Sexual and reproductive health and rights in selected migration-affected communities and migration corridors in East and Southern Africa

An in-depth analysis of policies, needs, barriers and rights to services

February 2018
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Recommended citation:
FOREWORD

The migration processes in East and Southern Africa (ESA) generate different streams of migrants. The sexual and reproductive health (SRH) of these migrants, as well as that of their hosting communities, is affected by the interplay of various structural, environmental and individual factors. Unfortunately, there is a dearth of information on SRH outcomes and access to SRH services among migrants in the migration-affected communities and corridors of ESA.

Existing studies and reports on the links between migration and health in ESA emphasise health concerns such as Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (Aids), tuberculosis (TB) and risky sexual behaviour among migrants in affected communities along transport corridors. It is also generally recognised that the reproductive and maternal healthcare needs of female and male migrants are not being met.

Improving access to quality sexual and reproductive health and rights (SRHR) services can be a challenge, especially among migrants who live on the fringes of larger communities. Meeting the SRH needs of migrants in developing countries is thus recognised as being complex and possibly more challenging than in developed countries as a result of developing countries’ already weakened healthcare systems. Even in developed regions, there are substantial gaps in the provision of SRHR to migrants, especially in relation to perinatal care and HIV screening. For migrants to receive adequate SRHR services, there must be a conscious effort by national and regional bodies to understand the specific SRH needs of migrants and to design appropriate policies and frameworks that deal either solely with the SRHR of migrants or policies that offer considerable attention and focus on the special needs of migrants in general.

In response to the United Nations Sustainable Development Goals (SDGs), this study provides an in-depth analysis of the healthcare needs and barriers to SRH services and rights among migrants and mobile populations in five selected migration corridors in ESA: Busia in Kenya, Karonga and Mchinji in Malawi, and Musina and Tembisa in South Africa. It analyses the incorporation of migrants’ rights into national and regional SRHR policies, and provides scientific evidence to inform programmes and policies to improve access to and use of SRH services, and to protect migrants’ SRHR in ESA.

This report serves as a call to action for stakeholders involved in national SRH and family planning strategies, policies and programmes to advocate for the SRHR of migrants and mobile populations in ESA and to engage in dialogue for the inclusion of migrants’ SRH needs and vulnerabilities in such strategies, policies and programmes. It focuses specifically on the importance of ensuring that issues such as language and cultural barriers, the absence of public education and outreach activities for migrants in isolated areas, as well as many other issues that have been identified in the findings of this report, are considered when developing appropriate national and regional strategies.

Mr Charles Kwenin
Regional Director for Southern Africa
International Organization for Migration
ACKNOWLEDGEMENTS

The authors recognise the fact that they have many people to thank for their contribution to this report. They also greatly appreciate the contribution of the following organisations and individuals for their dedication and technical guidance in the development of the project:

- The African Population and Health Research Center (APHRC): Dr Chimaraoke O. Izugbara, former senior research scientist, and Mr Stephen K. Mulupi, former research officer, as well as the entire APHRC team, both in the office and in the field. Special mention is made of Mr Edmond Madhuha, who coordinated the data collection and entry in Malawi and South Africa, and Mr Winstoun C. Muga, research assistant.
- The Urban Research and Advocacy Centre (URAC): Mr Mtafu Manda and his team.
- The International Organization for Migration (IOM): Ms Nkechi Obisie-Nmehielle, who managed the research project from its conceptualisation to the finalisation of data, as well as all the members involved in the Partnership on Health and Mobility in East and Southern Africa (PHAMESA II) programme, which has just been concluded. Special mention is made of Dr Erick Ventura, Ms Sunday Smith, Ms Kerry Kyaa, Dr Francis Mulekya Bwambale, Ms Rachelle Francisco and Ms Michela Martini, who are thanked for their technical guidance and review of the report.
- The School of Public Health, University of the Witwatersrand, Johannesburg, South Africa: Members of the Technical Reference Group, particularly Dr Latifat Ibisomi, for his valuable time and technical guidance throughout this project.

Furthermore, the authors wish to express their gratitude to the Swedish International Development Cooperation (SIDA) for their generous financial support to the PHAMESA programme and the IOM. The authors also acknowledge the financial contribution of the Dutch-funded Sexual and Reproductive Health and Rights Project for its support in the editing and layout of the final report.

Finally, the authors acknowledge the study participants, especially the migrants, for providing the information needed to achieve the objectives of this report. Without their input, this research would not have been possible.
EXECUTIVE SUMMARY

Background

The ESA experiences a complex mix of migration streams – both forced and voluntary, and regular and irregular flows. The majority of these migrants live at the margins of host communities. The problems of these migrants are compounded by intersecting inequalities such as low levels of education, income and employability skills, to mention a few.

The plethora of challenges they face substantively constrain their access to critical life-sustaining services and resources. Of particular note is their poor access to healthcare services, including SRH services. Given that migration flows are dominated by young people in the greatest reproductive brackets, offering reliable SRH services may be an important means of averting the many risks associated with poor sexual health practices and behaviour.

Inspired by instruments, policies and resolutions that seek to improve the health of migrants, the IOM, through the PHAMESA programme, implemented a project aimed at improving the standards of physical, mental and social wellbeing of migrant and migrant-affected populations in ESA.

The specific study objectives were as follows:

- Identify SRH vulnerabilities among migrants and non-migrants in migration-affected communities and migration corridors in ESA
- Identify specific SRH needs and barriers to services and rights among migrants in migration corridors in ESA by migration status, age group and location type
- Determine to what extent available policy instruments facilitate equitable access to SRH services for migrants/mobile populations in ESA and identify the gaps
- Gather stakeholder opinions on ways to strengthen policies and monitoring of SRHR access among migrant/mobile populations

Methodology

A mixed-method research strategy was used to gather data for five major migration corridors in ESA: Busia in Kenya, Karonga (on the Malawi-Tanzania corridor) and Mchinji (on the Malawi-Zambia border) in Malawi, and Musina (on the South Africa-Zimbabwe border) and Ekurhuleni (on the transport route from Lesotho, Swaziland, Malawi, Mozambique and Zambia) in South Africa. Data-gathering techniques included a desktop review, key informant interviews (KIIs) and household surveys. Participants included women and men aged 15 to 49 years. Quantitative data was obtained through random sampling, while qualitative data was obtained through the purposive sampling of participants. STATA 13 was used to analyse the quantitative data, while NVivo SQR was used to interpret the qualitative data.

Desktop review

A desktop review was performed to identify gaps in SRHR policies, strategies, framework and protocols at the national and regional levels.

The researchers specifically reviewed the SRHR policies of Kenya, Lesotho, South Africa, Uganda and Zambia for the period covered by the review. Although they identified various programmes that were implemented by different institutions in the region, there was evidence of a disengagement between HIV/AIDS-related issues and the generic spectrum of SRHR. The delivery of integrated services was thus limited.

Key informant interviews

Semi-structured interviews were conducted with selected government officials, local chiefs, staff of community-based organisations, healthcare providers and representatives of the informal sector. The purpose of the KIIs was to determine the extent to which the available policy instruments facilitated equitable access to SRH services for migrants in ESA in order to identify gaps, and to determine how monitoring SRH and SRHR among migrants could be established or improved in migration-affected communities and migration corridors in ESA. These interviews revealed the opinions of stakeholders on the available policies and monitoring instruments in Kenya, Malawi and South Africa.
Household surveys
Household interviews were conducted with men and women aged 15 to 49, migrant and non-migrant. Use was made of semi-structured questionnaires to determine the specific SRH needs and barriers to SRH services and rights among populations in migration corridors in ESA, and to determine whether there were any differences in barriers or access to SRH products and services between migrants and non-migrants in migration-affected communities and migration corridors in ESA.

Findings
The following findings emanated from the research study:

- The SRH vulnerabilities of migrants and non-migrants in migration-affected communities and migration corridors in ESA were identified.
  Specific vulnerabilities that were identified in the in-depth interviews (IDIs) with migrants and the focus-group discussions (FGDs) with long-term residents in Kenya, Malawi and South Africa included the following:
  - Lack of proper identification documents
  - Inability to communicate in the local language
  - Priority given to local residents
  - Obligation to pay higher medical costs

- Specific SRH needs and barriers to services and rights among migrants in migration corridors in ESA were identified by migration status, age group and location type.
  The following barriers to services were mentioned in the IDIs with migrants:
  - Perceptions that local populations discriminate against migrants
  - Discouraging work conditions that lead to SHHR violations, such as not allowing an employee who is ill time off to go to the hospital to collect medication

- The extent to which available policy instruments facilitated equitable access to SRH services for migrants/mobile populations in ESA was determined and gaps were identified.
  Eight regional policies on SRHR issues were identified. Six of these prioritised the health of migrants and were developed between 2003 and 2015. Most of the policies also focused on Southern African Development Community (SADC) and prioritised HIV/Aids-related activities as opposed to the other dimensions of SRHR.

- Stakeholder opinions were gathered on ways to strengthen policies and monitoring of SRHR access among migrant/mobile populations.
  Key informants indicated that, despite the existence of policies, adherence to these policies was weak. The issues that were identified were exacerbated by poor coordination among implementers.

Recommendations
A number of specific policy and programmatic recommendations were made that could help to substantially improve access to SRH services and SRHR among migrants and mobile populations in ESA. These included formulating and implementing clear policies and standard operating procedures on the provision of healthcare services, increasing the capacities of healthcare officials at border points to deal with migrants, encouraging partnership and coordination between departments of Health and Home Affairs, and taking full advantage of peer groups formed by migrants in certain professions.

Some other programmatic implications were also identified based on the findings on access to and use of SRH services. These included increasing awareness of HIV testing, increasing focus on consistent and correct condom use among vulnerable groups, intensifying SRHR campaigns to increase awareness of family planning methods, and training medical personnel and the staff of government agencies on the rights of access to SRH services for all categories of migrants in ESA.

Conclusion
While the study succeeded in identifying key policy instruments that were aimed at eliminating barriers to SRH services among migrants and mobile populations, implementation gaps and unfavourable service contexts continue to exist across countries. This is especially the case for irregular and undocumented migrants.

The study also revealed challenges specific to the reproductive health of migrants. For instance, in Kenya, migrants were required to show identification cards, pay higher fees and were served after Kenyan nationals. The evidence from Malawi also showed that migrants could be deported on the basis of their health. This served as a hindrance to dissuade migrants from seeking care.

While the results of the study confirmed the general disadvantage of migrants in terms of access to services, the quantitative data highlighted unexpected commonalities and differences between migrants and non-migrants across the study countries. Evidence showed that most differences between the two groups were not significant. For instance, there were no significant differences in the percentages of sexually active female respondents who had ever used and who currently use a contraceptive method in terms of their migration status. Yet, across all countries, migrants faced a severe SRHR vulnerability to rape and sexual violence.
## ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>Aids</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>AMREF</td>
<td>African Medical and Research Foundation</td>
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<tr>
<td>AMREF-ESRC</td>
<td>AMREF-Ethics and Scientific Review Committee</td>
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<tr>
<td>APHRC</td>
<td>African Population and Health Research Center</td>
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<td>ART</td>
<td>Antiretroviral therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>EAC</td>
<td>East African Community</td>
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<td>ESA</td>
<td>East and Southern Africa</td>
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<td>FGD</td>
<td>Focus group discussion</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IDI</td>
<td>In-depth interview</td>
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<td>IDP</td>
<td>Internally displaced persons</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IOM</td>
<td>International Organization for Migration</td>
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<tr>
<td>IUD</td>
<td>Intrauterine device</td>
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<tr>
<td>KII</td>
<td>Key informant interview</td>
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<tr>
<td>LARC</td>
<td>Long-acting and reversible contraceptives</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
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<tr>
<td>NACOSTI</td>
<td>National Commission for Science, Technology and Innovation</td>
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<tr>
<td>NCST</td>
<td>National Commission for Science and Technology</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for Aids Relief</td>
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<tr>
<td>PHAMESA</td>
<td>Partnership on Health and Mobility in East and Southern Africa</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother-To-Child Transmission</td>
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<tr>
<td>RAISE</td>
<td>Reproductive Health Access, Information and Services in Emergencies</td>
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<td>SADC</td>
<td>Southern African Development Community</td>
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<td>SDG</td>
<td>Sustainable Development Goals</td>
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<td>SIDA</td>
<td>Swedish International Development Cooperation</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>SRH-HIV</td>
<td>Sexual and reproductive health and HIV</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infections</td>
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<td>SSA</td>
<td>Sub-Saharan Africa</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>URAC</td>
<td>Urban Research and Advocacy Centre</td>
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<td>VCT</td>
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CHAPTER 1: BACKGROUND

1.1 Introduction

Migration is a ubiquitous reality of today’s globalised world and a progressively important element of international economic and social development. There are about 257.7 million international migrants in the world today; that is, foreign-born residents in a country, regardless of when they entered the country (UNDESA, 2017). About half of these people (122.4 million) are women and 24.7 million are from sub-Saharan Africa (UNDESA, 2017). These figures comprise a mix of different migrant populations, such as workers, refugees and asylum-seekers.

ESA experiences mixed migration flows that originate within or transit through the region. Particular characteristics of the mixed flows include their irregular nature, the multiplicity of push factors and the differentiated needs and profiles of persons involved (IOM, 2014a). Another particular trait of migration flows in the region is the fact that most migrants use unsafe modes of transportation and smuggling networks that have implications for injury, violence (including sexual violence), exploitation and abuse (IOM, 2014a). There were 2.7 million refugees and people in refugee-like situations reported in East Africa and the Horn of Africa in 2015 (UNHCR, 2016). For instance, Ethiopia had the fifth-largest refugee population in the world, as well as the largest refugee population in sub-Saharan Africa (SSA) at the end of 2015, estimated at 736,100 people (UNHCR, 2016). Kenya, on the other hand, was the largest host of refugees in SSA in 2015, providing protection and safety to 553,900 refugees (UNHCR, 2016).

In Southern Africa, South Africa and Zambia are magnets for skilled and unskilled migrant workers from within the region and elsewhere, notably the Horn of Africa and West Africa (IOM, 2013). The rise in regular and mixed-migration flows makes the migrant population in Southern Africa diverse, including migrant workers, refugees, asylum-seekers and victims of trafficking (women and children) (IOM, 2014b). Southern Africa is often used as the staging ground for regular and irregular migration to Europe and the Americas.

