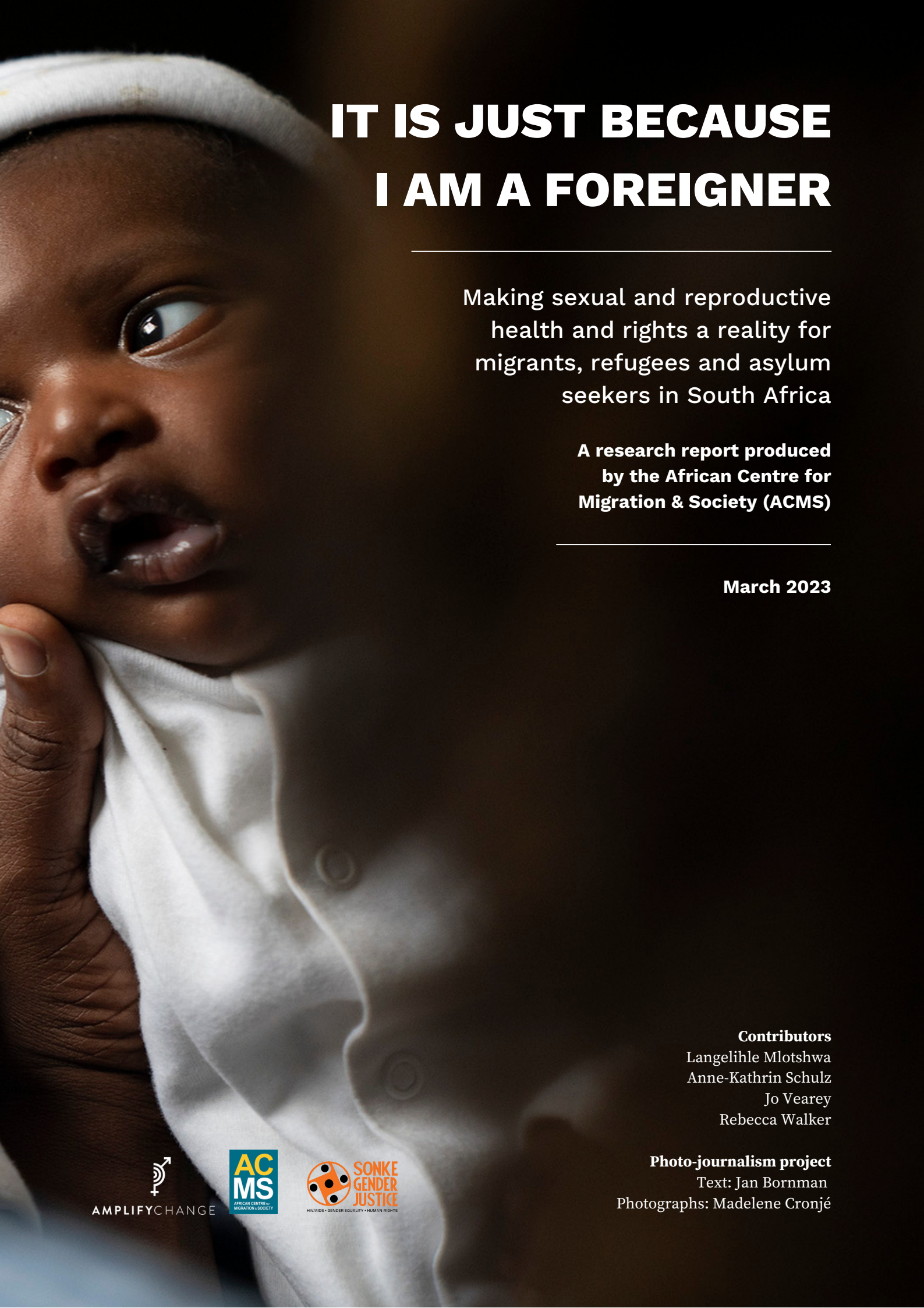




IT IS JUST BECAUSE I AM A FOREIGNER

Making sexual and reproductive
health and rights a reality for
migrants, refugees and asylum
seekers in South Africa

**A research report produced
by the African Centre for
Migration & Society (ACMS)**

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Cover photo: Josephine Kasongo (not her real name) and her baby, Kasendwe, in their one-bedroom flat. Madelene Cronjé.

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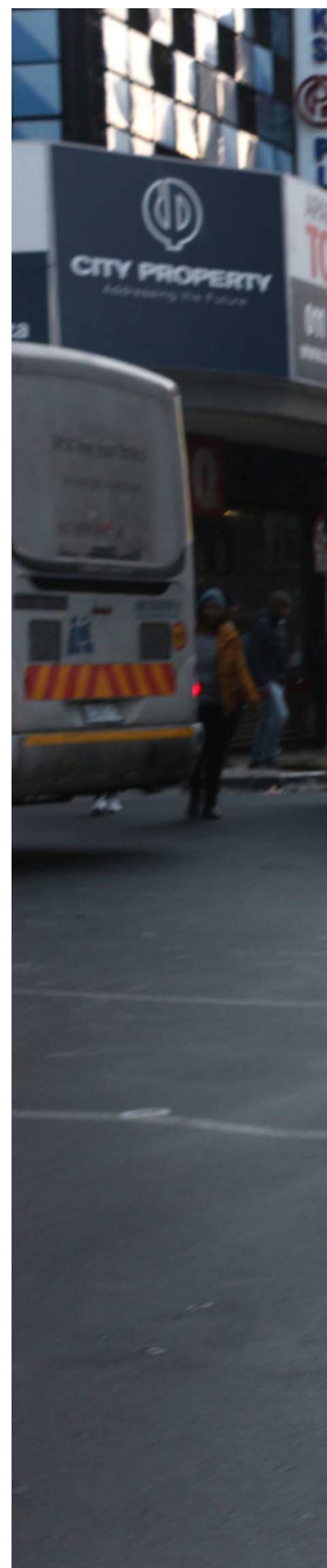
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Photo, Right: Johannesburg scene. by Madoda Makhobeni.







01

About this report

*Photo above and right:
A nervous Gloria Kalenga 11 days
before giving birth to her baby boy.
Photo by Madelene Cronjé.*

About this report

This report presents research undertaken between 2019 and 2021 by the African Centre for Migration & Society (ACMS), Wits University. The research contributes to a larger programme of work funded by AmplifyChange. Undertaken in collaboration with Sonke Gender Justice and the Consortium for Refugees and Migrants in South Africa (CoRMSA), the project focuses on making sexual and reproductive health and rights (SRHR) a reality for migrants, refugees and asylum seekers in South Africa.

The project coincided with the onset of the Covid-19 pandemic which had multiple impacts on the planned research approach. Due to lockdown restrictions, safety, and the ethics of undertaking research during this time, the decision was made to re-orient our approach. Initially designed to involve work with migrant communities and staff in healthcare facilities in the Gauteng, KwaZulu-Natal and Western Cape provinces, the research became desk-based, supported by virtual/remote interviews with key stakeholders. This was supplemented by a photo-journalism project undertaken in Johannesburg.

This project was co-ordinated by a team experienced in working with potentially vulnerable communities – in order to bring to the fore some of the lived experiences of migrants when trying to access their SRHR.

Future research should build on the work presented here and implement the research protocol we designed to work collaboratively with migrants to assess the quality of sexual and reproductive health (SRH) services provided to migrants in South Africa.

Photos

All photos © Madelene Cronjé and Madoda Makhobeni. The photographs and accompanying narratives contribute to an ongoing photo-journalism project undertaken by Jan Bornman, James Oatway and Madelene Cronjé in collaboration with the ACMS. To date, 'The Endless Journey' has been supported with funding from the ACMS, the Irish Embassy of South Africa, the International Organization for Migration (South Africa) and AmplifyChange. The project can be found online at www.medium.com/the-endless-journey.



This girl, she went for an abortion. Then the nurse was on her case like “You go there opening your legs [sleeping around] enjoying; now you want to do it [have an abortion]”. So, it was not a good experience, so she left. And she kept her pregnancy, unwanted one.

Senior community trainer

Executive summary

Over the past decade, there has been notable progress in addressing equitable access to **sexual and reproductive health and rights (SRHR)** across Southern Africa (International Organisation for Migration, 2020). Global commitments to the Sustainable Development Goals (SDGs) – which aim to ‘leave no-one behind’ and promote broad human rights-based approaches to development (United Nations, 2015a) – have provided unprecedented opportunities for better understandings of, and responding to, SRHR. This includes the ambitions set out in Goal 3 that aim to “ensure healthy lives and promote well-being for all at all ages” – specifically 3.7 that ensures universal **access to sexual and reproductive health (SRH)** and 3.8 that calls for Universal Health Coverage (UHC) (UHC2030, 2018; United Nations, 2015b).

However, despite an increasingly progressive legal framework designed to support improved access to SRHR in South Africa, the experiences of those reliant on the country’s public healthcare system highlight that policy is not effectively translated into practice.

As a result, while accessing SRHR is a challenge for all, it is amplified for marginalised and ‘key’ population groups. These **key populations** include, amongst others, asylum seekers, refugees, and other categories of migrants from other countries, including those without the valid documents required to be in the country legally. While internal migrants can face some of the same vulnerabilities as cross-border migrants in South Africa, especially if undocumented or LGBTQI+ they are not the focus of the report and so, the use of the term migrant refers to cross-border-migrant unless stated otherwise.

Recognising the role of historical and contemporary migration and mobility in shaping South Africa, the failure to respond to the SRHR of migrant populations – alongside the heightened SRH risks they may face – is a key public health concern.

This report presents research on the intersections of SRHR and migration to make recommendations for **how to make SRHR a reality for migrants in South Africa**. The focuses of the report is cross-border migrants.

Findings identify **three key issues** that currently limit the ability of refugees, asylum seekers and migrants to access quality SRH services in South Africa:

(1)

pervasive structural – also known as indirect – violence;

(2)

challenges in the public healthcare system; and

(3)

ineffective policy and programmatic responses.

Structural – or indirect – violence occurs when there is no specific person directly harming another. This can result from social structures and institutions causing harm or disadvantage to certain population groups through political or economic power. This unequal distribution of power results in unequal life experiences. Such violence can also be driven by social prejudices such as xenophobia, racism, homophobia and sexism (Galtung, 1969; SaferSpaces, 2022a; Weigert, 2008).

In the South African context, anti-foreigner sentiments, judgements around abortion and unplanned pregnancies, and homophobia are just some of the key drivers of structural violence that manifest in political processes and the poor implementation of protective policies.

Public healthcare system challenges

include difficulties faced when trying to access a safe termination of pregnancy i.e. abortion. Pervasive stigmatisation of, and moralisation regarding, abortion and sexuality compounds the challenges involved in accessing quality SRH services. This has been exacerbated by the impact of the Mexico City Policy – also known as the Global Gag Rule (GGR) – and the Covid-19 pandemic.

Policy and programmatic challenges

include an overall de-prioritisation of SRH and a failure to engage with migration and the needs of specific migrant groups, including refugees and asylum seekers. This is undermining efforts to respond to SRHR and to meet key global commitments, including the SDGs regarding UHC. Mapping the trajectory of SRHR in South Africa shows how structural violence – including discrimination on the basis of migration status, gender orientation and sexual identity, and the prevailing stigmatisation of abortion – has undermined key SRHR, especially the right to bodily autonomy.

Additionally, the report shows how the impact of the Covid-19 pandemic has amplified existing challenges while presenting new ones, and has exposed some missed opportunities to improve responses to SRHR. This is an emergent finding, however, given that the research was conducted during the pandemic and in advance of significant evidence as to the long-term impacts of the pandemic.

For this reason, the impact of the pandemic on SRHR among migrant populations is implicit throughout the report, and recognised as an issue that warrants further research. This is particularly important when considering future pandemic preparedness planning.

By centering the voices of key actors working at the forefront of SRHR in South Africa, the report shows why **an improved understanding of the complex, dynamic intersections of migration, gender, sexuality and SRHR is necessary.**

This is required not only to identify the current – and monitor future – challenges faced by migrants, refugees and asylum seekers when accessing SRH services, but also to provide evidence-informed recommendations for action to make access to SRHR a reality for migrants in South Africa.

Recommendations centre on the development of a **migration-aware response to SRH services**: a whole-system response whereby population movement is embedded as a central concern in the design of health interventions, policy, and research (Vearey et al., 2017). To achieve this, a focus on three key **Health System Building Blocks** is needed (World Health Organization, 2007a).

Block 1: Leadership and Governance

A multi-sectoral approach is needed, that recognises migration as a key determinant of health and that is led by the National Department of Health (NDoH). This can be achieved through establishing an **inter-sectoral National Migration & Health Task Team (N-MHTT)** with the mandate to build alliances across sectors, increase co-ordination, development, implementation and continuous evaluation of migration-aware responses to SRHR.

Block 2: Health Service Delivery

This would include working towards the implementation of the National Health Insurance (NHI) and the use of the recently published World Health Organization (WHO) Global Competency Standards for Healthcare Workers on Migration and Refugee Health. This should ensure that migrant populations have equitable access to quality SRH services that are rights-based, culturally appropriate and gender-responsive.

Block 3: Financing

This would entail promoting UHC through the implementation of the NHI.

inally, and most difficult to achieve, is a whole-of-government and **whole-of-society response to address underlying structural violence**. This includes addressing access to secure livelihood activities; anti-foreigner sentiments and xenophobia; stigma and moralising in relation to gender identity, sexual orientation and pregnancy. To do so “requires political changes in society, as well as changes in structures and patterns that govern people’s lives” (SaferSpaces, 2022b). Political accountability and the will to pursue change is a pre-requisite. Without this, attempts at reducing structural violence will fail.



On paper we have some of the best laws, if not the best laws, globally. In South Africa, you’re able to access termination [of pregnancy] at any age without parental consent, which is incredibly progressive. However, when it comes to in-facility access of termination of pregnancy, it is incredibly difficult.

Researcher

Acknowledgements

The research team extends their thanks to the individuals who participated in this research project. We are particularly grateful to you for finding the time to share your invaluable insights and expertise, particularly given the context within which we were all working at the time.

We appreciate the continued support from our colleagues and collaborators at Sonke Gender Justice and the Consortium for Refugees and Migrants in South Africa (CoRMSA) . Many thanks to Lenore Longwe and Fikile Radebe of ACMS for their operational support.

Thanks to Lotte Manicom at Surefire Communications for the design and layout of this report.

We thank AmplifyChange for supporting the project.

Report outline

The report starts with an introduction to sexual and reproductive health and rights (SRHR) within the broader context of migration and health. Recognising migration and health as a global health priority, SRHR are situated within calls for universal access and Universal Health Coverage (UHC) and in relation to determinants of migrant health and the key focus on making SRHR a reality for migrants.

Key terms are defined throughout this section and the rest of the report; in addition, a comprehensive glossary is provided. It is important to note here that while internal migrants can face some of the same vulnerabilities as cross-border migrants in South Africa, especially if undocumented or LGBTQI+ they are not the focus of the report. The use of the term migrant therefore refers to cross-border-migrant unless stated otherwise.

The methodology section describes the approach undertaken for the study, including a consideration of ethical issues and limitations like the main challenges created by the Covid-19 pandemic.

Subsequent sections provide an overview of key SRHR and migration concerns in South Africa. These are presented through a review of key literature as well as of the policy and legal landscape in the country pertaining to migration, gender, sexuality and SRHR. Key issues are also considered through a focus on access to abortion in South Africa and the impact of the Global Gag Rule (GGR).

The key findings from the interviews are then presented and discussed based on three key themes: structural violence; public healthcare system challenges; policy and programmatic responses to SRHR. The findings lead into a set of recommendations for making SRHR a reality for migrants. These involve applying the recently published World Health Organization (WHO) Competency Standards for Healthcare Workers and accompanying Knowledge Guide and Curriculum Guide.

Developing and implementing a South African approach to improving responses to migrants within the public healthcare system can support the integration of SRHR for migrants into continuous professional development for healthcare workers. Recommendations also call for the development of a National Migration and Health Task Team (N-MHTT) led by the National Department of Health (NDoH) and which would guide interventions to address the development of a migration-aware health response.



... this country doesn't prioritise anything that has to do with women and women's needs, whether it's our safety in the streets, whether it's issues of gender-based violence. So, this is for me, it's just another issue among many issues where the system generally doesn't prioritise and doesn't see women and issues of gender equality and rights as important for our own, you know, health and wellbeing, but also for the health and wellness of this country.

Technical advisor

Photo, overleaf: Millene Tshika with baby Donciel on her lap. Photo by Madelene Cronjé.





Acronyms

ACMS	African Centre for Migration & Society
AIDS	Acquired Immunodeficiency Syndrome
ARASA	AIDS & Rights Alliance for Southern Africa
ART	Antiretroviral treatment
ARV	antiretroviral
AU	African Union
CGE	Commission for Gender Equality
CoRMSA	Consortium for Refugees and Migrants in South Africa
CTOPA	Choice on Termination of Pregnancy Act
DHA	Department of Home Affairs
GGR	Global Gag Rule
HIV	Human Immunodeficiency Virus
ISA	informal sector abortion
JRS	Jesuit Refugee Services
LGBTQI+	Lesbian, Gay, Bisexual, Transexual, Queer, Intersex
MHF	Migrant Health Forum
MSM	men who have sex with men
NDoH	National Department of Health
NGO	non-governmental organisation
NHI	National Health Insurance
N-MHTT	National Migration and Health Task Team
NSP	National Strategic Plan
RISDP	Regional Indicative Strategic Development Plan
RMPPF	Regional Migration Policy Framework
RRO	Refugee Reception Office
SADC	Southern African Development Community
SAHRC	South African Human Rights Commission
SDGs	Sustainable Development Goals
SOGI	sexual orientation and gender identity
SRH	sexual and reproductive health

SRHR	Sexual and reproductive health and rights
SRJC	Sexual and Reproductive Justice Coalition
ToP	termination of pregnancy
UA	universal access
UHC	Universal Health Coverage
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WHA	World Health Assembly
WHO	World Health Organization



The use of foreigners to be trained as counsellors worked very well for us, especially working with HIV. When there is an interpreter in the room it sometimes makes the patient nervous or sometimes other words are lost in translation.

Community trainer

Summary of key findings

Findings identify **three key issues** that currently limit the ability of refugees, asylum seekers and migrants to access quality SRH services in South Africa:

(1)
pervasive structural – also known as indirect – violence;

(2)
challenges in the public healthcare system; and

(3)
ineffective policy and programmatic responses.

(1) Structural – or indirect – violence

Structural – or indirect – violence occurs when there is no specific person directly harming another. This can result from social structures and institutions causing harm or disadvantage to certain population groups through political or economic power. This unequal distribution of power results in unequal life experiences.

Such violence can also be driven by social prejudices such as xenophobia, racism, homophobia and sexism (Galtung, 1969; SaferSpaces, 2022a; Weigert, 2008). In the South African context, anti-foreigner sentiments, judgement around abortion and unplanned pregnancies, and homophobia are just some of the key drivers of structural violence that manifest in political processes and the poor implementation of protective policies.

(2) Public healthcare system challenges

Public healthcare system challenges include difficulties faced when trying to access a safe termination of pregnancy (ToP), i.e. abortion. Pervasive stigmatisation and moralisation of abortion and sexuality compounds the challenges involved in accessing quality SRH services. This has been exacerbated by the impact of the Mexico City Policy – also known as the Global Gag Rule (GGR) – and the Covid-19 pandemic.

(3) Policy and programmatic challenges

Policy and programmatic challenges include an overall de-prioritisation of sexual and reproductive health and rights (SRHR) and a failure to engage with migration and the needs of specific migrant groups, including refugees and asylum seekers. This is undermining efforts to respond to SRHR and to meet key global commitments, including the Sustainable Development Goal (SDG) of Universal Health Coverage (UHC). Mapping the trajectory of SRHR in South Africa shows how structural violence – including discrimination on the basis of migration status, gender orientation and sexual identity, and the prevailing stigmatisation of abortion – have undermined key sexual and reproductive health rights, especially the right to bodily autonomy.

Additionally, the report shows how the impact of the Covid-19 pandemic has amplified existing challenges while simultaneously presenting new ones, and has exposed missed opportunities for improving responses to SRHR. This is an emergent finding, however, given that the research was conducted during the pandemic and in advance of significant evidence as to the long-term impacts of the pandemic.

For this reason, the impact of the pandemic on SRHR among migrant populations is implicit throughout the report, and recognised as an issue that warrants further research. This is particularly important when considering future pandemic preparedness planning.

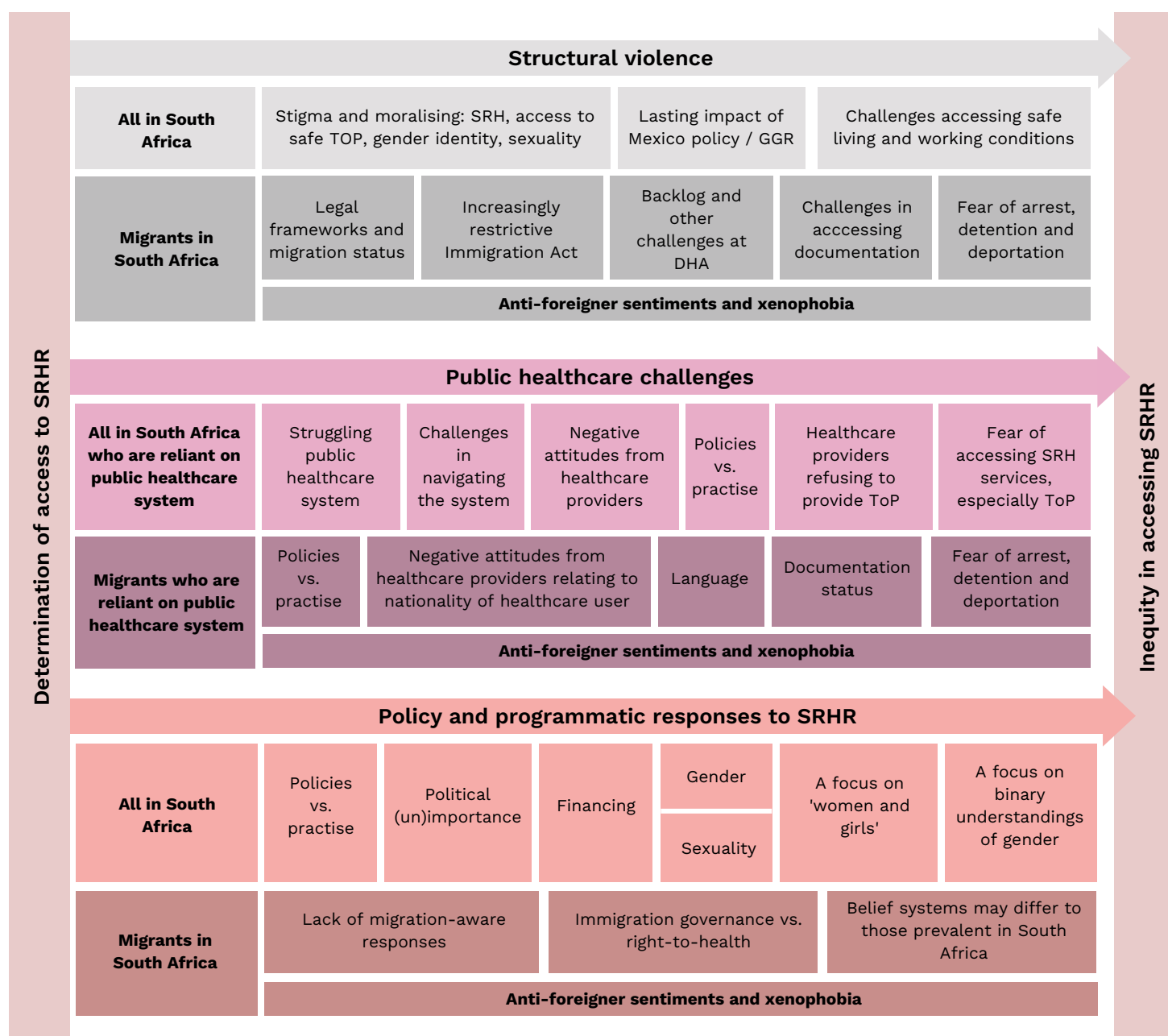


Figure 1: Factors impacting inequity in access to SRHR by migrants reliant on the public healthcare system in South Africa

Summary of key recommendations

Building on previous calls to do so (de Gruchy and Vearey, 2022; T. de Gruchy and Vearey, 2020; Vearey et al., 2017) recommendations centre on the development of a **migration-aware approach to SRHR** – a whole-healthcare system response whereby population movement is embedded as a central concern in the design of interventions, policy and research. This will contribute to progress towards Goal 3 of the Sustainable Development Goals (SDGs) that aims to “ensure healthy lives and promote well-being for all at all ages” – specifically 3.7 that ensures **universal access to sexual and reproductive health (SRH)** and 3.8 that calls for **Universal Health Coverage (UHC)** (UHC2030, 2018; United Nations, 2015a).

To achieve this, a focus on three of the six key Health System Building Blocks is needed (World Health Organization, 2010).

Block 1: Leadership and governance

A multi-sectoral approach is needed, that recognises migration as a key determinant of health – and that is led by the National Department of Health (NDoH).

This can be achieved through establishing an inter-sectoral **National Migration & Health Task Team (N-MHTT)** with the mandate to implement a migration-aware approach to SRHR. This will involve building alliances across sectors within and beyond government (Walker and Vearey, 2019a); and the development, implementation and continuous evaluation of migration-aware responses to SRHR.

Block 2: Health service delivery

This would include working towards the implementation of the National Health Insurance (NHI) and the use of the recently published World Health Organization (WHO) Global Competency Standards for Healthcare Workers on Migration and Refugee Health (World Health Organization, 2021a, 2021b, 2021c). This should ensure that migrant populations have equitable access to quality SRH services that are rights-based, culturally appropriate and gender-responsive.

Block 3: Financing

This would entail promoting UHC through implementation of the NHI.

Finally, and most difficult to achieve, is a whole-of-government and whole-of-society response to address underlying structural violence. This includes addressing access to secure livelihood activities; anti-foreigner sentiments and xenophobia; stigma and moralising in relation to gender identity, sexual orientation and pregnancy. To do so “requires political changes in society, as well as changes in structures and patterns that govern people’s lives” (SaferSpaces, 2022b). Political accountability and the will to pursue change is a pre-requisite. Without this, attempts at reducing structural violence will fail.



So, it think the way that the problems are, you know, they are older than five years, but they become more urgent... You have a health system that doesn’t respond in terms of policy updates, but also in ensuring that the health care providers, as well as the options available, are updated in terms of the recent and the...latest research; and that the options available can fit different women’s lifestyles in need whereas now, you don’t really have an option. Either you take an injection or a pill. I mean, that’s not really choice, is it?

Doctor | Women’s Health Clinic/Commission for Gender Equality (CGE)

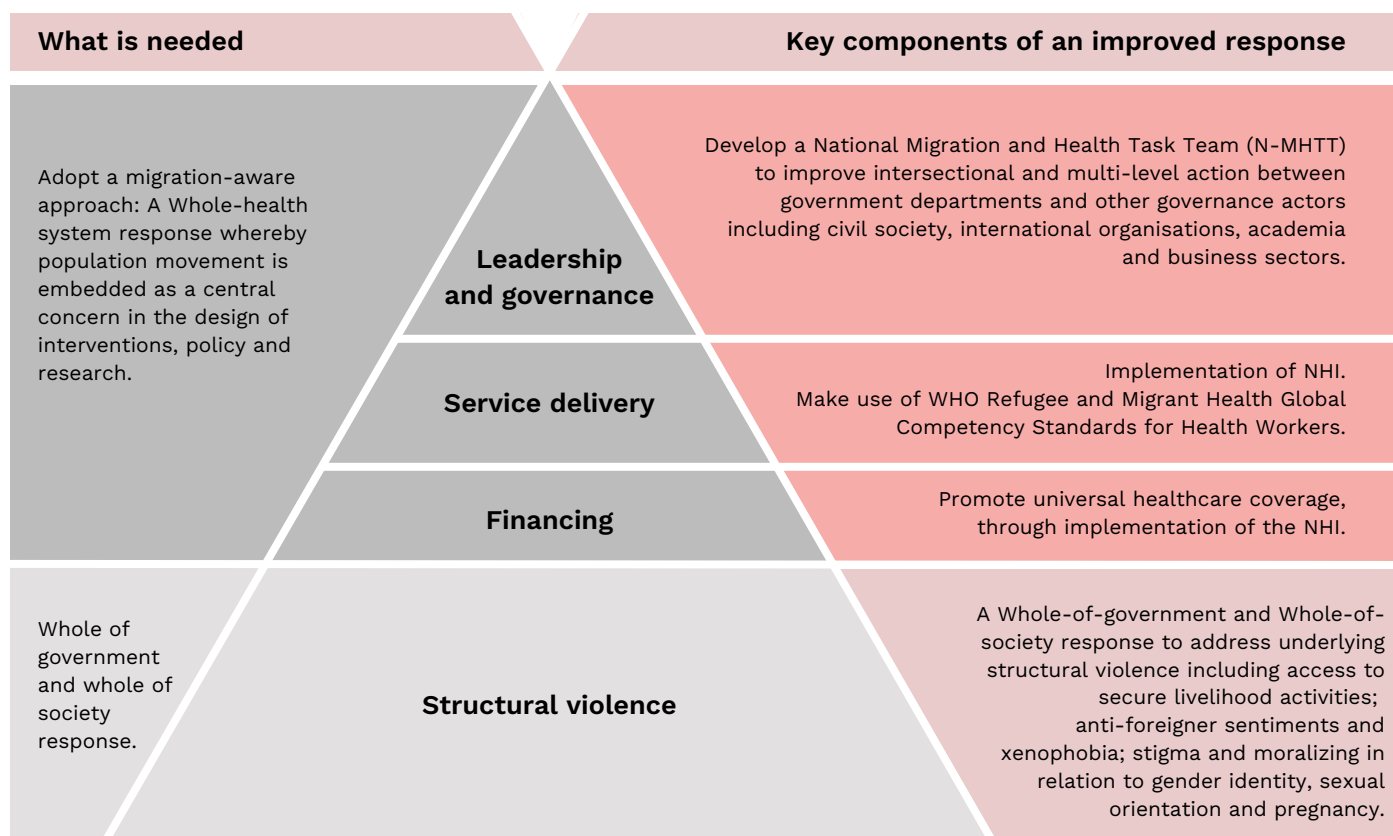


Figure 2: Key components of an improved response to make SRHR a reality for migrants, refugees and asylum seekers in South Africa



02

An introduction to sexual and reproductive health and migration

*Photo above and right:
Photo by Madoda Makhobeni.*



2.1 Sexual and reproductive health

Sexual Reproductive Health (SRH)

“Sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to sexuality and the reproductive system.”

