

Sexual and reproductive health of asylum seeking and refugee women in South Africa: understanding the determinants of vulnerability

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Abstract: *Women asylum seekers and refugees face huge challenges related to their sexual and reproductive health (SRH) and rights. In this article we explore the structural determinants of vulnerability to poor SRH for these women in South Africa, and focus particularly on the political, legal and economic structures which render them vulnerable. Based on a qualitative study carried out in Durban, South Africa, we argue that it is vital to go beyond analyses which prioritise the socio-cultural barriers to sexual and reproductive health and rights for asylum seekers and refugees, and to consider the wider national and international policies and legislation which create barriers to these women's rights to SRH. DOI: 10.1080/26410397.2020.1758440*

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Introduction

This article aims to explore the structural barriers to sexual and reproductive health (SRH) care for women asylum seekers and refugees* in South Africa, to demonstrate the ways in which their right to health is undermined by these barriers, and to call for improved policies and programmes to protect them and to provide better health outcomes. Previous research has demonstrated the

ways in which asylum seekers and refugees suffer from negative health as a result of multiple factors including experiences of violence in countries of origin and transit, dangerous and traumatic migration journeys, legal and political restrictions on their status and rights, and limited access to social and health services at all stages of migration.^{2–6} When they reach a country of destination, there are still significant obstacles for them to access sufficient health care and to realise their right to health. They are often not provided with sufficient information about accessing health services and may face language barriers with lack of translators and interpreters.⁷ Those who do not have the required legal documentation may be refused treatment by health service providers.^{8,9} Increasing xenophobia and racism within host countries, including xenophobic attitudes from health care providers themselves, may also provide an obstacle to asylum seekers and refugees obtaining health care.^{10,11} However, whilst migration and health has been widely researched in terms of the dangers that it may pose to host

*There has been much debate over the use of the term “refugee”. Under international refugee law, an asylum seeker is someone who has applied for refugee status in a third country, whilst a “refugee” has been recognised and granted that status by the country in which he or she seeks international protection or by UNHCR. However, there is a growing recognition amongst researchers that this type of categorisation is utilised by policy-makers to divide and stigmatise some groups, and various scholars have thus called for the abandonment of this “fetish of categorisation”.¹ It has thus become increasingly frequent to describe all people forced to migrate by violence or conflict (or sometimes by environmental circumstances) as refugees. It is this latter definition which we adopt in this article.

countries (e.g. through the risk that migrants will propagate HIV within the host population), there is still not enough research on the health insecurities of migrants themselves, and in particular a gap in research on the ways that gender inequalities intersect with health insecurities to produce negative health outcomes for migrant and refugee women.

Research has also shown that women asylum seekers and refugees face particular challenges because of gendered structures of violence and inequality in countries of origin and at all stages of their migratory journey.¹² One area which is particularly problematic is that of asylum-seeking and refugee women's SRH, an area which is still under-researched. What little research there is has shown that these women face high maternal mortality, unmet need for family planning, complications following unsafe abortion, and gender-based violence, as well as sexually transmitted diseases, including HIV.^{13–17} Asylum-seeking and refugee women's vulnerability to poor SRH outcomes may be heightened by restrictive migration laws and policies, limited employment or income generating opportunities resulting in poverty and economic insecurity, poor housing and accommodation, and restricted access to health and social services.^{18,19} High levels of domestic violence against these women have also been noted.^{20,21} Transformations in gender norms and relations during migration, and differing gender norms in countries of origin and destination may also pose problems for these women in accessing appropriate SRH health care. There is still however a gap in knowledge concerning the determinants of asylum-seeking and refugee women's SRH, the barriers they face in achieving good SRH, and the strategies they may employ in the face of these obstacles. This article, based on qualitative research carried out with asylum-seeking and refugee women in Durban, South Africa, explores the challenges and obstacles they face in terms of their SRH, and the strategies that they may employ to attempt to overcome these, in order to add to our understanding of the structural barriers to sexual and reproductive health and rights (SRHR) for these women.