Migrants experience unequal social processes. Unless there are clearly defined interventions, they might not be able to access basic services, including health services. The reality of the inequalities that migrants encounter may be exacerbated if they face a combination of legal, social, cultural, economic, behavioural and communication barriers during the migration process (Davies, Basten and Frattini, 2009). Migrant health policies aim to address, manage and protect the health of people who have moved from their usual place of residence voluntarily (such as for economic reasons) as a result of conflict or persecution (as in the case as refugees) or due to environmental disasters (as in the case of internally and externally displaced persons). The heterogeneity of migrants’ characteristics (geographic origin, conditions at settled camps, their personal and psychological state) means that they experience different health conditions and vulnerabilities, such as infectious diseases, trauma, TB and sexually transmitted infections (STIs) like HIV and syphilis (Palinkas et al., 2003).

Sexual health is defined as a state of physical, emotional, mental and social wellbeing, which is related to sexuality, not merely the absence of disease, dysfunction or infirmity. Sexual health embraces a positive and respectful approach to sexuality and sexual relationships. It also indicates the need for pleasurable and safe sexual experiences, free of coercion, discrimination and violence. This can be achieved in an atmosphere in which sexuality is either configured as a human right or takes a rights-based perspective. Sexual rights are human rights that must be acknowledged in policies that influence national laws, international human rights documents and other consensus statements that advocate for the right of all persons to be free of coercion, discrimination and violence on matters to do with sexual health and access to SRH care and family planning services, the respect of bodily integrity and the right to live satisfying, safe and pleasurable sexual lives (WHO, 2006).
Meeting the SRH needs and rights of populations can be daunting, especially when it comes to migrants who usually live on the fringes of larger communities. Meeting migrants’ SRHR needs in developing countries may also be more difficult to attain due to weak health systems. Indeed, even in many of the world’s developed regions, there are substantial gaps in the provision of SRHR services to migrants, specifically when it comes to addressing sexual health, where they tend to be limited to perinatal care and HIV screening (Keygnaert et al., 2014).

Reflecting an awareness of historical inequalities in addressing the SRH needs of migrants, the 1994 International Conference on Population and Development (ICPD) in Cairo provided an inclusive and a wide-ranging framework that acknowledged sexual health as a human rights issue. Among other things, the ICPD framework stated that for sexual health to be attained and maintained, the sexual rights of [all] persons must be respected, protected and fulfilled (UNFPA, 2004). The United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families states that “migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health” (OHCHR, 1990). This suggests that, for migrants to receive adequate SRH services, a conscious effort must be made by national and regional bodies to design appropriate policies and frameworks that deal either solely with migrants’ SRH needs, or generic policies that focus on the special needs of migrants in general. The SDG targets 3.7 and 5.6 of reaching universal access to SRH care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes by 2030, can be achieved by ensuring that SRH programmes and policies at the national and regional levels respond to migrants’ needs, while providing access to quality SRH services and products in migration-affected communities and migration corridors.

With high volumes of migration – both forced and voluntary – pervading ESA (see IOM, 2014a; IOM, 2014b), migrants’ SRH needs demand commensurate policy and programmatic attention. Building on the IOM’s PHAMESA programme objective to improve the standards of physical, mental and social wellbeing for migrant and migrant-affected populations in ESA, the proposed project aims to do the following:

- Identify gaps in existing SRHR policies and programmes in selected migration-affected communities and migration corridors in ESA
- Examine the SRH challenges migrants face, including barriers to care, access and existing programme gaps.

1.2 Conceptual framework to understand migrants’ SRH needs and barriers

The collective health needs and implications of migration are considerable (WHO, 2010). Wealth, employment, education, nutrition and historical experiences influence individual and population health. This is also true for migrant populations and host communities, where disparities in social and economic determinants of health affect their vulnerability and create adverse health outcomes (WHO, 2010). Some groups and communities – such as refugees, displaced populations, migrant workers (particularly those in an irregular situation), smuggled migrants and trafficked persons, and irregular and other migrants that face abuse or exploitation – may be particularly susceptible to the adverse influences on health, specifically those associated with migration. The application of particular health vulnerabilities to individuals or migrant communities differ in terms of place, time and person, and manifest through disparities in the availability of, access to and use of appropriate health and medical services, therapies and facilities, as well as relevant information about health (Hesketh et al., 2008).
The availability of and access to health and medical services has a major impact on health outcomes (López-Acuña, 2008). For instance, improving access to and use of maternal-child health services delivers better health outcomes (WHO, 2010). Consequently, facilitating access to healthcare primarily helps people optimise their health. Improved access to healthcare can reduce disparities in health outcomes, which relates to the link between access to healthcare services, human rights and equity in health (Norredam, 2011). According to Penchansky and Thomas (1981), access to health on a general level is the “fit” between patients and the healthcare system. More concretely, Rogers, Flowers and Pencheon (1999) define optimal access as “providing the right service at the right time in the right place”. However, access first depends on the availability of services and whether people use the facilities available to them (Gulliford et al., 2002). The use of services is often influenced by need as well as the acceptability, affordability and physical accessibility of services. The probability of using services depends on how an individual perceives their needs, attitudes, beliefs and previous experiences (Gulliford et al., 2002).

For migrants, access to healthcare is specifically hypothesised to be different following the operation of formal and informal barriers (Hall, 2006; Hargreaves, Holmes and Friedland, 2005; Norredam, Nielsen and Krasnik, 2007). Formal barriers include legal restrictions to access, which generally exist for asylum seekers and irregular migrants (Reijneveld et al., 2001; Torres-Cantero et al., 2007; Van Herten, 2003). Other formal barriers include organisational barriers (Burns et al, 2007), lack of information about available services (De Graaff and Francke, 2003; Howell, Barnett and Underwood, 2001), lack of referral between services and lack of specific services for migrants (De Graaff and Francke, 2003; Visser et al., 2005). Healthcare personnel might have different attitudes to migrant patients, compared with non-migrant patients, due to xenophobic attitudes or perceptions that migrants are more “demanding” (Michaelsen et al., 2004). Informal barriers to healthcare access can be divided into questions of language, communication and socio-cultural differences to do with health beliefs and behaviour. Access to healthcare services will often be influenced by a complex interaction between these factors (Howell et al., 2001). Issues related to patient stigmatisation, language barriers, and doctors’ passive bio-psycho-social approach to migrants (Nielsen, 2005) therefore affect healthcare service delivery. User ignorance might also affect recently arrived migrants’ access to care, or that of migrants who have received no introduction to the healthcare system.

In terms of access to healthcare, Andersen (1995) developed a model of access to healthcare over several decades that brings together the roles of the environment, population characteristics and health behaviour indicators (see Box 1). Environmental aspects address the healthcare system and the external environment. Here, the healthcare system encompasses policies, resources and organisation. The external environment concerns general legal and political frameworks of society. Population characteristics address predisposing characteristics, enabling resources and needs. Predisposing characteristics are socio-demographic factors (including ethnicity and migration status), health beliefs and genetic factors. Enabling resources focus on financial means and insurance status. Finally, there must be a perceived need: the problem must be sufficiently important for the person in question to seek professional help. Environment and population characteristics are seen as determinants of health behaviour. This includes personal health practices (diet, exercise, self-care) and the use of health services (type, site, purpose, time interval). These health behaviours result in subjective and objective health outcomes. Andersen’s model lacks specific provider characteristics, such as communication skills and cultural competencies, which are naturally of paramount importance in a multicultural setting. However, researchers using the model perceived provider characteristics that belong to the healthcare system (Norredam, 2011). Additional factors include push factors, travel experiences and migration status (see Box 1). Available evidence on migrants’ access to health services in Africa reveals that migrants face numerous challenges despite government commitments (Shaeffer and Human Rights Watch, 2009) and push by agencies that want to ensure migrant access to healthcare (IOM, 2016). In the case of South Africa, these challenges include inadequacies in the Department of Home Affairs, which result in delays in documenting refugees and asylum seekers, placing them in a precarious state with regard to their legal status. The lack of documentation has, at times, resulted in the denial of services (Shaeffer and Human Rights Watch, 2009), which is in contravention of the government’s policy on the right
of all migrants, whether documented or not, to access health services. Other challenges that affect access include discrimination by some health workers who report undocumented migrants to the authorities for deportation, extra-legal user-fees charged for services that are subsidised by the government or are expected to be provided for no fee, such as antenatal care and access to antiretroviral therapy (ART). Another barrier is the lack of adequate and accurate information, compounded by language barriers, especially among migrants who do not speak English and are not provided with interpreters at health facilities. Migrants are ignorant of the health risks they face, as well as their rights to healthcare, which results in poor health outcomes among migrant communities. Lastly, survivors of sexual violence often lack information on available services. The fact that healthcare providers are required to report rape before treatment discourages many survivors from seeking treatment for fear of deportation, especially among the undocumented (Shaeffer and Human Rights Watch, 2009). All these barriers delay or discourage migrants from seeking healthcare and result in poor health outcomes.

Furthermore, the PHAMESA programme has a range of research activities, including situational analyses, assessments and surveys, that document how the migration process and the social determinants of health affect the health of migrants during their movement across ESA (IOM 2017a). The bulk of PHAMESA’s research documents the effect of social determinants on migrants’ health at different migratory phases. IOM has published its migration and health research on spaces of vulnerability, such as urban informal settlements, transport corridors and sea ports, which address health vulnerabilities for migrants in those settings.

Box 1: Analytical framework on understanding barriers, meeting needs and achieving access to SRHR

<table>
<thead>
<tr>
<th>Environment</th>
<th>Cross-cutting population characteristics</th>
<th>Health-seeking behaviour</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>External environment at destination</td>
<td>Individual/household characteristics</td>
<td>Migration status</td>
<td>Achieved SRHR outcomes</td>
</tr>
<tr>
<td>□ Migration policy</td>
<td>□ Gender</td>
<td>□ Non-migrant</td>
<td>□ SRHR needs</td>
</tr>
<tr>
<td>□ Healthcare system</td>
<td>□ Age</td>
<td>□ Regular migrant</td>
<td>□ SRHR knowledge, attitudes and practices</td>
</tr>
<tr>
<td>□ Availability of services</td>
<td>□ Educational attainment</td>
<td>□ Irregular migrant</td>
<td>□ Perceived SRHR risks</td>
</tr>
<tr>
<td>□ Social exclusion</td>
<td></td>
<td>□ Mobile population</td>
<td>□ Cultural ideology</td>
</tr>
<tr>
<td>□ Discrimination/exploitation</td>
<td></td>
<td></td>
<td>□ Prior SRHR experiences</td>
</tr>
<tr>
<td>□ Migrant’s legal status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Cultural compatible services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Duration of stay at destination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-migration factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Push factors in origin: conflict, traumatic, governance failure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Social, physical and cultural distance to destination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Demographic and epidemiological profiles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel conditions/experiences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Perilous modes or otherwise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Trauma/abuse (sexual abuse, rape)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Lack of health services, including SRHR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Duration of journey</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.3 Study objectives
Building on the objective of the IOM’s PHAMESA programme to improve the standard of physical, mental and social wellbeing for migrant and migrant-affected populations in ESA, the aim of the proposed study is an in-depth analysis of existing policy instruments, needs, barriers and rights to services and products among male and female migrants and non-migrants aged 15 to 49 years in migrant-affected communities and migration corridors in ESA.
Specific objectives include the following:

- Identify SRH vulnerabilities among migrants and non-migrants in migration-affected communities and migration corridors in ESA
- Identify specific SRH needs and barriers to services and rights among migrants in migration corridors in ESA by migration status, age group and location type
- Determine to what extent available policy instruments facilitate equitable access to SRH services for migrants/mobile populations in ESA and identify the gaps
CHAPTER 2: METHODOLOGY

2.1 Study design

A mixed-method research strategy was used, which included the following elements:

1. A desk review to identify gaps on SRHR policies, strategies, framework and protocols at the national and regional levels

The desk review was conducted in February and March 2017 to identify regional and national policies, protocols, frameworks and practices related to migration and SRHR in ESA. The review also focused on past and current interventions to address the SRHR of migrants in ESA. Ethiopia, Kenya, Rwanda, Somalia, South Sudan, Sudan, Tanzania and Uganda were the focus countries in the eastern region, while Botswana, Lesotho, Malawi, Namibia, Swaziland, South Africa, Zambia and Zimbabwe were the focus countries considered for the southern region.

The review covered both governmental and non-governmental policy instruments that were designed for or with specific policy prescriptions that address the SRHR of migrants: voluntary, internally displaced persons (IDPs) and refugees. In each country or region (where available), the review focused on the most current and operational policy or document dealing with SRHR programmes and services. Relevant contents were extracted into a matrix of year, document title, applicable country and whether the policies emanated from state institutions or non-governmental organisations (NGOs). The researchers were particularly interested in policies that highlighted any component of SRHR services (reproductive health in general, family planning, unsafe abortion, HIV, gender-based violence, maternal and child health services) for migrant populations as a marginalised population. Documents did not necessarily have to be designated solely for migrants before inclusion. The following key search terms were used in documents: “migrants”, “migration”, “refugees”, “internally displaced persons”, “mobile population”, “humanitarian”. Where these terms were identified, the researchers undertook a closer examination to understand the context of the application.

2. Key informant interviews

Semi-structured interviews were conducted with selected government officials, local chiefs, staff of community-based organisations, health providers and representatives of the informal sector to determine the following:

- The extent to which available policy instruments facilitate equitable access to SRH services for migrants in ESA and the gaps that could be identified
- How monitoring SRH and SRHR among migrants could be established or improved in migration-affected communities and migration corridors in ESA.

Health providers were specific about the challenges they experienced in offering SRH services to migrants and how those challenges could be resolved.

3. Household survey with women and men aged 15-49, followed by in-depth interviews and focus-group discussions

Household interviews, using semi-structured questionnaires, were conducted with men and women aged 15 to 49, migrant and non-migrant, to determine the following:

- The specific SRH needs and barriers to SRH services and rights among populations in migration corridors in ESA
- Differences, if any, in barriers or access to SRH products and services between migrants and non-migrants in migration-affected communities and migration corridors in ESA.
In-depth interviews complemented the household survey. These interviews were conducted with identified migrants in households and migrant workers, such as truck drivers, sex workers and traders along national borders. The aim of the interviews was to determine the migration experiences of the interviewees, including SRHR challenges and health-related or other challenges encountered along the migration path. Focus group discussions with non-migrants enabled the researchers to gather further insights on challenges faced in accessing SRH products and services in selected study sites, and the perceptions of migrants on specific challenges that they face.