United Nations Population Fund, 2018

Sexual and Reproductive Health and Rights (SRHR)

"Sexual and Reproductive Health and Rights (SRHR) are fundamental human rights that are related to sexual reproductive health. These include issues like HIV and other STIs, abortion, maternal health rights, contraceptive access, gender-based violence, discrimination and stigma. The support of SRHR means equality for those communities that are treated unfairly such as women, girls, migrants and others who are discriminated against living the lives they want."

World Health Organization, 2022

Over the past decade, there has been notable progress in addressing equitable access to **sexual and reproductive health and rights (SRHR)** across Southern Africa (World Health Organization, 2022). Global commitments to the Sustainable Development Goals (SDGs) which aim to ‘leave no-one behind’ and promote broad human rights-based approaches to development (United Nations, 2015a), have provided unprecedented opportunities for better understanding, and responding to, SRHR. This includes the ambitions set out in Goal 3 that aims to “ensure healthy lives and promote well-being for all at all ages” – specifically 3.7 that ensures **universal access to SRH** and 3.8 that calls for **Universal Health Coverage (UHC)** (UHC2030, 2018; United Nations, 2015b).

Assessing progress towards Goal 3.7 requires the structural barriers that prevent people from achieving SRH to be confronted (Starrs et al., 2018: 1). This requires improved understanding and recognition of the ways in which laws and policies are developed and implemented, as well as societal norms and values in relation to SRH. This includes attitudes towards **gender** and **sexuality** – including to **lesbian, gay, bisexual, transgender, queer and intersex persons (LGBTQI+)**; to teenage pregnancy; to **abortion**; and – as a central focus of this report – to **migration**.

A human rights-based approach emphasises “that the ultimate goal of all health policies, strategies and programmes is to further advance the realisation of the right to health and other health-related human rights”. SRHR refer broadly to the improvement of people’s wellbeing linked to making decisions about their own sexual and reproductive lives and respecting the decisions of others – in other words, “the right to control one’s own body, define one’s sexuality, choose one’s partner, and receive confidential, respectful, and high-quality services” (Starrs et al., 2018).

A human rights-based approach emphasises “that the ultimate goal of all health policies, strategies and programmes is to further advance the realisation of the right to health and other health-related human rights”.

Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages

3.7

“By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.”

3.8

“Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”

SRHR refer broadly to the improvement of people’s wellbeing linked to making decisions about their own sexual and reproductive lives and respecting the decisions of others – in other words, “the right to control one’s own body, define one’s sexuality, choose one’s partner, and receive confidential, respectful, and high-quality services” (Starrs et al., 2018).

Gender

The roles, activities and attributes that a society considers appropriate for men and for women (i.e., the different qualities associated with being masculine or feminine).

Gender is distinguished from 'sex', with the latter referring to biological characteristics associated with men and women (such as sex organs, chromosomes and hormones).

Marnell et al., 2021: 228-9

LGBT

An acronym used to refer collectively to lesbian, gay, bisexual and transgender persons.

LGBTQI+

"An acronym used to refer collectively to lesbian, gay, bisexual, transgender, queer and intersex persons. The plus symbol is added in recognition of fluid and shifting sexual/gender identities that may not be adequately described by the other terms".

Marnell, 2021: 230

Sexuality

"A central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors."

World Health Organization, 2006a

Despite the rollout of an increasing number of interventions and programmes designed to improve SRHR across the globe, progress has been slow (Alarcão et al., 2021). This is the result of ongoing, and often increasing, challenges and failures due to entrenched systematic SRHR violations; punitive laws and policies; social norms and practices; and stigma and discrimination (AIDS and Rights Alliance, 2021). For this reason, SRHR is often regarded in terms of risk – with particular emphasis on ‘women and girls’ due to unmet needs for contraception, unplanned pregnancies, unsafe abortion, poor maternal and newborn health, and sexually transmitted infections (AIDS and Rights Alliance, 2021).

As a result, whilst SRHR are framed as universally upheld human rights, they remain contested and deprioritised and the right to equal enjoyment of SRHR for many is denied in many contexts (Starrs et al., 2018). Evidence clearly indicates that this is most acutely felt by some of the most vulnerable and ‘at risk’ populations – including migrants – who are often referred to as ‘key populations’ (AIDS and Rights Alliance, 2021). According to the UN, migrants face increased risks in accessing SRHR due to “a state of high exposure to certain risks and uncertainties, in combination with reduced ability to protect or defend oneself against those risks and uncertainties and cope with their negative consequences” (Keygnaert et al., 2014).



Key populations experience both increased impact from one or more of the diseases and decreased access to services. Widespread stigma and discrimination, state and non-state violence and harassment, restrictive laws and policies, and criminalization of behaviors or practices put key populations at heightened risks and undermine their access to services.

The Global Fund, 2021

Photo, overleaf: Photo by Madoda Makhobeni.





2.2 Migration and health: A global public health priority

The need to engage with the multiple forms of population movements and diverse migrant populations is increasingly recognised as a global public health priority (Abubakar et al., 2018; Vearey et al., 2020a; Wickramage et al., 2018). This is demonstrated through a growing migration and health governance movement which is linked to three key global agendas: development; immigration governance; and, global health (Vearey et al., 2020a). The global ‘development agenda’ focuses on the SDGs and their embedded actions which remind us that we must ‘leave no-one behind’. This includes addressing the goals associated with immigration governance and global health, notably three key global compacts:

The importance of investing in the field of migration and health is highlighted on the next page.

-
- (1)**
Universal Health Coverage (UHC) (UHC 2030, 2017);
 - (2)**
The Global Compact for Refugees (United Nations, 2018a)
 - (3)**
The Global Compact for Safe, Orderly and Regular Migration (United Nations, 2018b).
-



The field of migration and health explores the patterns in health found between migrants and the host population, and across different migrant groups, including in contexts where the host population may be struggling to meet their own mental, social and physical wellbeing needs.

Lee et al., 2018; Thomas, F., 2016

Firstly, the development of public health strategies over many decades recognises the need for inclusiveness—the need to incorporate whole societies when addressing communicable disease control, such as through immunization programmes; the exclusion of subpopulations – like migrant groups – must be avoided (Thomas, 2016). There is a significant burden of TB, HIV, Hepatitis B, Hepatitis C, and vaccine preventable diseases in migrant populations. Addressing this important group in surveillance, screening, and linkage to care is crucial to meet the public health targets of countries and regions (European Centre for Disease Prevention and Control, 2018).

Secondly, some health-related interventions developed for specific subpopulations, such as migrant groups, can provide or lead to health benefits for the whole population (Chung and Griffiths, 2018; Thomas, 2016; Wild and Dawson, 2018).

Thirdly, ensuring the best possible health of migrants before, during and following their migration journeys, enables them to maximise their inclusion and contributions to their host society, facilitate their support to families of origin and minimise potential health-related costs borne by both the destination country and migrants themselves (Lu and Zhang, 2016; Wickramage et al., 2018). Even in acute displacement situations, such as large-scale refugee flows, immediate health issues (along with food and shelter) are of primary concern, and dedicated resources are needed to meet these critical needs for the good of individuals, local communities as well as the broader society (Abbas et al., 2018; Griswold et al., 2018).

Understanding health vulnerability and resilience is central to the field of migration and health. Migrants are not a homogenous group, nor are their needs, health vulnerabilities and resilience factors. Gender is a key dimension that needs to be considered in particular.”

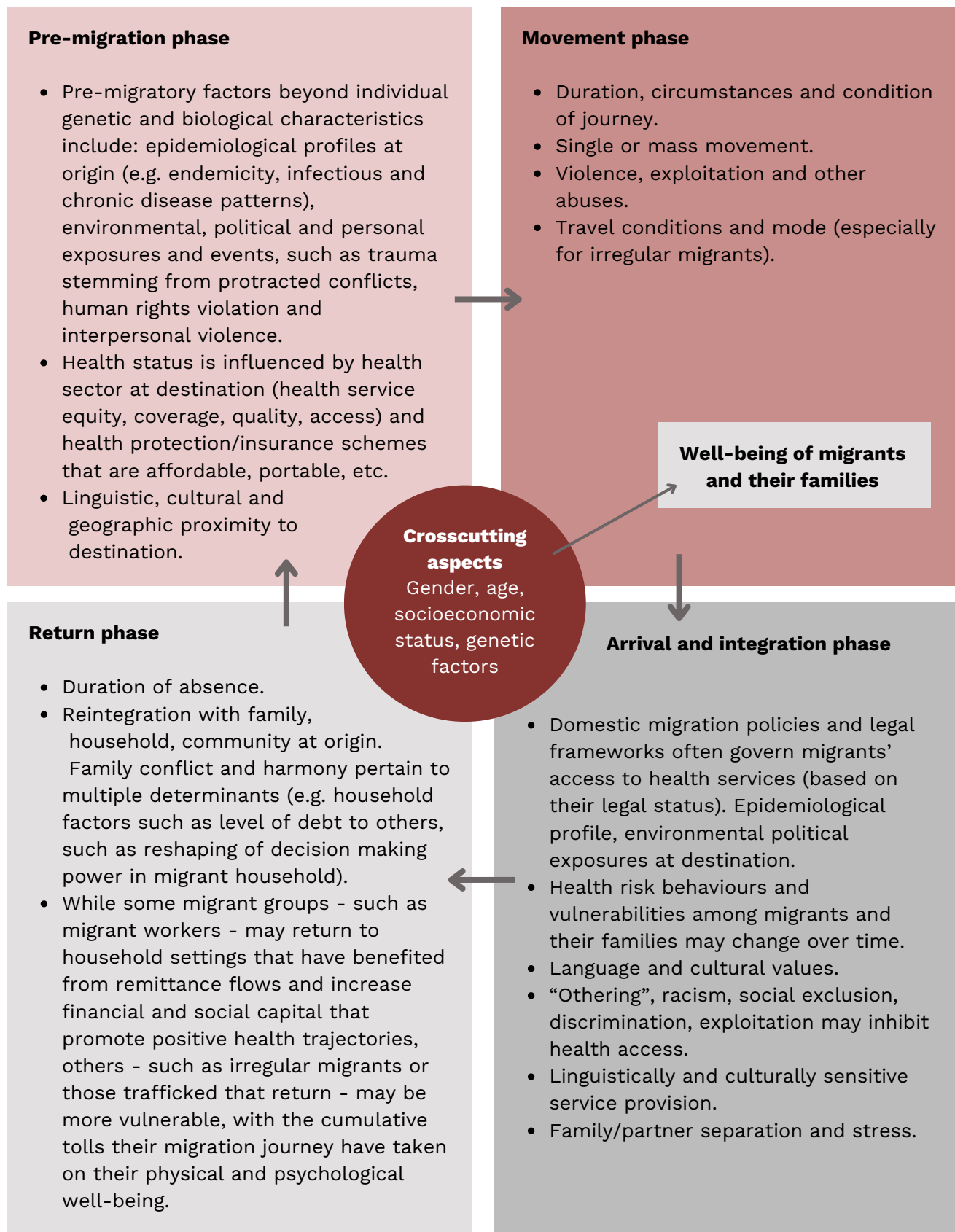


Figure 3: The determinants of migrant health throughout the migration cycle (Vearey et al., 2020b: 216)

2.3 Migration and SRH

Globally, research shows that poor SRH outcomes are heightened amongst refugee and migrant populations and especially migrant women, girls and LGBTQI+ individuals. The process of migration itself constitutes a social determinant of health through heightened risks, as do poor health systems and high disease-burden in migrant's home countries and in transit (International Organization for Migration, 2009). In addition for many migrants, life in their host/destination countries exposes them not only to harsh conditions but also to new or additional vulnerabilities, including risks for negative SRH outcomes. Irregular migration and the lack of documentation, for example, can lead to marginalisation or exclusion from national SRHR initiatives with “lasting impact on human development, not just for migrants, but for host communities and countries as well.” (International Organization for Migration, 2020).



The World Health Organization (WHO) defines good health as a "state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity".

This recognition of mental and social wellbeing, in addition to physical wellbeing, is critical and emphasises the importance of viewing health holistically. The state of a person's health is shaped not only by one's access to health services, but by a multitude of factors which are termed 'the determinants of health'.

Figure 3 (above) shows how the determinants of health can be applied to migrants across the migration cycle. Individual determinants are factors such as age, sex, and genetic predisposition to disease, and the epidemiological profile of a given context, and the disease exposures associated with it.

Structural determinants are usually politically mediated – such as legal frameworks and societal attitudes towards migrants – and result in a range of inequalities in socio-economic status. For migrants, structural determinants of health include the conditions associated with the different phases of their migration journey - pre-migration, movement, arrival and integration, and (for some) return.

Vearey et al., 2020b: 215.

2.4 Structural violence

In this report, the importance of structural violence as a key driver of the challenges faced by some migrant groups when trying to access SRHR is highlighted. Taking various forums, structural violence results from wider political and social contexts that drives the unequal distribution of power within a population (Galtung, 1969; SaferSpaces, 2022a; Weigert, 2008). The outcome is an unequal distribution of life experiences, with certain people facing more challenges and barriers to a just life than others.

In the South African context, the majority of the population – both citizens and non-citizens – face multiple, intersecting forms of structural violence that negatively impact their health and wellbeing. As outlined in Section 1.5 of this report, we focus on the experiences of international (non-citizen) **migrants**, including **refugees**, **asylum seekers** and those who are currently without the valid documents required to be in the country legally (**undocumented migrants**) in accessing SRHR in South Africa.

Structural violence

Structural – or indirect - violence occurs when there is no specific person directly harming another. This can result from social structures and institutions causing harm or disadvantage to certain population groups through political or economic power. This unequal distribution of power results in unequal life experiences. Such violence can also be driven by social problems, such as xenophobia, racism and sexism (Galtung, 1969; SaferSpaces, 2022a; Weigert, 2008).

“Redressing structural violence requires political changes in society, as well as changes in structures and patterns that govern people’s lives.”

SaferSpaces, 2022a

Migrant sensitive health systems	
Priorities to address	• Ensure that health services are delivered to migrants in culturally and linguistically appropriate ways, and enforce laws and regulations that prohibit discrimination. • Adopt measures to improve the ability of health systems to deliver migrant-inclusive services and programmes in comprehensive, co-ordinated, and financially sustainable ways. • Enhance the continuity and quality of care received by migrants in all settings, including that received from NGO health services and alternative providers. • Develop the capacity of the health and relevant non-health workforce to understand and address the health and social issues associated with migration.
Key actions	• Establish focal points within governments for migrant health issues. • Develop standards for health service delivery, organisational management and governance that address cultural and linguistic competence; epidemiological factors; and legal, administrative, and financial challenges. • Develop frameworks for the implementation and monitoring of health systems' performance in delivering migrant sensitive health services. • Develop methods to analyse the costs of addressing, or not addressing, migrant health issues. • Include diaspora migrant health workers in the design, implementation and evaluation of migrant sensitive health services and educational programmes. • Include migrant health in the graduate, postgraduate and continuous professional education training of all health personnel, including support and managerial staff.
Monitoring Migrant Health	
Priorities to address	• Ensure the standardisation and comparability of data on migrant health. Increase the better understanding of trends and outcomes through the appropriate disaggregation and analysis of migrant health information in ways that account for the diversity of migrant populations. Improve the monitoring of migrants' health-seeking behaviours, access to and utilisation of health services, and increase the collection of data related to health status and outcomes for migrants. Identify and map: 1) good practices in monitoring migrant health; 2) policy models that facilitate equitable access to health for migrants; and 3) migrant-inclusive health systems models and practices. Develop useful data that can be linked to decision-making and the monitoring of the impact of policies and programmes. • Priorities to address • Key actions • Establish focal points within governments for migrant health issues. Develop standards for health service delivery, organisational management and governance that address cultural and linguistic competence; epidemiological factors; and legal, administrative, and financial challenges. Develop frameworks for the implementation and monitoring of health systems' performance in delivering migrant sensitive health services. Develop methods to analyse the costs of addressing, or not addressing, migrant health issues. Include diaspora migrant health workers in the design, implementation and evaluation of migrant sensitive health services and educational programmes. Include migrant health in the graduate, postgraduate and continuous professional education training of all health personnel, including support and managerial staff.
Key actions	• Identify key indicators that are acceptable and useable across countries. • Promote the inclusion of migration variables in existing census, national statistics, targeted health surveys and routine health information systems, as well as in statistics from sectors such as housing, education, labour and migration. • Use innovative approaches to collect data on migrants beyond traditional instruments such as vital statistics and routine health information systems. • Clearly explain to migrants why health-related data is being collected and how this can benefit them; have safeguards in place to prevent use of data in a discriminatory or harmful fashion. • Raise awareness about data collection methods, uses, and data sharing related to migrant health among governments, civil society, and international organisations. • Produce a global report on the status of migrants' health including country-by-country progress reports.

Table 1: Key priorities and actions for developing migrant-sensitive healthcare systems and monitoring migrant health (World Health Organization, 2010)

2.5 Making SHRH rights a reality for migrants, refugees & asylum seekers in South Africa

In this report, we explore the experiences of international (non-citizen) **migrants**, including **refugees**, **asylum seekers** and those who are currently without the valid documents required to be in the country legally (**undocumented migrants**) in accessing SRHR in South Africa.

As a member state to the World Health Assembly (WHA), South Africa is constitutionally mandated to ensure access to healthcare for internal and cross-border migrant populations in line with the 2008 WHA resolution (Walls et al., 2015). In addition, the South African Constitution (1996), as interpreted within the National Health Act (2003), guarantees rights to access healthcare for everyone in South Africa and also provides for the right to dispute resolution (Human Rights Watch, 2009; Walls et al., 2016). The law is clear: at a primary level everyone is entitled to healthcare, regardless of nationality and documentation status.

Documented refugees and asylum seekers should be means-tested in the same way as South African citizens (meaning that unemployed asylum seekers and refugees should not be charged for treatment, as is the case for South African citizens); and all pregnant and lactating women and children under the age of six are entitled to free care at all levels (Walls et al., 2016). Yet the variation in how this legislation is interpreted – both regionally, locally and within specific facilities – not only creates space for discrimination, but also places frontline healthcare practitioners and facility staff as gate keepers and critical mediators of policy implementation (Walls et al., 2016). This is especially the case in South Africa where an over-burdened and under-resourced public healthcare system struggles to meet the needs of both citizens and non-citizens, and SRHR remain out of reach to many.

Asylum-seeker

“...An individual who is seeking international protection. In countries with individualized procedures, an asylum seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum seeker will ultimately be recognized as a refugee, but every recognized refugee is initially an asylum seeker.” (World Health Organization, 2022). In South Africa, asylum seekers are governed by the Refugee Act.

Migrant

“...While there is no formal legal definition of an international migrant, most experts agree that an international migrant is someone who changes his or her country of usual residence, irrespective of the reason for migration or legal status. Generally, a distinction is made between short-term or temporary migration, covering movements with a duration between three and 12 months, and long-term or permanent migration, referring to a change of country of residence for a duration of one year or more.” (IOM, 2019). In South Africa, migrants are governed by the Immigration Act.

Refugee

“...Refugees are persons who are outside their country of origin for reasons of feared persecution, conflict, generalized violence, or other circumstances that have seriously disturbed public order and, as a result, require international protection.” (IOM, 2019)

Undocumented migrant

Undocumented cross-border migrants in South Africa are governed (criminalised) by the Immigration Act.

On paper, South Africa stands out from other countries across the SADC region – the Southern African Development Community – for its robust constitutional and legislative frameworks to protect human rights, including the rights of migrants. This is seen, for example, in policies on access to healthcare, including SRH services, and the protection of people with diverse gender identities and sexual orientations (Gandar, 2019; Walker and Vearey, 2019a).

However, realities on the ground are different. Although classified as a middle-income country, the extreme levels of inequality in South Africa mean that 80-85% of the population rely on state-funded healthcare which, due to years of chronic underfunding, systemic weaknesses and a lack of political will, is severely compromised in its ability to respond to the needs of citizens and non-citizens in South Africa (Malakoane et al., 2020). Furthermore, those who face heightened vulnerabilities to poor health and SRH are disproportionately affected by, and carry the burden of, existing health inequities in the country in intersecting ways. These include women with a lower socio-economic status, young and adolescent women, migrant/refugee women, asylum seekers, women living with HIV, LGBTQI+ persons, sex workers and other marginalised groups (Amnesty International, 2017; Freedman et al., 2020; Meer and Müller, 2017a; Mosley et al., 2017).

The difficulties that non-national migrants face in accessing services have been widely documented (Chekero and Ross, 2017; Coovadia et al., 2009; Hunter-Adams and Rother, 2017; Lefko-Everett, 2007; Walker, 2021; Walker and Vearey, 2019b). Often described as ‘medical xenophobia’, the “negative attitudes and practices of health professionals and employees towards migrants and refugees” (Crush and Tawodzera, 2014: 1) can also be seen as a part of the structural violence that often goes unacknowledged in South Africa.

In fact, overall, the South African government’s rhetoric, policy approaches and practices at all levels reflect an increasingly overt anti-foreign sentiment. Everyday xenophobic rhetoric and actions are deeply entrenched within daily administrative structures and systems (Crush and Peberdy, 2018). In direct contradiction to the country’s progressive Constitution that states “South Africa belongs to all who live in it”, migrant rights are routinely violated; anti-immigration rhetoric spans across the political spectrum often inciting outbreaks of xenophobic violence, such as in 2008, 2015, 2017 and 2019 (Bornman, 2019; Gandar, 2019). The ruling African National Congress (ANC) increasingly uses migration and a call to secure borders as a playing card for popular support and to detract from the government’s own failures to meet the needs of all those within South Africa’s borders.

Although South Africa currently has a non-encampment policy (setting it apart from other African countries where refugees must stay in camps), there are no policies guiding, or resources supporting, this approach or the integration of refugees into South African society.

Shifts towards an increasingly regressive approach to migration are seen in recent amendments to South Africa's Refugee Act (signed into law in 2017) and in the Department of Home Affairs' White Paper on Immigration (2017).

These seek to amend the Immigration Act – to reverse the long-standing non-encampment policy and move towards establishing a 'Border Management Authority' (Department of Home Affairs, 2017; Kihato and Landau, 2017; National Department of Home Affairs, 2019). This also includes restrictions on the rights that non-citizens have to access public healthcare – including SRH services – as articulated in South Africa's National Health Insurance White Paper (Department of Health, 2017; Johannesburg Migrant Health Forum, 2016a).

The Johannesburg Migrant Health Forum Submission on The White Paper on National Health Insurance

"The coverage envisioned by NHI for refugees and asylum seekers is not commensurate with the coverage that these categories of people are entitled to receive currently. The prohibition of regression means that the following aspects of the White Paper are particularly problematic:

27.1 Under the White Paper, refugees will be entitled to “basic health care services”, a term that is used in the Refugees Act but that has never been defined. Currently, refugees are treated in the same way as South Africans. They are means tested to determine the level of subsidisation in hospitals, while being provided with all primary health care services free of charge.

27.2 Asylum-seekers are, under the White Paper, entitled only to emergency medical treatment and treatment for notifiable conditions. The treatment of asylum-seekers currently is the same as that of South Africans and refugees.

27.3 All other non-nationals under the White Paper will have to pay in full for health care services. Currently, both the Uniform Patient Fee Schedule and the SADC Protocol on Health mandate special treatment of nationals of SADC states. No such provision has been made in the White Paper.

27.4 The White Paper provides that a special contingency fund will be used to pay for health care services to refugees. This separation does not appear warranted under domestic, regional and international law; and the reason behind the development of this fund is unclear and raises concerns about the future funding of health care services to all types of migrants. It also reveals the Department’s apparent view that migrants are necessarily a burden on the state and should be treated as a contingency. In fact, as noted earlier, many migrants are productive economically and socially and contribute to public funds through taxation.

27.5 The White Paper makes no mention of, and therefore appears to offer no coverage to, pregnant and lactating women from outside South Africa or to their children below age six. This directly contradicts the protection given to pregnant and lactating women and children in the National Health Act and in the Constitution, and the policy imperative of providing special treatment to marginalised groups. It also impacts negatively on some of the most vulnerable migrants, including unaccompanied minors who will be particularly unable to pay for their own care. In the ways described above, the White Paper constitutes a regression in access to health care services by migrants and is, therefore, subject to legal challenge." (Kihato, 2018)

Box 1: A regression of migrant rights in South Africa

The increasingly restrictive approach to immigration and asylum seeking reflects global trends in the criminalisation of migration, incremental curtailments on the rights of asylum seekers and the militarisation of borders (Kihato, 2018). It is also linked to parallel processes at regional and (inter) continental levels, directly contradicting the goals of regional and continental free movement of SADC and the African Union (AU) (AU Agenda 2063).

As outlined in Box 2 this will have particularly negative impacts for individuals seeking refugee protection resulting from persecution based on their sexual orientation and gender identity (SOGI).

The Constitution of the Republic of South Africa

""Section 9 of the Constitution – part of the Bill of Rights – secures equality for all persons within the borders of South Africa, regardless of nationality or documentation status. It prohibits discrimination based on (among other things) race, gender, sex, sexual orientation, ethnic or social origin, disability, religion, culture and language. The Constitution states unequivocally that this provision applies to state and non-state actors alike. This means that neither private individuals nor state entities may engage in unfair discrimination. In a landmark judgement from 1998, known as *National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others*, the Constitutional Court interpreted the meaning of ‘sexual orientation’, ruling that it extends to people who are ‘bisexual or transsexual and also applies to the orientation of persons who might on a single occasion be erotically attracted to a member of their own sex.’⁶heir own sex.’

Many other rights are guaranteed in the Constitution, including a number that apply directly to LGBTI+ asylum seekers (as well as other vulnerable populations). Sections 10 and 12 provide for human dignity, freedom and security of the person, while sections 26, 27 and 29 enshrine the rights to healthcare, food, water, social security, education and housing. Other key rights are outlined in sections 32 and 33, which secure an individual’s access to information and fair administrative action, respectively. As with all the protections in the Bill of Rights, these clauses apply to everyone within South Africa’s borders, not just citizens. Finally, sections 39 and 233 of the Constitution state that courts, tribunals and forums must consider international law when interpreting the Bill of Rights. Foreign law may also be taken into consideration, but this is not a requirement.

The Refugees Act

When read in conjunction with the Constitution, the Refugees Act establishes the legal basis for claiming protection on the basis of SOGI. To qualify for refugee status in South Africa, a person must have ‘a well-founded fear of being persecuted by reason of his or her race, tribe, religion, nationality, political opinion or membership of a particular social group.’ They must also be outside of their country of origin and be ‘unable or unwilling to avail ... [themselves] to the protection of that country.’ The Refugees Act defines a ‘social group’ as ‘persons of particular gender, sexual orientation, disability, class or caste’.

The Refugees Act requires South Africa to extend protection to individuals who have a well-founded fear of SOGI-based persecution. This applies to those who identify as LGBTI+ and to those who are perceived by others to be LGBTI+. Crucially, section 2 of the Refugees Act specifies that South Africa cannot repatriate individuals to countries where they may reasonably fear persecution. An example of this is sending an LGBTI+ person to a country that has homophobic and/or transphobic laws. This prohibition is known as the principle of non-refoulement.

On 1 January 2020, two important pieces of legislation came into effect: the Refugees Amendment Act 11 of 2017 and the Refugees Act Regulations of 2019. The amended Refugees Act provides the legislative framework for refugee protection in South Africa, whereas the Regulations explain how the provisions of the Act are to be applied and implemented. This means the Regulations are subsidiary to the Act – in other words, they cannot extend beyond what is provided for in the Act. Both the amended Act and the Regulations make it more difficult for a person to claim asylum in South Africa and harder for them to stay legally documented once here. Of particular concern is a new rule that prohibits people with criminal records from applying for asylum. This may unfairly exclude LGBTI+ persons from accessing protection, given that same-sex sexual activities are criminalised across most of the continent. The amended Act also makes it harder for asylum seekers to work and study in South Africa. These are just two examples of how the new provisions may limit potential asylum seekers’ rights under international law.”

Mudarikwa et al., 2021: 11–12

Box 2: Increasingly precarious protection mechanisms in South Africa

The increasingly restrictive approach to immigration and asylum seeking reflects global trends in the criminalisation of migration, incremental curtailments on the rights of asylum seekers and the militarisation of borders (Kihato, 2018).

It is also linked to parallel processes at regional and (inter) continental levels, directly contradicting the goals of regional and continental free movement of SADC and the African Union (AU) (AU Agenda 2063).

2.6 Towards an inclusive response

This report presents research on the intersections of SRHR and migration to make recommendations for how to make SRHR a reality for migrants in South Africa. Key is the need for a migration-aware response to SRH services: a whole-system response whereby population movement is embedded as a central concern in the design of health interventions, policy, and research (Vearey et al., 2017).