Context

In order to understand the barriers that women asylum seekers and refugees face in accessing SRHR in South Africa, it is necessary to understand

the context of forced migration to the country and the immigration and asylum policies in place. It should be noted that South Africa occupies a particular position within the region, being the only country which has its own developed asylum and refugee determination system. Due to its perceived economic and political stability, South Africa has for many years been a country of destination for asylum seekers and refugees from across the region. The United Nations High Commission for Refugees (UNHCR) estimates that there are currently 275,000 asylum seekers and refugees in South Africa, 185,000 of whom are asylum seekers awaiting a decision on their claims. There are no accurate data concerning the proportion of women amongst asylum seekers and refugees in South Africa, but estimates suggest that in 2015, 35% of asylum claims were made by women.²²

South African refugee policy has been praised in the past as highly progressive,¹¹ with a legal framework which offers protection to those seeking asylum from a wide spectrum of persecutions including an explicit recognition of gender-based persecutions as grounds for asylum. This system was put in place following the end of apartheid in the country and involved the signature of an agreement between the South African government and the UNHCR in 1993 which indicated that the government would accept the principles of the 1951 Convention on the Status of Refugees. In 1998, South Africa passed a Refugees Act which was based on the 1951 Convention, as well as the Organisation of African Unity definition of a refugee which extends the 1951 Convention to recognise refugee status in contexts of mass displacement due to conflict. However, despite the seemingly progressive and inclusive definition of a refugee contained within this Refugee Act, the way in which it has been implemented has meant that it has become very difficult, particularly in recent years, to obtain refugee status in South Africa.²³ These difficulties can be attributed in part to the changing political climate around immigration in the country, and the increase in xenophobic attacks on migrants and refugees which have led successive governments to introduce increasingly restrictive immigration and refugee policies. As Johnson argues: "Despite the strong legal framework, refugee protection has existed uneasily next to the country's immigration regime and its focus on immigration control, particularly the control of undocumented migrants".²² There is also a major problem in the implementation of

refugee policy due to a lack of resources, which means that Refugee Reception Offices have been closed, and that there is a massive lack of capacity to deal with refugee status determination. In consequence, many claiming asylum face very long waiting times to have their cases considered, and may be turned away, or have to travel very long distances to get an appointment, which clearly impacts on their daily lives and their ability to access services such as health care.^{24,25}

In practice, the procedure for claiming asylum is as follows. An individual who indicates that they wish to claim asylum when they arrive in South Africa should apply to the nearest Refugee Reception Office. At the Refugee Reception Office they will meet an officer who records their claim and will give them what is known as a Section 22 permit which allows them to remain in the country temporarily as an asylum seeker whilst their claim is processed. Within six months they should have an interview with a refugee status determination officer who will then make a decision whether to accept their claim and award them refugee status or to reject it. In case of rejection, the asylum seeker can then appeal the decision and their case will be transferred to the Refugee Appeal Board. If the appeal is rejected again, then they should leave the country. The system should thus be relatively streamlined and clear, but in practice asylum seekers are waiting months or even years even to get a first appointment with a Refugee Reception Office.¹⁸ The closure of some of the country's main Refugee Reception Offices, including those in Cape Town and Johannesburg, which was allowed by the Refugee Amendment Act of 2017, means that an asylum seeker may have to travel a large distance to get to an office, and that if they do gain a Section 22 permit, they will have to travel back to the same office after six months to renew it. Failure to do so will mean that they lose their permit and become undocumented.^{19–21} Further, the increasing numbers of rejections of asylum claims mean that there are large numbers of rejected asylum seekers who then become undocumented migrants. As Amit concludes: "Migration control has displaced protection as the primary goal of the asylum system".²⁰ These difficulties in accessing legal status, and the increased risk of becoming undocumented, clearly create vulnerabilities for the women we interviewed and barriers to accessing health services, as will be discussed further in the results section.

The 2017 Refugee Amendment Act also restricts the rights of asylum seekers to work, study or be self-employed, thus creating economic insecurities as asylum seekers receive no financial aid from the State. Asylum seekers who have a Section 22 permit should in theory be able to access health services in South Africa, but due to lack of information and xenophobic attitudes from health care staff this might not always be a reality for them. Lacking documentation has been shown to be a barrier to health care with clinics and hospitals refusing to treat those who do not have the "correct" documentation.^{7,23}