2.2 Selected study sites

The PHAMESA programme identified five migration-affected communities and migration corridors that were selected for key informant interviews and household surveys:

- The Busia border in Kenya (with migrants from Kenya and Uganda)
- The Malawi-Tanzania border (Karonga)
- The Malawi-Zambia border (Mchinji)
- Musina in South Africa (with migrants from both South Africa and Zimbabwe)
- Ekurhuleni Municipality (the urban centre that links with Lesotho, Swaziland, Malawi, Mozambique and Zambia)

2.3 Data collection procedures

2.3.1 Quantitative data collection

A random sample of households in each study site (Busia, Karonga, Mchinji, Musina and Tembisa) was selected for interviews in the quantitative survey using a systematic sampling technique. A mapping exercise identified the locations with the maximum number of migrant residents per household. Within each location, a systematic sample of households was selected based on the total number of households in each location, using the formula below:

\[ F_{ij} = \frac{\text{Total households in cluster} (N_{ij})}{\text{Sample size per cluster} (n_{ij})} \]

For the \( j \)th cluster in the \( i \)th region, with total number of households in the cluster and a required sample size \( n_{ij} \).

In each cluster, a landmark starting point was identified and the interviewers visited every \( f_{ij} \)th household for interviews. If an interview was not successful, the survey team visited the next household. All eligible household members were invited to participate in the survey.

Fieldworkers were recruited and trained to collect data for the proposed survey in each survey site and were closely supervised by senior researchers. When identifying quantitative interviewers, preference was given to fieldworkers who were familiar with the target communities and fluent in the local languages, as well as national languages. All fieldworkers were trained in the study instruments and tools, best practices in the administration of the instruments, and ethical protocols to be followed during and after
fieldwork. Roleplay was used to develop fieldworkers’ understanding and familiarity with the tools. A field-based data quality system was developed and implemented to ensure high-quality data collection. Spot checks minimised data manipulation and falsification. Field supervisors reviewed all questionnaires for completeness prior to submission. Questionnaires with fieldworker errors were returned for verification before the final tools were transmitted to APHRC. All completed questionnaires were transferred to a centralised data-entry location to be processed. Data was captured and stored on an SQL server and later transferred to Stata® for further management and analysis.

2.3.2 Qualitative data collection

Participants were sampled purposively, based on their knowledge and experiences relating to the study’s objectives. Depending on the sensitivity of information sought, key informant interviews, in-depth interviews or FGDs were conducted with the relevant participant groups. Targeted participants include migrant or mobile individuals, local government administrators, community-based organisations involved in the provision of SRH services and those that provide legal aid for immigrants, such as local healthcare providers (public and private).

The qualitative data collection was done by trained collectors drawn from the countries in which the interviews took place. Specific interview guides were developed for key informant interviews, in-depth interviews and FGDs. The guide topics focused on study objectives and included sociodemographic details, experiences in accessing SRH services, perception of service quality and opinions on how access to services could be improved. The interviews were conducted in quiet, private places and recorded with participant consent. FGD participants were homogenously grouped in groups of eight according to gender and age. Data was collected to the point of theoretical saturation – the point at which no new information emerges.

2.4 Data management and analysis

Stata 13 was used to conduct quantitative data analysis. Indicators and outcomes of interest at different levels were defined and estimates produced based on all collected data, disaggregated by migration status (migrant or non-migrant), sex (male or female), age group (15 to 24 years or 25 to 49 years) and migration type (migrant worker, student, family and others).

Qualitative interviews were transcribed verbatim using Microsoft Word to accurately capture the participants’ opinions. Transcripts were stripped of participants’ identifying information to enhance confidentiality. Data was analysed using NVivo SQR software, using a thematic framework approach. These themes were based on the interview topics.

2.5 SRHR focus areas

The study focused on the following SRHR areas:

- Access to HIV/AIDS and other STI services for prevention, care and treatment, including prevention of mother-to-child transmission (PMTCT) services, voluntary counselling and testing (VCT) services, continuity of care and treatment, correct and consistent condom use, pre-exposure prophylaxis and uptake of HIV/STI testing
- Access to high-quality SRH services by women, including access to contraception or family planning services, pregnancy care and post-abortion care
- Access to age-appropriate adolescent SRH services, including access to youth-friendly SRH health facilities, family planning services and products
2.6 Ethical considerations

Ethical approval and research clearances were sought and obtained before implementation of the study from the African Medical and Research Foundation Ethics and Scientific Review Committee (AMREF-ESRC), the National Commission for Science, Technology and Innovation (NACOSTI) in Kenya, the National Commission for Science and Technology (NCST) in Malawi, and the Human Research Ethics Committee (non-medical) of the University of the Witwatersrand in South Africa.

Several measures were taken to minimise potential harm to the survey respondents. Training fieldworkers minimised process risk and ensured that interviews were conducted in a suitable, comfortable, private environment. The fieldworkers listened and observed without displaying judgmental attitudes towards the informants and/or the information received. They were trained in the meaning and process of informed consent, the importance of protecting participants’ privacy and the confidentiality of obtained information.

Given the sensitive nature of the information gathered, protecting and respecting informants’ confidentiality was a critical consideration throughout the study. Data was uploaded from collectors to a central data repository at APHRC, where all files are maintained on a secure server and dedicated computer system. Identifiers (name and residence) collected for recruitment procedures were removed from all analytical datasets.

Participants were provided with information about the study before any consent to participate was sought. They were adequately informed about the purpose of the study and the methods to be used, the institutional affiliation of the researchers, any anticipated indirect benefits and lack of direct benefits, such as material compensation, the potential risks and need for follow-up of the study, potential discomfort, their right to abstain from participating or to withdraw at any time without reprisal, and all measures taken to ensure confidentiality of information. All participants provided signed, informed consent or assent.
CHAPTER 3: EXISTING POLICIES ON MIGRATION AND SRHR IN ESA

The review identified several existing policies on migration and SRHR in ESA at the regional and national levels.

3.1 Regional programmes

At the regional level, the following policies address one or other aspect of SRHR in ESA:

3.1.1 The SADC Declaration on HIV/Aids, 2003 (referred to as the Maseru Declaration)

The Maseru Declaration was adopted by the Heads of State of 14 countries (Angola, Botswana, Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Namibia, Mozambique, Swaziland, South Africa, Seychelles, Zambia, Zimbabwe and Tanzania), largely drawn from the SADC region with the intention of combatting and reversing the spread of HIV/Aids as part of broader efforts towards development. The document recognises the need to enhance regional initiatives that advance access to HIV prevention, treatment, care and support for the highly mobile populations living along national borders.

3.1.2 The Regional Integrated Multisectoral HIV and Aids Strategic Plan 2007–2012

This initiative covered five countries: Kenya, Burundi, Rwanda, Tanzania and Uganda. It was devised to tackle the burden of HIV/Aids, which was highly prevalent within the East African Community (EAC). Although the plan appropriately mentioned the influx of refugees from unstable neighbouring countries, it failed to offer a specific strategy to deal with this population. However, the plan mentions the need to implement innovative approaches in service provision for migrant workers, particularly those in agricultural plantations and institutions of higher learning.

3.1.3 The SADC Policy Framework on Population Mobility and Communicable Diseases

The SADC Policy Framework on Population Mobility and Communicable Diseases was developed in 2008. It underscores the relevance of protecting the health of cross-border migrants with regard to communicable diseases, including HIV/Aids. The specific focus of the policy includes regional harmonisation and coordination, equitable access to health services by cross-border migrants, coordinated regional public health surveillance and epidemic preparedness, information, education and health promotion for migrants, operational research and strategic information, and legal, regulatory and administrative reforms.

3.1.4 The Sexual and Reproductive Health Strategy for the SADC Region 2010–2015

This strategy was amended in 2008 by the 15 SADC countries. It covers wider elements of SRHR, such as antenatal care, school-based assessment and postnatal care, family planning, the prevention of unsafe abortions, the prevention and treatment of STIs, the integration of HIV/Aids and SRH services, the treatment of sub-fertility and infertility, the prevention of female genital mutilation and the prevention of gender-based violence. In seeking to offer these broad-based SRHR services, the policy identified key target populations for significant attention. Among these were mobile and cross-border populations and displaced persons. Refugees and IDPs were, however, not mentioned in delineating vulnerable populations with concrete policy objectives and targets.
3.1.5 SADC HIV and Aids Strategic Framework (2009–2015)

This framework forms part of the general quest of SADC member states to improve the health of their citizens, focusing on HIV/Aids due to the high prevalence of the disease in this region. Direct policy actions in the framework intended to address HIV/Aids among migrant populations, including a review of policies affecting migrant workers, the monitoring and evaluation of workplace programmes in key sectors, including industry, mining and construction, and collaboration between member states in the development of harmonised policies. Overall, the policy prioritised HIV prevention among migrants.

3.1.6 SADC Policy Framework on Population Mobility and Communicable Diseases

The policy framework was formulated to coordinate the development of clear policies and programmes to deal with communicable diseases among migrants in the region. Specific gaps to be filled by the policy included the following:

- Inadequate harmonisation and coordination in the areas of disease management guidelines, port health services, cross-border referrals and disease control across borders
- Difficulty in accessing health services for communicable diseases when crossing borders
- Inadequate disease surveillance and epidemic preparedness
- Inadequate information, education and participation of mobile people
- Inadequate operations research and sharing of information on the dynamics between population mobility and communicable diseases in the region
- Legal and administrative barriers in accessing healthcare among migrants.

3.1.7 Sexual and Reproductive Health Business Plan for the SADC Region 2011–2015

The conceptualisation of this business plan was informed by the SADC Sexual and Reproductive Health Strategy for the SADC region for the period 2006 to 2015 (SADC, 2012). This strategic plan aims to achieve a healthy sexual and reproductive life for all citizens living in the SADC region. The business plan is therefore positioned to support the realisation of the changes envisioned in the strategic plan. It is grounded on the comparative regional advantages of SADC to advocate and influence the envisaged changes. In effect, the business plan gives expression to the SRH strategy referenced above. One other important feature of the plan is that it adds value in helping member states in the region to achieve the important targets that have been agreed upon regarding SRH. Nevertheless, because this cannot be done without resources, one of the priorities of the plan is to mobilise resources to help member states achieve the set SRH targets. It is important to underscore that, despite the fact that some progress has been made in the region, critical challenges tend to compromise the achievement of key SRH imperatives. One of the challenges relates to the underfunding of the SADC Secretariat, which, in turn, compromises efforts to address and meet regional SRH targets. This also impacts on monitoring, evaluation and capacity-building activities for member states. Thus, member states will need to strengthen the capacity of the SADC Secretariat by providing it with enough funding.

3.1.8 HIV and Aids/STI and TB Multisectoral Strategic Plan and Implementation Framework 2015–2020

This plan lays out the strategic intentions of the East African Community HIV and Aids programme for the period 2015–2020 (East African Community Secretariat, 2015). The plan is aimed at reducing the incidents and mitigating the impact of HIV, TB and STIs in order to secure sustained socio-economic development in the region. It has very ambitious targets: to reduce new cases of HIV, TB and STIs by 60%, 50% and 50%,
respectively, by 2020; to reduce HIV and TB-related mortality by 75% by 2020; and to increase access to and the utilisation of integrated HIV, TB and STI services by 50% in 2020.

In order to achieve these targets, the plan has outlined five key areas of focus:

- Access to integrated, high-quality HIV and Aids, TB and STI services and commodities in the EAC region must be improved
- Regional programmes targeting mobile, vulnerable and key populations must be established and implemented
- EAC research and a knowledge-management platform for evidence-based programming must be established
- A good governance, leadership and stewardship framework must be established in the EAC region
- Regional alternative and sustainable financing models for HIV and Aids, TB and STIs must be established.

In order to be able to implement this plan successfully, the EAC and member states will be guided by the following principles: a rights-based approach, a gender transformative approach, respect for the autonomy of the partner states, country and regional ownership, equitable regional capacity enhancement and multi-sectoral accountability.

3.1.9 Continental Policy Framework on Sexual and Reproductive Health and Rights

This framework was developed as a response to the call for the reduction in maternal and infant mortality on the African continent, and the mainstreaming of sexual and reproductive health and rights in primary healthcare as a means to achieve health-related Millennium Development Goals (MDGs). One of the facets of the framework addresses sexual and reproductive rights. It looks into “Africa and the International Consensus on Sexual and Reproductive Health and Rights” and the need for unifying national, subregional and continental efforts to promote reproductive health and reproductive rights into a top-priority flagship programme of the African Union (African Union Commission, 2006). The issues and challenges in reproductive health and rights acknowledged various broad categories such as the demographic situation, maternal mortality and morbidity, infant and child mortality, contraceptive use, unsafe abortion, STDs and HIV/Aids, adolescent reproductive health, female genital mutilation, sexual and domestic violence, and health budget allocation. A detailed discussion of each of these issues is contained in the policy framework (African Union Commission, 2006).
Table 1: Regional SRHR policies in ESA

<table>
<thead>
<tr>
<th>Title of policy</th>
<th>Country</th>
<th>Year</th>
<th>Level</th>
<th>Prioritises SRHR of migrants or refugees</th>
</tr>
</thead>
<tbody>
<tr>
<td>SADC Declaration on HIV/Aids, 2003 (referred to as the Maseru Declaration)</td>
<td>SADC</td>
<td>2003</td>
<td>Regional</td>
<td>Yes</td>
</tr>
<tr>
<td>Continental Policy Framework on Sexual and Reproductive Health and Rights</td>
<td>Africa</td>
<td>2006</td>
<td>Continental</td>
<td>No</td>
</tr>
<tr>
<td>Regional Integrated Multisectoral HIV and Aids Strategic Plan 2007–2012</td>
<td>EAC</td>
<td>2007</td>
<td>Regional</td>
<td>Yes</td>
</tr>
<tr>
<td>Sexual and Reproductive Health Strategy for the SADC Region 2010–2015</td>
<td>SADC</td>
<td>2008</td>
<td>Regional</td>
<td>No</td>
</tr>
<tr>
<td>SADC Policy Framework on Population Mobility and Communicable Diseases</td>
<td>SADC</td>
<td>2009</td>
<td>Regional</td>
<td>Yes</td>
</tr>
<tr>
<td>Leveraging Sexual and Reproductive Health and Rights to Reduce HIV-related Vulnerabilities in Southern Africa</td>
<td>SADC</td>
<td>2010</td>
<td>Regional</td>
<td>Yes</td>
</tr>
<tr>
<td>Sexual and Reproductive Health Business Plan for the SADC Region</td>
<td>SADC</td>
<td>2012</td>
<td>Regional</td>
<td>Yes</td>
</tr>
<tr>
<td>HIV and Aids/STI and TB Multisectoral Strategic Plan and Implementation Framework 2015–2020</td>
<td>EAC</td>
<td>2015</td>
<td>Regional</td>
<td>Yes</td>
</tr>
</tbody>
</table>

3.2 National programmes

At the national level, the review identified SRHR policies or frameworks in which specific mention was made of migrants in five countries in sub-Saharan Africa: Kenya, Lesotho, South Africa, Uganda and Zambia.