This should ensure that migrant populations have equitable access to quality SRH services that are rights-based, culturally appropriate and gender-responsive. To this end, the report considers the recommendations made by the WHO for the development of migrant-sensitive health systems and monitoring of migrant health (World Health Organization, 2010). These are outlined in Table 1 on page 40.

Photo, overleaf: Photo by Madoda Makhobeni.







03

Migrant mothers vs. the state: A photo-journalism project

*Photo above and right:
Gloria Kalenga takes a phone call as her two
older sons watch their favourite television
programme. Photo by Madelene Cronjé.*



3. Migrant mothers vs the state: A photo-journalism project

About this project

The text by Jan Bornman and photographs by Madelene Cronjé presented in this chapter (and report) are part of the broader project on SRHR and migration. The inclusion of this photojournalism project was an attempt to include some perspectives of migrants in relation to their SRHR experiences.

This project was undertaken in partnership with Wits University's African Centre for Migration and Society, Sonke Gender Justice and the Consortium for Refugees and Migrants in South Africa, with funding from AmplifyChange. This story is part of The Endless Journey. It has been published on New Frame. www.newframe.com/migrant-mothers-vs-the-state.

Migrants, refugees and asylum seekers are charged for pregnancy services at state hospitals in Gauteng, despite the Constitution ensuring access. If they cannot pay, birth documentation is withheld.

Nearly three years after losing her child during birth, Janet Dube, 43, still struggles to deal with the trauma of that night. It is not only her horrifying experience that haunts her but also the suffering of the other women in the hospital waiting room.

“It won’t go out of my mind. Because even sometimes when I am staying alone, it comes like a video to my mind ... There were 21 of us with no-one helping us,” Dube says, sitting on the edge of her bed in the 2x3m room she shares with her husband and four sons.

Dube and at least one other woman were left to give birth without any help until it was too late. Her child died, and she witnessed another woman die in front of her.



Photo above: The home of Janet Dube, who is originally from Zimbabwe and is a part-time domestic worker. Photo by Madelene Cronjé.

Horror stories of women being left to give birth unattended on floors in state hospitals are not uncommon. While understaffing and overworked healthcare workers contribute to the neglect women experience in hospitals, migrants, refugees and asylum seekers face greater levels of stress and ill treatment during pregnancy and childbirth.

Documentation withheld

Early in 2020, just as the Covid-19 pandemic hit, the Gauteng Department of Health issued a circular that reclassified non-citizens and made migrant,

refugee and asylum seeker mothers pay for antenatal and maternal healthcare services.

This is despite the National Health Act which guarantees access to healthcare for all pregnant and lactating women, and for children under six years.

Hospitals and clinics in the province demand money from mothers who mostly cannot afford to pay. Notices of birth, which are documents necessary to register a child with the Department of Home Affairs, are being withheld when migrant mothers do not settle their bills.



Photo above: Janet Dube with her three youngest children, Mayibongwe (back left), Mbongiseni and Mqondisi (front). Photo by Madelene Cronjé.

Dube, who is pregnant with her sixth child, says she worries about going to hospital for antenatal care and regular check-ups because of her past experiences. At a recent check-up, she was told to pay R370 because she was using a passport as opposed to an identity document. When she was unable to pay, it was noted in her file.

“Until today I did not pay that R370. But I have to go again to follow up, so I don’t know what it is that they are going to do,” Dube says. “Previous times when I was pregnant I did not pay.” When giving birth to her other children, Dube was asked only whether she had a valid passport.

“But they now said, whether you have a valid passport or permit, you have to pay.” “The thing I can tell you, being pregnant in South Africa, it’s not easy. Why? Because when you go to hospital, you will not be treated equally, as a foreigner,” Dube says, while her three-year-old son Mqondisi plays on the bed behind her.

Owing hospitals

Abigail Dawson, the advocacy co-ordinator at Jesuit Refugee Services (JRS) in South Africa, says, “Giving birth in South Africa’s public health system– for refugee, asylum seeker and migrant women – has become increasingly extracting.”

The clients that JRS have assisted express their fear of accessing further healthcare because of the debt they have at hospitals and worry they will be denied further access to health. Hospitals in Gauteng have been denying access to notice of birth documents for mothers who have not paid these fees,” Dawson says. “Imagine having your baby’s name, with all its meaning and presence in this world, and nowhere for their name to be legally recognised.”

Sibusisiwe Ndlela, an attorney at public interest law centre SECTION27, says it is not only that these women struggle to access sexual and reproductive healthcare, but this is also part of a broader issue of access to healthcare for migrants, refugees and asylum seekers.

The Constitution entrenches certain rights, especially the right to healthcare. Ndlela says:

“It includes reproductive healthcare services specifically. It is a right that applies to everyone. There is existing legal precedent that says ‘everyone’, which literally means everyone without limitation to anyone on any grounds ... irrespective of nationality and documentation status. So for instance, if the Constitution specifically says ‘citizens’, that would naturally exclude refugees, that would naturally exclude asylum seekers.

But the specific provisions we are dealing with says ‘everyone’, so there is no such limitation. And there is no limitation in statute. So no limitation can be imposed by a provincial department or a circular.”

Despite the guarantees in various pieces of legislation, the Gauteng Health Department still makes women such as Dube pay for services that, by law, should be free and which she cannot afford. Dube says she has not even started thinking about what it might cost to give birth again.

Charged as private patients

Motalatale Modiba, head of communications for the Gauteng Health Department, says only documented refugees were means tested and exempted from paying for maternity services.

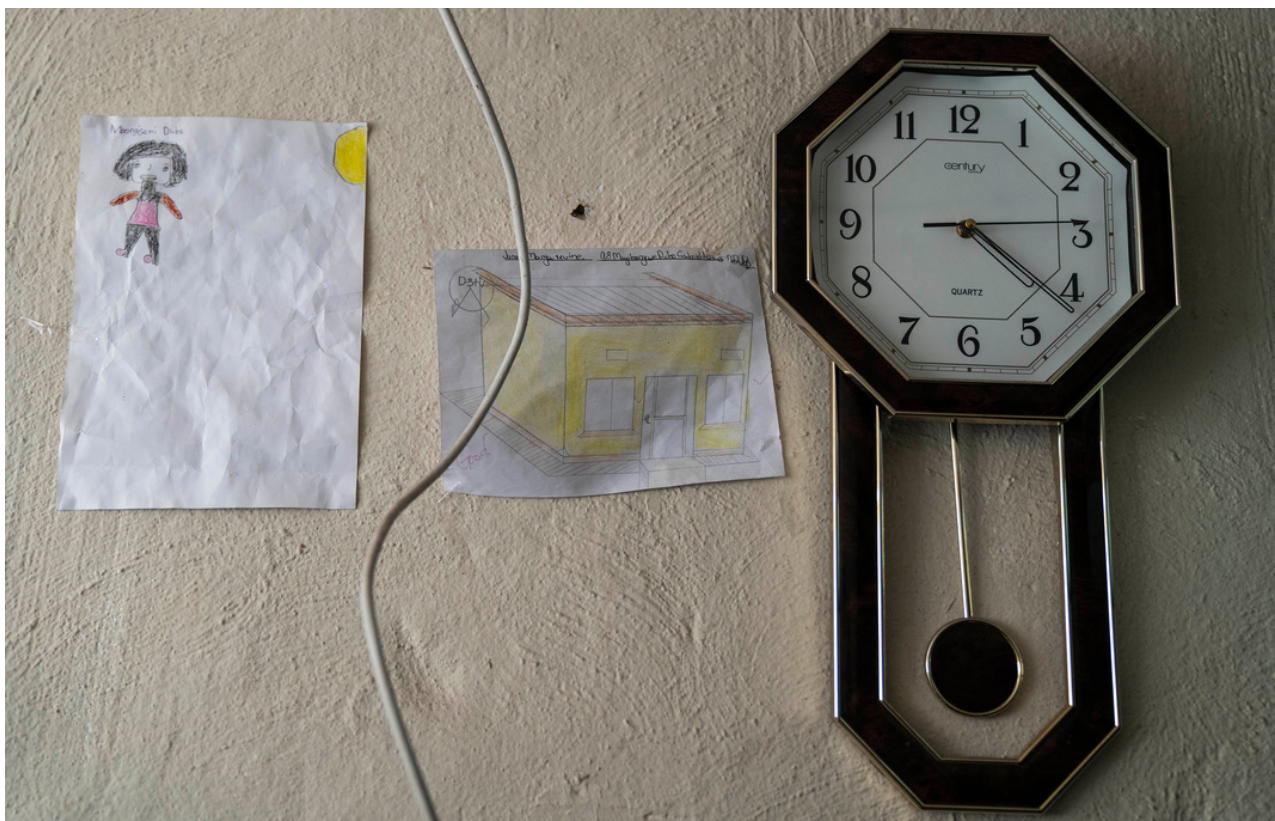
“All non-South African citizens are classified as full-paying patients, excluding refugees with valid documents ... The policy guideline complies with the laws of the land and was issued in consultation with legal experts,” Modiba says. “Primary healthcare services rendered at clinics and community health centres are free. Hospitals are paying facilities where all patients are expected to pay for the services rendered.”

But Modiba says the Department does have a constitutional obligation to ensure the provision of services at all levels that are equitable and cost-effective. “The practice of withholding notices of birth is not supported by the policy and legislation. Hospitals should refrain from that practice. It would be better if specific cases were reported so that those can be addressed.”

Patients who are unhappy with their experiences at government hospitals and clinics in the province can lodge complaints with the Department’s quality assurance unit for redress, says Modiba. Ndlela says that because migrants and asylum seekers are not means tested, they are automatically categorised as full-paying patients.

That’s basically saying they are paying the same amount that they will have to pay accessing private services ... It is largely happening in Gauteng. We don’t fully know what is happening in other provinces ... [but in Gauteng] we see a distinct move to charge migrants when they try to access healthcare services,” she says. Barriers to healthcare for migrants, refugees and asylum seekers have always existed; but Ndlela says that when these policies were introduced, SECTION27 became aware of a lot more cases of people being classified and charged as private patients.

Photo below: Artwork made by two of Janet Dube's children and a clock is the only decoration in the tiny flat that she shares with her husband and 4 boys, one of whom is 20 years old. . Photo by Madelene Cronjé.



Ndlela says that because migrants and asylum seekers are not means tested, they are automatically categorised as full-paying patients: “That’s basically saying they are paying the same amount that they will have to pay accessing private services ... It is largely happening in Gauteng. We don’t fully know what is happening in other provinces ... [but in Gauteng] we see a distinct move to charge migrants when they try to access healthcare services,” she says.

Barriers to healthcare for migrants, refugees and asylum seekers have always existed; but Ndlela says that when these policies were introduced, SECTION27 became aware of a lot more cases of people being classified and charged as private patients.

“The circular was introduced around the time when the pandemic started, when people were most vulnerable. They just couldn’t access the funds [for] basic healthcare services,” she says.

Mbali Baduza, a researcher at SECTION27, describes the circular as “insidious”, saying organisations working with migrants, refugees and asylum seekers were not warned about it.

“Instead, what happened is people were going to hospital and then getting rejected. Then when there’s follow-ups, people just decide not to go. [The Gauteng Health Department] knows this is really bad and is a regression, and that there is going to be pushback, as there should be.

All of this must be understood in the context that we are operating in – a failing public health system where resources are severely limited and shrinking every year with the budget cuts. Some of these horrific instances of lack of resources aren’t just felt by foreign nationals; even certain abusive treatment isn’t only felt by foreign nationals. That context is important and it can’t be ignored. I think [it shows in the way] our policies are drafted that there is an intention there to include foreign nationals specifically.”

‘It is just because I am a foreigner’

Josephine Kasongo*, 33, a single mother from the Democratic Republic of Congo, says her experience was mixed. “Giving birth, they were nice to me. But getting the birth certificate, that was the problem.” She cradles her nine-month-old son, Kasendwe, in her tiny apartment.

“They said I must pay R12,780. I did not have any work and I had no money. I said, how must I get that amount? They said I must get that amount otherwise I won’t get the birth certificate. I said I can’t afford that,” Kasongo says.

Like many women, she did not have trouble accessing her regular check-ups and scans but was told she had to start paying R350 for each appointment. “I told them I can’t even afford that. Even to survive, they helped me. But I can’t pay that. When I gave birth, they said I must pay all that money to get the certificate for the baby.”

Kasongo has not paid the hospital and so has not been able to register her son's birth. She is worried about the effect of her son growing up unregistered. The stress she feels about her child's future was something she also experienced during the birth. "When they scanned me, they didn't tell me they would operate on me. When I went to the hospital, they took me straight to the C-section."

She is not sure of the details, but after the birth of her son, she fainted and was taken to a different hospital for two days for observation before she was reunited with her baby. "I still don't know what happened to me."

Dube still suffers from the trauma and physical consequences of the death of her child in a state hospital. "It is just because I am a foreigner," she says. "I wish they can change the behaviour of how they treat people. Even if you go to Zimbabwe now, no-one is going to ask you, 'Where are you from? What do you want here?' I wish they can fix these things."

**Name changed to protect her identity.*

Photo, right: Josephine Kasongo (pseudonym), a migrant from the Democratic Republic of Congo, and her baby. Photo by Madelene Cronjé.







04

Methodology

*Photo above and right:
Photo by Madoda Makhobeni.*



4. Methodology

As part of a broader project on SRHR and migration undertaken by Sonke Gender Justice, the Consortium for Refugees and Migrants in South Africa (CoRMSA) and the African Centre for Migration & Society (ACMS) at Wits University, this study aimed to explore the challenges of upholding and delivering SRHR for cross-border migrant populations in South Africa. It aims to contribute to the development of a migration-aware response to SRHR: a whole-system response whereby population movement is embedded as a central concern in the design of health interventions, policy, and research (Vearey et al., 2017). This should ensure that migrant populations have equitable access to SRH services that are rights-based, culturally appropriate and gender-responsive. The research was guided by the following objectives:

(1)
gather evidence related to migrants' (in)ability to access SRH services;

(2)
understand the extent to which xenophobia and xenophobic attitudes within health service delivery affect migrant access to SRH services;

(3)
investigate the effects that the expanded Mexico City Policy ('the Global Gag Rule') has had on migrant women accessing SRH services, including termination of pregnancy, as well as on organisations and clinics offering SRH services in South Africa; and

(4)
develop key findings and lessons learnt into user-friendly popular education material and disseminate nationally and regionally to increase awareness and knowledge around SRHR and migrant rights.

4.1 Research approach and design

The study involved two phases. Firstly, a desk review of relevant literature and key policies was undertaken. Secondly, semi-structured interviews were conducted with key stakeholders.

4.1.1 Desk Review

The desk review explored key literature, reports and documentation pertaining to gender, migration, health and SRHR specifically, with an emphasis on the intersections of these issues. Policies were identified and reviewed at the national, regional (SADC) and continental (AU) levels. The review focused on exploring the extent to which relevant policies are gender-aware, migration-aware and health- and SRHR-aware. A ‘traffic-light system’ was used to assess the policies on each of these factors.

4.1.2 Semi-structured interviews

Interviews were carried out with 29 key informants engaged in the intersections of gender, migration and SRHR. This included government officials responsible for the delivery of SRH services, including to non-nationals; staff based in relevant government-run primary healthcare clinics;

managers and service providers in relevant non-governmental organisations providing/advocating for SRH services. See Appendix 1 for the complete list of key informants.

Key informants were selected through purposive sampling to ensure a focus on individuals working within the sectors and intersections of gender, migration, health and SRHR. The selection of informants began with CoRMSA – an organisation working directly with migrant populations in South Africa and which was engaged with this study – and then targeted other informants in the health sector providing SRH services to migrants. A snowballing approach was also incorporated through which informants provided further contacts for potential interviewees.

4.1.3 Consent, confidentiality and anonymity

Prior to the interview process, potential informants were sent an information sheet explaining the aims and objectives of the study and asking for their participation.

Verbal consent was sought at the start of each interview and we remained aware throughout the study that consent is an on-going process. This was explained in the information sheet and participants were informed that they could opt out at any time and did not have to answer any questions about which they felt uncomfortable.

Participants were informed that all interviews would remain confidential and their information would not be used other than in the research process. They were also assured that anonymity would be maintained as far as possible; as a result, no real names or identifying information are included in the report. Anonymity cannot be guaranteed, however, given that many organisations and individuals working across the various sectors know one another and collaborate with one another .

The nature of this study means that uncomfortable, sensitive and sometimes personal issues are touched upon. This is particularly the case where informants might have their own migration experiences and/or engage with the challenges that migrant populations face in South Africa. This can include issues of sexual violence, gender-based violence, xenophobia and other traumatic experiences. Remaining aware of these issues and ensuring a sensitive and careful approach to asking questions and probing has, therefore, been essential to the research process.

4.1.4 Analysis

Thematic analysis was applied to interview transcripts. Themes were validated by the research team and mapped using the online software Miro.

4.2 Ethical considerations and limitations

Ethical clearance was obtained from the University of the Witwatersrand's Human Research Ethics Committee non-medical (Protocol number H20/03/15).

Ethical issues were actively considered at all stages of the research process. However, many of the issues covered in the interview questions were sensitive – for example the termination of pregnancy as well as sexual violence – and might evoke strong feelings and responses. In addition, some stakeholders could have had ethical implications regarding what they could share in a research context. It was important to remain cognisant of these, and to create the space within the interview setting for different perspectives to emerge. At the same time, the researcher also needed to maintain a distinction between the research space and what might be seen as a therapeutic space. This was especially relevant given the pressures exerted on various stakeholders during the pandemic.

In terms of limitations, conducting remote interviews created restrictions in some ways, but also created some advantages. While acknowledging that much can be lost through remote interviews – like non-verbal cues, rapport and the somatic responses to issues being

discussed – it also became clear that “new social intimacies” of online engagement “through which new and different discussions can be generated” came into play (Rutherford, 2020).

For example, distance can enable more in-depth discussions or can provide a less intimidating context in which people feel it is easier to talk openly. This seemed to be the case in this study where key informants were perhaps more willing to share their experiences, frustrations and, particularly, criticisms of health systems and the socio-political contexts they were working in – perhaps more so than they might have done in-person.

That said, this advantage did not override the intense pressures of the work situation for key informants. This was particularly the case for those working in the overwhelmed health system and trying to support migrant communities – while also navigating the stresses of lockdown including the home-schooling of children, the threat of the virus itself and the many other challenges posed by the pandemic. Further limitations and impacts on the research process specifically related to Covid-19 are discussed below.

4.3 Research in a time of Covid-19

The pandemic brought a number of key issues relating to migration, gender and health into sharper view. While the study was planned with recognition of the sensitivities and ethical challenges of research in the areas of migration and SRHR, the challenges of conducting an empirical study in the middle of a pandemic could not have been anticipated. In South Africa, the arrival of the first case of Covid-19 in March 2020 was met with a strict nationwide lockdown, including containment measures preventing travel within, and outside of, the country's borders; and a curfew and restricted movement. Such restrictions created widespread and enduring challenges and heightened states of desperation for many of South Africa's poorest communities, particularly those working in the informal economy (Oliveira and Walker, 2021).

The research presented here was originally planned as part of a larger study that was designed to apply a 'mystery client' methodology to assess the experiences of migrant healthcare users in public health clinics in the Gauteng, Western Cape and KwaZulu-Natal provinces.

However, the Covid-19 pandemic presented a number of challenges – both ethical and practical – in relation to the scope, reach, and objectives of the study. Our modified approach – which required cancelling work with migrant communities, and a move to online interviews with key informants – allowed us to work within the bounds of the Covid-19 lockdown measures. In an attempt to bring some perspectives of migrants in relation to their SRHR experiences, however, an experienced photo-journalist team was appointed to undertake a project in the City of Johannesburg, once the lockdown measures allowed this kind of movement. Overall, the physical, emotional, psychological and financial challenges for all involved in the study – researchers and informants – were evident and need to be recognised as shaping the study and its finding.



[W]e have the Constitution that affirms in Chapter Two the rights to health, including reproductive, sexual... health. It lists it and it expresses it explicitly even in the Constitution. We have different policies that speak about adolescent health and different policies that speak about, you know, SRHR as a framework. We have the Choice of Pregnancy Act. I mean, what more do people need, you know what I mean? And I'm not sure why there is just no will to make SRHR more accessible and more dignified as a service.

Doctor, women's health clinic/CGE



05

Understanding migration and SRHR in South Africa

*Photo above and left:
Photo by Madoda Makhobeni.*



5.1 Mapping migration in South Africa

The report starts with an introduction to sexual and reproductive health and rights (SRHR) within the broader context of migration and health. Recognising migration and health as a global health priority, SRHR are situated within calls for universal access and Universal Health Coverage (UHC) and in relation to determinants of migrant health and the key focus on making SRHR a reality for migrants.

Key terms are defined throughout this section and the rest of the report; in addition, a comprehensive glossary is provided. It is important to note here that while internal migrants can face some of the same vulnerabilities as cross-border migrants in South Africa, especially if undocumented or LGBTQI+ they are not the focus of the report. The use of the term migrant therefore refers to cross-border-migrant unless stated otherwise.

The methodology section describes the approach undertaken for the study, including a consideration of ethical issues and limitations like the main challenges created by the Covid-19 pandemic.

reunification of families. In addition, many people also seek protection in South Africa from repressive regimes and political insecurities, gender-based violence and social and economic marginalisation (Landau, 2017; Mthembu-Salter et al., 2014).

According to the World Bank, in 2020 South Africa was home to approximately 2.9 million international migrants – just under 5% of the overall population (UNDESA, 2020). The United Nations High Commissioner for Refugees reports that in 2021 there were 76,729 refugees and 173,461 asylum seekers in South Africa (Department of Home Affairs, 2021).

Domestic mobility, unevenly distributed across South Africa's nine national provinces, remains numerically much more significant than cross-border movements, however. Gauteng – the country's most densely populated province with a gross domestic product (GDP) higher than any other country in sub-Saharan Africa (The World Bank, 2018) – hosts more than three times as many internal migrants than foreign migrants.

Following global trends, internal and cross-border migrants in South Africa tend to settle in urban areas where there is better access to work, opportunities and basic services.

However, the inability to obtain documentation pushes migrants and refugees further towards the margins of society. As previously noted, South Africa's asylum system is highly dysfunctional, overburdened and plagued by widespread bribery, corruption and abuse at Refugee Reception Offices (RROs) (Amit and Gastrow, 2015; Carciotto et al., 2015; Gandar, 2019). The Department of Home Affairs recognises that there is a backlog of over 153,000 applications to be reviewed:



As of the 2019/20 financial year the Refugee Appeal Authority of SA (RAASA), an independent statutory administrative tribunal tasked with ensuring that appeal cases are dealt with efficiently, effectively and in an unbiased manner, said the backlog stood at more than 153,000. The Auditor General of SA said if nothing changed, it would take 68 years to clear the backlog without taking new cases.

Department of Home Affairs, 2021

Lodging new applications has been made more difficult by the complete closure of a number of RROs, as well as the impact of the Covid-19 pandemic lockdown which saw all RROs close temporarily. As a result, applicants can wait for years – sometimes over a decade – for their applications to be resolved while navigating lengthy and futile processes to obtain or renew permits.

While being unable to access or finalise documentation, many migrants remain in a state of constant legal and economic vulnerability. They are unable to open bank accounts or enter into formal employment, which means they are subject to various restrictions, personal risks and exploitation prevalent in the informal sector (Vearey, 2010; Walker et al., 2017). Furthermore, criminalised as 'undocumented migrants' they often face official and popular discrimination and xenophobic violence (Walker and Vearey, 2019).

5.2 Gender and migration

The emphasis on prevention of movement (through the direct denial of documentation and indirect impact of xenophobia and discrimination) is framed by the South African government as a way of protecting migrants from xenophobic violence through ‘migration management’ and the ‘externalisation’ of borders. Similarly, issues such as gender-based violence and human trafficking are also instrumentalised to justify greater restrictions on movement in the name of protecting the most vulnerable, namely women and children. (Walker and Galvin, 2018)

This can be further understood through a focus on the increase in women on the move across Southern Africa, both internally and across borders. Findings from the United Nations Development Programme (show that, as a percentage of international migrants, female migrants in Southern Africa have increased from 40.9% in 2000 to 44.5% in 2017; and that, like men, women move for a range of reasons – as migrant workers; for employment and education opportunities; as business women; entrepreneurs and breadwinners.

Findings show that migrant women and girls are more vulnerable to health risks during the migration process as well as in their destination/host communities. These health risks emanate from exposure to sexual violence; dangers associated with engaging in risky migration decisions and survival strategies; vulnerabilities to exploitation, abuse and violence; and a lack of information on SRHR and access options (International Organization for Migration, 2010; Kiwanuka, 2009). Migrant women are also seen as being at risk of human trafficking when on the move; in addition some forms of irregular migration, including smuggling, is often subsumed under the ‘trafficking’ label to describe how and why women move.

Women are also more likely to travel with, and be responsible for, children and other dependents. This can heighten the challenges as well as risks taken when migrating across borders and negotiating life, both on arrival and over time. The realities of the heightened vulnerabilities faced by women and girls when on the move are captured in the following SADC report:



The feminisation of cross-border movement, with women and girls now crossing borders is on par with men. This has grave implications for the health of migrants, as [the] mobility process makes women more vulnerable to communicable diseases. They are more likely to suffer gender-based harassment and violence (including sexual). Also, women are also more likely to move with their young children who will also be susceptible to communicable diseases.

SADC, 2009: 6

While these risks and vulnerabilities need to remain central to responses to migration, gender and health it is also important that they are understood as being (1) shaped by the different profiles, backgrounds and the migration status of women (thus leading to different experiences); and (2) located within the wider context of increased securitisation of migration and the subsequent limited options for safe and regular migration, as discussed above.

Research shows that an increasingly restrictive and securitised approach to cross-border migration has, in turn, increased the number of migrants forced to cross the borders informally, often taking greater risks and facing greater exposure to more abuse, exploitation and violence (Walker and Vearey, 2019).

The framing of migration and gender as a security threat is summarised in the following way:



... we find ourselves in a world increasingly concerned with securitising national borders and restricting the movement of people between nation states. Much of this focus on security is driven by moral panics – public anxiety about issues thought to threaten the moral standards of society – associated with migration, including human trafficking and the independent movement of women.

Castelli Gattinara, 2017; Crawley and Skleparis, 2018; Heaven & Franck, 2017 in Vearey, 2018

Migration options, and especially the emphasis on “safe and orderly” migration (UN Global Compact) – which, in many contexts, translates as reduced options for regular migration and access to documentation – must be factored into any understanding of migration and health. Doing so will also highlight the need to open up the focus beyond women as victims to consider what puts migrants at risk and how they negotiate these risks (SADC, 2016; Walker and Oliveira, 2015; Walker and Vearey, 2019a).

5.3 Migration, the social determinants of health and intersecting vulnerabilities

Gender, combined with socio-economic, cultural, environmental and lifestyle factors, are all key determinants for the health of refugees and migrants; together they are largely responsible for the inequalities and inequities in terms of health and SRHR. According to the UN, migrants face increased risks to accessing SRHR, due to "a state of high exposure to certain risks and uncertainties, in combination with reduced ability to protect or defend oneself against those risks and uncertainties and cope with their negative consequences" (Walker and Vearey, 2019b).

Classified as a middle-income country, South Africa is shaped and fractured by structural and spatial inequalities, as are many countries across the region. Tied to the legacy of apartheid and exacerbated by protracted inequality and poor urban planning, South Africa is one of the most unequal countries in the world; income inequality and the subsequent gap between the wealthy and the poor continues to grow. In relation to Johannesburg and urban spaces in South Africa, Vearey notes that the wealthy minority and the poor majority "live very different versions of the city" (Vearey, 2017: 2).

In contrast to common assumptions that frame cities as spaces of improved livelihoods, Vearey (2017) highlights Johannesburg's "hidden intra-urban inequalities that clearly demonstrate that access to the urban benefit is unevenly distributed - in unjust and inequitable ways", disproportionately affecting urban poor groups, including migrants, with already "weak rights to the city" (Balbo and Marconi, 2005; Vearey, 2017, 2008).

Although migrants across South Africa find ways to make a living, contribute to the economy and create social connections and networks within their everyday lives, the heightened risks to their wellbeing, including negative SRH outcomes, cannot be ignored. These can include unmet family planning needs, unplanned pregnancies, maternal morbidity and mortality, a high prevalence of sexually transmitted infections, HIV/AIDS, cervical cancer and unsafe abortions. A growing body of work has underlined the importance of recognising that health risks are not increased by being a migrant per se, but by unhealthy contexts and precarious social conditions in which migrants often work and live (Vearey, 2011).

In this way, migrant health can be understood as:



a product of policies of entitlement and exclusion, which ultimately shape health risks and access to care, resulting in differential consequences of ill health.

Sargent, 2011: 855

An understanding of migrants' experiences of accessing healthcare, including SRHR, must start from the recognition that migrants are not an homogenous group and that different sub-groups (and differences within sub-groups) account for different social, economic and cultural circumstances which shape levels of vulnerability. Many of these key vulnerabilities are felt specifically by migrant women, particularly those without documentation, who face multiple forms of structural and gender-based violence, which impact negatively on their health and wellbeing and which lead to disproportionately poor SRH outcomes.

The multitude of systemic barriers to SRH services are predominantly attributed to weaknesses in the South African healthcare system and to stigma more broadly.

South Africa's health system is experiencing competing health priorities (Favier et al., 2018; IPAS Partners for Reproductive Justice, 2018; Lince-Deroche et al., 2018; Trueman and Magwentshu, 2013a) – above all, the world's largest HIV/AIDS epidemic. With an HIV prevalence of 20,4 % in the general population – and women being disproportionately affected by HIV (26%) – the national health budget is largely channelled into antiretroviral treatment (ART) programmes and other HIV prevention and awareness programmes (Avert, 2021). This means that other critical services such as abortion care is "under-resourced and pushed to the margins of public-sector maternal health care" and not necessarily considered a public health priority (IPAS Partners for Reproductive Justice, 2018: 1).