Both men and women asylum seekers and refugees face insecurities and violence as well as obstacles to adequate health care in South Africa, but there are specific insecurities and vulnerabilities facing women.²⁶ The reasons that force women to migrate are in some cases the same as those for men, but women fleeing from conflict-affected countries have often experienced rape and sexual violence during this conflict. Women may also flee from other gender-related forms of persecution such as forced marriage, domestic violence and female genital mutilation.¹⁵ Further, women, and particularly those travelling alone, face added insecurity and violence on their migration journeys from police and border guards, smugglers and other migrants. Lack of economic resources may mean that they must resort to transactional sex to pay for their journeys or support themselves and their children on the way.²⁷ On arrival in South Africa, women who have been forced to migrate because of gender-related forms of persecution should be able to claim asylum on those grounds; however, as noted above, the very high rate of rejection of asylum claims means that these claims would stand a very small chance of success. Moreover, the paucity of information regarding asylum claims means that many women are not even aware of this possibility. In the rest of this article we examine the experiences of asylum-seeking and refugee women in Durban, to explore their SRH needs and the challenges that they face in meeting these.

Methodology

This article is based on the result of qualitative research carried out with women asylum seekers and refugees in Durban, South Africa between June and November 2019. The research team, based at the University of KwaZulu-Natal, Durban,

conducted a series of focus group discussions (FGDs) ($n = 5$) and in-depth interviews ($n = 15$) with women asylum seekers and refugees living in the city, as well as interviews with key informants from organisations supporting asylum seekers and refugees in the city ($n = 4$). Interviews and FGDs with women asylum seekers and refugees were designed to gain insights into their experiences as asylum seekers and refugees, their SRH problems and the ways in which they were able or unable to seek support and treatment for these. Whilst interviews focused on the individual women's migratory journeys and experiences, their SRH needs and their experiences of access (or non-access) to SRH services, the FGDs allowed for a more wide-ranging exchange about experiences of being a female asylum seeker or refugee in South Africa, SRH problems and needs, experiences of discrimination and violence and the challenges posed by these. The interviews and FGDs took place in the areas where the women were living, or in their own accommodation, and this allowed the researchers to undertake additional ethnographic observation of their daily living conditions and the challenges that these posed. Women were selected for interviews and FGDs through purposive sampling, principally through two organisations which work to support asylum seekers and refugees in the city, Refugee Social Services, and the Dennis Hurley Centre. The women interviewed and participants in FGDs came from Burundi, the Democratic Republic of the Congo, Rwanda and Zimbabwe. FGDs were organised to group together women from the same country and speaking the same language. Women participants in FGDs and interviews ranged in age from 18 to 63 years old. The majority had come to South Africa alone or with their young children, although some came with husbands or partners, or with other family members such as siblings. Interviews and discussions were conducted in English, French or Shona, languages spoken by the researchers and participants. All interviews were audio-recorded with the participants' full written consent, and subsequently transcribed, and translated into English where necessary, for analysis. The transcriptions were collated and coded for themes and sub-themes by the first author (JF). Themes and sub-themes were inductively derived through a coding process as laid out by Strauss and Corbin.²⁸ Data was managed using Nvivo Software version 12. All participants in interviews and

FGDs gave written consent for participation and follow up measures were put in place with local organisations to ensure that they would receive appropriate support if they felt any distress as a result of their participation. Interviews were also carried out with key stakeholders working with refugee support organisations (Refugee Social Services and the Dennis Hurley Centre) in the city to gain their opinion on the barriers that these women faced in accessing adequate health services. The qualitative field research was supported with a review of all relevant literature on asylum seekers and refugees in South Africa, including academic articles and grey literature, such as reports from international NGOs and human rights organisations. Ethical clearance for the research was obtained from the University of KwaZulu-Natal's Humanities and Social Science Research Ethics Committee.

Research findings

Our research showed that women asylum seekers and refugees, many of whom arrive in the country with serious health concerns, face important barriers and challenges to enjoying good SRH, due to a range of political, economic and social factors. We present first the findings on determinants and women's experiences of sexual and gender-based violence at different stages of migration before discussing the various structural barriers to SRH care in South Africa.