3.2.1 Kenya

Recognising that it hosts one of the largest refugee camps in the world, Kenya’s government devoted appreciable attention to SRHR for vulnerable populations in the 2015 National Adolescent SRH Policy. Vulnerable populations were defined as adolescents in informal settlements, those with disabilities, and those in humanitarian settings (refugees and IDPs) (Republic of Kenya, 2015). To deal with these vulnerable populations, the policy aimed to support the provision of disability friendly SRH information and services, and support the generation of evidence and use of data to guide SRH programming. In addition, the 2016 Kenya Reproductive, Maternal, Newborn, Child and Adolescent Health Investment Framework focuses considerable attention on the needs of migrants, especially pastoralist populations. The framework reaches nomadic and pastoralist populations with high-quality maternal and child health (MCH) services by leveraging the use of available health facilities and outreach services to supplement the services offered by fixed facilities (Republic of Kenya, 2016).

3.2.2 Lesotho

The National HIV and Aids Strategic Plan (2006–2011), which was promulgated in 2006 and revised in 2009, appreciates the magnitude of the vulnerabilities that people such as migrants face. The policy framework sought to develop social and behavioural change material that targeted key populations such as men who have sex with men, sex workers, herd boys, women and girls, and migrant workers (The Kingdom of Lesotho, 2009). To achieve this, the approach was to pursue intensive condom awareness efforts in these population groups.
3.2.3 South Africa

The National Contraception and Fertility Planning Policy and Service Delivery Guidelines (2012) provide wide-ranging strategies to address the SRHR of migrants. The strategy takes a rights-based approach that is embedded within the country’s constitution. Among other things, the policy states that all migrants should receive contraceptive and fertility planning services, and be offered language translation when necessary. Furthermore, pregnant women on PMTCT treatment should be encouraged to delay possible movements; health passports should be provided to highly mobile persons; and abused migrants should receive counselling (Republic of South Africa, 2012).

3.2.4 Uganda

SRH needs among refugees are briefly captured under priority areas in the 2004 National Adolescent Health Policy for Uganda. However, no clear guidelines or strategies were outlined to address or advance an understanding of migrants’ SRHR (Republic of Uganda, 2004).

3.2.5 Zambia

The 2007 Zambian National Policy for HIV/AIDS states that the rights of refugees should be respected, protected and fulfilled. The policy clearly stipulates that refugees and other displaced persons should receive access to affordable and preventative treatment, care and support. They should also receive mitigation services pertaining to HIV/AIDS (Republic of Zambia, 2007).

3.3 Programmes aimed at improving SRHR in ESA

Despite existing SRHR policies in regions that do not focus specifically on the peculiar needs of migrants, there are past and ongoing programmes and interventions that are aimed at improving SRHR. These interventions are generally led by NGOs. The most recent programmes include the following:

3.3.1 SRHR-HIV Knows No Borders: Improving SRHR-HIV Outcomes for Migrants, Adolescents and Young People and Sex Workers in Migration-affected Communities in Southern Africa 2016–2020

This project is being implemented by a consortium of three institutions: the IOM, Save the Children Netherlands and the University of the Witwatersrand School of Public Health (IOM, 2017b). The consortium is geared at implementing a holistic, regional project to improve outcomes related to sexual and reproductive health and HIV (SRH-HIV) among migrants (including migrant adolescents, young people and sex workers) as well as non-migrant adolescents, young people, sex workers and any other migrants in Lesotho, Malawi, Mozambique, South Africa, Swaziland and Zambia. The goal of the project is to improve SRH and HIV-related health outcomes in targeted populations in selected migration-affected communities in the SADC region (IOM, 2017b). As the researchers observed, the sustainability of the project in terms of improving SRH-HIV will depend largely on households’ and communities’ respect for the freedom of choice of the targeted population referenced above. This depends on freedom of choice about sexuality and changes in social and cultural norms that undermine the attainment of SRH-HIV rights, among other things.
3.3.2 Cross-border Health Integrated Partnership Project (2014–2019)

This ongoing project is under the auspices of FHI 360 with the support of the US President’s Emergency Plan for Aids Relief (PEPFAR). The project catalyses and supports sustainable and African-led regional health development partnerships to improve health outcomes among migrants and vulnerable communities residing along Eastern, Central and Southern African transport corridors and cross-border sites. The objectives are to increase access to and uptake of integrated health and HIV/Aids services at strategic cross-border sites and a few regionally recognised HIV transmission “hotspots” along the Eastern, Central African and Southern transport corridors, provide alternative health-financing models for the long-term sustainability of service delivery, and strengthen leadership and governance by inter-governmental institutions to improve the health of mobile and vulnerable populations (FHI 360, 2015).

3.3.3 Partnership on Health and Mobility in East and Southern Africa (2010–2017)

Led by the IOM, PHAMESA takes a wide-ranging approach to dealing with public health concerns faced by migrants and communities, particularly HIV/Aids, TB and other reproductive health needs. The programme improves the physical, mental and social wellbeing standards of migrants and migrant-affected populations in Southern and East Africa. It is implemented in 11 countries throughout the two regions. The populations of interest are migrant workers, forced migrants and irregular migrants in their work, family and community environments, with a particular focus on vulnerable populations in spaces of vulnerability, such as truck drivers or transport workers, miners, fisherfolk, cross-border sex workers and so forth. The individual and structural factors that increase the vulnerabilities of these groups are brought into focus for relevant programmatic interventions. Activities to achieve project goals include service delivery and capacity development, advocacy and policy development, research and information dissemination, regional coordination, and governance and control (IOM, 2017a).

3.3.4 Regional Outreach Addressing HIV/AIDS through Development Strategies (Roads I and II) Project (2005–2013)

This project was implemented by FHI 360 and built on the recognition that the transport corridors of East, Central and Southern Africa are major hotspots of HIV transmission. Key population targets include truck drivers, traders, business people and workers in bars and lodgings, as well as border and customs officers. The targeted populations were reached through linking communities along corridors with critical HIV/Aids and other health services by collaborating with national Aids control programmes, government ministries, district health management teams, health facilities, and local, national and international companies. Activities to improve economic opportunities and food security were also used to reduce people’s vulnerabilities to HIV/AIDS infection. Some aspects of the programme included the provision of training and technical assistance in group savings and loans, livestock management (chickens, rabbits and goats), urban and organic gardening, and microenterprise development (FHI 360, 2013).

3.3.5 The Regional Nomadic Youth Reproductive Health Programme (2012)

The programme, which was implemented in Ethiopia, Kenya and Tanzania, addressed challenges associated with improving the SRH of nomadic youth between the ages of 10 and 24 by delivering sex education for both in- and out-of-school youth, improving access to quality and youth-friendly SRH services, reducing maternal and neonatal mortality, and countering dangerous "traditional" practices (mainly focusing on female genital mutilation) (Maro and Van der Kwaak, 2012).
3.3.6 The RAISE Initiative (2006-2011)

The Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative was a partnership between Marie Stopes International and the Colombia University Mailman School of Public Health. It aimed to enhance the quality of comprehensive reproductive health services routinely provided in humanitarian settings in Chad, the Democratic Republic of Congo, Sudan and Northern Uganda. The initiative’s specific focus areas were basic and comprehensive emergency obstetric care, including training on clinical care, post-abortion care, all family planning methods and emergency contraception, sexually transmitted infection prevention and treatment, HIV prevention, VCT, PMTCT and referral, and medical response and referral for gender-based violence (Austin et al., 2008).

3.4 Conclusions

The following conclusions can be drawn from the desk review:

- In all countries targeted for review, no specific SRHR policy or strategic plan was identified as being specifically dedicated to migrants or mobile populations.
- The SRHR policies that are available at the regional and national levels do, however, address the peculiar needs/or situation of migrants, particularly among refugees.
- Attention is predominantly given to HIV/Aids-related strategies, recognising that migrants, particularly truck drivers and female sex-workers along migration corridors, are major players in HIV/Aids transmission.
- SRHR issues such as abortion and post-abortion care, antenatal care and emergency obstetric care are rarely mentioned in existing policies.
- A study conducted in South Africa indicates that policy incoherence is another obstacle to SRHR access.
- While the South African constitution is against discrimination in terms of service provision on the basis of nationality, the reality is that undocumented migrants are often denied access to social services, including health services, due to sensitive discourses on migration at national level (Mukondwa and Gonah, 2016).
- The majority of past and current programmes and interventions target HIV/Aids. In terms of programming, there are strong indications of a disconnection between SRHR and HIV/Aids. This is despite the long-standing view that inclusive systems and programmes on SRHR and HIV are more cost-effective and achieve better results.
- Virtually all current and past interventions have been fixed-term projects. The implication of this is that, while these programmes were useful at an implementation level, the fluid nature of migration means that access to and availability of programmes that are important benchmarks of advancing SRHR needs could be constrained at different times.
- The review found practically no impact assessment reports on previous interventions.
- A study conducted in Uganda to assess health services to migrants or mobile populations showed that there are limited innovative and successful programming efforts, limited funding for HIV programmes for most-at-risk populations, weak coordination arrangements, fragmented HIV programmes, weak behavioural change interventions, inadequate health services, unsatisfactory monitoring and evaluation, capacity gaps among critical players and a need to strengthen public-private partnerships in response to most-at-risk populations (Ssebadduka et al., 2009).
CHAPTER 4: STAKEHOLDERS’ OPINIONS ON AVAILABLE POLICIES AND MONITORING INSTRUMENTS

The review revealed the following stakeholders’ opinions on the available policies and monitoring instruments for three countries in sub-Saharan Africa: Kenya, Malawi and South Africa:

4.1 Kenya

According to the key informants interviewed in Kenya, the current practices related to migrants’ access to health services require any patient who presents themselves in a health facility to identify themselves through the use of an identity card. Health service providers have standard operating procedures dealing with the right to access health services, confidentiality and being treated with dignity and privacy, among other aspects that should be followed in healthcare provision.

... You need to ask that person if they have a Ugandan or Kenyan ID because you know things to do with identification is something important.

_ KII, Male, community health volunteer_

... We even have the SOPs (standard operating procedures) where you are not supposed to be discriminated against, the confidentiality issues whenever you go to a public hospital and your right to be treated with confidentiality and in a friendly environment. We know these things are there and they are supposed to be adhered to by the service provider...

_ KII, Woman, Health Programme Manager_

The health providers interviewed reported that migrants are supposed to receive SRH services, including treatment for HIV and STIs, antenatal care and delivery services, without discrimination. Since migrants are not supposed to be discriminated against on the basis of residency status, they feel encouraged to seek SRH services.

_R: They are supposed to get services like treatment of HIV, sexually transmitted infections, they are also free for care of antenatal care (ANC), delivery and –_

_M: ANC and delivery?_

_R: Mmm they are also free to be treated for any minor illness without any discrimination._

_ KII, nurse, dispensary_

_HIV services are free and that is why we have the drop-in centre there at the custom so any migrant can access that service so …_

_ KII, nurse, private hospital_

So for not discriminating these migrants we also give them morale they say if I go in that facility they don’t choose ‘oh I am Ugandan or I am Kenyan I will be given services,’ so it has given them that morale to come to the facility to seek the service, yeah.

_ KII, nurse, public hospital_
However, health managers mentioned that service providers need to deliver health services to migrants in a friendly manner and without stigma or discrimination of any kind.

I don’t know what can be done because it is not even the immigrants even us indigenous people, it is all about the government putting those commodities free for services that if someone wants to access them they can get them free of charge regardless of being an immigrant or a citizen of that country so if- and what we need to do is to just sensitize the service provider to be providing services to all people without stigma or discrimination even if you are an immigrant it is your universal right to access health services at any particular hospital. Okay that is what we need to do continue sensitizing the service provider on how to provide stigma free and friendly services to the migrant.

*KII, Programme Manager, health programme*

In terms of ways to improve on policies and practices, the following suggestions were made:

- Conducting more research to establish who requires SRH services, the size of the population and where they come from so that decisions are made based on evidence.

  Just make them available accessible and available and then we should do what you are doing and survey so that we make- we know who requires this, how many are these people, where are they from so that we make decision that is evidence based.

  *KII, woman, public health officer*

- Awareness needs to be raised among sex workers so that they know what services NGOs who work on issues such as screenings for STIs, TB and cancer on the border offer to mobile populations in collaboration with the government.

  What I would like to say is these NGOs that have agreed to give us services especially the health services like testing, cancer screening, TB screening, STI screening those services if they did them quarterly it would be good. And then I am ready to wear that shoe of the sex worker to create awareness even through royal media services at least when an NGO comes up it knows within Busia County there is cross-border sex workers that need to access services because this is a mobile. You can find that some come from Rwanda, Burundi and joined us in Busia and the way they have joined us sometimes everyone comes with their own motive. Maybe after they access those services even when you are with them you can know how to help them. But we cannot access those services without the support of the government and those NGOs that work with the government so that is what I can say.

  *KII, woman, sex worker*

- Trained peer-educators need motivation to reach their peers with appropriate information.

  Yea we need to source for enough money, so that we can organise for all these activities. Yea we need to have we need to have this eh, the activities like the tournament match, football match tournament, the ones that I was telling you, we need to have tug of war, we need to have VCT-moonlight VCT. We have also trained the truck drivers eh, as peer educators, like the 60 ones. How do we maintain them? We need to motivate them so that we can have a mutual understanding and eh, retention. Yea, we have the, we have trained sixty peer educators. But to maintain them and retain them, we need also, it needs they need to be motivated.

  *KII, male, Truck Driver Association*
• The fact that migrants are required to produce their identification before they can be served at health facilities should be done away with.

I think to remove these issues maybe of asking from them the ID the identification and those they sometimes need some forms to be filled I think maybe if they remove that it will be easy for these people to access the services.

KII, woman nurse

4.2 Malawi

According to key informants in Malawi, the Immigration Act in Malawi requires every person entering the country, who is suspected of having a health condition that is dangerous to the local population, to be referred to a medical practitioner before being granted entry. Some of those health conditions include TB, leprosy, Ebola, gonorrhea and syphilis.

On knowledge of sexual reproductive policies, protocols dealing with migrants: really the Immigration Act because we are mandated to control the movement of people entering and exiting our country. So realizing that these people have various health needs, that is why it was included to say that upon entry, since we are not health experts, a person who is being suspected of suffering from a certain disease that may endanger our population, that person must be referred to a competent health officials and upon full examination and confirmation that they really don't possess those diseases we allow them entry....

