Original Report

Accessing Adolescent Sexual and Reproductive Health Services among Undocumented Migrants in South Africa: A Documentary Review

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ABSTRACT

Adolescent sexual and reproductive health access continues to dominate the development agenda since the historic 1994 Cairo Conference and becomes a huge public health concern for the increasing diverse of undocumented adolescents who have become an important component as irregular migration patterns and profiles shifts in South Africa. The inherent nature of irregular migration poses exposure and vulnerabilities making access to sexual and reproductive health services (SRH) imperative. Findings from this study revealed that access to SRH services among undocumented adolescents migrants is poor attributed to diverse structural, socio-cultural and financial barriers. For South Africa, conflicting health and migration policies leads to inconsistencies in service provision making it difficult for both adolescents and health service providers to strike a balance between migration and health considerations. Migration remains politically sensitive with punitive measures for those in undocumented state who are subsequently marginalized and excluded from accessing all social services, health included. Health policies on the other hand are non discriminatory, employing an all inclusive approach to all adolescents irrespective of migration status. While the study demonstrated that adolescent SRH services among undocumented adolescent in South Africa may be poor, such findings are however inconclusive to suggest that SRH outcomes are also poor.

INTRODUCTION

As international migratory trends and movements shifts, reaching an all time high of 214 million of which 10-15% is estimated to be undocumented, children and youth under the age of 20 years are slowly becoming an important part of these flows.[1,2] The proportion of undocumented adolescent migrants in South Africa undertaking the perilous journey or overstaying on their visa regulations has also increased considerably. These migrants are coming from different countries, for different purposes and different lengths of stay. While the bulk of them are coming from Southern Africa , it is sudden growth of undocumented adolescent migrants from other African countries: Congo, Nigeria, Somalia, Ethiopia; as well as Asian countries like Thailand and Bangladesh, that raises a lot of concerns and implication.[1]

Of increasing concern is the finding that this diverse population by opting for the undocumented route, no adequate preparation or consideration is paid towards potential challenges likely to be faced in host countries. The inherent nature of irregular migration poses exposure and vulnerabilities making access to sexual and reproductive health services (SRH) imperative, more especially for a region known to be problematic with ASRH access.

Given the increased diversity and complexity of migrants in SA, coupled with a number of vulnerabilities, need and access to ASRH services becomes a very important issue

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for this particular group. Access is further compromised by the fact that this group is often young, geographically clustered in certain areas and the need to stay in South Africa for considerably longer periods of time. However, possible source of care for this group is within government public health agencies as access to private **sources of care is poor owing to actual or perceived costs.[3,4] Owing to this factor, access to government run health agencies becomes a central issue to explore in this study.**

METHODOLOGY

The study applied a narrative review design to a qualitative documentary research on barriers to access SRH services among undocumented adolescent migrants in South Africa, analyzing journals, articles, unpublished and published reports as well as relevant documents. Data sources included related research publications, services evaluation reports, government, international agencies (for example IOM, ILO, UNHCR, WHO) and non-government (for example, Justice Without Borders, Institute of Race relations) reports and documents and unpublished works on access to SRH services among undocumented migrants in South Africa. Following sampling strategy was applied: document searches were facilitated by the use of search engines as Medline, PubMed, The Lancet, Google Scholar, Findia, Embase and internet based public access domains, applying a Boolean search strategy to retrieve relevant research publications, "grey-literature" (internal and unpublished reports), and expert working group reports on South Africa from 1994-2015 serving as content analysis. The search terms used included: (undocumented "OR" irregular) "AND" (adolescents "OR" migrants) "AND" (reproductive "OR" sexual health) "AND" (health barriers "OR" health services access "OR" services "OR" HIV/AIDS) "AND" ("OR" health equity "OR" migration policies) "AND" (South Africa "OR" Sub-Saharan Africa "OR" SADC). Additional literature was obtained by reviewing the reference lists of retrieved publications that were relevant to the study.