Gender-based violence in countries of origin and during migration

A large proportion of the women participants in this research had experienced rape and sexual violence in their countries of origin, or on their journeys to South Africa. Women from Burundi and DRC recounted experiences of rape by soldiers and militia, in many cases accompanied by other physical violence, and murder of close family members. The story of one of these women is typical of the violence that they face:

“At that time there were some rebel fighters who would come to our village. They would come during the night, killing people and treating them badly. So, on that day it was on 6 March, they come during the night and they took my husband. They hit me first, you see [she shows us the scars on her left arm]. Yes, they were hitting me, and at that time my children

were so young, they took my husband and do not know where they took him. I was also living with my brother and they said that my brother must sleep with me. And because my brother said no, no I can't do that, they shot him ... Then because I was so scared about all the things that were happening, I just stayed in my village. But after that they came again, and they raped me. I went to the hospital and I stayed there for two days. After I came back from the hospital, I decided to take all of my children and run away because I could see that I was not safe." (Interview 13)

Several women also described how they had been victims of rape and sexual violence on their journey to South Africa, perpetrated by truck drivers with whom they travelled, for example. One Congolese woman explained:

"When we got to Zimbabwe my sister started a relationship with the man who was driving the truck that we used coming from Congo. She said we should stay in Zimbabwe, but I told sister that I did not want to stay in Zimbabwe. Then the driver also tried to rape me, but I fought him and ran away and came to South Africa on my own ... I haven't talked to my sister since because I do not even know her number, and the truck driver he hated me for not giving it to him [Long pause] It is difficult because even her, my sister, she just stayed with that truck driver because she had no choice. It is hard." (Interview 15)

This violence on the journey was made more likely by women's lack of money or economic resources to pay for their journeys, and by the fact of them travelling alone without any partner or family who might help to protect them. Key informants from refugee support organisations also described the large proportion of women arriving who had been victims of sexual violence and said that it was difficult for these women to access adequate medical, psychological or social support services to deal with the consequences of this violence. (K11, K12, K14)

Traumatic experiences of violence in their countries of origin were often the reason why the women had fled to seek protection in another country. They had hoped to find security in South Africa but had found that this was not the case. The experiences and determinants of these women's vulnerability to violence once they have arrived in South Africa are explored in the following section.

Gender-based violence on arrival in South Africa

Women also experience sexual and gender-based violence once they arrive in South Africa.

As one woman told us:

"We run away from home because of the war and we thought there was going to be peace and some of us when we got here, we were raped and beaten." (FGD5, Participant 1)

The sexual and gender-based violence they experience within South Africa may come from partners with whom they arrive in the country, or from men whom they meet after arrival. Key informants talked about the huge issue of intimate partner violence for women who migrate with husbands or partners. An extreme example we were given was that of a Burundian woman who was beaten, humiliated and paraded naked in the street by her husband (K14). Although not all cases of violence are as extreme as this, many women do face violence from partners and may be unable to leave them because of legal or economic dependencies which are created or reinforced by the South African asylum system.

Legal dependency and lack of independent status

One issue which was raised by many was that of legal dependency on a partner. Women who have come to South Africa to seek asylum with their husbands have their claims treated in the same file as their husband, and so they are unable to make a separate claim. The husband is treated as the "file holder" by the refugee office, and so if a woman separates from this husband on whose file her case is dependent, she will forfeit her claim. This creates a legal dependency, so that women cannot leave a violent partner for fear of becoming undocumented and thus an "illegal" migrant. One woman who had left her husband because of problems of violence explained: *"No, I do not have any documentation because I am in the same file as my husband. At Home Affairs they say I have to wait for my husband to come with me because we are in the same file. We have to go together."* (Interview 7)

There is also a serious problem of husbands leaving their wives and families after arriving in the country, and so rendering these women undocumented. Several of the women we talked to had found themselves without any legal documentation after their husbands had abandoned

them after arrival in South Africa. As one woman explained:

“After I had been abused at home during the war I had to run away and come to South Africa. When we were here, my husband left and went to marry another woman and left me with four children. We had joint papers because, at Home Affairs we were registered under him, and so when he left me and got married to another person, I was undocumented.” (FGD5, Participant 7)