KII, Immigration Department Officer

According to some respondents, the policy that ensures that migrants with infectious diseases do not enter a country is helpful to the migrants themselves, since they can be referred to medical personnel for treatment upon diagnosis.

On policies which can help migrants, the existing health policy on migrants is good because it examines the people coming in the country whether they have the right papers while coming in or whether they are exposed to diseases which they can bring here. So officer at the border are in control to give the necessary treatment if someone doesn’t have diseases.

KII, taxi rank chairman, Mchinji

There might not be specific policies or guidelines relating to migrants as far as healthcare provision in Malawi is concerned, but respondents were of the opinion that non-discriminatory health service provision ensures that migrants can receive the same level and quality of health services given to local residents.

So far the policies and guidelines that we follow are general and they don’t segregate or specify that for migrants you need to do this specifically, no there are no such policies. The same service that we offer to Malawians is the same service that we will offer to migrants if they manage to get the service, may be the only difference could be in case of an abortion because here in Malawi the policy says we can’t abort a pregnancy unless it’s medically indicated.

KII, reproductive health coordinator
In terms of ways to improve on policies and practices, the following suggestions were made:

- Incorporating health service provision for migrants into policies by specifying how migrants should be handled at all borders so that they can be streamlined in all countries with shared borders.

  On what can be done to improve the policies they just need to incorporate the concept of migrants whereby they have to specify if it comes to issues of migrants and this is how we have to handle them and if that guidance comes up, it will be easy for us to provide services because these will become like cross-border policy and even our colleagues that have bordered us they would have to be aware of these policies so that we have to be talking the same language.

  *KII, youth-friendly health services coordinator*

  On sexually reproductive health policies specifically targeting migrants, I think there are some policies that limit service provision, I think it’s an issue of the countries that we are bordering with they have to agree with our country on how best we can deal with these migrants because I know they are some people from here that are moving to Zambia and from Zambia to here, so there are some policies that do limit you how you can provide services to these migrants I feel like it’s about these two countries agreeing to say when it comes to health services there are some policies that are deliberately frustrating health service provision to migrants.

  *KII, youth-friendly health services coordinator*

- Encourage networking among organisations and institutions that implement programmes related to SRH.

  ... I hope as Mchinji, all the institutions headed by the district health office, all institutions that are carrying out programmes in relation to sexual reproductive health should meet and they strategize how best we can assist the immigrants because if we do not take this seriously maybe they can bring in certain diseases which can affect the whole country or the district. So these people have to be assisted so that even Malawians are protected from various diseases or infections that can affect them. So I can say the plan is to train the youth or other people as peer educators or community-based distribution agents. Secondly is to ensure that there is a good relationship, good partnership and good networking of all the institutions that are providing sexual reproductive health information and services so that the immigrants are assisted holistically and this should be something sustainable.

  *KII, Executive Director, Community-based organisation*

- Recruit more health officials to serve at the border, and conduct capacity-building for immigration officers in dealing with immigrant issues. There should also be a fully equipped clinic at border points where migrants can access SRH services.

  On what must be done for migrants to access SRH services: yes, as I said in the beginning we need to have health officers here at the border that are well equipped in terms of the resources they need to deliver their services and also capacity building for us officers is needed. So that when we are dealing with these issues when we come across these migrants, we really provide the necessary link to those who may help them. And also as I said already, we need to have a vibrant clinic here at the border where these services can be provided. Those I think can do better to improve issues to do with sexual reproductive health.

  *KII, Banda PRO, Immigration Department*
### 4.3 South Africa

According to key informants in South Africa, progressive policies related to service provision to migrants exist but the main issue is adherence to these policies. The policies also include clauses on non-discrimination against migrants seeking access to health services but it is evident that migrants are discriminated against.

I would say, for South Africa we do have those progressive policies but the problem is on failure to implement; they talk of non-discrimination yet we hear that non-national woman was charged to have her implant removed at the clinic so we could say in theory they do have such policies yet in practice they are still lacking.

*KII, Lawyer for Human Rights*

The number of clinics serving migrants should be increased so that they can have easier access to SRH services. As of now, there are no clinics in Matswale, Muchongo, where most migrants stay.

Yah I also think that they should increase the number of clinics so that health is next to people like here the rest of Matswale doesn’t have a clinic yet that’s where most of the migrant people are staying. They rely on a clinic in Nancefield and another one in town. In between these two there is no clinic again between Matswale and Extension 4 there next to the border, there is a location next to the border Muchongo, again there is no clinic and that’s where these migrant populations are staying so yah, to me it is a challenge.

*KII, Project Manager, CBO*

The key informants also added that migrants in South Africa meet their needs for family planning services by visiting the health centres nearest to them. However, others choose to buy smuggled family planning products on the street. For HIV testing, some migrants buy self-testing kits, others access testing at organisations that provide mobile testing services. Community health volunteers trained for HIV counselling and testing also provide information and services to migrants, especially those that work on commercial farms. Migrants usually access antenatal services from mobile clinics.

Other than going to the clinics there is no other way. For some they resort on those who would be doing illegal selling of those family planning tablets like medication is smuggled in and people buy from there because like they have this blockage to say instead of going to the clinic, I will buy from here instead. So, yah.

*KII, Project Manager Boys Shelter*

What I have noted is that, without visiting the nearest health centre there is no way they can be able to access health services. I have seen some Zimbabwean women selling family planning tablets in the street. I am not very sure but this has actually become a business for some. I haven’t researched much on this but from what I got some were saying they prefer buying those from home even if they are written “not for sale” because they react to the family planning tablets here in South Africa.

*KII, Lawyer for Human Rights*

For those ones who have money they go and buy the kits (HIV self-testing) at the pharmacies but it’s not yet popular around Musina and even the medication they buy from pharmacies but the problem is the proper administering of such medication....There is one organisation which moves around with some kits for testing, they are home-based care, when they are doing their campaign they can actually provide for people to test.

*KII, Project Manager Boys Shelter*
Yes, they do know. Like I have said, I will talk about the farms, that one I am working there. They know like I said we are working with the CHW (community health worker), the CHW are trained for HIV counselling and testing. So, they know when they reach there, the CHW is responsible for letting them know that the mobile clinic is coming on this day, we are doing this and this. But also, us we do tell them that when you want to be tested you can come for testing, when you want to do this, you can come for this, where? We are having stations. So, we tell them.

*KII, Sister, mobile clinic*

Even that one it’s like that, when you are coming for antenatal clinic, you go to that car, there is a sister like myself I am specialising in antenatal, so they know, I am working inside the car because there is a bed there, so they know. When they reach there, they tell them, this service is done here, children this side. Everybody is doing their role. ARVs there are specific people who are doing that, we can’t say for ARVs come this side, no. We test you after testing we tell you next time when you come, you come to this room.

*KII, Sister, mobile clinic*

In terms of ways to improve policies and practices, the main suggestion was coordination between the departments of Health and Home Affairs to streamline the documentation process for migrants. Most migrants are given only five days to stay in South Africa, yet they come for work and find themselves overstaying their visa allowance. In this case, they fear presenting expired documentation in hospitals due to victimisation.

Yes, and they have also to see that their policies are applicable because they say you have to go to your country of origin for you to apply for permits; people come because they are hungry they want to work and for them to be sent back to their home countries just to apply for a permit becomes a challenge. If someone is issued only five days at the border, the only plan they have is to overstay. Believe me the majority of migrants are just here illegally so they always fear to be victimised because they cannot present the required documents at the hospitals. Even in marginalised areas like the farms there is need for clinics so that people can easily access these health services.

*KII, Programme Officer, CSO*
CHAPTER 5: SRH NEEDS AMONG MIGRANTS

5.1 Migrants’ utilisation of SRH services

This section presents findings on the levels of migrants’ utilisation of SRH services to gauge where needs are. Statistics for non-migrants are also presented to give a comparative overview. Data was extracted from the household survey data. Table 2 presents details on targeted samples and response rates. The total number of individual interviews completed was 2,330 in Kenya, 1,624 in South Africa and 1,204 in Malawi.

Table 2: Household survey sample sizes and response rates

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Kenya</th>
<th>South Africa</th>
<th>Malawi</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Busia</td>
<td>Musina</td>
<td>Tembisa</td>
</tr>
<tr>
<td>Clusters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of clusters</td>
<td>46</td>
<td>65</td>
<td>7</td>
</tr>
<tr>
<td>Total number of sampled clusters</td>
<td>21</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total number of clusters participating in survey</td>
<td>21</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Cluster response rate</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Households</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of households listed</td>
<td>1,388</td>
<td>654</td>
<td>463</td>
</tr>
<tr>
<td>Total number of households where at least one person was interviewed</td>
<td>1,295</td>
<td>654</td>
<td>463</td>
</tr>
<tr>
<td>Household response rate</td>
<td>93.3%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Respondents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of eligible respondents</td>
<td>2,874</td>
<td>1,858</td>
<td>1,482</td>
</tr>
<tr>
<td>Total number of completed interviews</td>
<td>2,330</td>
<td>1,624</td>
<td>1,204</td>
</tr>
<tr>
<td>Individual response rate</td>
<td>81.1%</td>
<td>87.4%</td>
<td>81.2%</td>
</tr>
</tbody>
</table>

The locations chosen for data collection in all three countries were specifically targeted as they were assumed to have large populations of migrants either settling or in transit. However, as depicted in Table 3, migrant populations represented only 1.5% of the total sample in Malawi (18 respondents), 5.7% of the sample in Kenya (133 respondents) and 28.1% in South Africa (457 respondents). The lowest percentage of migrant respondents in Malawi was due to migrants’ refusal to report their status, despite all precautions by field interviewers to reassure respondents on confidentiality rules. The reason for the low number in Kenya can be explained by the pendular nature of migration between Uganda and Kenya in Busia. Most Ugandans who constitute the majority of the migrant population in Busia maintain homes in Uganda, as illustrated in this excerpt from the qualitative discussions:

When you go there you are told to pay- you are given for free in Kenya that is why on the health side now that our friends from Kenya had showed us Kenya, some of us started migrating they go and rent a house on the Kenyan side but during the day they come to work in Uganda. You know in Uganda we are fair because the pubs operate for 24 hours so during the day you just go somewhere, get a room and target clients the way they are drinking at the bar you look during the day. When evening comes, late at night you go to Kenya because Kenyans open their bars late so that is how we survive but on the health side Kenya is really helpful.

KII, woman sex worker, Kenya

In terms of migrant type, most migrants captured in the survey were labour migrants or migrants reuniting with their families. Most migrants had stayed for two years or more in the area where they were interviewed.
Table 3: Socio-demographic characteristics of household survey respondents

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Kenya</th>
<th>South Africa</th>
<th>Malawi</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Busia</td>
<td>Musina</td>
<td>Tembisa</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>No</td>
<td>%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>41.1</td>
<td>957</td>
<td>43.3</td>
</tr>
<tr>
<td>Female</td>
<td>58.9</td>
<td>1 373</td>
<td>56.7</td>
</tr>
<tr>
<td>Age group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15–24 years</td>
<td>44.0</td>
<td>1 026</td>
<td>35.9</td>
</tr>
<tr>
<td>25–49 years</td>
<td>55.3</td>
<td>1 288</td>
<td>62.2</td>
</tr>
<tr>
<td>Missing</td>
<td>0.7</td>
<td>16</td>
<td>1.8</td>
</tr>
<tr>
<td>Migration status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-migrant</td>
<td>92.9</td>
<td>2 166</td>
<td>57.7</td>
</tr>
<tr>
<td>Migrant, settled in area</td>
<td>5.7</td>
<td>133</td>
<td>40.3</td>
</tr>
<tr>
<td>Migrant, on transit</td>
<td>0.0</td>
<td>0</td>
<td>0.1</td>
</tr>
<tr>
<td>Missing</td>
<td>1.3</td>
<td>31</td>
<td>1.8</td>
</tr>
<tr>
<td>Migrant type (among migrants)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labor</td>
<td>33.8</td>
<td>45</td>
<td>73.4</td>
</tr>
<tr>
<td>Family</td>
<td>23.3</td>
<td>31</td>
<td>22.8</td>
</tr>
<tr>
<td>Student</td>
<td>2.3</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>Visitor</td>
<td>0.0</td>
<td>0</td>
<td>0.2</td>
</tr>
<tr>
<td>Refugee</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Tourist</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Others</td>
<td>2.2</td>
<td>2</td>
<td>0.7</td>
</tr>
<tr>
<td>Missing</td>
<td>39.1</td>
<td>52</td>
<td>0.7</td>
</tr>
<tr>
<td>Duration of stay in the area (among migrants)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than a month</td>
<td>2.3</td>
<td>3</td>
<td>4.3</td>
</tr>
<tr>
<td>1 month to less than 1 year</td>
<td>28.5</td>
<td>38</td>
<td>18.2</td>
</tr>
<tr>
<td>1 to 2 years</td>
<td>12.7</td>
<td>17</td>
<td>11.2</td>
</tr>
<tr>
<td>More than 2 years</td>
<td>55.6</td>
<td>74</td>
<td>66.1</td>
</tr>
<tr>
<td>Missing</td>
<td>0.7</td>
<td>1</td>
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<tr>
<td>Total</td>
<td>100.0</td>
<td>2 330</td>
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</table>

5.2 HIV and VCT services

With regard to HIV testing needs, findings indicate that the number of individuals who underwent testing in the selected migration corridors in the past 12 months is relatively high and, in the three countries, about 70% of these were women (Figure 1). The level of HIV testing, as expected, is relatively lower among males. There were no significant differences between migrants and non-migrants in the three countries. Insignificant differences were also observed between migrants and non-migrants by age group (Figure 2). These findings point to the fact that efforts to move to universal HIV testing in migration corridors should focus on both migrants and non-migrants.
The key informant discussions on how migrants fulfil their needs for HIV testing revealed that, in South Africa, for instance, some migrants buy self-testing kits, while others access mobile testing services.

For those ones who have money they go and buy the kits (HIV self-testing) at the pharmacies but it’s not yet popular around Musina and even the medication they buy from pharmacies but the problem is the proper administering of such medication....There is one organisation which moves around with some kits for testing, they are home-based care, when they are doing their campaign they can actually provide for people to test.

*KII, Project Manager Boys Shelter, South Africa*

Yes, they do know. Like I have said, I will talk about the farms, that one I am working there. They know like I said we are working with the CHW (community health worker), the CHW are trained for HIV counselling and testing. So, they know when they reach there, the community health worker is responsible for letting them know that the mobile clinic is coming on this day, we are doing this and this. But also, us we do tell them that when you want to be tested you can come for testing, when you want to do this, you can come for this, where? We are having stations. So, we tell them.