The inclusion criteria considered documents /journals /reports/unpublished articles on barriers to access SRH services among undocumented adolescent migrants in South Africa written in English language, and published or produced between 1995 and 2015. As sexual and reproductive health is a broad area, publications focusing on the following issues were included; HIV/AIDS and STI's, abortion, family planning; fertility and contraceptive use, antenatal care and sexual assault.

All abstracts were excluded. Since the subject of "undocumented adolescent migrant health and access to health care" is broad, clear parameters were set to scope the review. Abstracts, studies for specific disease conditions other than SRH, studies on documented migrants were excluded.

Initially, 75 papers were identified, but 4o of these were excluded, for they did not meet the inclusion criteria. Content analysis of qualitative data was then applied to the remaining 35 documents which met the inclusion criteria, for direct or indirect factors adversely affecting access to SRH care services among undocumented adolescent migrants in South Africa. Identified barriers were subsequently classified in terms of socio-cultural, economic and structural factors.

FINDINGS AND DISCUSSION

Literature meeting the search criteria consisted of 35 publications from which 15 were "grey literature" publications consisting primarily of reports and online publications, 11 were publications from various UN Agencies, 5 were peer-reviewed publications, 3 were media publications and 2 publications by the South African Government. The unbalanced representation of literature articles which made up the study sample is evidence to the dearth of information on the scope and dimension of adolescent migration providing basis for future studies on the same area. The review also established that access to SRH services among undocumented adolescent migrants is poor due to diverse structural, socio-cultural and financial barriers shown below.

Table 1: Factor analysis table

	Structural factors N=30				Social-Cultural factors N=26				Financial N=15		
	T1	T2	T3	T4	T1	T2	T3	T4	T1	T2	T3
N(%) covered in articles per variable	25 (83%)	17 (56%)	15 (50%)	10 (33%)	19 (73%)	16 (61%)	10 (38%)	7 (26%)	9 (60%)	8 (53%)	5 (33%)
Rank	4	3	2	1	4	3	2	1	4	3	2
(%) covered in all articles when N=35	(85%)				(74%)				(43%)		

KEY

T* = Theme

Structural barriers		Socio-cultural barriers		Financial barriers	
T1	Conflicting policies	T1	Communication challenges	T1	Affordability of health related costs
T2	Legal status	T2	Community and social exclusion	T2	Exploitative working conditions
T3	Quality of services provided	T3	Challenges in cultural integration	T3	Poverty
T4	Inadequate state protection and security	T4	Lower educational levels		

Structural, socio-cultural and financial barriers are all broad categories, with many other factors falling under each of them as shown in table 1 above. Thus the ranking of these broad categories according to the frequency with which they appear in literature becomes impossible, and an inadequate measure, prompting the need to establish which of the structural, socio-cultural and financial factors were reported more frequently, and their subsequent ranking. The ranking system used in this study was thus based on an improvised Likert Scale where frequency was used as a basis for measurement in an ascending order, assigning factors with fewer citations to a lower rank and those with more citations ranked higher as shown below:

Ranking: According to frequency with which a factor was mentioned in literature

Occasionally			**Often**
1	2	3	4

Structural barriers

Structural barriers (conflicting health and migration policies, legal status, inadequate state protection, quality of services) emerged most frequently cited in 30 of the 35 reviewed articles, meaning that 85% of the literature highlighted their profound effects on ASRH access. All structural factors were then placed on a Likert scale and frequency was used as a basis for measurement. Conflicting policies were more frequently cited by 25 of 30 articles on structural barriers, giving them a total of 83% thus ranked fourth. The discriminatory nature of migration policies makes them not congruent with growing migrant health needs leaving gaps which further exposes vulnerability while health policies built on equality principle reaffirms the government's commitment towards realization of SRH to all adolescents.[5, 6, 7, 8] This conflict makes it difficult for both adolescents and health service providers to strike a balance between migration and health considerations leading to neglect of ASRH needs.