Despite plans to introduce a National Health Insurance (NHI) system that "will bring significant adjustments to healthcare financing mechanisms on the national level" (Lince-Deroche et al., 2018: 174-175) there is little promise that this will positively impact SRH. In this way the South African healthcare system acts as a determinant of SRHR itself (Vearey, 2008; Vearey 2017).

Photo, overleaf: Proud dad Patrick Ilunga holds Donciel. Ilunga says being caregivers made it easier for them to navigate the government hospital system. Photo by Madelene Cronjé.





5.4 Structural violence: Heightened risks and intersecting vulnerabilities

The overall issue of inaccessible maternal care, SRH and abortion services is indicative of South Africa's post-apartheid society that remains deeply patriarchal, racialised and unequal. Women are disproportionately affected by, and carry the burden of, existing health inequities in the country in intersecting ways – particularly black women, women with a lower socio-economic status, young and adolescent women, migrant/refugee women, asylum seekers, women living with HIV, LGBTQI+ persons, sex workers and other marginalised groups (Amnesty International, 2017; Freedman et al., 2020; Mabaso et al., 2019; Meer and Müller, 2017b; Mosley et al., 2017). A study focussing on access to SRH and abortion services for cross-border migrant women found that their access to these services is constrained by a variety of structural, socio-economic, and financial barriers. These include conflicting health and migration policies; legal status; inadequate state protection; differences in language, culture, and religion; as well as medical xenophobia – all of which result in widespread practices of discrimination and ill-treatment (Freedman et al., 2020; Mukondwa and Gonah, 2016; Munyaneza and Mhlongo, 2019).

Research shows that in accessing services such as maternal care, SRH services and abortion care, women commonly experience disrespect, abuse and neglect by healthcare workers; a lack of privacy and fear of confidentiality breach; fears of discrimination as well as being obligated to test for HIV (Chemlal and Russo, 2019; Cooper et al., 2016; IPAS Partners for Reproductive Justice, 2018; Mosley et al., 2017)

A counter-narrative to 'medical xenophobia', presented in a qualitative study argues that despite several institutional and policy-related challenges, there is a need to recognise the “complexity, ambivalence and a range of possible experiences of non-nationals in South Africa's public healthcare system than the current extant literature on “medical xenophobia” has suggested” (Vanyoro, 2019: 1-2). Moreover, access challenges such as a lack of documentation, different languages being spoken and discrimination also seem to shape internal migrant's experiences of public healthcare facilities (Vearey et al., 2018, 2017).

Where research has focused broadly on cross-border migrants' barriers in the South African healthcare system – and on specific key issue such as the relationship between migration and HIV, for example – there remains a dearth of information relating specifically to migrants and their access to SRH services, especially beyond the common focuses of HIV/AIDS, maternal health and sexual violence.

For example, a handful of scholarly articles explore barriers relating specifically to SRH service-seeking migrant women in South Africa, with a focus on undocumented migrants, refugee women and asylum seekers. These are located within the broader picture of intersectional inequities that impact migrant's SRHR, as well as the risks and vulnerabilities faced by migrant women when trying to access healthcare in South Africa. However, where far less is known about the general gendered accessibility of SRH services, there is also a lack of in-depth understanding of some of the central issues, such as experiences of abortion services for both cross-border and internal migrant women.

For example, there is no study focusing on Johannesburg – a context of high mobility – and on access to safe abortion services for migrant women, including internal migrant women. While two recently conducted qualitative studies examined challenges in accessing SRH services and determinants of vulnerabilities of refugee women relating to SRH in Durban, KwaZulu-Natal (Freedman et al., 2020; Munyaneza & Mhlongo; 2019), abortion was included as part of SRH services but was not investigated in more detail.

5.5 Migration-aware responses

When identifying intersecting vulnerabilities and needs, it is critical to incorporate 'spatially sensitive' or 'place-based' approaches to health which consider specific contexts, living conditions, as well as diverse migration trajectories and profiles (Vearey, 2011; Vearey et al., 2018). Recognising that different migrant groups face different vulnerabilities, approaches and planning need to be based on the “multi-sited lives of Southern Africa’s populations” (Freemantle & Landau, 2017: 11). As Freemantle and Landau argue:



While mobility is by nature dynamic, there are identifiable patterns and trends to how people move: understanding patterns and complexities empowers authorities at all levels to respond and anticipate to related challenges rather than being overwhelmed by them. From local to continental level, planning without considering mobility is not planning at all.

Freemantle & Landau, 2017:11

However, evidence clearly shows that health systems have largely failed to engage with the realities of migration and mobility. Moreover, in South Africa – a country built on decades of migrant labour and movement within and across borders – the practices of providing healthcare for all are not only absent, but often deliberately exclude migrants from healthcare services. To this end, calls have been made for a migration-aware response to health: a whole-system response whereby population movement is embedded as a central concern in the design of health interventions, policy, and research (Vearey et al., 2017). This should ensure that both migrant and local populations have equitable access to quality healthcare services that are rights-based, culturally appropriate and gender-responsive.

5.6 The impact of the Covid-19 pandemic

The failure to engage with migration and mobility is perhaps shown most clearly through the impact of the Covid-19 pandemic. While research is still emerging regarding how the pandemic has shaped and impacted on migration and health, preliminary data suggests that where migrants have faced heightened vulnerabilities – especially those who are forcibly displaced, through loss of jobs and livelihoods – increased challenges accessing healthcare and the de-prioritisation of SRH services has left them at greater risk (Jacobson et al., 2020; Lokot and Avakyan, 2020; Mukumbang et al., 2020).

For example, evidence suggests that although the socio-economic conditions created by COVID-19 are likely to facilitate greater engagement in transactional sex SRH responses to the pandemic have largely ignored this. As Jacobson et al., argue, “An increase in transactional sex among forcibly displaced populations has the potential to devastate already poor SRH indicators.” (Jacobson et al., 2020: 82)

Lessons from the 2013–2015 Ebola crisis in West Africa are especially relevant in the context of Covid-19, as SRH services were not prioritised before, during and after the outbreak.

As a result, affected countries saw increased rates of teenage pregnancy, obstetric complications, and delayed prenatal care, while women cited fear of Ebola infection as a barrier to accessing the limited SRH services that were available (Jacobson et al., 2020: 78).

Data also suggests increased challenges in accessing SRH services – for example a reduction in access to family planning counselling, contraceptives and ARTs; the lack of availability of abortion services; and an increase in teenage pregnancy, among others – which have increased the pressure on an already strained health system. The pandemic itself highlights the needs for effective policies which ensure equitable, timely access to SRH services for people and vulnerable groups.

5.7 Sexual health and a human rights-based approach

The realisation of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognised in international and regional human rights documents, in other consensus documents and in national laws.

Human rights are essentially and inherently biopolitical as they intend to protect human life in a highly contested space where the right to a healthy life, particularly for women, is continually being challenged. They therefore provide a critical tool to highlight the "productive and positive capacities" of (bio)power and to reiterate the need for states to meet their obligation to exercise it in a manner that respects, protects and promotes the individual rights to liberty and equality, and guarantees reproductive justice for all women (Adams, 2017). A human right based-approach to health, adopted by the WHO and the Office of the High Commissioner for Human Rights is normatively rooted in "international human rights standards and operationally directed to promoting and protecting human rights" (United Nations, 2014: 76).

In this way it "emphasises that the ultimate goal of all health policies, strategies and programmes is to further advance the realization of the right to health and other health-related human rights" – and acknowledges safe abortion for all women, including migrant women regardless of their legal status, as a fundamental and universal human right (Bustreo et al., 2013).

Sexual health and human rights

"There is a growing consensus that sexual health cannot be achieved and maintained without respect for, and protection of, certain human rights. The working definition of sexual rights given below is a contribution to the continuing dialogue on human rights related to sexual health. The application of existing human rights to sexuality and sexual health constitutes sexual rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination."

The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws.

Rights critical to the realization of sexual health include:

- the rights to equality and non-discrimination;
- the right to be free from torture or to cruel, inhumane or degrading treatment or punishment;
- the right to privacy;
- the rights to the highest attainable standard of health (including sexual health) and social security;
- the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage;
- the right to decide the number and spacing of one's children;
- the rights to information, as well as education;
- the rights to freedom of opinion and expression; and
- the right to an effective remedy for violations of fundamental rights.

The responsible exercise of human rights requires that all persons respect the rights of others."

World Health Organization, 2007a

Box 3: Sexual health and human rights

5.8 Universal access

Within the context of migration, gender and health, a global commitment to the SDGs has opened up unprecedented opportunities for better understanding and responding to SRHR and ensuring a broad, human rights-based approach which emphasises “that the ultimate goal of all health policies, strategies and programmes is to further advance the realisation of the right to health and other health-related human rights.” (OHCHR, 2017). However, SRHR are often not only de-prioritised in terms of financing healthcare and the allocation of resources, but there is also a failure to engage with the complex realities of migration and mobility. This results in undermining progress towards universal access as well as increases the challenges faced, resulting in worse SRH outcomes generally (Freedman et al., 2020).

Target 3.7 of the SDGs affirms a commitment to universal access to SRHR, and extends the deadline for its achievement to 2030.

This stands alongside Target 3.8 – of achieving universal health coverage (UHC) – which is recognised as a state when “all people obtain the health services they need – prevention, promotion, treatment, rehabilitation, and palliation – without risk of financial ruin or impoverishment, now and in the future” (World Health Organization, 2013).

Universal access similarly calls for a well-functioning healthcare system with adequate human and financial resources, which is responsive to the needs of all sections of the population. As universal access is seen as contingent upon UHC, they are mutually reinforcing with access to SRHR.

5.9 Broadening the gender and sexuality lens beyond key populations and key problems

Sexual health cannot be defined, understood or made operational without a broad consideration of sexuality, which underlies important behaviours and outcomes related to sexual health. The working definition of sexuality is as follows:



A central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.

World Health Organization, 2006a

As previously noted, gender is identified as a key determining factor when it comes to healthcare and SRHR. In accordance with the primary focus on women and girls, however, gender also continues to be defined through a narrow understanding embedded in binary and heteronormative assumptions. This excludes a recognition of gender as a spectrum and as being composed of diverse and different identities, for example transgender men and women and non-binary individuals. As Walker and Vearey explain, "the integration of a gender perspective into health and migration policies is, at best, patchy. Where gender is included, this often fails to translate into practice, or is done in superficial ways that, on the one hand, fail to engage with the complexity of female migrants' experiences and, on the other, completely exclude an understanding of gender beyond women and girls – thus ignoring LGBTQI+ migrants" (Walker & Vearey, 2019: 73).

Mapped onto a binary view of gender is also an emphasis on heterosexual, cisgender norms, which results in the limited understanding of sexuality and sexual orientation and precludes recognition of lesbian, gay, bisexual, transgender, queer and asexual persons (LGBTQI+).

UNAIDS recognises LGBTQI+ persons as ‘key populations’, being those who are particularly vulnerable to HIV and frequently lack adequate access to services. UNAIDS’ five main key population groups are gay men and other men who have sex with men (MSM); sex workers; transgender people; people who inject drugs; and prisoners and other incarcerated people (The Global Fund, 2021).

However, the framing of ‘key populations’ has been criticised for its over-emphasis on risk behaviours and HIV/AIDS (at the expense of other vulnerabilities and needs) and for conflating gender identity with sexual orientation. This limited view restricts a full understanding of these intersections and complexities of gender, sexuality and migration in relation to health; it also risks ignoring the barriers faced by LGBTQI+ persons in accessing healthcare, especially the impact of law, policy, and practice on their access to SRHR, both in South Africa and across the region.

Individuals across the gender, sexuality and other spectrums, including LGBTQI+ persons, face some of the harshest impacts of punitive laws, policies and/or practices, entrenched in societal behaviour and attitudes. These are exacerbated by forms of conservatism and fundamentalism whose moralisation and stigma undermine individual agency and have severe implications for the right, and responses, to health (Angotti et al., 2019; Meer and Müller, 2017a). There is clear evidence that LGBTQI+ migrants face particular difficulties in accessing the healthcare system (Meer and Müller, 2017a; Zihindula et al., 2015). Highlighting the significant overlaps of heightened vulnerabilities for all women, transgender or cisgender, a transilience study on violence against trans women in South Africa showed that “85% of trans women have experienced violence in one way or the other, and the picture is worse for trans women of colour” .

A recent study exploring the socio-political contexts of trans men, women and non-binary persons, and the impact of law, policy, and practice on their access to sexual and reproductive health and HIV services highlighted the unique set of vulnerabilities and forms of discrimination which continue to pervade the law, political rhetoric and interactions with service providers, family members and broader communities.

A regional scan across six southern and east African countries found that



[t]rans people experience hostility, stigmatisation and violence for being ‘different’ while simultaneously being invisible (in legal frameworks, in healthcare approaches, through NGO and other programming) and hypervisible (when in public, to law enforcement, when at work or accessing healthcare). This results in a unique set of vulnerabilities and forms of discrimination which continue to pervade the law, political rhetoric and interactions with service providers, family members and broader communities.

Reisner et al., 2016

In addition, that report shows how health interventions designed to specifically meet trans needs as a ‘key population’ “may heighten and amplify the marginalisation of transgender people”. It also suggests that the predominant focus on HIV/AIDS for trans persons in particular, “... ignores the unique and specific needs of trans people to healthcare but also diverts attention from the many simple and effective forms of advocacy that LGBTQI+ and trans-led organisations rely upon” (AIDS and Rights Alliance, 2021).

This is particularly important when considering what issues are left out or, at least, less considered within the SRHR discourse and regarding interventions and access. For example, as has been pointed out, SRHR should not be restricted to maternal care and access to contraceptive and abortion services but should focus on issues of bodily autonomy and choices, and should especially be “promoting the protection of the rights to bodily autonomy and integrity (BAI) to reduce inequality, especially pertaining to gender, and to promote health, dignity, and wellbeing” (AIDS and Rights Alliance, 2021).

Reproductive rights, abortion, and the impact of the Global Gag Rule

06



*Photo above and left:
Photo by Madelene Cronjé.*



6. Reproductive rights, abortion, and the impact of the Global Gag Rule

As noted, a number of key SRHR issues have been addressed in scholarly literature and have been a concern for state and non-state organisations. These issues are frequently framed in terms of the challenges they pose both to the health outcomes of individuals and in terms of provision and access.

This section provides an overview of one of these key issues – access to the termination of pregnancies (ToP) in South Africa. It explores the legal framework, provision across healthcare and SRH services, as well as the challenges faced by women accessing this service. Given a lack of information concerning migrants' access to abortion in particular, a more generalised picture of all women's access is presented here – though the barriers and challenges discussed can be read as heightened in all cases for women who are migrant, non-national and undocumented.

6.1 Access to safe termination of pregnancy: An endemic challenge for all in South Africa

In order to change social norms, laws and policies to uphold human rights, countries must invariably take actions beyond the health sector. One of the most crucial reforms are those that promote gender equality and give women greater control over their bodies and lives (Starrs et al., 2018).

Despite a progressive legal framework which makes abortion available to all, free of charge and upon request up until the 12th week of gestation (first trimester) – and, under certain conditions, until the 20th week (second trimester) – access to safe abortion is difficult and inequitable for most women in South Africa. The availability of abortions in the public healthcare system is extremely limited. A telephonic survey in 2017 found that "less than 200 (or 4%) of the country's 5,048 public health facilities that could potentially offer abortion services actually did so". This in a context in which approximately 83% of the South African population relies on the public healthcare system (Amnesty International, 2017; Mabaso, 2019: 3).

The profound imbalance of demand and supply, and a deteriorating socio-economic climate coupled with services in the private or NGO sector which are costly and therefore inaccessible – means that most women wishing to terminate a pregnancy have no other option than to make use of the usually more affordable informal health services (Trueman and Magwentshu, 2013a).

The obstacles to implementing the abortion law have been the subject of public health research, and academic work has previously shed light on the numerous barriers and complex power dynamics that perpetuate unsafe abortion and systematically "discourage[e] positive health-seeking behaviours" (Mabaso, 2019: 3) as detailed below.

6.2 Barriers to abortion and the “conspiracy of silence”*

Discrimination against, and stigmatisation of, abortion-seeking women are found to be the most prevalent barriers that impede access to safe services in public healthcare facilities in South Africa; they continue to violate women’s reproductive rights, affecting their health and wellbeing in harmful ways.

The legal status of abortion suggests that it is important, if not critical, to women’s and girl’s health and reproductive rights. Despite this, abortion remains a controversial, uncomfortable and, in many instances, deliberately hidden issue – a “conspiracy of silence” (Rhodes University, 2013). As illustrated in Figure 4, abortion stigma is driven by a “mutually reinforcing cycle of silence that penetrates all spheres of societal life” (Kumar et al., 2009: 629). Silence and secrecy hamper women’s ability to access safe abortion services more broadly as the issue is continuously and systematically ignored at the micro and macro levels of society, ultimately contributing to “harmful abortion practices and delayed care-seeking” (Cleeve et al., 2017: 1286). Inevitably the cycle is also maintained and reproduced by women themselves as they seek to terminate their pregnancies in ways that usually “uphold the norms

of silence and concealment”, to avoid discrimination and moral judgements by healthcare providers and/or their communities. They do this despite imminent hazards of physical harm, and risks of public exposure (Hodes, 2016: 80).

It has also been suggested that women may be vulnerable to what has been conceptualised as ‘intersectional stigma’; that felt stigma can be exacerbated by other stigmatised identities as “each stigmatised status intersects with, and is shaped by, existing social hierarchies”, resulting in even greater health inequities in marginalised population groups (LeTourneau, 2016; Mosley et al., 2017: 8). For example, studies in South Africa have explored the ways in which stigma impacts women living with HIV who considered an abortion after falling pregnant unintentionally, and found that they felt stigmatised in multiple ways (LeTourneau, 2016; Orner et al., 2011, 2010). Furthermore, existing stigma is compounded by erroneous assumptions and claims made about women crossing into South Africa specifically to access free maternal care and or other SRH services.

**Rhodes University, 2013*

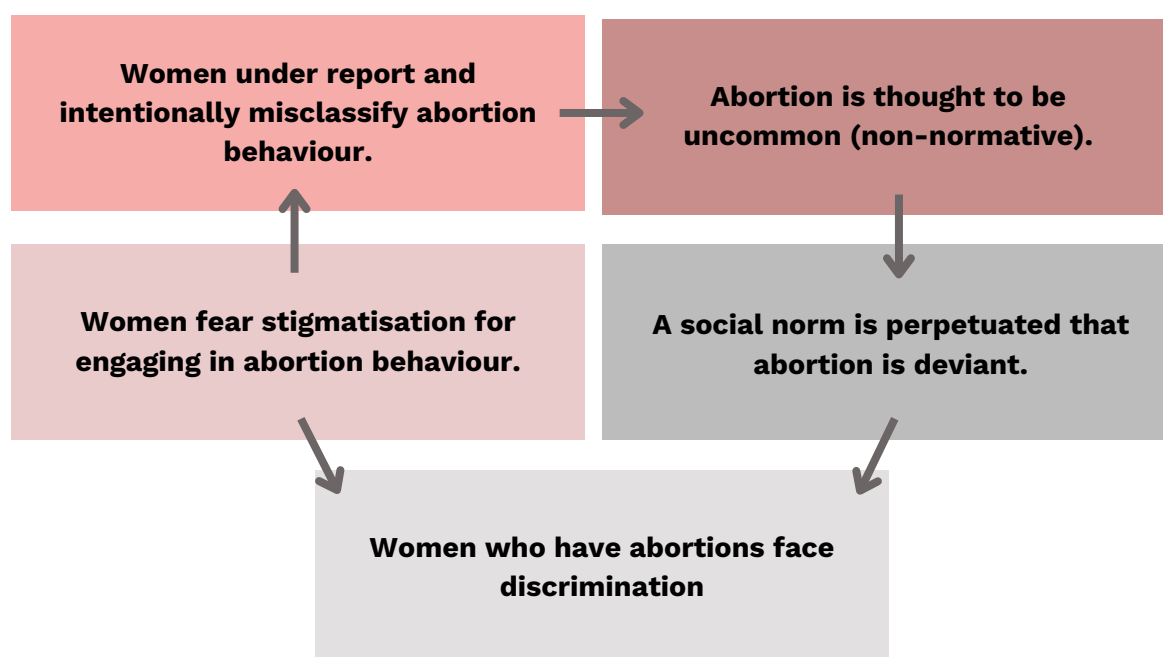


Figure 4: Social and political factors result in a mutually reinforcing cycle of stigma surrounding abortion (Kumar et al., 2009b)

Accessibility and availability also depend on geographical location and province. Most of the equipped facilities providing abortion services are located in Gauteng and the Western Cape. This is in contrast to KwaZulu-Natal which, although it is home to the country's largest female population, performs only 10% of reported abortions (Favier et al., 2018; Varkey, 2000). The disparities in accessibility also generally exist between urban and rural areas, with rural women remaining at a disadvantage (Cooper et al., 2005; Favier et al., 2018). However, contrary to these findings, evidence also indicates that women residing in Gauteng are at higher risk of unsafe abortion and consequently of dying from abortion-related causes compared to other provinces with a larger rural population. This points to existing intra-urban inequalities (Bomela, 2020; Mosley et al., 2017).

Communities and service-seeking women lack information and education about abortion rights under the Choice on Termination of Pregnancy Act (CTOPA); there is also insufficient information on where to obtain a safe abortion, particularly in the second trimester (Amnesty International, 2017; Favier et al., 2018; Harries et al., 2009). Access to safe abortions in the public healthcare sector is also impeded by the lack of availability of generic abortion drugs (mifepristone and misoprostol) (Cooper et al., 2005; Harries, 2010a; Stevens, 2020). It is also undermined by limited accessibility, affordability, quality and acceptability of abortion services and providers – which can mean long distances to the next provider, a lack of transport, long waiting lists, gestational limits and financial constraints (Chemlal and Russo, 2019; Mosley et al., 2017; Trueman and Magwentshu, 2013a).

6.3 Healthcare professionals: Objections and obstructions

From the perspective of healthcare providers, barriers to access include:

(1)
a lack of clinical guidelines on, and institutional support for, the provision and management of abortion care (Stevens, 2020; Wheeler et al., 2012); and

(2)
a lack of clarity on information amongst health personnel (Amnesty International, 2017; Favier et al., 2018; Harries et al., 2009; Harrison et al., 2000; Jewkes et al., 2005; Morroni et al., 2006; Trueman and Magwentshu, 2013a; Wheeler et al., 2012)

Studies also show that healthcare professionals report:

(1)
being overworked;

(2)
the lack of a supportive work

(3)
environment (Harries, 2010a; Mokgethi et al., 2006; Teffo and Rispel, 2020)

(4)
a shortages of trained providers; and

(5)
a lack of effective abortion training, including abortion counselling (Orner et al., 2010; Stevens, 2020; Wheeler et al., 2012).

Central here are also the judgemental attitudes to abortion, both within communities and among healthcare professionals. The broad use of "conscientious objection" – whereby providers can opt out of providing terminations for religious or moral reasons – not only impacts on the availability of services but also on the context, exacerbating the lack of a supportive environment in which they are provided (Amnesty International, 2017; Cooper et al., 2016, 2005, 2004; Favier et al., 2018; Harries, 2010b; Harries et al., 2014, 2009; Harrison et al., 2000; Mbali and Mthembu, 2012; Mosley et al., 2017; Rehnström Loi et al., 2015; Trueman and Magwentshu, 2013a; Varkey, 2000). Research shows that although conscientious objection is fully not regulated in CTOPA, many healthcare providers, sometimes whole facilities, use it “to avoid and to obstruct all stages of abortion” (Favier et al., 2018: 41). Conscientious objection is common, even where healthcare workers may not be involved in abortion procedures directly, and are only obliged to assist abortion-seeking women with appropriate information and referrals (Harries et al., 2009; Harries et al., 2014; Amnesty International, 2017). Reasons for conscientious objection may go beyond negative abortion attitudes, however, to include healthcare workers’ fears of experience discrimination and stigma against them, when they are associated with the performance of abortions (Faúndes et al., 2013).

Although a National Strategic Plan (NSP) for the Implementation of the CTOPA was developed by the National Department of Health – and a National Policy for Conscientious Objection in the Implementation of the CTOPA was drafted in 2007 – failures in the provision of abortions and in referral processes persist, undermining the CTOPA and the right to safe abortion (Amnesty International, 2017). Insufficient efforts to educate healthcare workers and medical students about the meaning of conscientious objection, and about abortion care more broadly, has led to more clandestine and unsafe abortions in South Africa. This is despite evidence that education and training, including comprehensive curricula, are crucial to delivering high-quality reproductive services and in disseminating knowledge about human rights in healthcare, particularly in diverse and high-mobility contexts (Endler et al., 2020; Favier et al., 2018; Harries et al., 2014; Harrison et al., 2000; Smit et al., 2009). In a wider sense, healthcare workers and others working within healthcare settings can be viewed as gatekeepers to safe and high-quality abortion care, as they play a key role in ensuring that women can or, in this case, cannot exercise their right to bodily autonomy and choice.

Overall, the multitude of these barriers increases the burden on service delivery and, consequently, on those public health facilities and providers that offer the service. This ultimately results in a delay of care; in long queues at facilities; in women being turned away because the pregnancy is already too advanced (no eligibility for first-trimester abortion) – and hence in a high number of abortions being done later than necessary (Favier et al., 2018; Harries, 2010; Harries, 2012; Trueman & Magwentshu, 2013).

Second-trimester abortion accounts for an estimated 25% of all abortions and many women attempt to self-induce abortions before going to a facility for second-trimester abortion (Constant et al., 2014; Favier et al., 2018). However, a lack of infrastructure, physical space, and trained personnel cause fragmented and poor-quality care in second-trimester abortion services (Harries et al., 2012). There is no reliable data on facilities or on trained providers offering second-trimester abortions, but research suggests that there are only a few public sector facilities in the country that provide the service. This is why most safe second-trimester abortions are performed by the private or NGO sectors, such as Marie Stopes, in cases where women can afford it (Harries et al., 2012; Trueman and Magwentshu, 2013a).

Most medical practitioners were also found to be reluctant to provide second-trimester abortion, due to a perceived greater and direct involvement in the abortion process, as procedures may include dilation and evacuation (D&E) or other methods of surgical removal of the foetus, resulting in greater physical and emotional responses to viewing an aborted and more formed foetus (Harries et al., 2009; Harries, 2010; Harries et al., 2012; Trueman & Magwentshu, 2013). Many practitioners expressed a preference to administer pills, and research has documented more effective methods to medically induce second-trimester abortions, which would result in greater access to such services for women and reduce the involvement of medical personnel (Harries et al., 2012; Lince-Deroche et al., 2018; Mokgethi et al., 2006).

6.4 Legal abortions and informal (illegal) procedures

The extent of the barriers to accessing legal terminations as detailed above means that women are effectively pushed towards dangerous, illegal methods as they run out of other options. Despite heavy stigmatisation of the procedure making it difficult to measure the true incidence of abortions (performed in both the formal and informal healthcare sectors), it is estimated that more than half (54%) of the approximately 260,000 abortions performed annually in South Africa are unsafe and currently take place in the informal sector (Guttmacher et al., 1998; Mosley et al., 2017; Sedgh et al., 2012). Informal sector abortion (ISA) is a well-known phenomenon. Studies have found that there is widespread awareness in communities about women who have undergone procedures clandestinely (Chemlal & Russo, 2019). Informal services are mostly provided by unlicensed practitioners, promising to provide what "is often lacking in the public sector – succour, immediacy and privacy ('pain-free', 'same-day', '100% safe', 'cleaning')" (Hodes, 2016: 93). Informal providers are known to offer women unsafe and incorrect medical and herbal/traditional alternatives, often making them ill, placing their health at risk, and not terminating the pregnancy (Mabaso, 2019: 3).

Informal providers use "tactics to appear sufficiently legitimate" and are known as 'lamp-post providers' as they advertise their services openly through "flyers and posters at taxi ranks, retail centres and along city walls and thoroughfares" (Hodes, 2016:3; Mabaso, 2019: 90). The fact that such advertisements can also be found "outside public healthcare facilities across South Africa, including the National Department of Health in Pretoria - the seat of reproductive health" (Hodes, 2016: 93) starkly captures the paradox of abortion access, as well as the undermining of progressive and critical reproductive rights. It also illustrates the apparent normality with which these informal services are advertised – indicating how normalised the provision of unsafe abortion is in the general public as well as, perhaps, the usefulness of the informal services as a response to the failures of state provision.

The fact that society, law enforcement and politicians know about the plethora of unsafe practices and the potentially life-threatening consequences women may face in accessing informal abortions – and yet do not intervene or work to systematically identify such 'lamp-post providers' – points to a further paradox: that a service that is legal and should be easily accessible through state services is deemed 'too controversial' or too insignificant to address (Brown and Kotze, 2017; Trueman and Magwentshu, 2013a).

6.4.1 Factors shaping access to informal abortion

Through exploring motivations for seeking abortions in the informal sector, determinants of unsafe abortion were found to be multi-faceted and complex. Research suggests that women may prefer to access ISAs outside of institutional settings because they are simply treated as clients seeking a service without being asked many questions (Cooper et al., 2016; Favier et al., 2018). Informal providers may also be traditional healers and women seek their assistance as a 'natural' response to a health problem (Jewkes et al., 2005).

Other reasons were found to be a perceived poor quality of designated facilities and procuring an ISA may also be the result of an unsuccessful attempt to obtain an abortion in the formal sector.