*KII, Sister, Mobile Clinic, South Africa*

**Figure 1: Percentage of respondents who tested for HIV in the last 12 months, by country, migration status, and gender**

![Bar chart showing percentage of respondents who tested for HIV in the last 12 months, by country, migration status, and gender.](chart.png)
Results show that 10% of respondents in Kenya who tested for HIV in the past 12 months did not receive counselling prior to the test (Figure 3). The corresponding percentages are 20% in South Africa. There were no significant differences by gender or migration status.

As the data provided by key informants reveals, findings indicate that a good proportion of migrants and non-migrants are using HIV self-testing kits (Figure 4). The proportions are higher among migrant men in the three countries (Figure 4) and among older migrants (Figure 5). HIV self-testing methods offer an option for those individuals who do not use facility-based, standard HIV testing services due to privacy concerns, stigma, transport costs or other barriers (Frith, 2007; Spielberg, Levine and Weaver, 2004). Research on HIV self-testing, (particularly oral self-testing, shows that it is not only acceptable or feasible, but can also produce accurate results and improve testing uptake (IOM, 2014a; IOM, 2014b). Self-testing options should therefore be explored to increase the rates of HIV testing among migrants, particularly men, in migration corridors.
Due to the relatively low numbers of HIV-positive individuals in the samples for Kenya and Malawi, percentages of HIV respondents on antiretroviral (ARV) treatment were only explored in South Africa (Figure 5). Findings indicate that the proportion of HIV-positive male migrants on ARV treatment is relatively higher (66.7%) than the proportion of HIV positive non-migrants (64.3%). The inverse is noted among women where the proportions of HIV respondents on ARV treatment were respectively 71.4% among migrants and 78.1% among non-migrants. However, these differences are insignificant.
Qualitative interviews with migrants in Kenya revealed that Ugandan migrants are more likely to access ARV treatment:

Okay in Uganda we don’t have enough condoms you know am a sex worker there is no way I can hide it so we usually network with the Kenyan side but it wasn’t easy to network with the Kenyan side because of these- there is an NGO in Kenya called FHI 360 that opened cross-border networking so they trained peer educators. So we got access to condoms but the NGO has worked for three years now. It came when most of us were already infected we are HIV positive but at least they empower us we get condoms from the Kenyan side and also the services we were not getting them well here in Uganda. You could go and you are told there are no ARVs so go back and go back so we were linked to Kenya whereby if you go you find that they are there.

IDI woman sex worker, 35 years, Kenya.

In Malawi, migrants reported accessing ARVs free of charge from public hospitals, which is the same in Tanzania:

As of now, I am HIV positive and I am taking ARV drugs which I get from the public hospital for free. For me, I see no difference in accessing the ARVs between Malawi and Tanzania, they are all provided to patients for free.

IDI, sex worker, Malawi

In South Africa, migrants reported difficulties accessing HIV care and treatment unless they had proper identification documents. Some also reported stopping ARV treatment due to a lack of the time needed away from work to collect the drugs.

At some point when I wanted to go and collect my ARVs, they asked for my ID for them to help me and the nurses helped me so that I could be allowed in.

IDI, woman sex worker, 19 years, South Africa
I worked for Pakistanis and Ethiopians. I had no time to even ask to go to the clinic to collect my medication. So, eventually I stopped going to the clinic and also stopped taking ARVs. But the good thing is I never got sick. When I went back they had to make me undergo the process of testing again. They took my blood and asked me to come back the following Tuesday and I did like that. I was given the same type of tablets like the ones that I had been previously taking. After some time I went back for check-up and he told me that my viral load was now better compared to the time when I had stopped taking medication; I had been having millions of virus. He told me that if I ever stopped taking my medication again he won’t ever want to be my nurse but rather he would hand me over to a rough nurse.

IDI, woman sex worker, South Africa

5.3 Family planning and other SRH services

5.3.1 Use of condom at last sex

Findings indicate significantly higher proportions of male respondents who used a condom at last sex in Kenya compared with Malawi and South Africa (Figure 7). Findings also indicate higher percentages of condom use at last sex among older respondents in all three countries. There were significant differences in condom use at last sex among younger respondents by migration type in South Africa and Malawi, with young migrants being more likely to use condoms.

Figure 7: Among male respondents, percentage who did not use a condom at last sex, by country, migration status and age group

Focus group discussions in Kenya revealed that youths face the challenge of buying condoms from shops because they shy away when sellers ask them questions that make them feel uncomfortable. Young men also face pressure from peers who taunt them for using protection when having sex. Misleading information spread in the community about the dangers of condoms is also an issue that contributes to unsafe sex. Condoms are said to cause cancer and other afflictions to the sexual organs, which makes people avoid condom use.
When you go to a place like the centre they start asking you a lot of questions you are a young child, you don’t know how to use it.

*FGD, males 15–24 years, Kenya*

Another challenge is that you can find the youth like in this area, this area they are using condoms a boy can ask you a question there is a day that you have gone to the shop to buy a lollipop and you ate with the paper?

*FGD, males 25–49 years, Kenya*

For me it’s a question and also it’s like we would like help from you because there are people from health that visited us and they were teaching about condoms and one of them I don’t know if it was a slip but he said this condom we use but it has some oil in it. This oil causes cancer, that oil has some things that causes effects in our bodies so I can say that those teachings or those views might have made a lot of people (cough) to avoid condoms.

*FGD, males 25–49 years, Kenya*

Qualitative interviews with migrants in Kenya also revealed that a challenge faced by truck drivers is a lack of information on where they can access condoms for safe sex, as well as a lack of information on the treatment of STIs:

**M:** Yes let’s say if you want something like a condom do you know where you can get it?

**R:** No

**M:** You have no information?

**R:** I have no information because I cannot go looking for that thing here.”

*IDI, male truck driver, Burundi, Kenya*

**M:** If you wanted information about let’s say syphilis here in Kenya, do you know where you can get it?

**R:** No

*IDI, male truck driver, Burundi, Kenya*

Migrants interviewed in Malawi spoke about accessing condoms at border clinics:

On how we can access reproductive health products like condoms, we sometimes collect them from our border post for free before entering Malawi.

*IDI, truck driver, Zambia*

5.3.2 Family planning services

Exposure to SRH messages through the mediums of radio, television, mobile outreach and other sources is key to improving the use of health services among women and men. Respondents were asked if they had seen or heard messages from any source on how to improve their reproductive health in the past six months, including information on how to prevent unintended pregnancies, how to live healthy sexual lives and where to go when they need reproductive health services. Findings indicate that 55% of male migrants and 40% of female migrants in South Africa had neither heard nor seen reproductive health messages in the past six months (Figure 8). The difference between migrants and non-migrants is particularly significant among female respondents. The proportion of respondents not exposed to reproductive health messages in the past six months was relatively lower in Malawi and Kenya, with no significant differences between migrants and non-migrants by gender (Figure 8). Findings by age indicate that younger migrants in Malawi were significantly more likely than older migrants to have been exposed to reproductive health messages (Figure 9).
Results show that knowledge of any family planning method is high among respondents in all three countries, with no significant differences by gender, age or migration status (Table 4 and Table 5). However, findings indicate that knowledge of long-acting and reversible contraceptives (LARC), which are proven to be more effective, is relatively lower among migrant women in Kenya compared with their counterparts in Malawi and South Africa (Table 4).
Table 4: Among migrants, distribution of respondents by family planning knowledge, by country, gender, age group and migration type

<table>
<thead>
<tr>
<th>Variables</th>
<th>Gender</th>
<th>Age group</th>
<th>Migration type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>15–24 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Labour</td>
</tr>
<tr>
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</tr>
<tr>
<td>(n = 193)</td>
<td>Any method</td>
<td>97.9</td>
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</tr>
<tr>
<td></td>
<td>Any modern method</td>
<td>97.9</td>
<td>99.3</td>
</tr>
<tr>
<td></td>
<td>Any LARC method</td>
<td>42.6</td>
<td>78.1</td>
</tr>
<tr>
<td></td>
<td>Any traditional method</td>
<td>74.5</td>
<td>67.1</td>
</tr>
<tr>
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<td>100.0</td>
</tr>
<tr>
<td>(n = 29)</td>
<td>Any modern method</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>Any LARC method</td>
<td>90.9</td>
<td>83.3</td>
</tr>
<tr>
<td></td>
<td>Any traditional method</td>
<td>90.9</td>
<td>94.4</td>
</tr>
<tr>
<td>South Africa</td>
<td>Any method</td>
<td>98.9</td>
<td>99.6</td>
</tr>
<tr>
<td>(n = 433)</td>
<td>Any modern method</td>
<td>98.9</td>
<td>99.6</td>
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<td>Any LARC method</td>
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</tr>
<tr>
<td></td>
<td>Any traditional method</td>
<td>83.2</td>
<td>77.2</td>
</tr>
</tbody>
</table>

Modern methods include intrauterine device (IUD), contraceptive pills, condoms, emergency contraceptives and vasectomy.

Traditional methods include standard days and withdrawal.

LARC-only methods include IUD.

Note: Implants were not included in the study.
Table 5: Among non-migrants, distribution of respondents by family planning knowledge, by country, gender and age group

<table>
<thead>
<tr>
<th>Variables</th>
<th>Gender</th>
<th></th>
<th>Age group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>15–24 years</td>
</tr>
<tr>
<td>Kenya (n = 2 123)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any method</td>
<td>98.7</td>
<td>98.3</td>
<td>97.4</td>
</tr>
<tr>
<td>Any modern method</td>
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<td>98.0</td>
<td>97.0</td>
</tr>
<tr>
<td>Any LARC method</td>
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</tr>
<tr>
<td>Any traditional method</td>
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<td>70.4</td>
<td>63.9</td>
</tr>
<tr>
<td>Malawi (n = 1 161)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Any method</td>
<td>98.8</td>
<td>99.1</td>
<td>98.9</td>
</tr>
<tr>
<td>Any modern method</td>
<td>98.5</td>
<td>99.0</td>
<td>98.7</td>
</tr>
<tr>
<td>Any LARC method</td>
<td>65.4</td>
<td>83.3</td>
<td>64.5</td>
</tr>
<tr>
<td>Any traditional method</td>
<td>84.2</td>
<td>86.2</td>
<td>81.3</td>
</tr>
<tr>
<td>South Africa (n = 1 169)</td>
<td>Any method</td>
<td>99.6</td>
<td>99.7</td>
</tr>
<tr>
<td>Any modern method</td>
<td>99.6</td>
<td>99.5</td>
<td>98.9</td>
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<tr>
<td>Any LARC method</td>
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<td>78.1</td>
<td>63.2</td>
</tr>
<tr>
<td>Any traditional method</td>
<td>85.1</td>
<td>76.6</td>
<td>74.8</td>
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</tbody>
</table>

Modern methods include IUD, contraceptive pills, condoms, emergency contraceptives and vasectomy.

Traditional methods include standard days and withdrawal

LARC-only methods include IUD.

Note: Implants were not included in the study.

Figure 10 and Figure 11 present the percentages of sexually active female respondents who had ever used and currently use a contraceptive method in all three countries by migration status. With regard to "ever" use, the percentage is 80% in all three countries, with no significant differences by migration status (Figure 10). However, it can be noted that sexually active female migrants in Kenya and Malawi had relatively lower percentages of "ever" use than their non-migrant counterparts. The same pattern can be observed for "current" use (Figure 11), with an observed significant difference by migration status in Kenya. Younger migrants in Kenya (40%) are significantly less likely than older migrants (62%) to be using a contraceptive method (Figure 12).
Figure 10: Among sexually active female respondents, percentage who ever used a modern contraceptive method, by country and migration status

![Graph showing percentage of women who ever used modern contraception by country and migration status.]

Figure 11: Among sexually active female respondents, percentage currently using a modern contraceptive method, by country, migration status and age group

![Graph showing percentage of women currently using modern contraception by country, migration status, and age group.]

Figure 12: Among sexually active female respondents, percentage currently using a modern contraceptive method, by country, migration status and age group

![Graph showing percentage of women currently using modern contraception by country, migration status, and age group, with additional data for age groups 25–49 and 15–24 years.]
Regarding the family planning methods used, findings indicate that female migrants in Kenya mostly use implants and injectables (Table 6), whereas female migrants in Malawi mostly use injectables and IUDs. Female migrants in South Africa mostly use injectables and daily contraceptive pills. One notable finding is that a relatively high proportion of female migrants in South Africa reported using condoms (15.2%) compared with their counterparts in Kenya (3.9%) and Malawi (6.7%). This finding might be explained by the fact that HIV prevalence is relatively high in South Africa and women migrants are more likely to put emphasis on protection against pregnancy and HIV.

