africa was viewed as affordable some migrants raised concerns about geographic accessibility in terms of transportation costs which resulted in the services not being affordable. In addition, the unavailability of some SRHR services led migrant women to access them from private facilities and unauthorised individuals. Internal and international migrant women have expressed experiencing language or

communication challenges, discrimination based on migration status, HIV status, age and language, cultural and religious challenges, lack of required documents, prolonged waiting time, negative healthcare worker attitude and lack of interpretation services in accessing and utilising SRHR and HIV services. Similarly, healthcare workers highlighted experiencing language/communication challenges, religious challenges, lack of referral or transfer letters and lack of interpretation services as barriers in provision of SRHR and HIV services. This study highlights the need for the development and enforcement of policies that require healthcare workers to provide migrant friendly services which also include interpretation services, supportive, non-judgmental migrant youth friendly services and consideration of diverse cultural aspects to improve both migrant women and healthcare workers experiences in accessing and providing SRHR services. There is a need for strengthening the referral system within the health facilities in South Africa and across the Southern Africa region and promote collaboration with non-governmental organizations to ensure continuity of care and minimise unavailability of services and waiting time. In addition, policies should be reviewed and revised regarding documentation requirements for accessing SRHR services to ensure that migrant women, including those without legal identification documents, can still receive necessary care.

Ethics approval and consent to participate

All the methods were performed in accordance with the relevant guidelines and regulations. Ethical clearance for the study was obtained from Human Research Ethics Committee-Medical of the University of Witwatersrand (Clearance Certificate Number M190601). In addition, permission to carry out the study was obtained from the Ekurhuleni Health District Research Committee (GP_201909_037). Information Sheets containing details of the study were shared with participants and participation in the study was voluntary and did not involve any risks. Consent to participate was obtained from the participants by signing or thumb printing. To maintain confidentiality, all the information that contained the participant's identity was removed from the transcripts and labelled with codes.

Availability of data and materials

The data is not publicly available. Information about the data can be provided by the corresponding author upon reasonable request.

Competing interests

The authors declare that they have no competing interest.

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Authors' contributions

CC, OO, JL and LI participated in conceptualising and designing the manuscript. CC acquired the data. CC, OO, JL and LI were involved in data analysis and interpretation. CC, OO, JL and LI drafted the manuscript, critically reviewed it and approved the final manuscript.

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