In some cases, women expressed a preference for self-managed abortion at home as it felt less medicalised and yielded a "greater feeling of independence and control" (Chemlal and Russo, 2019:9; Jewkes et al., 2005).

A woman's social network was found to be another important factor that profoundly shaped her trajectory to procuring an ISA (Chemlal & Russo, 2019). Social networks are an important source of information and friends sometimes even become directly "involved in the abortion attempt itself" (Chemlal and Russo, 2019: 7). Women in South Africa reported they felt informal provision to be increasingly safe, which may give them a false sense of security (Favier et al., 2018). Consequently, the discrepancy between perceived safety and actual mortality/morbidity rates as a result of unsafe abortions has very problematic implications for addressing and reducing health hazards in the future.

6.5 Abortion, stigma, and (a lack of) political will

Current academic discourses in the field of SRHR, in the context of South Africa and beyond, mainly argue from a human rights perspective. They emphasise abortion care as being a fundamental right for women and reiterate the need for the state to meet its constitutional obligations to provide comprehensive SRH services for all. This argumentative strategy remains imperative in the light of issues such as inequitable healthcare provision in an overall malfunctioning healthcare system and a lack of political will to fully implement the CTOPA and ensure the right to SRH (Albertyn, 2015; Berro Pizzarossa and Durojaye, 2019; Favier et al., 2018; Mabaso et al., 2019; Mofokeng, 2020; Trueman and Magwentshu, 2013a). While the lack of access to, and availability of, abortion services remains a human rights issue in South Africa, abortion stigma, as a conceivably less tangible issue, is still rarely addressed in any depth. Situated in the broader context of governance and fundamental human rights violations, it remains largely invisible and unchallenged. Broader processes of moralisation and/or pathologizing of women play an important role in the production and perpetuation of abortion stigma and need to be considered (Kumar et al., 2009a; Norris et al., 2011).

Although abortion stigma has received greater attention in academia in recent years, it is still poorly understood, researched and theorised in many contexts (Hanschmidt et al., 2016; Kumar et al., 2009a; Norris et al., 2011) – especially in relation to migration. Previous work has shown that abortion stigma is deeply contextual and manifests in many core structures of society such as economic, health, educational and welfare systems; and it is "articulated in various spaces and mechanisms" that mutually reinforce each other (Kumar et al., 2009: 630; Norris et al., 2011; LeTourneau, 2016).

Foreign policies of the US government, such as the Global Gag Rule (GGR) or the Helms Amendment, which frame abortion as something that needs to be managed and regulated, are a prime example of how abortion stigma reflects in policy. According to Kumar et al. (2009), the GGR stigmatises in two ways: "it marginalises abortion services by physically isolating them from other reproductive health services", and it "seeks to silence and forestall abortion advocacy" (Kumar et al., 2009: 361-362).





6.6 Abortion and migration

Despite South Africa's liberalisation of abortion law and the commitment to equity in health and to health rights, it is clear that women struggle to access SRH services, including abortion services.

These challenges exist within a global context of reproductive governance, a significant piece being the Global Gag Rule enacted by the United States of America in 1984. Also known as the Mexico City Policy, this policy refuses funding to foreign NGOs that advance or conduct abortion as a method of family planning in USAID recipient countries. The policy applies to both primary recipients and NGO sub-recipients (Population Research Institute, 2017) and states that (see left hand side).

“

...when dealing with nations which support abortion with funds not provided by the United States Government, the United States will contribute to such nations through segregated accounts which cannot be used for abortion.

Photo , previous page:

Photo by Madoda Makhobeni.

Moreover, the United States will no longer contribute to separate nongovernmental organizations which perform or actively promote abortion as a method of family planning in other nations. With regard to the United Nations Fund for Population Activities (UNFPA), the U.S. will insist that no part of its contribution be used for abortion. The U.S. will also call for concrete assurances that the UNFPA is not engaged in, or does not provide funding for, abortion or coercive family planning programs; if such assurances are not forthcoming, the U.S. will redirect the amount of its contribution to other, non-UNFPA, family planning programs.

Office of Public Communication, Bureau of Public Affairs, 1984

The Policy was rescinded in 2021 but the damage created is likely to reverberate for years to come.

This is not the only policy that affects healthcare provision transnationally, however; rather it is part of a much larger conservative and anti-abortion lobby.

Hence access to abortion services in South Africa is a highly contested space in which global governance and a convergence of multiple factors, systems (cultural, social, legal etc.) and actors (e.g. healthcare providers) challenge the right to safe abortion by constraining access and thereby hampering the implementation of South Africa's laws.

Research has found that many non-nationals face challenges in accessing healthcare in general, focusing predominantly on "socio-cultural factors concerning adaption to host societies". There is a lack of engagement with the structural barriers to service accessibility for migrants, however, that does not only take into account the written migration and health policies, "but also the ways in which these are implemented, and the ways State inaction and failure to provide services can itself be a source of vulnerability and violence for women" – particularly in contexts of high mobility like Johannesburg (Freedman et al., 2020: 332). Furthermore, given the lack of knowledge around access to abortion services for both cross-border and internal migrant women specifically, there is a need to explore how migration and mobility might additionally mediate women's gendered experiences and navigation strategies.

While the three themes – migration/mobility, abortion access and the GGR – have been studied in the context of South Africa and/or Johannesburg, these have been done separately from each other and there is a notable lack of detailed preliminary research that focuses on the intersectional effects of the GGR on mobile population groups. No study has yet looked at all three themes together and investigated how the GGR might mediate experiences of migrant women when seeking abortion-related care.

Rights and realities: SRHR policies, interventions and key gaps

07



*Photo above and left:
Gloria Kalenga before giving birth to her baby
boy. Photo by Madelene Cronjé.*



7. Rights and realities: SRHR policies, interventions and key gaps

Just as themes and key issues pertaining to migration, gender and health, including SRHR, have primarily been considered in silos, the same can be said of policy and legal frameworks that respond to these issues. To better understand how policies shape and impact experiences of SRHR, this section provides an overview of laws, policies and frameworks relating to SRHR and migration, at international, continental (African Union), regional (SADC) and national (South Africa) levels. In so doing, it identifies the extent to which they are migration-aware, gender-aware, sexuality-aware and SRHR-aware. This is not an exhaustive list of policies but rather a selection of those most relevant to a focus on SRHR.

The four indicators are as follows:

(1) Migration-aware

Migration-aware refers to policies that engage with issues relating to migrant and mobile communities (including internal and external) and their unique experiences and needs.

(2) Gender-aware

Gender-aware refers to the policies that speak about gender directly and also how gender may influence experiences of migration. It should incorporate an open and inclusive understanding of gender which includes transgender and non-binary individuals and the unique vulnerabilities that are faced by each group.

(3) Sexuality-aware

Sexuality-aware refers to the extent to which policies address sexuality and engage with the spectrum of sexual orientations and the associated specific experiences and needs.

(4) SRHR-aware

SRHR-aware refers to policies that engage and address issues relating to sexual and reproductive health and rights in terms of needs and access to dignity and rights for all.

7.1 Key global governance processes, documents, policies and frameworks for addressing migration and health

As outlined in Box 4, global governance approaches to migration and health have increased in recent years. These varied processes, documents, policies and frameworks provide strategic opportunities for advocating to national government departments to implement migration-aware responses to health. As illustrated in Figure 6, these opportunities bridge the agendas to do with migration governance; development; and global health – including with respect to migration and labour.

"Governance is central to the development and implementation of any response to migration and health. [By governance, we mean the ways in which an entity functions to develop and implement policy and practice, incorporating the state, civil society, the private sector and other key actors including international organisations.] Migration governance rests primarily upon the fulcrum of national sovereignty (Wickramage et al., 2018), and ensuring positive health outcomes require well-managed migration. However, there is often limited engagement from health authorities in high-level migration governance decision beyond issues concerning global health security – including quarantine and border-health management – and migration is frequently forgotten in the development of health programmes (Wickramage and Annunziata, 2018). Many countries have explicitly stated before international human rights bodies that they cannot, or do not wish to, ensure health protection, including the provision of essential health services to migrants, and especially to irregular migrants (IOM, 2013).

A range of governance agendas on the domains of migration and health have developed in recent years, providing important opportunities for garnering political support for intervention (see Figure 5 below). These agendas bridge the fields of migration governance, development, and global health governance, and include: the Global Compact on Safe and Orderly Migration; the Global Compact on Refugees; Sustainable Development Goals (SDGs); Universal Health Coverage; World Health Assembly processes; disease prevention and control programmes (including for malaria, HIV, TB); and, the Global Health Security Agenda (IOM, 2017a; UHC2030, 2018; United Nations, 2015a; WHO, 2017, 2007; World Health Assembly, 2017). Effective governance requires strategic leadership and investment to build alliances between migration management systems and the health sector.

The SDGs suggest multiple demands to bring the migration, development and health sectors together to develop and implement unified and co-ordinated responses (United Nations, 2015a). Target 3.8 of the SDGs calls for Universal Health Coverage (UHC) - a key SDG target providing a strategic opportunity to improve responses to migration and health which will, by ensuring the good health of migrant workers and the associated flow of remittances, indirectly benefit social and economic development (UHC 2030, 2017). Migrants [are] unaccounted for in UHC programmes and are often missed in discussions at country level on UHC goals." (Guinto et al., 2015).

Vearey et al., 2020b: 227–228

Box 4: An overview of the Global Governance of Migration and Health (Vearey et al., 2020b: 227–228)

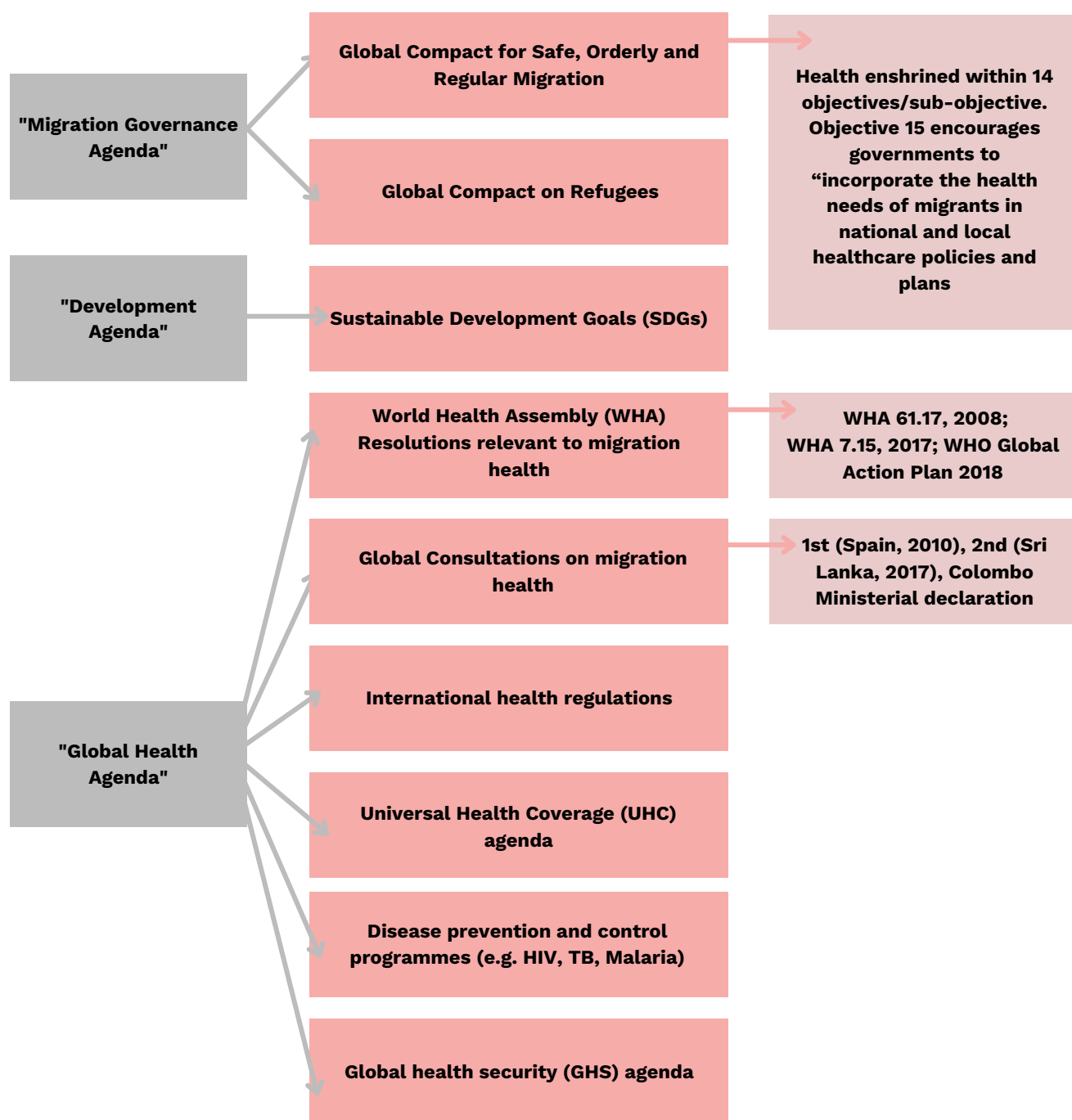


Figure 5: Key global agendas for advancing responses to migration and health
(Vearey et al., 2020b: 228)

Figure 6: Timeline of relevant global governance processes, documents, policies and frameworks in the field of migration and health

Year adopted	Process/Document/Policy/Framework
2003	International Organization for Migration (IOM) Position Paper on Psychosocial and Mental Well-Being of Migrants (International Organisation for Migration, 2003)
2003	WHO publishes International Migration, Health and Human Rights (World Health Organisation, 2003)
2005	International Health Regulations (3rd Revision in 2016) (World Health Organization, 2016a)
2008	WHA Resolution 61.17 on the Health of Migrants (World Health Assembly, 2008)
2010	First Global Consultation on the Health of Migrants (World Health Organization, 2010)
2011	Report of the United Nations Special Rapporteur on the Human Rights of Migrants, Jorge Bustamante (United Nations, 2011: 19)
2015	2030 Agenda for Sustainable Development
2015	IOM 106th Council Session: 26th Nov 2015, Geneva, Switzerland Advancing the Unfinished Agenda of Migrant Health for the Benefit of All - C/106/INF/15 (International Organization for Migration, 2015a) High-level panel discussion on 'Migration, human mobility and global health: A matter for diplomacy and intersectional partnership' (International Organization for Migration, 2015b in (Vearey, 2018))
2016	UN General Assembly: 9th May 2016 - High-level meeting on Addressing Large Movements of Refugees and Migrants Report of the Secretary-General: In Safety and Dignity: Addressing Large Movements of Refugees and Migrants (Nyaradzo, 2016) (United Nations, 2016)

Year adopted	Process/Document/Policy/Framework
2016	69th World Health Assembly: 27th May 2016 Technical briefing on Migration and Health (World Health Organization, 2016b) Promoting the Health of Migrants. Report from the Secretariat. (World Health Organization, 2017a)
2016	UN General Assembly: 22nd Sept 2016 - High-level meeting to Address Large Movements of Refugees and Migrants Side event report - Health in the Context of Migration and Forced Displacement (World Health Organization, 2016c)
2016	New York Declaration for Refugees and Migrants (OHCHR, 2016)
2016	Leaving no-one behind: The imperative of inclusive development. Report on the World Social Situation 2016 (United Nations, 2016)
2017	Global Compact for Progress Towards Universal Health Coverage (UHC 2030, 2017)
2017	140th Session of the WHO Executive Board of the World Health: January 2017 Noted the WHO Secretariat report on 'Promoting the health of migrants' (World Health Organization, 2016d) Adopted Decision EB140(9) – Promoting the Health of Refugees and Migrants (World Health Organization, 2017b)
2017	Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A Framework for Action. Report by International Labour Organization (ILO) ((International Labour Organization, 2017: xiv)
2017	2nd Global Consultation on Migration and Health, February 2017 – 'Resetting the Agenda' (International Organization for Migration, 2017a)
2017	WHO Input to the 70th World Health Assembly - Draft framework of priorities and guiding principles. A70/24 (World Health Organization, 2017b)
2017	Promoting the Health of Refugees and Migrants. Draft Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants. Report by the Secretariat (World Health Organization, 2017b)

Year adopted	Process/Document/Policy/Framework
2017	World Health Assembly Resolution 70.15: Promoting the Health of Refugees and Migrants (World Health Assembly, 2017)
2017	Global Compact Process - IOM Thematic Paper: The Health of Migrants: A Core Cross-Cutting Theme (International Organisation for Migration, 2017)
2017	IOM Migration Health Division – Thematic Paper Series: Migration Health in the Sustainable Development Goals: ‘Leave No-one Behind’ in an increasingly mobile society (International Organisation for Migration, 2017b)
2018	142nd WHO Executive Board meeting; 71st World Health Assembly; 109th IOM Council Global: Global Compact on Refugees (United Nations, 2018a); Global Compact for Safe, Regular and Orderly Migration (United Nations, 2018b)
2019	Report A72/25 to the World Health Assembly. Promoting the Health of Refugees and Migrants Draft Global Action Plan, 2019–2023. Report by the Director-General (World Health Organization, 2019a)
2019	144th WHO Executive Board session; 72nd World Health Assembly; WHO Draft Global Action Plan on the Health of Refugees and Migrants to be submitted for consideration (World Health Organisation, 2019)
2021	WHO Migration and Health Programme publishes two reviews: Common Health Needs of Refugees and Migrants (WHO, 2021a); Mapping Health System Responsiveness to Refugee and Migrant Health Needs (World Health Organization, 2021b)
2021	WHO Global Competency Standards for Health Workers (World Health Organization, 2021a)WHO Knowledge Guide & Curriculum Guide to Support the Operationalisation of Refugee and Migrant Health (WHO, 2021c, 2021b)
2022	WHO Global Migration and Health Report

7.2 An overview of key global governance processes

2008

WHA Resolution 61.17 on the Health of Migrants recognises that “the health of migrants is an important public health matter” and calls for action to address the health of migrants (World Health Assembly, 2008).

2010

The First Global Consultation on the Health of Migrants reviewed progress made towards the objectives outlined in the 2008 WHA Resolution. As outlined in Figure 6, it identified four key priority areas for action.

2011

The United Nations Special Rapporteur on the Human Rights of Migrants, Jorge Bustamante, highlighted the need for governments to enact the recommendations made in the 2008 WHA Resolution:

"84. Regarding access to health services, the Special Rapporteur recommends that the Government carry out and comply with the existing national framework as well as with policies and national guidelines, regardless of a person's legal status in the country.

85. In addition, the Special Rapporteur calls upon the Government to implement fully the

recommendations made in World Health Assembly resolution WHA61.17, as well as to ensure equal practices and access for everyone to health services and treatment, regardless of a person's legal status or location" (United Nations, 2011: 19).

2015

During the 106th Council Session of the International Migration for Organization (IOM), a position paper called for action as presented in ‘Advancing the Unfinished Agenda of Migrant Health for the Benefit of All - C/106/INF/15 .

2016

The 69th World Health Assembly involved two relevant inputs from the WHO: A Technical briefing (World Health Organization, 2016b) and a report from the Secretariat on the need to promote the health of migrants (World Health Organization, 2016c)

2017

In 2017, several key processes took place. Firstly, the Global Compact for Progress Towards Universal Health Coverage was actioned . As outlined in Figure 6, the principles guiding action towards UHC highlight that no-one should be left behind in responses.

(1)

"Monitoring migrant health: ensure the standardization and comparability of data on migrant health; support the appropriate aggregation and assembling of migrant health information; map good practices in monitoring migrant health, policy models, health system models.

(2)

Policy and legal frameworks: adopt relevant international standards on the protection of migrants and respect for rights to health in national law and practice; implement national health policies that promote equal access to health services for migrants; extend social protections in health and improve social security for all migrants.

(3)

Migrant-sensitive health systems: ensure that health services are delivered to migrants in a culturally and linguistically appropriate way; enhance the capacity of the health and relevant non-health workforce to address the health issues associated with migration; deliver migrant inclusive services in a comprehensive, coordinated, and financially sustainable fashion.

(4)

Partnerships, networks & multi-country frameworks: establish and support migration health dialogues and cooperation across sectors and among large cities and countries of origin, transit and destination; address migrant health matters in global and regional consultative migration, economic and development processes (e.g. Global Forum on Migration and Development)."

World Health Organisation, 2010

*Box 5: Four key priority areas for action on the health of migrants
(World Health Organization WHO, 2010)*

In January, the 140th Session of the WHO Executive Board of the World Health Assembly noted the WHO Secretariat report on 'Promoting the health of migrants' (World Health Organization, 2016b) and adopted decision EB140(9) – Promoting the health of refugees and migrants (World Health Organization, 2017a). This was followed by the 2nd Global Consultation on Migration and Health which took place in February 2017. The Consultation focused on 'Resetting the Agenda' by 'taking stock' of actions taken to date towards the objectives laid out in the 2008 WHA Resolution (IOM, 2017b). In May 2017, the WHA Secretariat presented a report to the Assembly outlining priorities and principles required to promote the health of refugees and migrants (World Health Organization, 2017b). Resolution 70.15 - Promoting the Health of Refugees and Migrants – was then adopted (World Health Assembly, 2017). This resolution called for the development of a Global Action Plan.

2019

The Director-General of the WHO presented Report A72/25 – Promoting the Health of Refugees and Migrants Draft Global Action Plan, 2019-2023 – to the World Health Assembly in 2019 (World Health Organization, 2019a). The report presents a Global Action Plan, as requested in the 2017 Resolution Promoting the Health of Refugees and Migrants. Six objectives were outlined, as shown in Box 6.

Structural violence

In our efforts to strengthen health systems and achieve UHC, we collectively subscribe to the following key principles to guide our action:

- Leaving no one behind: a commitment to equity, non-discrimination and a rights-based approach
- Transparency and accountability for results
- Evidence-based national health strategies and leadership, with government stewardship to ensure availability, accessibility, acceptability and quality of service delivery
- Making health systems everybody's business – with engagement of citizens, communities, civil society and private sector
- International cooperation based on mutual learning across countries regardless of development status and progress in achieving and sustaining UHC, and development effectiveness principles.

Box 6: Principles guiding the global compact for progress towards Universal Health Coverage (UHC 2030, 2017)

2021

The WHO Migration and Health Programme published two reviews: 'Common Health Needs of Refugees and Migrants' (World Health Organization, 2021a) and 'Mapping Health System Responsiveness to Refugee and Migrant Health Needs' (World Health Organization, 2021b). Following this, the 'WHO Global Competency Standards for Health Workers', along with a knowledge and curriculum guide, were also published (World Health Organization, 2021a, 2021c, 2021b).

1. Promote the health of refugees and migrants through a mix of short-term and long-term public health interventions.
2. Promote continuity and quality of essential health care, while developing, reinforcing and implementing occupational health and safety measures.
3. Advocate the mainstreaming of refugee and migrant health into global, regional and country agendas and the promotion of refugee-sensitive and migrant-sensitive health policies and legal and social protection; the health and well-being of refugee and migrant women, children and adolescents; gender equality and empowerment of refugee and migrant women and girls; and partnerships and intersectoral, intercountry and interagency coordination and collaboration mechanisms.
4. Enhance capacity to tackle the social determinants of health and to accelerate progress towards achieving the Sustainable Development Goals, including universal health coverage.
5. Strengthen health monitoring and health information systems.
6. Support measures to improve evidence-based health communication and to counter misperceptions about migrant and refugee health.

Box 7: Six objectives of the Global Action Plan (World Health Organization, 2019a).



The Global Competency Standards highlight the competencies and behaviours needed to provide high-quality health services to refugees and migrants with the aim to support the development of competency-based curricula tailored to the local context and for health workers to achieve a minimum level of competence to ensure better health outcomes for refugees and migrants.

The Standards are accompanied by a Knowledge Guide for health workers and health administrators and a Curriculum Guide for educational institutions. The Knowledge Guide identifies the foundational knowledge, skills and attitudes for the Global Competency Standards. The Curriculum Guide sets out considerations and options to deliver and assess competency-based learning outcomes of health workers at different stages in their career development. These have been adapted from the Global Competency and Outcomes Framework for Universal Health Coverage.

The Standards and the two Guides have been developed by the Health and Migration Programme in close collaboration with the Health Workforce Department. It is the first set of its kind to be produced for health workers who provide health services to refugees and migrants as well as for educational institutions to incorporate these standards and foundational knowledge and skills into health worker training.

World Health Organization, 2021a



08

Traffic light review of legal & policy landscape across the AU, SADC & SA

*Photo above and left:
Photo by Madoda Makhobeni.*



8.1 Summary of key laws and policies at continental, regional and national levels

The information presented in Table 2 below provides a summary of key laws and policies impacting on SRHR from continental, regional (SADC) and national (South African) perspectives.

The key legislation and policies have been reviewed to determine the extent to which they are migration-aware, gender-aware, sexuality-aware and SRHR-aware.

Awareness is indicated through a simple visual ‘snapshot’ using a traffic light system to indicate the level of awareness in the legislation or policy analysed. [The traffic light approach was developed to assess laws and policies relating to gender, migration and health in SADC in a Sonke publication focusing on women and girls in SADC (Walker & Vearey, 2019: 24).]

Green is used to indicate that the document is aware; red is used when it is not; and amber represents limited awareness.

A full overview of the policies reviewed can be found in the accompanying ‘Summary of relevant global, continental, regional and national governance responses to SRHR, migration and health’.

The four indicators are the same as those outlined in Chapter 6 above, and are as follows:

(1) Migration-aware

Migration-aware refers to policies that engage with issues relating to migrant and mobile communities (including internal and external) and their unique experiences and needs.

(2) Gender-aware

Gender-aware refers to the policies that speak about gender directly and also how gender may influence experiences of migration. It should incorporate an open and inclusive understanding of gender which includes transgender and non-binary individuals and the unique vulnerabilities that are faced by each group.

(3) Sexuality-aware

Sexuality-aware refers to the extent to which policies address sexuality and engage with the spectrum of sexual orientations and the associated specific experiences and needs.

(4) SRHR-aware

SRHR-aware refers to policies that engage and address issues relating to sexual and reproductive health and rights in terms of needs and access to dignity and rights for all.

Figure 7: Key global agendas for advancing responses to migration and health
(Vearey et al., 2020b: 228)

Continental

Policies/Framework	Migration-Aware	Gender-Aware	Sexuality-Aware	SRHR-Aware	Status
African Charter on Human and Peoples Rights (1981)					Adopted
African Charter on The Rights and Welfare of The Child (1999)					Adopted
The African Women's Protocol to The African Charter on Human and People's Right (2003)					Adopted
The Continental Policy Framework for Sexual and Reproductive Health and Rights (2005)					Adopted
African Youth Charter (2006)					Adopted
AU Maputo Plan of Action (MPOA) 2016-2030 For the Operationalisation of The Continental Policy Framework for Sexual and Reproductive Health Rights (Draft) 2016					
Sexual and Reproductive Health and Rights (SRHR) In WHO African Region (2019)					Implemented
African Health Strategy Reviewed (2016-2030)					Adopted

SADC

Policies/Framework	Migration-Aware	Gender-Aware	Sexuality-Aware	SRHR-Aware	Status
Maseru Declaration 2003					Adopted
SADC Protocol on Health (2004)					Adopted
SADC Regional Indicative Strategic Development Plan (RISDP) 2001					Adopted
Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2006 – 2015 (adopted 2008)					Finalised 2008
Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2019-2030					Adopted
Model Law on HIV in Southern Africa (2008)					Adopted
Draft Policy Framework for Population Mobility and Communicable Diseases in the SADC Region (2009)					Draft
SADC HIV and AIDS Strategic Framework (2010-2015)					Final draft
The ESA Commitment on Comprehensive Sexuality Education and SRH Services (2013 – revised 2021)					Adopted
The Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage (2016)					Finalised

SADC

Policies/Framework	Migration-Aware	Gender-Aware	Sexuality-Aware	SRHR-Aware	Status
SADC Protocol on Gender and Development Plan (2008 - revised 2016)					Adopted
SADC Gender and Development Monitor Tracking Progress Implementation of the SADC Protocol on Gender Development (2016)					Adopted
The Regional Strategy for HIV and AIDS Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations (2017)					Adopted
SADC Regional Migration Policy Framework (RMPF) 2018-2030 and Plan of Action					Adopted
Revised SADC Regional Indicative Strategic Development Plan (RISDP) 2020-2030					Adopted
SADC Vision 2050					Adopted

South Africa

Policies/Framework	Migration-Aware	Gender-Aware	Sexuality-Aware	SRHR-Aware	Status
The Constitution of South Africa (1996)					Implemented
The Choice on Termination of Pregnancy Act (1996)					Assented
The Refugee Act (1998)					Approved
The Domestic Violence Act (1998) Amended 2008					Approved
Promotion of Equality and Prevention of Unfair Discrimination Act (2000) Amended 2008					Adopted
National Health Act (2003)					Adopted
National Development Plan 2030: Our Future - Make it Work					Adopted
The National Strategic Plan (NSP) for HIV, TB and STIs (2012-2022)					Adopted
The Women Empowerment and Gender Equality Bill (WEGE) (2013)					Adopted
The Integrated Programme of Action addressing Violence Against Women and Children 2013-2018					Planned Interventions

South Africa

Policies/Framework	Migration-Aware	Gender-Aware	Sexuality-Aware	SRHR-Aware	Status
South African Integrated Programme of Action addressing Violence Against Women, Children, and LGBTQI persons (2019 – 2024) Draft 8: 17 October 2018 – to review					Adopted
White Paper on International Migration for South Africa (2017)					Approved
The National Health Insurance (NHI) (2017)					Approved
South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022					Adopted
National Integrated Sexual and Reproductive Health and Rights Policy (2019)					Adopted

8.2 Continental policies and frameworks relating to migration and SRHR

The African Union (AU) has made health and development a continental priority, with a range of strong policy frameworks that encompass SRHR. Agenda 2063, for example, which is focused on inclusive growth and sustainable development, highlights the importance of investing in women and young people; while the Maputo Plan of Action 2016-2030, as a strategic long-term planning instrument, advocates for the inclusion and empowerment of all people. To realise these intentions, the continent with its member states needs to ensure that its population is healthy and can access and afford quality healthcare services, including SRH services.