Table 6: Among sexually active female migrant respondents, percentage distribution by family planning method used, by country, age group and migration type

<table>
<thead>
<tr>
<th>Variables</th>
<th>Percentage</th>
<th>Age group</th>
<th>Migration type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>15–24 years</td>
<td>25–49 years</td>
</tr>
<tr>
<td>Daily pill</td>
<td>5.4</td>
<td>0.0</td>
<td>9.9</td>
</tr>
<tr>
<td>Emergency pill</td>
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<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Male/female condom</td>
<td>3.9</td>
<td>3.4</td>
<td>4.2</td>
</tr>
<tr>
<td>Implant</td>
<td>19.4</td>
<td>17.2</td>
<td>21.1</td>
</tr>
<tr>
<td>Injectables</td>
<td>20.2</td>
<td>19.0</td>
<td>21.1</td>
</tr>
<tr>
<td>IUD</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other</td>
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<td>8.5</td>
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<td>46.5</td>
<td>60.3</td>
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<table>
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<th>Variables</th>
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<th>Age group</th>
<th>Migration type</th>
</tr>
</thead>
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<tr>
<td></td>
<td></td>
<td>15–24 years</td>
<td>25–49 years</td>
</tr>
<tr>
<td>Daily pill</td>
<td>6.7</td>
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<td>9.1</td>
</tr>
<tr>
<td>Emergency pill</td>
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<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Male/female condom</td>
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<td>25.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Implant</td>
<td>6.7</td>
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<td>9.1</td>
</tr>
<tr>
<td>Injectables</td>
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<td>18.2</td>
</tr>
<tr>
<td>IUD</td>
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<td>18.2</td>
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<tr>
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<td></td>
<td>15–24 years</td>
<td>25–49 years</td>
</tr>
<tr>
<td>Daily pill</td>
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</tr>
<tr>
<td>Emergency pill</td>
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<td>Male/female condom</td>
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<td>17.4</td>
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<td>Implant</td>
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<td>30.3</td>
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<td>5.2</td>
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<td>23.8</td>
<td>29.4</td>
<td>21.3</td>
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</table>

- = no respondents in the category
Table 7: Among sexually active female non-migrant respondents, percentage distribution by family planning method used, by country, age group and migration type

<table>
<thead>
<tr>
<th>Variables</th>
<th>Percentage</th>
<th>15–24 years</th>
<th>25–49 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya (n = 922)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Daily pill</td>
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<td>5.1</td>
</tr>
<tr>
<td>Emergency pill</td>
<td>0.8</td>
<td>1.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Male/female condom</td>
<td>8.0</td>
<td>14.4</td>
<td>4.2</td>
</tr>
<tr>
<td>Implant</td>
<td>24.6</td>
<td>19.0</td>
<td>28.0</td>
</tr>
<tr>
<td>Injectable</td>
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<td>22.4</td>
<td>26.3</td>
</tr>
<tr>
<td>IUD</td>
<td>3.4</td>
<td>2.3</td>
<td>4.0</td>
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<td>None</td>
<td>31.5</td>
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Malawi (n = 566)

<table>
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<th>Variables</th>
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<th>25–49 years</th>
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<tr>
<td>Emergency pill</td>
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<td></td>
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</tr>
<tr>
<td>Male/female condom</td>
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<td>6.5</td>
</tr>
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<td>Implant</td>
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<td>13.2</td>
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<td>Injectable</td>
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<td>18.6</td>
<td>27.2</td>
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<td>IUD</td>
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<td>4.1</td>
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<tr>
<td>None</td>
<td>34.1</td>
<td>43.3</td>
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South Africa (n = 484)

<table>
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<tr>
<th>Variables</th>
<th>Percentage</th>
<th>15–24 years</th>
<th>25–49 years</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Emergency pill</td>
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<td>3.7</td>
<td>1.2</td>
</tr>
<tr>
<td>Male/female condom</td>
<td>24.8</td>
<td>29.6</td>
<td>22.4</td>
</tr>
<tr>
<td>Implant</td>
<td>3.9</td>
<td>5.6</td>
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<td>27.3</td>
<td>22.2</td>
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<td>IUD</td>
<td>2.9</td>
<td>4.3</td>
<td>2.2</td>
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<td>24.1</td>
<td>29.8</td>
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</tbody>
</table>

With regard to knowledge of where to access family planning methods, 15% or less of the female respondents in all three countries reported not knowing where to go to access family planning advice (Figure 13). A significant difference was observed by migration status in Malawi (Figure 13), with 6% of women among migrants reporting not knowing where to access family planning advice, compared with 12% among non-migrants. Findings also indicate that younger migrants in Kenya are significantly less likely to know where to go to access contraceptive methods (Figure 14), compared with older migrants (22% as opposed to 11%), but this was also the case among non-migrants (17% as opposed to 5%).
Finally, with regards to knowledge of a youth-friendly place at which to access family planning methods among young respondents, findings reveal that 60% of non-migrant youth and 50% of migrant youth in Malawi do not know a youth-friendly place to access family planning advice (Figure 15). Findings also indicate significant differences by migration status in Kenya and South Africa. In South Africa, only 6% of youth migrants know a youth-friendly place at which to access family planning advice, compared with 32% of non-migrant youth.
Figure 15: Percentage of young respondents who know a youth-friendly place to access family planning methods

5.3.3 Pregnancy care

Antenatal care visits during pregnancy are vital to protect the lives of mothers and babies by facilitating the early identification of birth defects or complications. Findings show nearly universal levels in all three countries of at least one visit, with no significant differences by migration status and age (Figure 16). There were also no significant differences by migration status with regard to four or more antenatal visits (Figure 17).

Figure 16: Among female respondents pregnant in the last three years, percentage who had at least one antenatal care visit
Figure 17: Among female respondents pregnant in the last three years, percentage who had four or more antenatal care visits.
CHAPTER 6: SRHR VULNERABILITIES AND BARRIERS TO SERVICES FACED BY MIGRANTS

6.1 Findings

Findings related to SRHR vulnerabilities faced by migrants were extracted from data collected in in-depth interviews with migrants and focus-group discussions with long-term residents (nationals). Table 8 presents statistics on the number of interviews conducted in each country and site.

Table 8: Qualitative interview samples

<table>
<thead>
<tr>
<th>Type of interviews</th>
<th>Kenya</th>
<th>South Africa</th>
<th>Malawi</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Busia)</td>
<td>(Musina and</td>
<td>(Karonga and Mchinji)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tembisa)</td>
<td></td>
</tr>
<tr>
<td>Key informant interviews</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of interviews</td>
<td>17</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>In-depth interviews</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of interviews</td>
<td>28</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>Interviews by gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>14</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Focus group discussions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of group discussions</td>
<td>8</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Interviews by gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Interviews by age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15–24 years</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>25–49 years</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

Generally, migrants in ESA face different health vulnerabilities throughout the migratory period, starting from the onset of migration as soon as they leave their community or country of origin, through the transit period for most international migrants, until they reach their destinations. Discussions of SRH vulnerabilities mostly focused on experiences of rape and sexual violence. Migrants to Kenya, particularly sex workers, are raped by policemen who arrest them for not having the proper identification. They also face sexual rights violations by some clients who refuse to pay for services rendered and who force the sex worker to have sex with them without condoms.

Yes they force you because, like the policemen in Kenya, when you get to Kenya he arrests you and tells you let me ‘go’ with you first. So when you ‘go’ with him he lets you go then you go so you can’t refuse. That is like he is forcing you and he has tied you with a rope you cannot refuse.

IDI, migrant woman, sex worker, 27 years, Kenya
Maybe the migrants have come maybe they live somewhere and there are people who just lust after others they say that ‘I want you’ and you tell him ‘I don’t want you’ and maybe he might just force you to have sex with him and because you are a migrant there is no way you will refuse...there are people from Uganda who go around selling fruits or something like that. So they go to someone they go to like the construction site to sell the things they are selling to the construction workers. So one can get hold of her in that process and rape her.

**FGD, young women 15–24 years, Kenya**

The non-migrants interviewed in FGDs mentioned that, on top of experiencing rape and sexual violence, migrants face difficulties reporting cases of rape, since reporting means exposing themselves as illegal immigrants and, instead of receiving assistance, they will be arrested for being in the country illegally. They are also discriminated against on the basis of their nationality. Local residents in Malawi get priority in terms of assistance in issues concerning rape and/or abortion.

On issues to do with rape, migrants may be afraid to report such cases to people around due to fear of being arrested if they are illegal migrants...On the issue of abortion and rape, there is segregation. Malawians are prioritized when it comes to getting assistance by those who have been raped. If you are a Malawian you get a better treatment that than migrants.

**FGD, men, 15–24 years, Malawi**

6.1.1 *Lack of proper identification documents*

In terms of barriers to services, discrimination due to a lack of proper documentation was highly cited. Migrants in Kenya, Malawi and South Africa reported difficulties accessing care and treatment unless they had proper identification documents.

... when you go there [referring to nearby hospital] when you don’t have an ID you will not get care. They don’t care maybe on the side of HIV there when you are going for blood check-up they check you minus asking you this and this. But when you are sick someone to take care of you when you don’t have money nobody will take you because you have no money.

**IDI, migrant, business woman, Kenya**

I faced challenges on my journey on accessing medical services because it was a foreign country and I did not have identity cards. I also did not have money to buy drugs in the shops.

**IDI, asylum seeker, Malawi**

At some point when I wanted to go and collect my ARVs, they asked for my ID for them to help me and the nurses helped me so that I could be allowed in.

**IDI, woman sex worker, 19 years, South Africa**

Focus group discussions with long-term residents and KIs also revealed that migrants’ lack of proper documentation is a contributing factor of why migrants face health and reproductive health challenges.

You might have gotten pregnant when, especially the Ugandan migrants they get pregnant when they are at home and maybe they dot attend clinics so when they come here you have to present the card so you can start getting treatment. So you will find that she has gone there and she does not have a card she does not have anything. The things they want the documents at the District maybe she does not have and maybe at the midwives it has become difficult for her so it brings her problems because she does not have a card so they chase her.

**FGD, women, 15–24 years, Kenya**
Yah it’s tricky because for them to go into the hospital it’s a mentality because when they go to the hospital you find out that the nurse will say if you don’t have an ID how are we going to help you because you don’t have an ID. So for the migrant it also becomes a problem and in case of diseases like HIV and STIs you can imagine if these people are sexually active and them being human they also get involved with other people and yet maybe their health card and accessibility to medication has its kind they are shying away from it.

KII, Project Manager, boy’s shelter, South Africa

Long-term residents in South Africa mentioned that not having proper identification particularly affects migrants seeking delivery services at public health facilities. If a foreigner goes to a health facility without a maternity file, she cannot receive delivery services. On the other hand, a local resident without a maternity file will be allowed to deliver while the hospital waits for her maternity file. Migrants are usually turned away at public health facilities if they do not present the proper documentation. However, private hospitals usually offer their services as long as the patient is able to afford them.

If you forget your file and you are going into labour, they might refuse to assist you when you are a foreigner, but if you are a citizen you might get assisted and told to call someone to bring your file for you.

FGD, women, 25–49 years, South Africa

The issues at public clinics and hospitals are identification documents, but at private hospitals, as long as you have money, it is not an issue.

FGD, men, 25–49 years, South Africa

6.1.2 Inability to communicate in the local language

The second major barrier to services is related to migrants’ ability to communicate in the local language. Migrants in Kenya and Malawi reported that not knowing the local language affected their ability to explain their illnesses and obtain the appropriate assistance.

There is a very big problem when it comes to accessing health services or sexual reproductive health services here in Malawi among us truck drivers from Tanzania. The major problem is language, we fail to explain very well of our illness to the doctor when we go to the hospital here in Malawi unlike when we are in Tanzania.

IDI, truck driver, Kenya

Long-term residents interviewed in Kenya confirmed the fact the nurses and staff usually use Kiswahili and/or English, and some Ugandan migrants can only speak their local language; understanding one another thus becomes an issue. They also stressed that most Ugandans, who constitute the majority of migrants in Busia, do not speak Kiswahili, which creates a huge barrier when it comes to accessing health services or even SRH information from the radio.

When these Ugandans come to Kenya they only know English and Buganda, but Swahili it’s hard for them to understand so the things that- and many radio stations announce things in Swahili so most of the information- they miss that information.

FGD, women, 15–24 years, Kenya

I would like to contribute and say this now like in the interiors of Uganda most of them know theirs and English. So you can find someone, and there is someone who doesn’t know that English. Maybe she has come this side and she is sick and has gone to the hospital. Now the doctor only understands English and Swahili, but now this one doesn’t understand that language. So now communicating with the doctor there becomes hard.

FGD, women, 25–49 years, Kenya
6.1.3 Priority given to local residents

The third major barrier to services mentioned by migrants is the priority given to local residents in healthcare facilities.

I don’t have a problem to access family planning methods. We face challenges however sometimes when we go to the government hospital, for example there would be some cases where you would be treated badly like when there is a shortage of beds in a ward and I have been given a bed, people would be talking bad about you being a foreigner and yet you have found a bed. You would even hear some patients, perhaps out of pain, they would say “you are finishing our medicine, go back”. Some doctors would also say just wait for your turn, let me treat my friends first. So these are some of the issues that we face at the hospital.

IDI, migrant business person, Malawi

The issue of discrimination was discussed at length by non-migrants interviewed in Kenya, Malawi and, particularly, South Africa. For instance, long-term migrants interviewed in Kenya mentioned that migrants risk not being treated at a healthcare facility if they are not very familiar with where they stay. At the healthcare facilities in Kenya, every patient must indicate the exact location of their abode, up to the sub-location level. If one is not well versed with where one stays, migrants risk not being served until they can pinpoint the location and sub-location from which they come. Meanwhile, residents always get priority treatment, while migrants are served last.

So, when they are asked let us say they are married here and she goes to the health centre, they are asked which sub-location she comes from, she doesn’t know you ask her the location she doesn’t know so you see there that person will get angry and tell her to move back and he will attend to someone who knows.

FGD, men, 25–49 years, Kenya

I think we were in the challenges of immigrants, the ones they face when they go to the hospital. I think they are ever segregated or served last.

FGD, men, 15–24 years, Kenya

Long-term residents in South Africa mostly spoke about their dehumanising treatment. Migrants endure verbal abuse from nurses and general neglect, including not being given enough provisions, like blankets. Migrants are also discriminated against in terms of being allocated ARV medication as there is a general assumption by nurses at health facilities that migrants will use the ARVs as drugs and not put them to the correct use. Healthcare providers, especially nurses, are even harsh towards women migrants seeking delivery services in hospitals.

You find that they do not receive the right supplies of ARVs because these nurses assume that they will make drugs out of them and this has an influence on their reproductive health.

FGD, men, 25–49 years, South Africa

“There are so many of these challenges here. There is discrimination in terms of nationality. In the maternity ward, foreigners get abused when giving birth because they are foreigners, sometimes nurses will say there are no beds and not even provide the patient with a blanket, sometimes you find that they are not even bothered about you as they are busy on social media.

FGD, women, 25–49, South Africa
... Where you come from matters in that if you are not a South African citizen you might not receive the same level of service, sometimes they even remove the migrants from the bed and have them sleep on the floor in the maternity ward, they then give the bed to a South African citizen.

*FGD, women, 25–49 years, South Africa*

Okay, myself I faced such a challenge in 2013 when I was at the clinic about to give birth. There was a migrant there going into labour, she was in a lot of pain, they beat her with a pipe because she couldn’t push anymore, they wanted to assault me with the same pipe but refrained because I promised I would press charges once I got discharged. That’s when they realized I am a South African and they didn’t proceed to beat me. The other patient was speaking Shona and that’s why they could beat her.

*FGD, women, 25–49 years, South Africa*

When people from Zimbabwe visit the clinics, they are called all sorts of names. They are discriminated against. They are insulted and called names “those behind the ears” and there is no such thing, we are all the same. They get mistreated especially when they go into labour, they are told that they are conceiving too many children.

*FGD, women, 25–49 years, South Africa*

6.1.4 **Obligation to pay higher medical costs**

The fourth major barrier to services mentioned by migrants, with which long-term residents concurred, is migrants’ obligation to pay higher medical costs than nationals in order to receive services. In Kenya, for instance, migrants have to pay sometimes several times the normal fee for SRH services at hospitals even if the services are supposed to be free. They are also required to report to hospital for delivery with their own delivery supplies, such as gloves and cotton wool.