Economic dependency

The system also creates economic insecurities and dependencies as asylum seekers receive no state financial support or aid, and no help in finding accommodation or employment. This forces many into homelessness and destitution which renders them vulnerable. Both women and men suffer from economic insecurities, but for women the consequences can be a heightened exposure to violence because they are forced into or forced to stay in violent relationships. One woman we interviewed explained that she had met her husband whilst she was homeless and sleeping on the beach in Durban. He came and found her there and offered her accommodation but made it clear that she would have to enter into a sexual relationship with him. They now have children together, but he can become violent and when he does, he reminds her of the circumstances which forced her to flee the DRC, and of the way they met, to reinforce the message of her dependency: *“When he is angry, he takes advantage of what happened to me, and how I was living when I met him. But I can’t leave. I have nowhere else.”* (Interview 2)

Women who do choose to leave an abusive partner should have access to South African women’s shelters, but these shelters do not always have places for them, so they may be left homeless. Women are also deterred from going to shelters because children over a certain age are not accepted, and so they are forced to leave their older children behind. Thus, there are few solutions for women experiencing intimate partner violence and many legal and economic reasons that force them to stay with violent men.

Accommodation and precarity

Difficulties in finding adequate accommodation also expose women to violence. Asylum seekers and refugees do not receive any help from the State in finding accommodation, nor any financial

assistance to pay rent, and they are often forced to live in cheap and insalubrious accommodation, which is overcrowded and where they have to share cooking and bathroom and toilet facilities with many others. For example, one of our FGDs was held in the home of a Burundian refugee. Her single room was located in a building shared with other refugees, male and female. The roof of the building was so badly damaged that birds were nesting in it and there were bird droppings all over the communal areas. The refugees shared a toilet and bathroom with no lockable doors, exposing them to risks of intrusion and violence each time they used them. The bathroom and toilet were filthy and had broken pipes leaking water all over the floor of the building. The women told us that these conditions were common in buildings occupied by refugees, and that they felt at risk all the time. Risks of violence from other occupants or intruders from outside the building were combined with risks to their health posed by the unhygienic conditions.

Lack of accommodation and fear of sleeping in the streets, mean that women become dependent on men for accommodation and this renders them vulnerable. One young Burundian woman explained her experiences when she first arrived in South Africa:

“When I got here I was sleeping in the streets and I went to the mosque to try and get help. A man came to the mosque and I told him what had happened. He took me home. But him and his wife tried to sell my body to men to get income. They wanted to force me. So I had to run away.” (Interview 6)

And another woman told a similar story:

“A man took me in but after a few days he told me I had to become his wife or else look for a new place. I had no option, I had to stay with him.” (FGD1, Participant 2)

Some of the women we met were sleeping in the streets for lack of any accommodation alternatives. They recognised this as a major risk for them:

“For a man they can sleep on the street but for a woman if they sleep on the street they will be exposed and raped.” (FGD2, Participant 5)

And as one young woman explained:

“I slept downstairs in the entrance of the building, but one of the men in the flats tried to rape me. Now I’m sleeping outside. I can’t get rent.” (Interview 9)

Transactional sex

Women's lack of economic resources and accommodation, and their inability to find jobs in South Africa, push them into situations of extreme vulnerability which have a major impact on their health. Transactional sex is frequent and several women talked about the fact that they had been asked to have sex with men in return for money or accommodation. Gendered inequalities and gender divisions of labour mean that it is easier for men, even male asylum seekers and refugees, to find informal work, and so both South African men and other refugee men may pressure women into sexual relationships for money. Many women talked about the frequency of transactional sexual relationships, driven by economic necessity:

"If you are not working it is even difficult for you to get money to buy bread, some of us are even selling their bodies." (FGD5, Participant 5)

"Yesterday, because my children were hungry, I had to ask this guy I know back from home for some money, but he told me that I had to sleep with him." (FGD1, Participant 8)

"Sometimes you end up taking your own clothes to sell for food but you end up not having anything to wear, so you end up going to those men because most of the times they are the ones that are working." (FGD1, Participant 4)

"You have to go to the men. They are the ones who are working and who have money." (FGD2, Participant 4):

Risks of STIs

Experiences of sexual violence and transactional sexual relationships expose these women to high risks of HIV and other STIs. Women spoke of the fact that they did not have adequate knowledge of HIV and of how to protect themselves from infection. For example, one woman told us:

"Sometimes the man has got HIV and maybe you are a newcomer and you have never had someone to tell you that there is HIV in South Africa. So you will get yourself sick because of five minutes of sex. Because of the suffering and poverty, it will push you to do things that you also do not like and gets you exposed diseases." (FGD4, Participant 5)