The International Conference on Population and Development held in 1994 in Cairo changed the way in which population related to development – shifting the idea of population policy and programmes to centre on human lives, rather than on human numbers. Its emphasis was to improve the lives of individual people as well as increase human rights and respect.

Clear progression in thinking and awareness can be seen through the development of policies, especially in terms of more explicit recognition of broadening women's human rights, including their sexual and reproductive rights. Overall, three key trends can be observed:

(1)

The AU has a strong and comprehensive framework on gender equality and sexual and reproductive rights and a clear progression can be seen in terms of how policies are becoming aware of gender, sexuality and the inclusion of SRHR.

(2)

Policies largely remain limited in terms of gender and sexuality awareness, however. This is primarily due to the failure to look beyond a hetero-normative, binary understanding of gender and to there being no consideration of sexual orientation.

(3)

Mobility and migration awareness remains minimal, with only the African Charter on Human and Peoples Rights (1981) and African Youth Charter (2006) mentioning mobile populations. For a continent built on historical and contemporary migration, and with the increasing awareness of vulnerabilities to poor SRHR determined by migration (as well as gender and sexuality), this is a concerning omission.

Finally, implementation occurs at a national level. In South Africa, there is a clear shift towards restricting migrant rights as well as a dissonance between progressive policies and repressive realities. This raises a concern as to what can be done at a continental level.

Overall, while policies and laws are becoming stronger, there is a need for broader and more inclusive understanding. Moreover, it is important to consider the extent to which policies at a continental level can effect change. Such policies and frameworks are largely regarded as idealistic with implementation undermined by limited finances, lack of ownership, lack of political will and “diverse and sometimes conflicting interests” which could include traditional, cultural ideas rather than global objectives (Ndizera and Muzee, 2018). Without adequate measures to address these challenges, the policies remain planning documents and aspirations rather than concrete steps towards gender-, sexuality- and migration-aware approaches.

8.3 Regional policies relating to migration and SRHR

Like the continental policies, SADC policies and frameworks show clear progression in terms of becoming more migration-aware, as well as having more complex approaches to gender equality and SRHR, which include a shift in language and understanding of gender and sexuality.

There is also evidence of becoming more aware of the intersections of migration and health and how approaches should remain cognisant of opportunities and key vulnerabilities. This is indicated in a number of key policies and strategies including the Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2019-2030, which provides a strong example of best practice in terms of ensuring that the SRHR needs of all – including migrants – are met in SADC. In fact, this strategy is the only one that engages all four indicators (migration, gender, sexuality and SRHR). Others such as the Model Law on HIV in Southern Africa and the SADC HIV and AIDS Strategic Framework (2010-2015) are generally aware, but lack strong engagement with migration and sexuality, respectively. Overall, there is evidence that regional awareness is increasing and that policies and frameworks have been developed and expanded to address both a

general need for better understanding of migration and health as well as a specific need to engage with gender, sexuality and SRHR beyond the most basic and binary understanding. There is, however, a way to go since the main lens of SRHR remains on women, to the exclusion of people of other genders and with different sexual orientations.

- SADC has **comprehensive policies and frameworks** which are increasingly aware of migration and the importance of engaging with mobile populations and developing broader approaches to SRHR.
- However, **key priority areas continue to be restricted** to refugees and migrants within vulnerable groups as well as on HIV and AIDS, contraception and access to safe abortions. The focus needs to remain on these issues AND address a more complex and inclusive understanding of SRHR.
- The **gender lens continues to be on women** and while there is clear progression in engaging with women's rights to SRH, the exclusion of other genders and the needs and rights of LGBTQI+ individuals is of concern.

8.3.1 National policies and frameworks relating to migration and SRHR

South Africa's laws, policies and guidelines provide a supportive, rights-based framework for delivery of SRH services. In terms of healthcare access this is guaranteed through the country's Constitution, which asserts the right for all to access healthcare services, including sexual and reproductive health services. The National Health Act (61 of 2003) also acknowledges the particular health needs of vulnerable groups, including women, and provides for free healthcare for pregnant women, including women undergoing termination of pregnancy. The National Development Plan considers "providing affordable access to quality health care while promoting health and wellbeing" as central to achieving its domestic development goals. The new National Adolescent Sexual and Reproductive Health and Rights Framework Strategy (2014–2019) is broadly supportive of adolescents' and women's rights and access to health services and specifically acknowledges the challenges faced by young women in accessing SRH services.

Policies regarding gender have become more comprehensive, addressing and promoting gender equality and recognising gender-based violence as an increasingly urgent problem in South Africa. However, there remains limited awareness of vulnerable groups.

While understanding the nature of mobile communities and the vulnerabilities they face, particularly women migrants, many of the gender policies do not account for mobile communities and the diversity in gender and sexuality issues.

However, the development of the framework policies and laws show a simultaneous positive growth in recognising SRHR alongside an increasingly restrictive approach to migration and migrant's rights – including to healthcare. Therefore, the review shows:

- a positive shift in recognition of rights and heightened awareness of a broader understanding of SRHR including gender and sexuality as considered beyond heteronormative ideas and LGBTQI individuals; as well as:
- the development of laws and policies relating to immigration which indicate an increasingly restrictive approach that limits rights for cross-border migrants and increases their challenges in accessing public healthcare. This is reflected in various amendments to immigration laws and is also seen in the proposals for the National Health Insurance (NHI).

8.4 Conclusion

The review presented here shows that whilst strategic opportunities have been identified to promote SRHR, and there are concrete examples of best practice in terms of policies and frameworks, overall progress is limited. When considering SRHR in the broader field of migration and health, and the overall increased interest in the associations between the movement of people and health at the global level, there is little evidence of improved responses, locally. In fact, a review of the relevant policies from continental to national suggests, rather, that the contentious and politicised debates that underlie the intersecting fields of SRHR, migration and health, not only prevent significant change but, in some cases, show significant roll back on fundamental rights to sexual and reproductive health.

Where migration – from global approaches to local – is problematised in terms of (in)security, and (a burden on) resources and access to services, policy responses have been to heighten restrictions, securitise borders and criminalise those without the correct documentation.

Simultaneously, approaches to migration and health, specifically access to healthcare, have acknowledged the need for inclusive health for all that will ‘leave no-one behind’. Yet in practice, in countries such as South Africa policy is becoming more restrictive and specific, increasing the barriers to healthcare for many of the country’s most vulnerable, including migrants. Amendments to immigration and health laws, as well as a proposal for National Health Insurance, for example, clearly illustrate this.

This review has shown the need to understand the influence of the broader global politics and international funding (especially from the USA and the EU – the European Union) and, how these shape and impact policies and frameworks filtering down from a continental, regional and national level. It also shows how the different key issues – migration, gender, sexuality and SRHR – intersect and impact one another at a policy level. Considered alongside an understanding of practices regarding migrants’ access to SRHR, the review gives a useful picture of the relationships and disconnects between policy and practice.

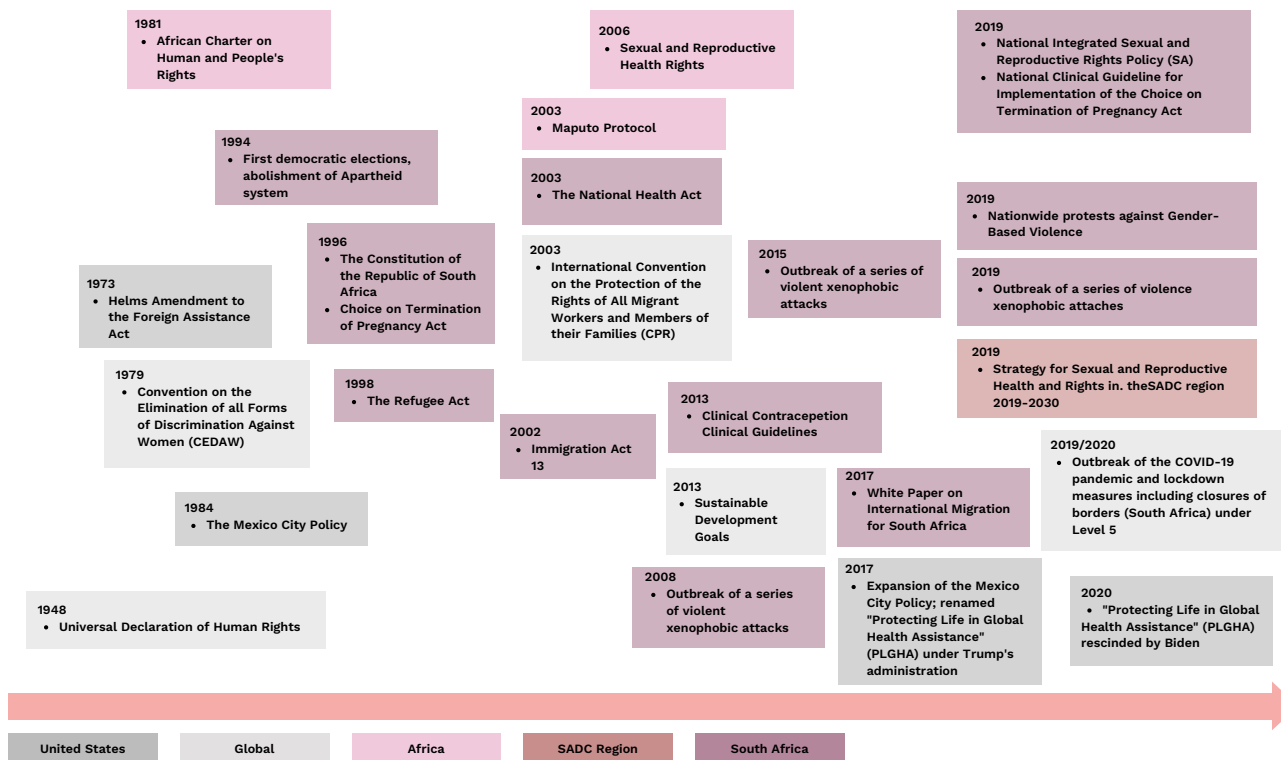


Figure 8: Timeline of key events and policies shaping access to SRHR in South Africa



[There's a need to] ... start recognising that the undocumented migrants – and, for a country like South Africa that espouses human rights, we need to start recognizing, even departments like the Department of Women, Youth and Persons with Disabilities – we need to start mainstreaming issues around migration... We may have a gender lens around issues but not when it comes to migrants, some of the [most] vulnerable populations...

Programme advisor, UN agency



09

Caregivers advocate for migrant mothers: A photo- journalism project

*Photo above and left:
Mama Marceline Sangara, head nurse of the
Jesuit Refugee Services' home-based care
programme, checks on Gloria Kalenga during
her pregnancy. Photo by Madelene Cronjé.*



9. Caregivers advocate for migrant mothers: A photo-journalism project

About this project

The text by Jan Bornman and photographs by Madelene Cronjé presented in this chapter (and report) are part of the broader project on SRHR and migration. The inclusion of this photojournalism project was an attempt to include some perspectives of migrants in relation to their SRHR experiences.

This project was undertaken in partnership with Wits University's African Centre for Migration and Society, Sonke Gender Justice and the Consortium for Refugees and Migrants in South Africa, with funding from AmplifyChange. This story is part of The Endless Journey. It has been published on New Frame. www.newframe.com/migrant-mothers-vs-the-state.

Home-based caregivers help women navigate Gauteng state hospitals that force pregnant migrants, refugees and asylum seekers to pay for services that should be free.

Mama Marceline Sangara spends her days travelling between some of Johannesburg's most densely populated migrant neighbourhoods. As the head nurse at the Jesuit Refugee Services' (JRS) home-based care programme, she provides a lifeline to migrants, refugees and asylum seekers who have been marginalised and excluded from public healthcare services. Besides giving treatment to people who live with serious and chronic health conditions, Mama Sangara also plays a role in a woman's pregnancy journey, ensuring the mother and baby stay healthy and safe.

Mama Sangara, 53, is the mother of three children. She says her work tending to the healthcare needs of migrants, refugees and asylum seekers requires the same compassion and strength one needs to raise children.



Photo above: The baby boy of a migrant woman using the pseudonym Gloria Kalenga. Photo by Madelene Cronjé.

While she is warm and soft with her patients, she is stern and determined with healthcare workers and officials at the state facilities where her patients are often neglected.

“It’s very difficult fighting with nurses and doctors in the hospital. It is not easy because they will tell you to pay money that you don’t have or they will tell you to go back home,” Mama Sangara says about her work accompanying many of her patients to state healthcare facilities.

During the nearly two years that South Africa has been in a state of disaster to enforce lockdown measures against the

Covid-19 pandemic, Mama Sangara has seen a shift in the attitudes of healthcare workers and facilities to provide services to migrants, refugees and asylum seekers.

“For the past two years, since the start of the pandemic, things have totally changed because they [healthcare providers] make migrants and asylum seekers pay money now. Especially when they send them to hospitals,” she says. “It is quite strange because antenatal care is free of charge. But for pregnant women, once they send them to hospital – to big hospitals – they have to start paying money for consultations and that is not fair.”



Photo above: Gloria Kalenga takes a phone call as her two older sons watch their favourite television programme. Photo by Madelene Cronjé.

The need for informed caregivers

One of Mama Sangara's more recent patients was Gloria Kalenga*, 36, a refugee from the Democratic Republic of Congo, who gave birth to her third son on Boxing Day. On Mama Sangara's advice, Kalenga went to the Hillbrow Clinic to give birth after doing all her check-ups and antenatal care at Edenvale hospital.

"Even myself, I was surprised. For my youngest child, I gave birth at Hillbrow, it was not the same. I was in Hillbrow in 2017, the nurses I found there just sat there and said "push". So the baby just came.

I was so surprised this time with the new baby, because there were not too many people and the nurses were kind. Even when I went to get the proof of birth certificate they were so nice. They didn't make any complications," says Kalenga, who shares a room with her three sons and husband in a house to the east of Johannesburg's inner city.

Kalenga received the birth registration document for her newborn baby in January without any problems. "For my first son, it took very long to get his birth certificate. It took four years ... For the second one, I went after giving birth and they gave it to me quicker."

For Congolese parents Patrick Ilunga, 35, and Millene Tshika, 28, navigating the birth of their second child in November was easier than their first because they both have experience as home-based caregivers. Ilunga works for the JRS and closely followed his wife's pregnancy. But there were complications when their son, Donciel, was born.

"The challenging part was mostly on the delivery day. The staff were not very friendly and helpful. She got tired and she was suffering because of that," Ilunga says. "It was very complicated but luckily the doctor who was looking after her just passed by and saw her and found that it was a case that he was following. My wife had a miscarriage before this pregnancy and that doctor knew this story very well, so he followed it closely. Luckily he came and pushed really hard to help her ... It was really a sad time for us because having the professional understanding we knew what was happening and that it was a very complicated birth."

"I was scared and confused when it was happening. I was asking myself what was going to happen," Tshika says, holding Donciel close. Her daughter, five-year-old Gladness, sits next to them. Despite the complicated birth, Donciel and Tshika were both healthy and able to go home soon after the birth. "I did not leave anything up to the clinic," Ilunga says. "As a caregiver, I made sure she went for the scans. I made sure that the medication was taken correctly, looking for any dangerous signs for her and the

pregnancy. When you are not informed, [the hospital staff] can just tell you anything and you will go with it. But when you are informed, you try to understand that in this stage they should do this or in that stage they should do that."

"So I can make sure everything goes well. If I was not a caregiver and working in these communities, it would be different. If it was someone else, you can just find yourself in trouble and not knowing what to do," he says.

Tshika says her second pregnancy and birth was easier than her first with Gladness. "Sometimes they reject you at the hospital or they leave you and don't help you. It was a worry in the back of our minds going to hospital this time," she says. "Even giving birth to the first one, it was difficult and it took long to get the birth certificate. But now it went better. It helps that we are informed about what to expect at the hospital."

Mama Sangara says her experience navigating the healthcare system makes pregnancy and birth easier for some patients. "Many foreigners can't speak English and most of the time when you go with them to the hospital as they are about to deliver, they can't understand what the nurse is asking them to do, so it is important that I am there to help them."

**Name changed to protect her identity.*



10

Key findings and discussion

Photo above and left: At Gloria Kalenga's house. Photo by Madelene Cronjé.



10.1 Key findings and discussion

The findings discussed below highlight a number of key issues which have been divided into three broad, intersecting themes:

(1)

pervasive structural – also known as indirect – violence;

(2)

challenges in the public healthcare system; and

(3)

ineffective policy and programmatic responses.

Due to the nature of their work and understanding of realities on the ground, many of the respondents shared broad and informed understandings of SRHR as well as the current challenges to making them a reality for migrants as shown in the quotes below:

‘Sexual reproductive health and rights’ is an umbrella term for a basket of rights. It’s rights that enable one to maintain a status of health basically. It doesn’t necessarily speak only to my decision to have children or not, my decision to get married or not.

It also touches on my mental wellbeing as well as, in the same rights, protects you from sexual and gender-based violence"

(Doctor, women's health clinic/Commission for Gender Equality, CGE).

"It's really about social cohesion and much more than just sexual and reproductive health. Sexual and reproductive health is just part of broader ecosystem of how we live"
(Programme advisor, UN agency).

"...It's about holistically taking care of individuals, you know, mental health and how that impacts their sexual health.... It also speaks about just affirming people's sexual rights; right to be who they are, regardless of their gender identity or sexual orientation"

(Doctor, women's health clinic/CGE).

In what follows, the themes presented are intersecting and run as overlapping threads through one another to represent how migration, gender and SRHR in South Africa are entangled issues (Walker and Vearey, 2019c). Subsequently, recognising this entanglement both heightens the vulnerabilities faced by migrants in accessing SRH and rights as well as sharpening the spotlight on what needs to be addressed and in what ways to make SRHR a reality for migrants.

In particular, key issues are foregrounded – such as access to termination of pregnancy and pervasive stigmatisation and moralisation of abortion, as well as the impact of structural violence on SRH in heightening the vulnerabilities of citizens and non-citizens in South Africa. The levels of structural violence embedded in the experiences of SRH are clear – whether it takes the form of barriers to accessing care due to a lack of documentation; or refusal to provide abortion services; or heightened risks in living and working environments; or stigmatisation and discrimination from healthcare providers. Although it was pointed out that, in some cases, a lack of resources, time and support in the public healthcare system undermined efforts to respond to SRH overall, there was a pervasive sense that SRH is deprioritised and that there is a disregard for, and failure to respond to, the needs of women and how their wellbeing is shaped by structural and sexual violence, as illustrated in the quotes above.

Furthermore, specific issues are not only neglected but, in some cases, deliberately ignored. Examples are access to terminations of pregnancies, providing information about SRHR, as well as responding to the specific needs and vulnerabilities of populations who face heightened risks.

Overall, it was made clear that a failure to understand the connection between SRHR and structural violence not only weakens the effectiveness of SRH services but leads to increased risks for all – and also specifically for migrants who already face poor SRH outcomes.

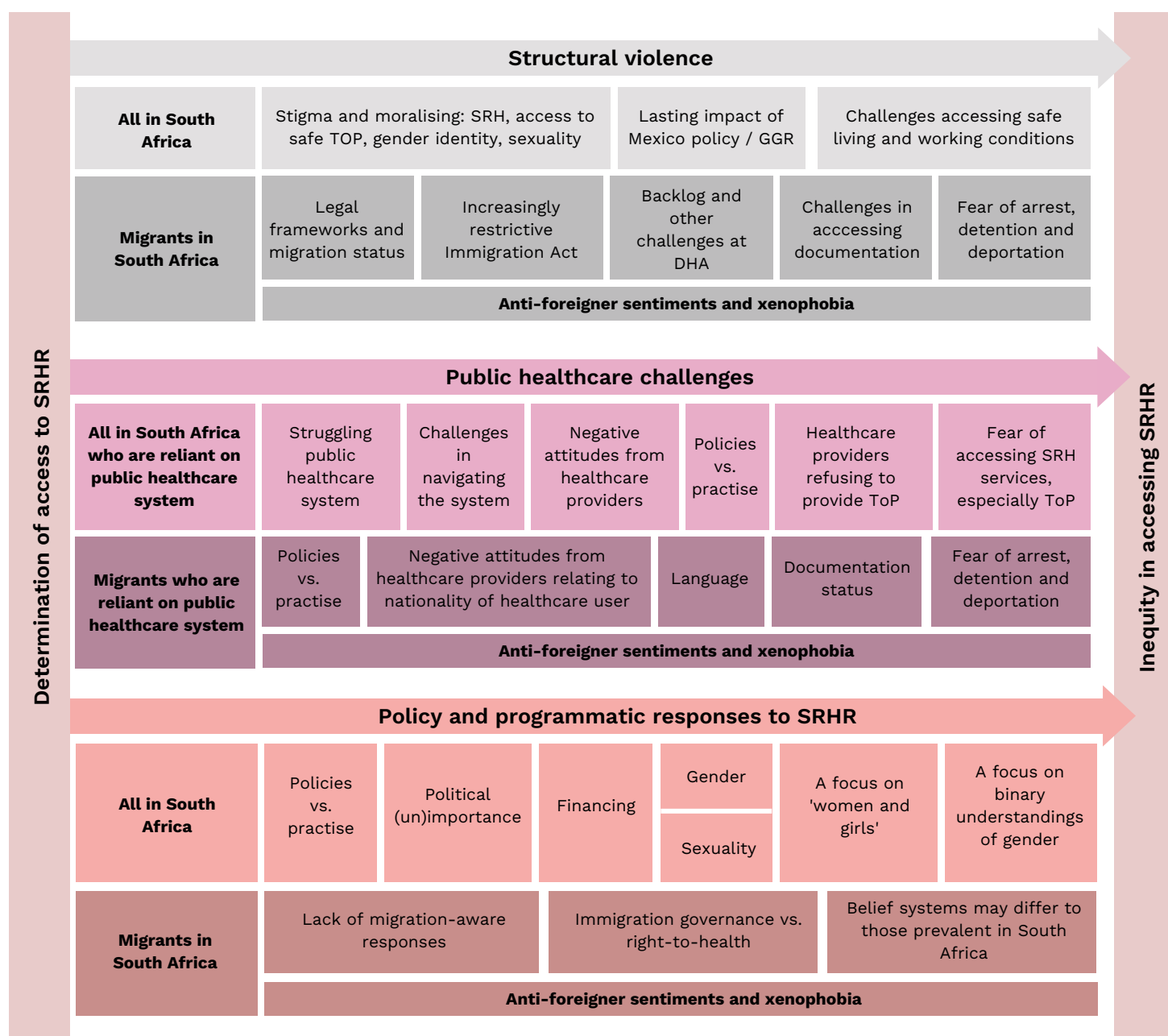


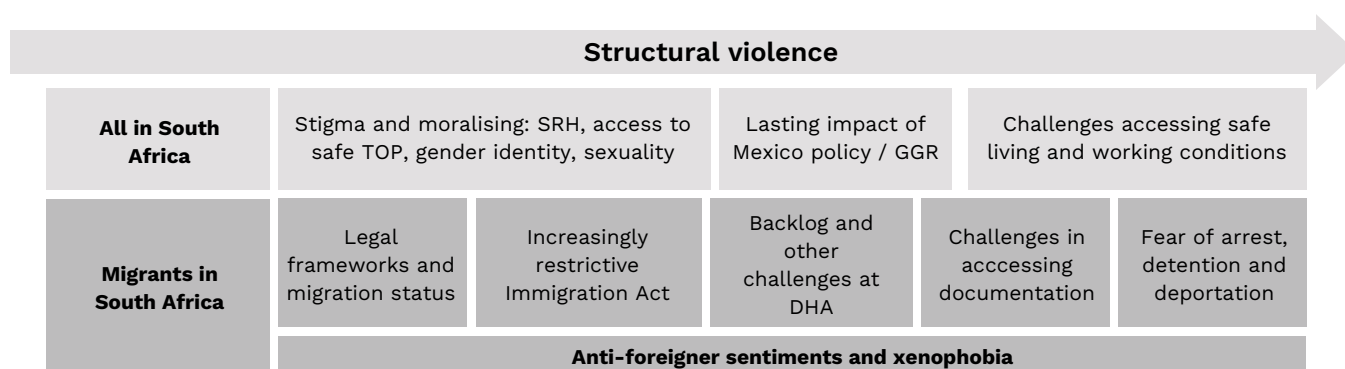
Figure 9: Factors impacting inequity in access to SRHR by migrants reliant on the public healthcare system in South Africa

10.2 Structural violence



But then there's also the social determinants of health, you know, so the structural drivers of health are also other issues that we have to acknowledge. So, policy alone is not going [to] change how our statistics are looking like.

Women's Legal NGO



10.2.1 Politicisation of SRHR

Many respondents described the significance of the laws and policies protecting SRHR in South Africa, as well as the extent to which they remain highly political issues – not just in terms of decision-making by the government but also in terms of the level (or lack) of support in ensuring access to SRHR. This was most evident in the comments around the abortion law and the ongoing contestation of this right, despite its legalisation.

As a key SRH provider in Johannesburg explained, "...the minute we vote, everybody plays the abortion card just like Trump. They always play the abortion card. Abortion has been legal for 26 years. You know, it's a medical procedure" (Specialist, SRH clinic).

In addition, attention was also drawn to how the Global Gag Rule became a part of this politicisation.

Pointing to the contestations around the rights to abortion despite the law, respondents noted that the GGR was used to support the local reluctance to provide access to abortion.

In this way the GGR is entangled with the South African state's failure to ensure facilities are funded and staff are trained to provide termination of a pregnancy (ToP). Both impact access overall, as the comment by a legal advocate from a women's rights organisation explains:

10.2.2

Stigma/moralising/prevaling assumptions/norms/judgements

The findings show how structural violence heightens vulnerabilities for both citizens and non-citizens. Experiences of structural violence includes stigma, moralising, assumptions, norms and judgements about those with SRH challenges and those trying to access SRH services.



It's also tricky in South Africa, because we have such issues ... around abortion implementation to begin with, that you do not know if it's the state or if it's the GGR that's affecting. And you do not know the extent to which either affects, because the state ... in itself is just so problematic with the way it implements. So, for that fact, it's quite fascinating, because inasmuch as you can get funding over and above the Global Gag Rule, you may not even get designation as a facility to provide access to abortion; or you may not even be an NGO that works within ... comprehensive sexual reproductive health services or health services that includes those.

Women's rights organisation

It is expressed by healthcare workers, staff in healthcare facilities and also wider communities. As the findings show, this is particularly the case for those accessing the ToP where the extent of stigma and judgement can block access and/or women and girls chose not to access the service. This is shown, for example, in the comment by the senior community trainer, "This girl, she went for an abortion. Then the nurse was on her case – like “You go there opening your legs [sleeping around] enjoying; now you want to do it [have an abortion]”. So, it was not a good experience, so she left. And she kept her pregnancy, unwanted one" (Senior community trainer).

Respondents also spoke about the challenges faced in accessing advice regarding contraceptives because of the assumptions made about women and girls ‘sleeping around’ and being promiscuous. Nurses working in an SRH clinic in a government hospital, for example, described how it is always women and girls who come for contraception and they nearly always come alone – suggesting that SRH is seen as a ‘woman’s issue’ which, at the same time, compounds the stigma and moralisation directed at females.

Similarly, questioning why healthcare workers refuse to provide terminations on religious grounds (an issue discussed under point 6.3 above) a nurse and public health specialist blamed stigma towards abortion amongst healthcare workers but also within communities.

The findings show that the levels of structural violence embedded in the experiences of SRH services are clear – whether they are in barriers to accessing care due to a lack of documentation, refusal to provide abortion services, heightened risks in living and working environments, or stigmatisation and discrimination from healthcare providers. As the comment below suggests, many challenges related to structural violence are heightened for migrants – although the connection between SRH and structural violence impacts on all accessing SRH services. In doing so, it not only weakens the effectiveness of SRH services but leads to increased risks in general – and also specifically for migrants who already face poor SRH outcomes. The findings presented here indicate the importance of understanding, and responding to, the structural determinants of health equity, as illustrated in Figure 10, overleaf.



A lot of the problems that we are experiencing in the system, because you are a migrant person or a migrant worker or a non-citizen – the discrimination gets heightened, because you are in a vulnerable situation, because of your lack of documentation. But in terms of your actual experience as a patient, it’s just as bad even for South Africans.