When you want to have this Norplant they tell you to pay Kshs.200 and when you go with a Kenyan here they don’t charge her anything but if you are Ugandan and you want to put that pay Ksh.200. Just for the injection they will tell you ‘pay Kshs.50’ and you wonder what that Kshs.50 is for and they tell you- and they even announce over the radio they tell you family planning is free so why are they charging us...

*IDI, migrant, woman salonist, Kenya*

And when you go to a hospital, you see they can’t attend to you without an ID to show that you are Kenyan and when they see that you are Ugandan they increase the amount of money to be paid.

*IDI, male salonist, Kenya*

Here in Kenya on things to do with treatment- you know when I go to the hospital here when they see my ID that I am Congolese that is it even if the medicine was 200 it will be 400.

*IDI, male Congolese, Kenya*

I decided to come to Kenya because I saw the treatment there is low but when you come to Kenya if they know you come from a different country they attend to the others first then they will attend to you later or sometimes they leave you.

*IDI, male, illegal immigrant, Kenya*
In Malawi, interviewed non-migrants reported that migrants are forced to give bribes to access health services. In addition, they have to pay for services that are usually provided free of charge. Poor migrants thus find it more difficult to access SRH services than rich migrants do.

Between Malawians and migrants, its migrants who face a lot of challenges in accessing health services in Malawi. There also rumours however that migrants give money as bribe to get health services as a result Malawians suffer or lack access to the service.

FGD, women, 14–24 years, Malawi

They are also told to pay money in government hospitals in order to access medical services failing which they are will not be assisted.

FGD, men, 25–49 years, Malawi

On sexually transmitted diseases, migrants are also discriminated. The services offered to local Malawians are not the same as those given to migrants. Sometimes those migrants who are rich find it easy to access health services in our local hospital unlike those who are poor.

FGD, men, 15–24 years, Malawi

In South Africa, long-term residents mentioned that a migrant who does not have the money to open a file at the health facility will be turned away without any treatment. Migrants also have to buy medication which is usually free.

The way migrants get treated is not the same as South African citizens. You can easily see from the way the nursing staff address the migrants, hai, its dehumanising if I may say. I have seen it, when I went to see my spouse after she had given birth, there was a migrant about to give birth, the hospital was full, a South African woman came in and the nurses removed the migrant off the bed and put her on the floor and put the South African in her place.

FGD, men, 25–49 years, South Africa

6.1.5 Other barriers to services

Other barriers to services that were mentioned include perceptions that local populations discriminate against migrants, and discouraging work conditions. Local residents in Malawi, for instance, often perceive that migrants disrupt business in the countries to which they migrate by offering cheaper goods, thereby making the profits of local resident dwindle. Therefore, they are not very welcome, even when they are seeking services from health facilities. In South Africa, local residents hold negative perceptions about migrants in terms of their inability to take care of their health or that of their children.

Also, they don’t look after themselves, they can go a week without bathing women might be on her periods and not be changing her pad, this will affect her reproductive health, it also affects the people around them in terms of odour and allergies...They don’t take care of themselves, when their kids are sick they don’t take them to the clinic, you find them sleeping at the taxi rank eating food from the garbage bins that might even be rotten, this may lead to kwashiorkor and other diseases.

FGD, women, 25–49 years, South Africa

Work conditions can lead to SRHR violations if an employee is not allowed time off to go to the hospital to collect medication. Only if an employee is seriously ill are they guaranteed time off to visit a healthcare facility.
When you ask the maguras (derogatory name usually labelled against Asians but in this case Ethiopian and/or Somalian employers) for permission to go to the clinic, you should really be sick, yet when you just want to go to collect ARV medication you won’t be necessarily that sick and they might not believe you when you say you are sick and you want to go to the clinic. So when I finally went to the clinic my friend advised to lie saying that I was taking a child to the hospital who was sick because if I speak for myself they would not believe me they would just see that I was not sick.

IDI, migrant woman, sex worker, South Africa
CHAPTER 7: DISCUSSION

7.1 Introduction

The study undertook an in-depth analysis of existing policy instruments, needs, barriers and rights to SRHR services among migrants and non-migrants in migrant-affected communities and migration corridors in Kenya, Malawi and South Africa. It used a mixed-method research approach that triangulated data from desk reviews and a random sample survey of households. It used the qualitative tools of key informant interviews, in-depth interviews and focus group discussions.

The study identified key policy instruments that were aimed at eliminating barriers to SRH services among migrants and mobile populations. However, implementation gaps and unfavourable service contexts continue to exist across study countries, especially for irregular and undocumented migrants and despite their unique health vulnerabilities due to the generally grim conditions of migration. These conditions are consistent with previous findings, which report that irregular migrants often seek medical assistance only when there is no alternate course due to mistrust or a fear of being deported or discriminated against. Because of this, they miss out on important promotive health measures such as immunisations, pregnancy care and safe childbirth (IOM, 2011a).

Further evidence on migrant health in Kenya suggests that some vulnerable groups, including undocumented migrants, are often overlooked in family planning, antenatal, delivery, postnatal and early childhood healthcare services and health promotion activities (IOM, 2011a). In a survey conducted in the migrant-affected Nairobi suburb of Eastleigh, women cited SRH barriers such as costs, language, religious beliefs, lack of trust in available services and the quality of services within reach (IOM, 2011b). There is also evidence that difficulties in accessing SRH services among the pastoralist communities in Northern Kenya is due to the fact that health systems were not adapted to mobile lifestyles (IOM, 2011a). This study shows similar findings, emphasising the fact that Kenyan policies that require identification cards for services have a detrimental effect in terms of access among migrants. Key informants in Kenya noted that policies are clear on non-discrimination, but interviews with migrants and long-term residents indicated prevalent discrimination against migrants. They are often forced to pay higher amounts for SRH services in public health facilities and yet are served after the Kenyan nationals.

In Malawi, there are clear policies that seek to prevent migrants suffering from certain diseases (TB, gonorrhoea and syphilis) from entering the country in the interest of public health, and people can be deported on health grounds (Shaeffer and Human Rights Watch, 2009). While these rules govern migrants’ entry to and exit from Malawi, the exclusion from the country of certain migrants due to their health status affects resident migrants’ access to reproductive health services. In others words, the fact that a migrant can be deported on the basis of their health status means that migrants will not access health services if it means that they could be detected and declared prohibited migrants (Shaeffer and Human Rights Watch, 2009). This study further shows that sexually assaulted migrants, particularly irregular migrants, are afraid to report cases or to ask for abortion services for fear of deportation. Migrants in Malawi also suffer from the same discrimination in service provision as migrants in Kenya as they have to pay higher costs for services and are served after the locals.

In South Africa, previous evidence indicates that ambiguity persists within the public system about refugees’ and asylum seekers’ rights to access healthcare in general and ARV treatment in particular (Shaeffer and Human Rights Watch, 2009; Amon and Todrys, 2009; IOM, 2008). Previous research conducted in South Africa observed that public health clinics and hospitals are not willing to provide services such as ART to non-citizens, including refugees and asylum seekers, because they do not have green,
barcoded identification documents (Shaeffer and Human Rights Watch, 2009; Amon and Todrys, 2009; Alfaro-Velcamp, 2017). In addition, a systematic review established that access to SRH services among undocumented adolescent migrants is poor due to diverse structural, socio-cultural and financial barriers (Mukondwa and Gonah, 2016; Hunter-Adams and Rother, 2017). The condition of migrants in South Africa has worsened as a result of general assumptions that regional migrant populations are larger than they actually are; movement of people is associated with poor health, hence the notion that foreigners bring diseases; and present regional migrants are placing an additional burden on the public health systems of destination countries (Veary, 2010). While access to healthcare is guaranteed by the South African government policy, obtaining the documentation needed to access healthcare remains a big challenge for undocumented migrants, who are scared of being identified and deported (HDN and IOM PHAMSA, 2006). This study confirms previous evidence and highlights the particular SRHR vulnerability of migrants in South Africa. Its findings clearly show that, despite progressive policies on access to services, migrants in South Africa suffer a great deal of discrimination in the form of physical and verbal abuse in healthcare facilities. This abuse is extended to migrant women in maternity wards, who are forced to sleep on the floor to give space to nationals. There is an urgent need to implement non-discriminatory service provision policies in South Africa.

Recognising that the migration corridors are largely stable communities made up of non-migrants that are indigenous or permanent residents, the study employed a random survey sampling of households in each selected site to establish the relative volume of migrants vis-à-vis non-migrants and to quantify the differences between migrants and non-migrants in accessing SRHR services. The study established that migrants constitute 5.7% of sampled households in Busia, Kenya, 5.4% in Tembisa and 40% in Musina (the latter two are both in South Africa), and only 2% of households in the Karonga-Mchinji axis in Malawi. Across all study sites, the survey generally identified settled migrant households, highlighting the limitation of the household survey methodology in identifying migrants in transit. However, qualitative study tools supplemented the sample surveys and enabled deeper enquiry into the challenges of all categories of migrants in all study sites.

While confirming the general disadvantage of migrants when it comes to accessing health services, the quantitative data highlighted further commonalities and differences between migrants and non-migrants across study countries, including evidence that most differences are insignificant. For instance, the percentage of sexually active female respondents who had ever used and currently use a contraceptive method shows no significant differences by migration status across all countries. It can also be noted that sexually active female migrants in Kenya and Malawi had relatively lower percentages of “ever” use of modern contraception than their non-migrant counterparts. The same pattern can be observed for “current” use with an observed significant difference by migration status in Kenya only. Further commonalities and differences were observed across countries in relation to the kind of services used. Female migrants in Kenya mostly use implants and injectables, whereas female migrants in Malawi mostly use injectables and IUDs. Female migrants in South Africa mostly use injectables and a daily contraceptive pill. One notable finding is the relatively high proportion of female migrants in South Africa who reported the use of condoms (15.2%) compared with their counterparts in Kenya (3.9%) and Malawi (6.7%). While this could be explained by the relatively high HIV prevalence in South Africa, which predisposes women migrants to be more likely to engage in protective behaviour against pregnancy and HIV, these differences remain significant pointers to contexts that need to be understood in order to inform policy and programme actions across ESA.

Qualitative interviews and discussions identified particular SRH vulnerabilities faced by migrants to include rape and sexual violence. In Kenya, illegal migrants avoid reporting cases of rape since reporting exposes them to the authorities for arrest on immigration charges. Migrants are discriminated against on the basis of their nationality and lack of proper documentation in Kenya, Malawi and South Africa. In South Africa, foreigners cannot receive delivery services without a maternity file, unlike local residents. They face neglect
and dehumanising treatments, including verbal abuse from nurses, and are not given enough provisions, like blankets and ARV medication supplies. Migrants in Kenya and Malawi face language barriers that hinder their ability to explain their illnesses and obtain appropriate assistance. In Kenya, migrants pay higher medical costs than nationals and often pay for free SRH services. In Malawi, migrants are forced into bribery to access health services and, as in Kenya, they are made to pay for free services. The same was true for South Africa, where a migrant who does not have the money to open a file at the health facility is turned away without treatment and made to buy free medication. Other barriers to services identified in Malawi and South Africa include negative perceptions of migrants by local populations and migrant employees that are denied time off to go to the hospital to get medication, unless they become seriously ill.

In sum, the study shows that migrants’ access to SRHR services in ESA is restricted or dependent on legal restrictions that hamper access, organisational barriers, a lack of information about available services and lack of specific services for migrants.

7.2 Study limitations

Despite the many methodological strengths of this study, especially on the representativeness of its findings, there were a number of limitations related to both its design and implementation. These must be interpreted against the backdrop of the findings presented here. By design, the selection of study sites was largely determined based on a presumed and non-imperial population of migrants, which were anticipated by a determination of the study’s sample size. However, some of the study sites did not exhibit a considerable number of migrants throughout the survey period.

Furthermore, by design, the purpose of the study was to identify a considerable number of migrants for strong comparative analysis between migrants and non-migrants. Consequently, the number of migrants identified and interviewed in households within the sampled clusters, especially in Malawi, was not large enough to provide a strong statistical comparison with their non-migrant counterparts. Notably, to safeguard the integrity of the study design, expanding the survey areas in order to gain a substantive number of migrants would have led to an over-sampling of non-migrants. Such a decision would be unnecessary, based on parsimony.

By implementation, based on the sensitivity of migration status in these study sites, especially in Malawi, some migrants were reluctant to identify themselves as “migrants”. Some did so intentionally, while others believed they were non-migrants based on the duration of their stay and their reasons for migration. Similar circumstances were noted in Busia, Kenya, although not as profoundly as was the case in Malawi, but slightly higher than was the case in the two South African sites. Additionally, most were labour migrants and often worked either in factories or farms, away from their residences. These were less likely to be found at home, and more likely to exceed the predetermined number of household revisits in this study. Notably, both the above design and implementation pitfalls affected the two Malawian sites, but provided a highly representative sample of both migrants and non-migrants in Kenya and South Africa.

In anticipation of these shortcomings, the investigators complemented the above quantitative survey design and its strong qualitative study component with a non-household, non-random and targeted recruitment of participants for this study. This additional component provided a more diverse mix of both migrants and non-migrants in order to gain more in-depth exploration of both worlds of service access challenges and how these are interrelated with individual migration status.
CHAPTER 8: RECOMMENDATIONS

8.1 Policy and programmatic recommendations

The following are specific policy and programmatic recommendations – as proposed by the key informants interviewed in the study – that could help to substantially improve access to SRH services and SRHR among migrants and mobile populations in ESA:

- Formulate and implement clear policies and standard operating procedures on the provision of healthcare services to migrants and mobile populations
- Increase the capacities of healthcare officials at border points to deal with migrants and fully equip healthcare posts at borders that have an important role to play in the provision of services to migrants and mobile populations
- Encourage partnerships and coordination between the departments of Health and Home Affairs to streamline the documentation process for migrants and mobile populations
- Take full advantage of peer groups formed by migrants in certain professions (truck drivers and sex workers) as a vehicle to provide SRH information among migrants, as well as guidance as to where to access services.

8.2 Other programmatic implications

Other programmatic implications based on findings on access to and use of SRH services include the following:

- Increase awareness of HIV testing (and take advantage of self-testing) to reach the HIV testing target of 90% among both migrants and non-migrants of the Joint United Nations Programme on HIV/AIDS (UNAIDS).
- Increase focus on consistent and correct condom use among vulnerable groups (truck drivers, sex workers and young people) among both migrants and non-migrants.
- Intensify SRHR campaigns to increase awareness of family planning methods, including where to access family planning methods and youth-friendly services among migrants.
- Train medical personnel, government agencies linked to immigration and individual migrants on the rights of access to SRH services for all categories of migrants in ESA.
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