Barriers related to legal status were cited in 15 of the 30 articles with 50% and ranked second on the Likert scale. Poor legal status induces fear of arrest and deportation which drives migrants into clandestine further amplified by the absence of a child perspective within migration laws and policies which largely result in migration control taking precedence over child protection making them even prone to gross human rights violations.[7, 9] Children's rights are enshrined in the South African Constitution.[1, 10] and reaffirmed by South Africa commitment as well as obligations to several international and regional declarations, conventions and legislations relating to children. Upholding these rights within the migration context becomes a mammoth task due to the absence of adequate protective factors. Additionally, there is lack of awareness on specific rights for undocumented adolescent migrants from health service providers and the migrants themselves making it challenging to implement target specific interventions.

Barriers in relation to inadequate state protection were cited in 10 of the 30 articles with 33% and ranked first on the Likert scale. Underpinned by fragmented policy response, the plight of undocumented children remains ignored. The fact that it is not explicitly clear in South African laws especially in the Child Care Act on how this population is covered and protected leaves more loopholes for vulnerability and exploitation.[5, 11, 12] The results thus indicate that barriers related to conflicting health and migration policies were cited more often than others making them more important while barriers related to state protection were occasionally mentioned hence less important.

Socio-cultural barriers

Applying the same method shown above, socio-cultural barriers (difference in languages, culture and religion, limited education, weak social support) were mentioned in 26 of the 35 literature sources which came to 74%. Each of the key factors was also measured, with language related barriers ranked fourth on the Likert scale, as they were mentioned in 19 out of the 26 articles with 73%. Language differences emerged as a dominant theme inducing fear of improper diagnosis as well as development of distorted and biased understanding of the functioning of the health system as noted by various scholars.[13, 14] Barriers on community and social exclusion were mentioned in 16 of the 26 sources, with 61% they were ranked third. This arises from a context that to date South Africa has experienced three extremely violent waves of xenophobic attacks on foreigners. Fear of being attacked results in limited social movement, especially in public spaces and impacts greatly on SRH services given that public spaces are often seen as starting points for distribution and access. Living in exclusion and hibernation impacts heavily on community integration and weakens social support structures with potential implications on social participation in economic, social and political spheres, a pre-requisite for successful realization of SRH access. Culture related barriers were mentioned by 10 authors from 26 authors, with 38% and ranked second on the Likert scale, but were also found to be a major stumbling block on expedient access to ASRH services, with grave consequences being felt by undocumented adolescent migrants outside Southern Africa. These cultural conflicts give public health officials unjustified power to either withdraw consent to service provision. Barriers on education were only mentioned in 7 sources, with 36% and ranked first. With limited educational levels, this could impact on knowledge of service availability and services offered rendering the use of school based interventions invaluable for this migrant population. Decision making and risk taking is worsened in contexts whereby lack of education is already a barrier. The conclusion made is that language related barriers were cited more often while barriers related to education were occasionally mentioned.

Financial barriers

Financial barriers (health-related costs, poor working conditions and poverty) were mentioned in 15 of the 35 sources, meaning 42% of literature spoke of them. A breakdown down of each key factor was duly done and affordability of health related costs emerged strongly having cited by 9 of the 15 authors thus 60%. Whether these costs are real or perceived, South African public health system is denoted by the patient user principle which is however subject to various interpretations. Of particular importance is the fact that most migrants lack accurate information on how this principle is applied creating distorted images on health care costs. Exploitative working conditions was ranked second, mentioned by 8 authors and with 53%. Lack of documentation may present room for increased exploitation from unscrupulous employers who create unfavourable working conditions which may have important implications towards prioritization of ASRH health needs. Barriers associated with poverty were mentioned in 5 articles, with 33% and duly raked first. For undocumented adolescents, increasing poverty levels highlight uncertain livelihoods where priority is often placed towards pursuing economic livelihoods over health issues. The socio-economic context in turn shapes sexual behaviours and decisions whereby potential SRH needs are not considered, which can be equally disastrous especially in relation to HIV/AIDS and STIs.

CONCLUSION

Barriers in the realization of ASRH among undocumented migrants exist, whether perceived or real. The evidence

provided in this study thus indicates that access to SRH services among undocumented adolescent may be poor and such findings are however inconclusive to suggest that SRH outcomes are also poor. Taking into account this observation, it is therefore imperative that an epidemiological study on the SRH status of undocumented adolescent migrants be conducted.

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