Legal advisor, NGO



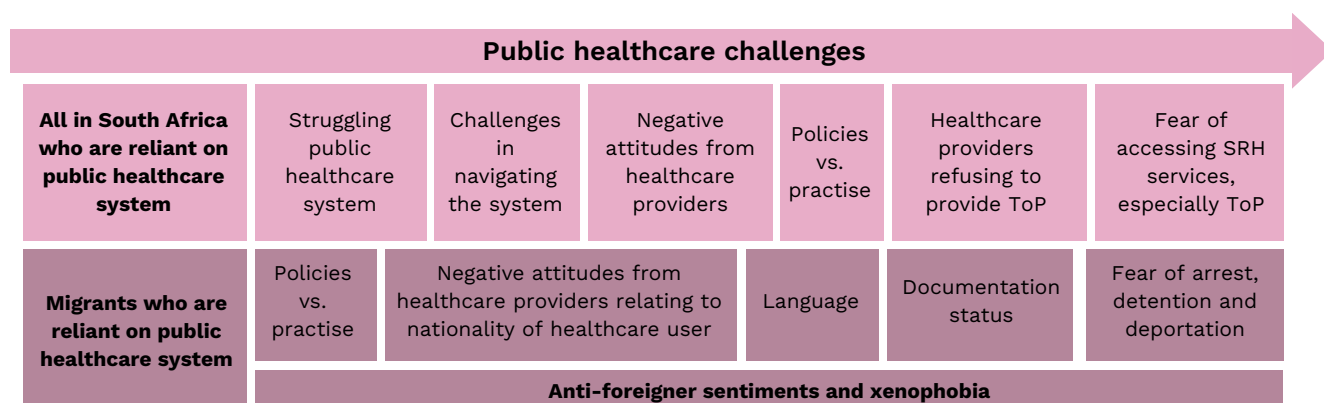
Figure 10: A summary of the structural determinants of SRH inequity experienced by migrants in South Africa. Source: (Vearey, 2013: 131 drawing on Malmusi et al. (2010); Solar and Irwin (2007))

10.3 Public healthcare system challenges



I think if the clinics are full, everyone is affected ... from the healthcare providers to local people, as well as migrants.

SRH/HIV specialist, UN agency



10.3.1 A struggling public healthcare system is a challenge for all

Respondents were very clear that citizens and non-citizens face access challenges and that this impacts on SRH outcomes and can heighten the vulnerabilities to poor health of all concerned. Reflecting on the poorly resourced and over-burdened public clinics and hospitals, reference was made to the failures to ensure that SRH was prioritised, properly

managed and that there was enough training to ensure services like termination of pregnancies could be provided more widely. Key challenges identified as impacting everyone's access to SRH services included a public healthcare system that is

- “understaffed, underpaid and under-resourced and under-acknowledged” (nurse, medical NGO);
- “lacking in capacity”; “deprioritises healthcare needs of women” (lawyer, women’s rights NGO); and

- crippled by stock-outs and supply-chain problems, including a lack of medication for ToP.

That being said, SRH services are neither integrated nor comprehensive. This is illustrated, for example, by the separation of ToP from other SRH services or HIV/AIDs programmes in a way that only increases the stigmatisation and sense of shame that gets associated with abortions.

A respondent working with an organisation supporting migrants commented on the often-unfriendly environment for SRH services, lacking in privacy for those that require it. They stated "...when you are seated in the open and then they are shouting...everyone is judging you" (migrant support organisation).

But a member of the Sexual Reproductive Justice Coalition commented that "the reality is that the services in general are terrible for all" (member of SRJC).

10.3.2 Policies vs practice

As previously noted, South Africa has a strong range of laws and policies that promote and protect SRHR, described by a respondent as "progressive policies and the impressive legal framework" (legal advisor, NGO). In theory these should protect and provide a broad range of SRH services and rights for all in South Africa: "We have laws in place that are actually respectful, or seemingly respectful, of persons, of women and their right to

bodily autonomy and seek to give affect; to that – but we have an issue of implementation" (Lawyer, women's rights organisation). Describing how South Africa at one time had "one of the best contraceptive rollout programmes in the world", the director of an SRHR programme spoke of what he felt was a deliberate attempt to undermine access to SRH:



It's so easy to run up every single obstacle, they [are] all the ones you throw up; it's like, you know, you can just make it hard. You can be unfriendly, but you can also just bureaucratised it, you can throw out the fact "There's no-one in the clinic today to do it"; "There's no-one at the hospital"; "You must bring the following documents"; "You must bring parental consent". Yeah. Which is not true. There's just thousands of ways you can toss all of this out there... What I found with bureaucracy, particularly health bureaucracy, [is] what you're doing is you make it actually more work to actually screen and block care than ... to just allow...So there [in hospitals] they [patients] get blocked all the time, illegally often. But for the bureaucrats and for the staff, it actually makes the effort worth it, because stopping them stops them from doing a lot of the work.

Specialist, SRHR programme

Respondents also referred to practices on the ground which clearly violate policy and discriminate against migrants. An example was given of migrant women trying to access maternal health who were turned away by security guards: "At a lot of the services, the security guards are the gatekeepers. So, if women arrive at a service and it depends on who the security guard is. He'll either say, "Oh, the clinic is closed"; or "Where are your papers?". So it is about educating because security guards are not the gatekeepers; they cannot be the gate keepers of maternal health" (Programme manager, UN agency).

In such cases, policy and legal frameworks providing the rights to SRH are seen as less relevant than those acting as 'gatekeepers'. Security guards, nurses, resource managers etc. use their power to decide who can access healthcare, including SRH, and who will be prevented from doing so. This is done in such a way that it reveals migrants as "the lowest hanging fruits" in terms of trying to solve problems around access and resources. Describing how access challenges for migrants are embedded in the belief that migrants are over-burdening the healthcare system, a person working for the UN commented:



A circular would be sent by the Department to a number of clinics to say that we are no longer offering services to undocumented migrants. In such instances, though, [it] would say it's because the health systems are overburdened and they are struggling to give services to the people who are actually documented and who deserve the service. However, that's illegal because that's opposed to what the Constitution says. Then you write to them to remind them of that and then they quickly remove it. I guess it's usually them being unable to meet the needs of everyone and then thinking who is the lowest hanging fruits that would just be removed ... for us to be able to have more services.

Specialist, SRHR programme

Access challenges for all were also described in terms of an erosion of SRH services in South Africa which has increased access challenges: "If you look at the rape stuff, if you look at the abortion rights stuff, if you look at the access to contraception – there had been for 25 years [and] it's just been steadily eroded" (Director, SRHR programme).

Photo overlaf: Photo by Madelene Cronjé.





10.3.3 Healthcare providers refusing to provide ToP

Despite ToP being legalised in South Africa through an Act which "provides an enduring basis for pursuing reproductive justice, including attainable abortion rights" (Albertyn, 2015: 450), many healthcare workers continue to block access to this service and to object to providing terminations. Describing 'conscientious objection' a respondent raised the issue of 'competing rights' and how this impacts women's access to SRH services: "...the issue of conscientious objection, where the Constitution guarantees everyone the right to freedom of conscience, opinion and belief; and based on that you have competing rights where someone can say that they are unable to provide a service because they do not believe in that. In that case you have competing rights, as it is getting in the way of other people receiving services. You still have a duty to refer them, which is not so in many situations" (Researcher).

Expressing a similar view more strongly, the director of a women's health clinic exclaimed "Get those nurses to do their bloody work" and argued the following quotation.



You can't choose the parts of the body of the woman that you want to work with; then please don't be a nurse or a doctor! You can't just say, "Okay I'll stich up a drunk driver who has just killed a whole family but I am not going to help women requesting a medical procedure – a legal medical procedure". But everybody becomes Christians or Muslims or whatever the moment abortion is mentioned.

Doctor, women's health clinic

Although not all respondents felt that healthcare practitioners should have to provide ToP, there was a clear consensus that the unwillingness to do so directly heightens the stigmatisation and moralisation of abortion which, in turn, simply increases access challenges and poor SRH outcomes. For example, a nursing sister working in a clinic in the Western Cape commented that she provided abortion because "it is a job and a service that is needed" and that although she respects those who opt out, "it doesn't help the women who are fearful of coming here and feel ashamed or embarrassed...it makes them feel more that they have done something wrong" (Charge sister, SRH clinic).

Respondents also described the entrenched nature of abortion stigma through the ways in which healthcare workers deliberately exploit the lack of information and knowledge amongst some women and girls – by turning them away or booking them in advance so that they miss the window within which they can legally access an abortion. While evidence shows there are clear structural challenges in terms of the number of women wanting to access the service, exacerbated by poor staffing and lack of resources, the key issue is that the deliberate blocking of access ultimately places women and girls in more precarious situations. As a lawyer explained:



...we have a lot of such cases. They[women] end up with us and say “I went when I was still six weeks and I was told that they only offer [ToP] after 13 or 14 weeks. And when I went back, they then told me that they only offer from 12th and then we check on the system as well. It also shows that this is a first trimester facility that was supposed to have helped you. But because they [the healthcare staff] are uncomfortable with conducting the procedure, they then delay you, especially if you don't know.

Lawyer, women's rights organisation

In addition, the role of the GGR in heightening the challenges of access to abortions was noted, through decreasing “the capacity of the South African health service to respond adequately” (member of the SRJC). However, a number of respondents felt that the GGR impact was not only due to a decrease in funding but also became a convenient reason for the Department of Health's lack of support for abortion training and ensuring there is access for everyone. This is described by the director of a women's health organisation in terms of a “chilling effect”: “It's really the chilling effect. Not only information, but also on the extent to which the Department of Health supports abortion training and providers in procurement of the reproductive commodities required to offer this service in the public sector” (Doctor, women's health organisation).

A lawyer also described the potentially fatal consequences of women being turned away and looking for alternative, dangerous ways to terminate their pregnancies through informal providers or their own actions: “So, if you show that you know [you can get a termination], you might get the service – or you may be referred to somewhere else because they say “We have a very long list”. But these are the tricks that nurses play when they're uncomfortable to offer the service, basically.

10.3.4 Fear of accessing SRH services

As noted above, some people do not go to clinics because of the kind of poor treatment they expect to get: "We see this with the LGBTQI community. The kind of treatment they get when they go to a health facility is so much that it becomes a deterrent for them to access services" (UN agency).

Respondents spoke explicitly both about migrants' fear that they will be turned away from services and/or discriminated against (both by healthcare workers and communities), as well as the stigmatisation and abuse of migrants accessing services at all. In particular, they highlighted how stigmatisation and discrimination directed at LGBTQI+ migrants and/or those seen to break from gender norms not only pose challenges to accessing care, but also leads to abusive and structural violence: "When you listen to nurses' attitudes: "So, what do you do with a transgender patient that comes in?" – they're like "We don't want to work with those people". You just need to listen to the language that is used ... This is 2020! How can we still feel like this? We're progressive. I can understand if we were in Uganda or in Rwanda or Nigeria, but in South Africa we've got a Constitution where you can be whatever you want to be" (Director, SRH clinic).

Referring to research with migrant sex workers, another respondent described similar fears of mistreatment in which

"the fear of stigma and of being judged" pushed migrant sex workers to seek alternative, and often more risky, ways to deal with their SRH needs, such as terminations:



We saw that the migrant sex workers feared going to the hospital to seek SRH services. The fact that some are undocumented, or [have] expired documentation, caused challenges when seeking health services. It was a challenge for them to walk in a clinic set-up and say "We are looking for condoms" or "I am here to talk to someone about reproductive health or contraceptives". They reported that they would end up taking Panado [pain killer] instead of the real service that they should be [getting]. Abortion was worse as it's something that they cannot even discuss, which left many going to seek the service from back street people. The fear of being judged and stigma was often too much.

Researcher, migrant-focused NGO

The experiences of migrant women accessing maternal and reproductive health services were also identified as some of the worst forms of structural violence in relation to SRH. This is not only in terms of the extent of stigmatisation and judgement, but also the harmful and potentially life-threatening consequences of fearing access. While this is shown in the comments about women being unable to access ToP (above), it was also described in terms of accessing antenatal care: "And we've seen a number of women who would delay in going for antenatal care visits when they're pregnant; and you find that they're also living with HIV. But they don't want to go is because of the mistreatment from the healthcare providers" (Lawyer, legal and health NGO).

10.3.5 (Not) knowing the system/ lack of information

Findings show that the lack of understanding and knowledge of the public healthcare system impacts the ability of migrants to navigate and negotiate access to SRH. For example, respondents highlighted the lack of accessible information on where to get a ToP – for both women seeking the service but also for healthcare providers wanting to refer them. One respondent noted that that there is no information on the

National Department of Health's website, despite the government investing millions of rands on apps which fail to have any information.



Knowing your rights only means something if you're living in a country and a culture that supports it.

Nurse, medical NGO

However, even where information and knowledge of rights is available, the assumptions, norms and judgements about migrants, gender and sexuality deny their access to SRHR.



Rights knowledge is very important when you want to access services most of the time because you can be turned away by something so minor, something very minor.

Director, international NGO

Photo overleaf:

Gloria Kalenga before giving birth to her baby boy. Photo by Madelene Cronjé.





A legal advisor working for a women's rights NGO also made the point that access challenges, and particularly experiences of being turned away or mistreated, cannot be challenged when communities do not have information and do not know their rights: "...You cannot know when your rights have been infringed or whether or not you enjoying them to your fullest extent if you do not know what their content is. And so, with that comes access to information– the right to make an informed decision concerning your reproduction, concerning your sexuality. So with that comes education and access to information" (Legal advisor, women's NGO).

A nurse working in an SRH clinic highlighted the role of social media and the internet in broadening the access to information on SRH services – to ensure that “ young people know where they need to go and what they can get ... that's how they find us”. She described how migrant women from surrounding communities often arrived unsure of the services – whether they were allowed to access them especially if they did not have documentation, fearful that they would be turned away. The nurse explained that her clinic provides first trimester abortions to anyone who comes to the clinic, regardless of migration or documentation status – but that this is not widely known or deliberately communicated via government programmes or SRHR interventions.

10.3.6 Negative attitudes towards migrants

Despite the fact that ‘medical xenophobia’, or at least negative attitudes towards migrants, is a well-documented issue in relation to healthcare in South Africa, there is little understanding of specific experiences of accessing SRH services. This research has revealed how simply being labelled a ‘migrant’ or ‘other’ intersects with other challenges. In addition, barriers to accessing SRH services in particular can be heightened by a lack of documentation; language challenges; a lack of information about services and rights; and negative perceptions and judgemental attitudes, including stigma and discrimination, towards people with certain health issues. As said above, these can be expressed both by healthcare providers and by individuals and communities more generally.



One of the biggest challenges that I have noticed in the course of doing my work in the past years has been the language barrier. Another big challenge is that of language. Some of the migrants do not speak English or the local languages, therefore communication becomes a challenge, especially where there is no interpreter at the health facility.

Regional SRHR officer

However, as has been shown, while challenges with provision of services and issues of under-resourcing and a lack of staffing exist in some facilities and in some regions, it is actually the perceptions of, attitudes towards and stigmatisation of migrants that drives the heightened barriers they face in accessing SRHR: "So, I think, for me the stigma around issue and access [to] ... SRHR continue to be a problem. And, of course, then they get heightened or increased, because people are migrants; the delay in care, the non-dignified services that they receive and the lack of recourse" (Nurse, medical NGO). This was also confirmed by a respondent working for an SRH organisation: "So, in many cases, it's not necessarily the absence of commodities and the absence of services, but rather the attitudes and the behaviours of healthcare

workers that become disincentives for adolescents and young people to want to access their services and, in the broader spectrum, realise their rights, because of the hostility that is experienced within the health facility" (Trainer, SRH organisation).

10.3.7 Documentation

While access challenges were identified as impacting citizens and non-citizens alike, respondents were also clear that these challenges are often heightened for migrants, especially those without documentation. An example was given of earlier responses to the HIV/AIDS epidemic, in this case regarding the rollout of ARV programmes in 2004/2005: "This is a public health programme; you have people being turned away from the ARV programme because they didn't have the official ID documents. It's ridiculous, because lots of South Africans didn't have the ID books" (Director, SRHR programme).

A charge sister working for an SRH government clinic also described how her clinic had to refer women for second-trimester abortions to a certain hospital and that "...the hospital is very strict; I know that if they're not documented they can't access; they will be restricted. I don't actually don't know what happens further" (Sister, SRH clinic).

10.4 Policy and programmatic responses

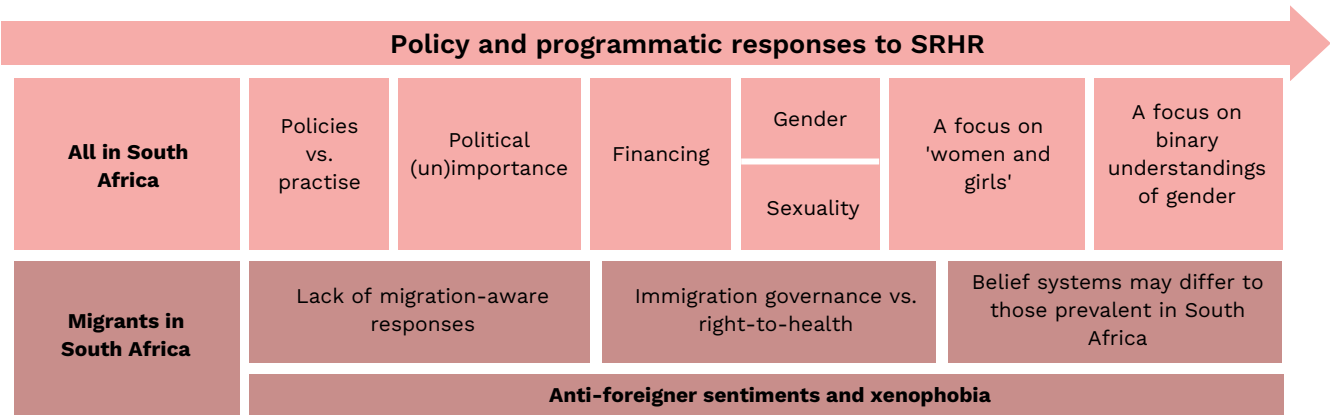
“

South Africa is known to have progressive laws, but appalling implementation.

Lawyer, women’s rights NGO

[W]e have the Constitution that affirms in Chapter Two the rights to health, including reproductive, sexual... health. It lists it and it expresses it explicitly even in the Constitution. We have different policies that speak about adolescent health and different policies that speak about, you know, SRHR as a framework. We have the Choice of Pregnancy Act. I mean, what more do people need, you know what I mean? And I’m not sure why there is just no will to make SRHR more accessible and more dignified as a service.

Doctor, women's health clinic/CGE



10.4.1 Policy vs practice: Progressive laws and ‘appalling implementation’

Respondents frequently referenced the disconnect between the landscape of progressive laws in South Africa and the restrictive and badly implemented practices on the ground in terms of SRHR. Some expressed outrage at the fact that such rights, hard-earned over decades and resulting in an “impressive picture of protecting reproductive and body choices” exists “only as a picture” (organisation working with migrants and health) – and that in reality these rights are being denied and eroded through a lack of provision and access.

As the comments above illustrate, the protection of SRHR in law is not enough when it is not implemented effectively – the result of which is actually worse SRH outcomes within a context of progressive rights as the comment below as indicates: "We have laws in place that are actually respectful or seemingly respectful of persons, of women and their right to bodily autonomy and seek to give affect...; but we have an issue of implementation" (Women’s rights NGO).

Although the challenges of implementation have been clearly described throughout these findings, reference was also made to how the implementation of policies is weakened through the failure to address structural violence, especially the heightened risks

faced by certain groups including migrants. For example, one respondent (a programme advisor from a UN agency) reported how their organisation worked to support SRH access for women and adolescent girls in clinics, but that they did not “consciously identify migrants.”

While stating their focus is on “vulnerable populations” and “around women empowerment and gender equality”, the absence of a specific focus on migrant women and migrant LGBTQI+ individuals raised questions for her about limited implementation. This is, again, a weak response to a strong set of protective policies and laws. She went on to describe a clear need to:



[There's a need to]...start recognising that the undocumented migrants – and, for a country like South Africa that espouses human rights, we need to start recognizing, even departments like the Department of Women, Youth and Persons with Disabilities – we need to start mainstreaming issues around migration... We may have a gender lens around issues but not when it comes to migrants, some of the [most] vulnerable populations...

Programme advisor, UN agency

Another key example of a lack of prioritisation and poor implementation was given in terms of the impacts of the Covid-19 pandemic on SRH services, and especially on access to ToP. Respondents in Gauteng described a general reduction of services during the Covid-19 lockdown, as well as confusion as to whether SRH services and ToP were seen “as an essential service”:



...a lot of women were coming to us saying, “I went to a clinic, I was told that this is not an essential service. They're only attending to Covid related matters.” So, a number of women came back to us and we ended up writing to the Minister and the MEC of Health in Gauteng. So, in his response, he said he had sent a circular that may have been interpreted as stating that abortion services and sexual reproductive health-related services were not an essential service. However, he admits that it may have been miswritten or misinterpreted in that manner, but then released another circular stating that (...) they were a critical service. So, at the beginning there was huge impact on access in that every clinic was turning people away.

Lawyer, legal and health NGO

The MEC addressed the issue through a letter in which he included a contact number of someone from the provincial Department of Health for when the NGO received such cases. She thought the damage had been done, however: "And it's just unfortunate that a number of women were turned away at the beginning when they were trying to access services and told that it's not an essential service; as if everything just stops because Covid is here. You still need your contraceptives; you still need antenatal care services; you still need to perform an abortion if you don't want to carry the pregnancy to term" (Lawyer, legal and health NGO).

10.4.2 Lack of investment, financing and SRHR as politically unimportant

Respondents referred to what they saw as a form of only passive support for SRHR, despite the progressive framework of laws and policies that protect the issue of choice and bodily autonomy in South Africa. This was illustrated through the lack of investment, funding and training of SRHR, as well as an explicit undermining of laws.

The director of an SRHR programme in Johannesburg, for example, described the former Minister for Health, Dr Aaron Motsoaledi as being “quite vocal in terms of their support for SRHR and services more broadly in terms of modern

contraception, family planning, HIV services and integration” but yet “incredibly conservative” in his views on abortion and the right to reproductive choice.

This view was supported by an activist who argued that “[t]he political will to provide reproductive justice just got eroded over time. And Aaron Motsoaledi was no use at all. He apparently said the right things but, apparently, according to people who know, who work with him, he was actually anti-abortion” (activist/community support worker).

The lack of support for – and, in fact, clear undermining of SRHR, especially the ToP – is seen in the poor allocation of funding, as well as in the lack of willingness to fund the promotion of SRHR programmes to ensure communities know about, and can access, their full rights. As pointed out by an SRH organisation: “Health is our second biggest expenditure item for the country; but in terms of how you resource SRHR, there’s a lot to be desired when it comes to, you know, commodity, security” (SRH organisation).

In line with the arguments about the failure to politically support and uphold access to SRHR, respondents also referred to the failures to ensure that SRH was prioritised, was properly managed and that there was enough training to ensure services like the TOP.

The lack of training and of understanding the links between structural violence and SRHR was commented on by a technical advisor within an NGO:



So, firstly, you have undergraduate nurses and doctors who still qualify with their undergraduate education without a good grasp of human rights and without understanding how the practice of medicine or nursing is in itself an enabler or a disabler, of people’s accessing their rights and services. So, the training, I think, it’s still not up to par with what the citizens need in terms of the language that’s being used, including other people of all gendered entities and sexual orientation, and disability.

NGO, technical advisor

A trainer working for a gender rights organisation also described the failure of the Department of Health to ensure that communities know about their rights to SRHR, leaving a gap that NGOs and civil society organisations are left to fill: “So, the Department of Health, I think they are waiting for the community to come to the clinic. But I will say the challenge is the clinic or the health workers: they’re not

going to the community to give education regarding, and especially on, sexual reproductive health and rights" (Trainer, gender rights organisation).

In addition, a community worker supporting migrants and their access to services also noted the lack of effort being made to take services to communities – especially providing education materials in different languages and targeting some of the most marginalised groups, including undocumented migrants and migrant women needing to access maternal and reproductive health.

10.4.3 Diversion of funds and deprioritisation of SRH services during the Covid-19 pandemic



We have a Covid hotline. Why can't we have an abortion hotline?

Director, SRH clinic

The concern about a lack of political will to support SRH services – especially to uphold and progress the laws and policies to strengthen access – was brought into sharp focus in relation to the impact of the Covid-19 pandemic.

Respondents mentioned:

- the diversion of funds from SRH services, including sex education in schools, to the pandemic response;
- the failure to explicitly list SRH as an “essential service”; and
- the heightened fear amongst migrant communities in accessing services.

An advisor from a UN agency summarised the overall impact of the pandemic as a “reversal in all the gains in all SRHR indicators” thus confirming the claims that “[g]lobally, the reallocation of resources to fight the pandemic has left humanitarian and SRH programmes short of staff, supplies, and other essential resources” (Jacobson et al., 2021).

Commenting on the diversion of funding from advocacy and education in schools, a lawyer described how this meant not only that critical education was being missed, but that young people were being denied access to information in a context of high levels of sexual violence, especially during lockdown: “We recently found out that R100 million that were budgeted for life orientation or comprehensive sexuality education – and R40 million of that was supposed to be used to train teachers that are supposed to teach comprehensive sexuality education in schools – has been re-allocated or repurposed towards the Covid response. So that already tells us that kids are not going to learn about very critical things, whereas we live in a country that has the highest sexual violence cases.

And with our experience on the ground, we've seen that a lot of kids don't know anything related to sex. A lot of them know what a contraceptive is but there are heightened teenage pregnancy rates and high sexual violence cases. So Covid has really impacted on access to services, to sexual reproductive health" (Lawyer, legal and health NGO).

Other respondents explained how the pandemic exacerbated an already bad situation and that the failure to recognise SRH services as essential compounded existing concerns about support and investment in SRHR:



I mean, we're already starting off on a bad footing, right. So, what Covid did, was, severely stretch those very stretched resources that we had. In some provinces, like Gauteng for example, they had listed, and communicated ..., the public list of services available during the hard lockdown on Level 5, and they had not put in sexual and reproductive health-related services. And we had to take it up with them to say they have to explicitly include it, like they did with all the other ones that they had listed, because these services are primary healthcare-related.

Doctor, women's health clinic



At the beginning of lockdown, remember when there were the first regulations that outlined that only essential services would be allowed? There was a circular that the Gauteng Department of Health released that said they're only attending to Covid-related matters, and they kind of implied that anything related to sexual reproductive health [was not essential]. So a lot of women went there for contraceptives, [but] they were turned away. We had to write a letter to the Minister and the MECs reminding them that sexual [and] reproductive health and rights is, and should be, part of the essential services package; [that these] services are considered essential. So we did see a lot of disturbances and people; obviously Covid inflicted a lot of fear within people.

Researcher

The confusion around SRH services during lockdown also led to people failing to collect ARV sort to attend antenatal appointments: "People [were] not going to the facilities to collect their ARVs; but you may find that even women who are pregnant [and] have to go for the antenatal visits, were probably not going Because now most of the health facilities are focusing on screening and testing for HIV...so whilst they [NDoH]

were saying “We will continue providing these services” but on the ground we do know for various reasons some people were not getting the services, either because of what was happening within the health facilities or ...because people were also fearful of going to the facilities" (Advisor, UN agency).

10.4.4 Poor engagement and understanding of gender and sexuality



This country doesn't prioritise anything that has to do with women and women's needs, whether it's our safety in the streets, whether it's issues of gender-based violence. So this is, for me, it's just another issue among many issues where the system generally doesn't prioritise and doesn't see women and issues of gender equality and rights as important for our own, you know, health and wellbeing – but also for the health and wellness of this country...

Nurse, medical NGO



When people are talking about SRHR, it's still very much within the hetero-normative framing and it's very exclusionary in terms of, you know, people who are disabled who need these services. People who may have different / other requirements, who are not in married relationships, or who are young people and who are not necessarily looking to abstain, right?; or a young person who was already born with HIV. A lot of the programming is around HIV prevention, but when you have a country such as South Africa where many young people are teens themselves and they were born with HIV, where do they go for information if everything is around prevention?

Doctor, women's health clinic/CGE

In particular, where respondents framed an understanding of structural violence impacting on SRH in broad and inclusive terms, they also identified the limits of how migrants, and especially female migrants, are viewed in relation to SRH. They noted, for example, that this is often through a focus on sexual violence.

While this reflects the harsh realities of the sexual and gender-based violence that migrant women face – often from their countries of origin, in transit, and within their destination/host countries (as also shown through the literature) – this can also come to frame all of their health and SRH experiences. As a medical doctor working for an NGO explained:



Okay so you can't [have] migrant populations or migrant projects or migration projects with a strong SRH component. No, they swap it and they call it 'sexual violence projects'. But then you take a population you know [and it] becomes a little bit ... nondescript again.

Nurse, medical NGO

For migrant women, then, being seen as victims of rape, trafficking and sexual exploitation extends the focus of 'women as victims' into healthcare responses at the expense of recognising other experiences and needs. Moreover, it ignores more embedded forms of structural violence which can, in turn, heighten the vulnerabilities faced. A nursing sister working in an SRH clinic in the Western Cape also explained this in the following way: "We see women who cannot speak the language and they are

quiet; and...you know, they seem like there is something they can't say...and we think maybe it's, you know, it's the rape, or they are traumatised or something like that" (Charge sister, SRH clinic).

Noting that "sexual violence is a kind of more universal thing" the NGO nurse described how all forms of sexual transactions end up being interpreted as sexual violence because of the universality of the term and understanding. This includes so-called 'survival sex' and sex work in which, as the literature shows, some migrants choose to engage given a lack of other viable options.

This, however, is at the expense of a "multi-layered approach to understanding people's vulnerabilities and health vulnerabilities in relation to migration" (nurse, medical NGO). Therefore, migrant women seeking contraceptive advice or the termination of a pregnancy – or transgender migrant women wanting information about accessing hormones or surgery – are either seen through the lens of victims or "not seen at all", as the director of an SRHR organisation commented. This limited view risks preventing a more complex understanding of how structural violence impacts sexual violence and, in turn, the various ways in which these factors shape and determines access to SRHR.

10.4.5 Belief systems, norms and local understandings

A lack of knowledge has also been linked to cultural norms of non-nationals from countries where SRH is taboo and abortion, for example, is illegal. This then prohibits them finding out about their access and rights, as a community trainer for SRH explained:



Some of them [foreign nationals], they don't know because they still have those mind sets of back home where abortion is prohibited. So, they think "Ah okay, so I can't abort. So it happened, it happened. I have to keep this pregnancy".