Two of the women who we interviewed told us that they had been diagnosed as HIV positive after arriving in South Africa. Both only found out they

were positive when they went for pregnancy testing. Key informants spoke of the huge stigma that women face on disclosing their HIV status, and on problems in adhering to ART regimes. And one Burundian woman told us how hard it was for her:

"I need to take my ARV medicine with food, but I don't have any money to buy food. So, I feel terrible all the time. I feel like I'm carrying a rock on my head. But there's nothing I can do. It's so hard for me." (Interview 1)

Access to health care

Many of the women we spoke to had not been able to access health services for their SRH issues. Barriers to health care were created by women's lack of documentation, lack of money, and by xenophobic attitudes and behaviour of health care staff. These barriers meant that many women respondents had not even tried to access care when they needed it.

Several of the women we spoke to were pregnant when they arrived in South Africa as a result of rape experienced in their country of origin or on the journey to South Africa. In some cases they did not even know that they were pregnant and found out by accident. One Congolese woman, for example, went to hospital a few months after she had been raped:

"After three months I started feeling like in my vagina something was itching, and that is when it hit me that maybe those people had given me some sickness, let me go to the clinic and see. Then I got to the hospital and then I am doing the exam, because they check your urine, I found out I was pregnant. I feel like I wanted to kill myself, in this situation, in this land, where will I take this child." (Interview 7)

She asked the nurse to help her terminate the pregnancy because she did not want to keep the child in the circumstances. But although abortion is legal in South Africa the nurse refused to give her any information about how she could terminate her pregnancy. She also found out that she was HIV positive.

"They also told me that I was positive, you see now I was stressed, this side I am pregnant, and this side I am positive, so what am I going to do? But that nurse said that we have to protect the baby and they started to give me the pills until I delivered the baby but I was not happy." (Interview 7)

For women such as this, on top of the trauma they experience as a result of the rape they have suffered, finding out that they are pregnant is an additional burden. The barriers to obtaining medical care, including access to abortion, when they request it, create another layer of stress and trauma for them.

Lack of documentation

Many of the women respondents had difficulties in accessing health care for SRH issues because of lack of legal documentation, and in some cases they did not even try to get antenatal care as they knew that they would have problems because of their lack of papers. Most said that they avoided going to hospitals or clinics because they felt that they would be sent away because of their lack of documentation. They also raised the issue of paying for medicine, and of their inability to afford any medicine or treatment that they might need. As one woman explained:

“I went to the hospital because I had an infection. But they wouldn’t take me because I didn’t have any documents.” (Interview 9)

And another added:

“Hospitals charge you seventy rand for a consultation and then they won’t give you any medicine if you owe them money.” (FGD3, Participant 8):

Even basic medical or sanitary products are beyond the reach of many of these women. One young woman we interviewed told us in tears that she had her period but could not even afford sanitary towels. (Interview 10)

Women’s reluctance to go to hospitals or clinics because of lack of official documentation can lead to serious health risks for themselves and their children. One woman told us that she had not attended an antenatal clinic when she was pregnant and that this led to complications with her baby being discovered too late:

“The time I was pregnant, I didn’t attend antenatal clinic on time because I did not have papers at that time. I only started to attend clinic when I was 7 months. When I reached there, they were shouting at me and telling me that the child had a problem.” (FGD2, Participant 5)

Lack of a papers can lead to women being turned away by hospitals even when they are in urgent need of treatment. One woman explained that

when she had a miscarriage, she was refused treatment by a public hospital:

“I had a big challenge when I was pregnant and miscarried, I went to the hospital and the blood was already on my legs, they could see the blood, but they could not help me because I did not have a permit. So, people had to gather money and take me to a private doctor where they cleaned my womb. At that time, I just had an appointment to go to Home Affairs and I was still waiting for my appointment when it happened.” (FGD2, Participant 1)

Xenophobic attitudes

Another barrier to adequate SRH care for women was said to be xenophobic attitudes from hospital staff, which reflects a wider xenophobia and racism in South African society. As one woman said: *“The people do not like us and they call us kwere kwere”*. (FGD4, Participant 2)

Often this xenophobia is expressed by staff as anger that women do not speak local languages. As one woman said: *“When you are sick and when you go to the doctor they say that you do not know Zulu, you have to speak in Zulu”*. (FGD4, Participant 5)