Senior community trainer

This same respondent explained that this was also an issue for younger migrants who, although they have more access to information and a greater awareness about SRHR, are constrained by the cultural norms of their families and older generations, impacting their ability to access their rights in practice.



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Doctor, women's health clinic/CGE

A lack of knowledge and cultural issues among men were also identified as driving barriers to SRH. A community trainer, for example, who was involved in trying to educate communities about SRHR through setting up information points and starting discussions with community members, described the challenges of engaging men in this work:



If you check, like, our cultures – men they don't go to the clinic to seek assistance because it's a sign of weakness in some cultures; and men to go to a clinic, it shows that you are weak, yet they said a man must be strong. So, I think we need, like, outreach where even men, they will hear the importance of ... sexual reproductive health ... and rights; because ... some they don't know or some they're just ignorant. But the education, when we talk about sexual reproductive health and rights, most of the time when you start talking about it, you'll see men running away.

Senior community trainer

10.4.6 Shifts in attitudes and responses: Small steps forward and back

All respondents spoke of their concerns about a lack of political will in making SRHR a reality for migrants, noting an increasingly conservative, restrictive environment, along with efforts to undermine SRHR and access for migrants.



I would imagine that access might have become more limited. I think with the expression of xenophobia and the lack of governmental response to xenophobia, I think people might feel more emboldened to discriminate against migrants. I think politically, South Africa has become more conservative. I think following trends internationally, I think the politics in the United States, they can definitely have an impact on domestic engagement, on health issues.

Researcher

All respondents spoke of their concerns about a lack of political will in making SRHR a reality for migrants, noting an increasingly conservative, restrictive environment, along with efforts to undermine SRHR and access for migrants. At the same time, however, there has also been some significant shifts, however small, that have contributed to positive change. These have included the reduction in cases of migrants being turned away from hospitals; a focus on the availability of hormones and other treatments for transgender individuals; and also, in some spaces, more openness to talking about sexuality, diversity and rights.



So, I think we are changing. I think we are changing because we are talking about sex and sexuality and diversity and all of them things. So that's rights, isn't it? I think that we are talking about sex in a more positive way, not in a punitive way.

SRH organisation

All respondents spoke of their concerns about a lack of political will in making SRHR a reality for migrants, noting an increasingly conservative, restrictive environment, along with efforts to undermine SRHR and access for migrants.

Respondents affirmed such shifts and attitude changes as small steps forward, despite their acute awareness of the many steps backwards too. A respondent working for an international organisation providing abortion care commented that “CTOPA is progressive. Key opportunities have been missed to be more progressive”. Moreover, she noted that “where progress has been made, there is a real challenge in sustaining progress” (international NGO, abortion care). In terms of being able to stop hospitals from turning migrants away a lawyer described how: “hospitals that had been notoriously refusing to offer care to some marginalised groups, including refugees

and asylum seekers, have sort of changed their tune..... For the longest time, Charlotte Maxeke hospital refused to offer services to some migrants and they expected them to pay a particular amount; and others would be turned away even though they're pregnant and living with HIV, which was putting the unborn fetus at risk of contracting HIV. But if they didn't have money they'd be turned away. And we've had a number of engagements with them. And it seems like they've changed. So now we no longer have many cases. So, it's usually easy now for migrants to have access to life-saving medicines such as ARVs or services related to antenatal care” (Lawyer, legal and health NGO).

Another respondent supported this positive experience:



Some clinics become more inclusive; [they] have expanded their peer education networks to reach out to communities and inner-city clinics have educators who speak non-South African languages.

Legal advisor, law clinic

The nurse from a medical NGO also described the success of training workshops in “making people [health workers] warm up” in their attitudes to migration and migrants, gender, sexuality and SRH services, such as safe abortions. She described how a workshop in Tshwane helped nurses to “...change their minds about who is a migrant and what is a migrant and what makes you migrant, and all that. So suddenly you, as a provider, you become a bit of a friendly provider” (nurse, medical NGO).

While these changes may be small in respect of the extent of the abuse and discrimination experienced by migrants, they are significant and pave the way for making access easier. In addition, a number of respondents also highlighted what they saw as a really positive response internationally to challenging the impact of the GGR, which also received support in South Africa. Noting the South African government’s support for the SheDecides Movement, a respondent indicated how this exemplifies a positive step: “So yes, the Global Gag Rule has had catastrophic effects on the continent, but in particular the global South. However, I think it’s worth then footnoting at the same time that we’ve seen tremendous responses from the international community to the Global Gag Rule. So the Global Gag Rule was reinstated in 2017 and in the same year we saw the rise of the SheDecides Movement through careful political

partnerships and collaboration at the European Union level, but also supported by progressive Southern African governments, mainly South Africa and Namibia at the time” (Member of SRJC).

Regarding policy development in relation to SRH for transgender individuals, it was described how “gender affirming guidelines” have been released recently in South Africa and have “forced discussion amongst the doctors and nurses”:



... A lot of it is happening there, again, within the medical community; and the Department of Health is having to re-learn the language and having to re-learn policy and all the rest of it. Again, we're developing very, very well, what I think is pretty good policy – internationally recognised as good policy.

Director, SRHR programme

However, there was also scepticism expressed about how attitudes would change and the healthcare facilities would effectively respond to the SRH needs of the transgender communities. Capturing the concern that a failure to implement would effectively mean more progressive laws but repressive practices, a director also noted:

Ultimately it is this perspective which reverberates through all of the themes here and illustrates the extent to which respondents believe South Africa finds itself in a quagmire. On the one hand there is a framework of impressive laws and policies reflecting, at least on paper, an inclusive and progressive response to “making SRHR more accessible and more dignified as a service” (doctor, women's health clinic/CGE) – for both citizens and non-citizens. On the other, there are the realities of entrenched and pervasive levels of stigmatisation, discrimination and violence that not only heighten the vulnerabilities faced by migrants in accessing SRHR but erode the protective and progressive framework. Thus the realities of SRHR for migrants seem to be moving in the wrong direction or, as a nurse in a medical NGO commented, “Every now and then we’re better, and every now and then we lose” (nurse, medical NGO).



I can tell you that it's probably not going to trickle down beyond the most extreme echelons of Department of Health. Yeah, it's certainly not gonna make its way even to the top of national or the provincial departments. So, we have exactly the same situation where, you know, we can have amazing gender guidelines and ... pronoun guidance and all the rest of it, and how to talk to your children and adolescent guidelines. And guiding everything from how to talk about hormones all the way to where to refer for the surgery ... And that's not going to do diddly squat [nothing] for 99.999% of the population.

Director, SRHR programme

Photo overleaf:

Photo by Madoda Makhobeni.



100%...
**THE AVBOB
FAMILY TREE.**
FOR 100 years,
STANDING STRONG
FOR OUR PEOPLE.

studio

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11

Making SRHR a reality

*Photo above and left:
A woman going by the pseudonym of Josephine
Kasongo and her baby Kasendwe in their one-
bedroom flat. Photo by Madelene Cronjé.*



11.1 Making SRHR a reality



...Well, it would be disingenuous for any policy maker to think that by neglecting a migrant or any other specific key population, that we are doing ourselves any good. It would be disingenuous to think that we'd be able to realise the SDGs without expanding services to this sort of population. So, there's definitely no chance of realising the fullest aspiration of the SDGs which is underlined by the principle of "leaving no-one behind" – to think that one can undertake policies and a public policy and programming which doesn't cater to people who are migrants, refugees, drug users, LGBTQTI population...

Policy officer

This report provides an in-depth picture of the current experiences of access challenges and the (lack of) provision of SRHR for cross-border migrants in South Africa. Focusing on the intersections and entanglements of migration, gender, health and SRHR, the report examines how intersecting vulnerabilities impact on SRH needs, access to services and the treatment/services available through bringing together various sources – a review of existing literature; the legal and policy framework in South Africa (and in the region, on the continent and abroad); and the experiences and perspectives of key stakeholders working in migration and SRHR.

Overall, the report argues that understanding the complex intersections of migration, gender and SRHR in the South African context can help to recognise not only the current challenges and barriers to care but, critically, map what needs to be done to make access to SRHR a reality for migrants in South Africa. It also shows many of the complexities that currently exist and how key SRHR continue to be violated, made unobtainable and are a source of prevailing stigma and marginalisation, despite being protected by law in South Africa.

The report shows how abortion in particular remains a politicised issue and that the diluted and contested support for CTOPA has not only limited access to abortion provision – which is very central to SRHR – but also led to heightened risks, particularly for migrant women.

As the quote above indicates, people's options are limited by the failure to ensure that

- rights are known;
- there are advocates for rights; and
- healthcare providers and others can respond sensitively and urgently to SRH needs and rights.

Ultimately, this leads to the picture painted in this report of a healthcare system that is both progressive and inclusive in law, and repressive and exclusive in practice. Given the importance placed globally, continentally and regionally on SRHR as a part of obtaining SDGs and UHC, this is a concerning and urgent situation.

Therefore, where SRHR are far from a reality for all – for citizens and non-citizens in South Africa – it is clear from the review of literature and policies and from the key findings, that for migrants, SRHR are even further away. This is to the extent that migrants, and especially migrant women, are forced to negotiate, navigate and find alternative ways of accessing care, often leading to greater vulnerabilities.

11.2 Conclusion

Findings identify **three key issues** that currently limit the ability of refugees, asylum seekers and migrants to access quality SRH services in South Africa:

(1)
pervasive structural – also known as indirect – violence;

(2)
challenges in the public healthcare system; and

(3)
ineffective policy and programmatic responses.

Structural – or indirect – violence occurs when there is no specific person directly harming another. This can result from social structures and institutions causing harm or disadvantage to certain population groups through political or economic power. This unequal distribution of power results in unequal life experiences. Such violence can also be driven by social prejudices, such as xenophobia, racism, homophobia and sexism (Galtung, 1969; SaferSpaces, 2022a; Weigert, 2008).

In the South African context, anti-foreigner sentiments, judgement around abortion and unplanned pregnancies, and homophobia are just some of the key drivers of structural violence that manifest in political processes and the poor implementation of protective policies.

Public healthcare system challenges include difficulties faced when trying to access a safe termination of pregnancy, i.e. abortion. Pervasive stigmatisation and moralisation of abortion and sexuality compounds the challenges involved in accessing quality SRH services. This has been exacerbated by the impact of the Mexico City Policy – also known as the Global Gag Rule (GGR) – and the Covid-19 pandemic.

Policy and programmatic challenges include an overall de-prioritisation of SRH and a failure to engage with migration and the needs of specific migrant groups, including refugees and asylum seekers. This is undermining efforts to respond to SRHR and to meet key global commitments, including the SDGs of Universal Health Coverage (UHC).

Mapping the trajectory of SRHR in South Africa shows how structural violence – including discrimination on the basis of migration status, gender orientation and sexual identity, and the prevailing stigmatisation of abortion– has undermined key SRHR, especially the right to bodily autonomy.

Additionally, the report shows how the impact of the Covid-19 pandemic has amplified existing challenges, while presenting new ones, and has exposed missed opportunities to improve responses to SRHR. This is an emergent finding, however, given that the research was conducted during the pandemic and in advance of significant evidence as to the long-term impacts of the pandemic. For this reason, the impact of the pandemic on SRHR among migrant populations is implicit throughout the report, and recognised as an issue that warrants further research. This is particularly important when considering future pandemic preparedness planning.

11.3 Recommendations

Findings identify **three key issues** that currently limit the ability of refugees, asylum seekers and migrants to access quality SRH services in South Africa:

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Building on previous calls to do so (De Gruchy & Vearey, 2020, 2022; Vearey et al., 2017), recommendations centre on the development of a **migration-aware approach to SRHR** – a whole-healthcare system response whereby population movement is embedded as a central concern in the design of interventions, policy and research. This will contribute to progress towards Goal 3 of the SDGs that aims to “ensure healthy lives and promote well-being for all at all ages”, specifically 3.7 that ensures **universal access to SRH** and 3.8 that calls for **Universal Health Coverage (UHC)** (UHC 2030, 2017; United Nations, 2015a).

To achieve this, a focus on three of the six key **Health System Building Blocks** (World Health Organization, 2007b) (World Health Organization, 2007a) is needed, as illustrated in Figure 8. Details for suggested actions are presented in Box 6 and Box 7.

Block 1: Leadership and Governance

A multi-sectoral approach is needed, that recognises migration as a key determinant of health – and that is led by the National Department of Health (NDoH). This can be achieved through establishing an inter-sectoral National Migration & Health TaskTeam (N-MHTT) with the mandate to implement a migration-aware approach to SRHR. This will involve: building alliances across sectors within and beyond government (Vearey et al., 2019); and the development, implementation and continuous evaluation of migration-aware responses to SRHR.

Block 2: Health Service Delivery

This would include working towards the implementation of the NHI and the use of the recently published WHO Global Competency Standards for Healthcare Workers on Migration and Refugee Health (World Health Organization, 2021a, 2021b, 2021c). This should ensure that migrant populations have equitable access to quality SRH services that are rights-based, culturally appropriate and gender-responsive.

Block 3: Financing

This would entail promoting UHC through implementation of the NHI.

Finally, and most difficult to achieve, is a whole-of-government and **whole-of-society response to address underlying structural violence**. This includes addressing access to secure livelihood activities; anti-foreigner sentiments and xenophobia; stigma and moralising in relation to gender identity, sexual orientation and pregnancy. To do so ‘requires political changes in society, as well as changes in structures and patterns that govern people’s lives’ (SaferSpaces, 2022). Political accountability and the will to pursue change is a pre-requisite. Without this, attempts at reducing structural violence will fail.

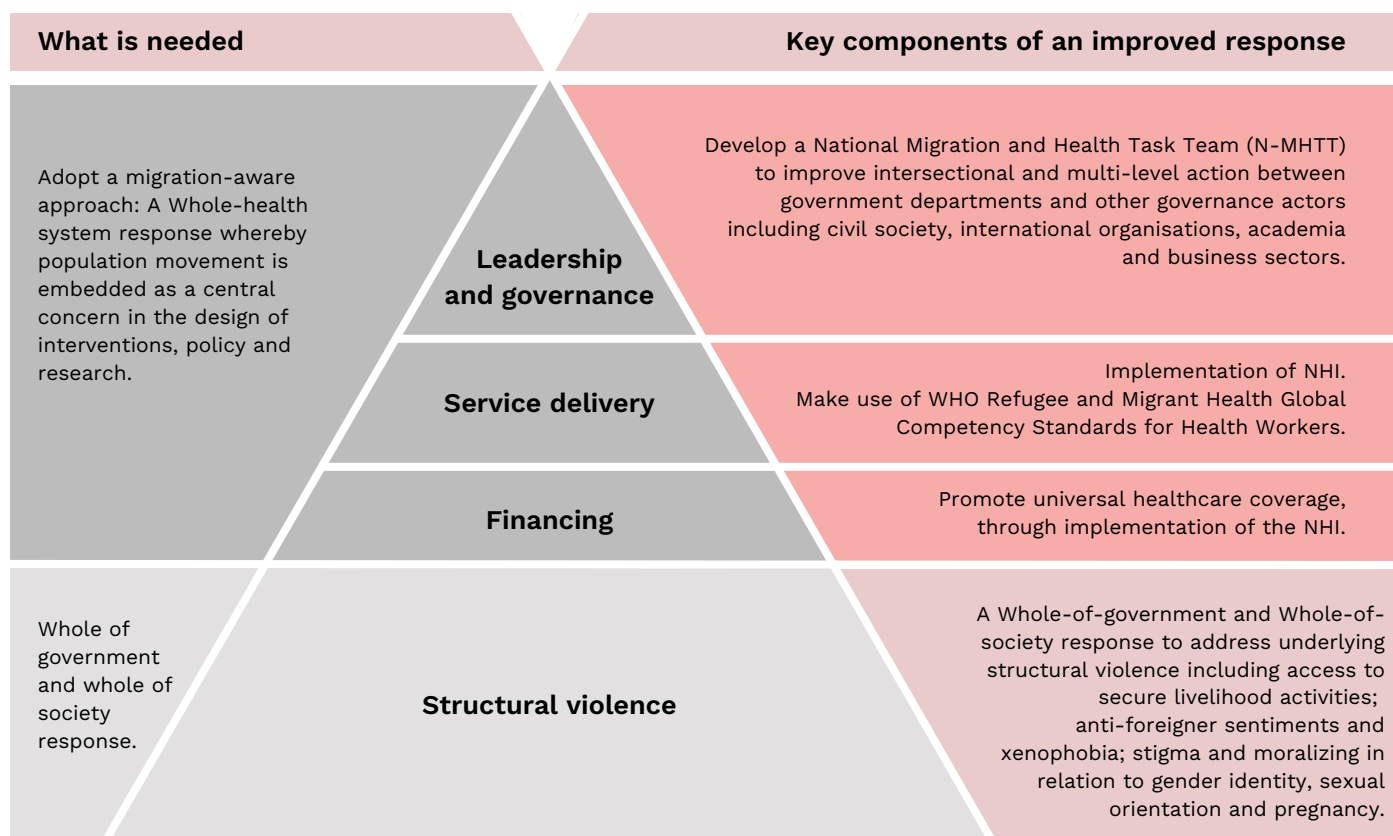


Figure 11: Realising the SRHR of migrants, refugees and asylum seekers in South Africa

What is needed

Establish an inter-sectoral National Migration & Health Task Team (N-MHTT) to build alliances across sectors, increase co-ordination, development, implementation and continuous evaluation of migration-aware responses to SRHR. Membership should include: National government National Department of Health (NDoH): electronic data systems/health information systems; logistics; district healthcare Department of Social Development (DSD): access to social security nets Department of Home Affairs (DHA): address asylum application backlog; improve refugee status determination process; firewall development; training International organisations South African civil society Migrant-led organisations Migrant health forums Cross-border forums Researchers: Continued assessment of SRHR response; support to development of score card, including monitoring and evaluation mechanisms.

Create a basic 'score card' to guide SA in developing, and effectively implementing, a migration-aware response to health, with dedicated indicators for SRHR. Key indicators should include actions to support health system strengthening in (1) Leadership and governance; (2) Health service delivery; and (3) Financing. Suggested indicators include: Immediate Functioning N-MHTT, including regular meetings, reporting mechanisms, terms of reference for members, partnership with migrant-led networks. Evolving research agenda to inform the development and implementation of appropriate responses. Support and lessons from local-level responses and co-ordination, including in cross-border areas. Medium-term A migration-aware NHI. Local-level responses to migration and SRH, and including in cross-border areas. Long-term A National Migration and Health Policy and Action Framework.

First steps

Coordinate development of a N-MHTT, in collaboration with the NDoH. Apply a 'Whole of Society' and 'Whole of Government' approach. Update mapping of key actors, identification of key policy documents and processes. Advocate for establishment of local-level migration & health task teams within existing district health planning systems/local community health forums. Improve access to documentation for all non-citizens.

Buy-in from NDoH to develop and implement monitoring system & accountability measures, in partnership with civil society. Draw on the ambitions of UHC and the GAP for the Health of Migrants and Refugees to ensure that migration is embedded within all health responses. Build on good practice examples previously documented including: migrant health forums.

Box 6: Recommendations for developing a migration-aware response to realising the SRHR for migrants in South Africa (de Gruchy and Vearey, 2022; Vearey et al., 2017)

Box 7 (overleaf): Developing a migration-aware response to SRHR in South Africa requires health system strengthening and addressing structural violence (Vearey et al., 2017; World Health Organization, 2007a)

Examples of Actions Needed

Health System Strengthening

Leadership and Governance

- Develop a multi-sectoral approach that recognises migration as a determinant of health, based on the principle of 'equity and health in all policies'.
- Establish a National Migration and Health Task Team (N-MHTT) comprising technical focal points from key government and non-governmental agencies that would contribute actively to a migration-aware healthcare system response.
- Strengthen networks between different stakeholders - such as national, provincial and local Migrant Health Forums (MHFs) - inter-sectoral forums that involve civil society and state structures.
- Provide outreach to share information about the public healthcare system and about ways to access care for cross-border migrant.
- Develop a whole-of-government, comprehensive, consultative and evidence-based approach to develop a National Migration and Health Policy Framework.

Improve service delivery

- Adopt a migration-aware approach: a whole-health system response whereby population movement is embedded as a central concern in the design of interventions, policy and research.
- Strengthen and ensure that primary healthcare reform initiatives integrate a migration-aware response as a key feature.
- Ensure that responses to migration and mobility are integrated into the existing healthcare system to avoid institutionalising social exclusion, to ensure quality control, and to guarantee sustainability and scale-up of responses.
- Develop tailored interventions to meet the needs of certain migrant groups, where evidence indicates this is necessary.
- Work to implement a co-ordinated regional response to cross-border migration and SRH, with an emphasis on ensuring continuity of access to SRH services regardless of immigration status.
- Scale-up pilot projects and tested interventions to support access to SRH services for migrants.

Financing

- Reduce financial barriers to healthcare by limiting out-of-pocket payments and promoting universal coverage, through implementation of the NHI.
- Use equity-oriented health impact assessments to help articulate the relationship between policy measures, health outcomes, costs and benefits.

Address Structural Violence

Improve and implement existing policies addressing individual and institutional discrimination, education, employment, social protection, housing, environment and health services for migrants and host communities. Reduce barriers to the formal labour market for cross-border migrants. Improve access to affordable and secure housing for migrants, particularly in urban and peri-urban spaces. Strengthen prevention, treatment, care and support programme for migrants, through participation in existing national interventions.

Building on previous calls to do so (De Gruchy & Vearey, 2020, 2022; Vearey et al., 2017), recommendations centre on the development of a **migration-aware approach to SRHR** – a whole-healthcare system response whereby population movement is embedded as a central concern in the design of interventions, policy and research. This will contribute to progress towards Goal 3 of the SDGs that aims to “ensure healthy lives and promote well-being for all at all ages”, specifically 3.7 that ensures **universal access to SRH** and 3.8 that calls for **Universal Health Coverage (UHC)** (UHC 2030, 2017; United Nations, 2015a).

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12

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*Photo above and left:
Photo by Madoda Makhobeni.*



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12.2 Appendix A: Glossary

Abortion

“Refers to the termination of a pregnancy; this can either be induced purposefully or occur spontaneously (usually referred to as a miscarriage). Induced abortions can be performed either safely or unsafely, legally or illegally, using a variety of methods depending on the gestational age of the embryo/foetus, legal barriers, and resources available. Safe abortions are always performed by skilled and trained professionals in a formal medical setting (sterilized etc.) with modern equipment and medicine. In contrast, unsafe abortions are performed by unskilled individuals, using hazardous and non-sterile equipment or chemicals, often in unsanitary facilities” (World Health Organization, 2022a).

Asylum seeker

An individual who is seeking international protection. In countries with individualized procedures, an asylum seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum seeker will ultimately be recognized as a refugee, but every recognized refugee is initially an asylum seeker (International Organization for Migration, 2022).

Contraception

“...Contraceptives help reduce the chance of pregnancy by creating either a hormonal or a physical barrier. It is important to note that most contraceptives do not protect against STIs. Safety and service delivery of contraceptive methods and on ensuring human rights in contraceptive programs are very important” (World Health Organization, 2020).

Gender

“The roles, activities and attributes that a society considers appropriate for men and for women (i.e., the different qualities associated with being masculine or feminine). Gender is distinguished from ‘sex’, with the latter referring to biological characteristics associated with men and women (such as sex organs, chromosomes and hormones)” (Marnell, 2021: p228-9).

Gender-based violence

“Any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private” (UNFPA, 2019, v).

LGBT

An acronym used to refer collectively to lesbian, gay, bisexual and transgender persons.

LGBTQI+

An acronym used to refer collectively to lesbian, gay, bisexual, transgender, queer and intersex persons. The plus symbol is added in recognition of fluid and shifting sexual/gender identities that may not be adequately described by the other terms (UNHCR, 2021).

Mexico City Policy

Also referred to as the Global Gag Rule, this is a policy of the US government that refuses funding to foreign NGOs that advance or conduct abortion as a method of family planning in USAID recipient countries. The policy applies to both primary recipients and NGO sub-recipients (Population Research Institute, 2017).

Migrant

“...While there is no formal legal definition of an international migrant, most experts agree that an international migrant is someone who changes his or her country of usual residence, irrespective of the reason for migration or legal status. Generally, a distinction is made between short-term or temporary migration, covering movements with a duration between three and 12 months, and long-term or permanent migration, referring to a change of country of residence for a duration of one year or more” (United Nations, 2022).

Migration-aware health response

“A whole-system response whereby population movement is embedded as a central concern in the design of health interventions policy, and research” (Vearey et al., 2017:93).

Refugee

“...Refugees are persons who are outside their country of origin for reasons of feared persecution, conflict, generalized violence, or other circumstances that have seriously disturbed public order and, as a result, require international protection” (United Nations, 2022).

Reproductive health

“... the complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes” (UNFPA, 2021).

Reproductive rights

Reproductive Rights (RR) are the rights of all individuals, to attain the highest standard of reproductive health possible, and to decide freely over their own reproductive capacities without discrimination, coercion, or violence (Staggenborg, 2001).

Sexual identity

How a person understands themselves in relation to their sexual, emotional and romantic attractions. A person’s sexual identity and sexual behaviours are closely related to their sexual orientation, but are distinguished as separate concepts: identity refers to an individual’s self-perception of their sexuality; behaviour refers to their actual sexual practices; and orientation refers to their overall sexual, emotional and romantic attractions (Dillon et al., 2011).

Sexual orientation

An enduring pattern of sexual, emotional and romantic attraction (i.e. whether a person is primarily attracted to people of the opposite sex, the same sex, both sexes or neither sex) (Rokach and Patel, 2021).

Sexual health

“...A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled” (World Health Organization, 2006a).

Sexual and reproductive health (SRH)

“...a state of complete physical, mental and social well-being in all matters relating to sexuality and the reproductive system” (UNFPA, 2018).

Sexual and reproductive health and rights (SRHR)

SRHR are fundamental human rights that are related to sexual and reproductive health. These include issues like HIV and other STIs, abortion, maternal health rights, contraceptive access, gender-based violence, discrimination and stigma. The support of SRHR means equality for those communities that are treated unfairly such as women, girls, migrants and others who are discriminated against living the lives they want (World Health Organization, 2022c).

Sexuality

“...A central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.” (World Health Organization, 2006a).

Transgender (or Trans)

An umbrella term for anyone whose internal experience of gender doesn't match the sex they were assigned at birth (cf. cisgender). Transgender people may experience discomfort or distress due to their gender not aligning with their sex and therefore wish to transition to the gender with which they identify (Marnell, 2021b).

Undocumented migrant

Non-citizens who are currently without the valid documents required to be in the country legally (IOM, 2011).

Xenophobia

The fear or hatred of that which is perceived to be foreign or strange. In South Africa, it is often expressed as anti-migrant sentiments, discrimination and violence, including anti-migrant policies and practices by state officials and agencies (IOM, 2011).

12.3 Appendix B: List of KIs

Participant	Organisation	Position	Location	Type of organisation	SRHR Action Area
1	International Organization for Migration (IOM) Southern Africa	Regional coordinator: SRHR & migration	Regional	International organisation	Implementation: migration & SRHR
2	AIDS & Rights Alliance for Southern Africa (ARASA)	Programme leader	Regional	Regional NGO	Advocacy
3	Marie Stopes	Marketing specialist	South Africa	International organisation	Implementation: SRHR
4	Sonke Gender Justice [now Health Justice Initiative]	Community trainer	South Africa	Regional NGO	Implementation: SRHR
5	Frontline AIDS	Senior advisor: SRHR & gender	South Africa	International organisation	Advocacy, research, implementation: SRHR
6	Victoria Hospital: SRH clinic	Operations manager	South Africa	Public hospital	Government SRH service
7	Bhekisisa	Journalist	South Africa	International organisation	Research
8	SECTION27	Legal researcher	South Africa	National NGO	Research and policy

Participant	Organisation	Position	Location	Type of organisation	SRHR Action Area
9	Victoria Hospital: SRH clinic	Operations manager	South Africa	Public hospital	Government: SRH services
10	African Centre for Migration and Society (ACMS)	Researcher	South Africa	National academic organisation	Research: migration and health
11	Graça Machel Trust (GMT)	Researcher	Regional	Regional NGO	Research
12	United Nations Population Fund (UNFPA)	Public health specialist	Regional	International organisation	Implementation: SRHR
13	Independent Activist	Activist	South Africa	Local NGO	Implementation: sexual health
14	SECTION27	Legal researcher & activist	South Africa	National NGO	Research, policy & advocacy
15	Ipas Partners for Reproductive Justice	Country director	South Africa	International organisation	Implementation: SRHR
16	DISA Health Care	Researcher/sexual health advisor	South Africa	Private clinic	Research: SRHR

Participant	Organisation	Position	Location	Type of organisation	SRHR Action Area
21	Consortium for Refugees and Migrants in South Africa (CoRMSA)	Advocacy officer	South Africa	National NGO	Implementation & advocacy: SRHR and migration
22	ACMS/Sonke Gender Justice [now Health Justice Initiative]	Researcher	South Africa	National NGO	Research
23	United Nations Population Fund (UNFPA)	HIV specialist	Regional	International organisation	Implementation: SRHR
24	Sexual and Reproductive Health and Rights African Trust (SAT)	Regional and youth policy officer	Regional	Regional NGO	Implementation: youth and young people/ advocacy
25	Women's Legal Centre	Legal expert	South Africa	National NGO	Legal & policy, advocacy
26	Sexual and Reproductive Justice Coalition (SRJC)	Policy analyst	South Africa	National organisation	Research
27	Ezintsha, Wits University	Divisional director	South Africa	National academic institution	Research
28	African Centre for Migration and Society (ACMS)	Researcher	South Africa	National academic institution	Research: migration and health