And another woman explained:

“I had a caesarean section and the nurses did not treat me well at all. They were vicious to me and kept telling me that if I couldn’t speak the language I should just go home.” (Interview 1)

These attitudes lead to highly negative experiences of health care for many women. One Congolese woman described how after she had delivered her baby she was left alone in a room to deliver the placenta by herself:

“They refused to take the placenta out. I had to do it myself. I delivered my baby at one o’clock in the morning, and they left me alone until eleven o’clock. I was all alone for ten hours until they came at eleven to stitch me up. I still have nightmares about that experience.” (FGD3, Participant 6)

And another woman also describes the trauma of her childbirth:

“They didn’t look after me at all. I was left all alone to give birth. I was bleeding and bleeding and they ignored me. My baby was very small but they told me to leave.” (Interview 3)

And another recounted a similar story:

“When I gave birth, the nurse told my husband that “why are you wasting time with people from your country, who cannot even speak English. You should leave her and marry us, we will give you rent, food and take care of you. These won’t even help you. Why are you even marrying these kwere kwere.” When I was bleeding too much the only thing that I could say was “come help me” but the nurse said “why are you calling me, call your sister in law”.” (FGD4, Participant 6)

The combination of lack of legal papers and such xenophobic attitudes from staff clearly has an impact on women’s SRH. One of our key informants noted that she believed there were very high rates of maternal and child mortality amongst asylum-seeking and refugee women and attributed this to the problems that these women had in accessing adequate medical care. (KI2)

Discussion

Our research pointed to the various ways in which asylum-seeking and refugee women in South Africa are made vulnerable to a range of negative SRH outcomes. In addition to the violence and insecurities these women have faced in their countries of origin and on their journey to South Africa, they are rendered vulnerable by the structural violence of the South African asylum system, and the increasing levels of xenophobia in the country. The increasingly restrictive migration discourses and policies in the country have demonstrably impacted on these women’s vulnerability to poor SRH outcomes, and their ability to access SRH services. The legal violence of the current asylum system which leaves many women undocumented, even when they have fled from extreme violence and persecution including sexual and gender-based forms of violence, coupled with the economic violence inherent in a system which does not permit asylum seekers to work, and which offers them no state benefits or subsidies, creates a situation in which it is nearly impossible for these women to realise their rights to SRH. This situation exacerbates underlying gender inequalities both within refugee communities, and in the host nation. These gender inequalities then combine with racial and ethnic discrimination and violence to produce intersecting systems of vulnerability within which women find themselves the most at risk of negative health outcomes. These SRH challenges for women asylum seekers and refugees are clearly not confined to South Africa, and our

research results point to wider problems of the neglect of SRH for women asylum seekers and refugees worldwide. Whilst the UNHCR, the WHO and other international organisations and NGOs have produced guidelines and plans on how to improve SRH for migrants and refugees, including SRH for women asylum seekers and refugees,^{29–32} clearly progress has not been good enough. And in many countries around the world the securitisation[†] of migration and the restrictive policies put in place to deal with asylum seekers and refugees have actually made the situation worse. States are in fact prioritising their own political goals of restricting migration over their obligations to support migrants’ and refugees’ right to health.

The Sustainable Development Goals call for universal access to SRH by 2030 but it is difficult to see how this will be achieved for women asylum seekers and refugees. It is imperative to take action not only in the humanitarian settings of refugee camps but also within refugee-receiving countries such as South Africa, where the seemingly open and positive refugee law masks the realities of exclusion and violence.²⁴ Likewise, in order to make a positive difference to the SRH of women asylum seekers and refugees, more research is needed which focuses not just on camp settings, which have been more largely studied by researchers, but also within urban settings in refugee-receiving countries. Further, whilst research on the social determinants of health of migrants and refugees has often focused on socio-cultural factors concerning adaptation to host societies, it is vital that more research explores the structural determinants found in legal, political and economic systems. This research needs to take into account not only the written asylum and migration laws and policies that exist in various countries, but also the ways in which these are implemented, and the ways in which State inaction and failure to provide services can itself be a source of vulnerability and violence for women. The failure of States and governments to ensure the SRH of women asylum seekers and refugees may be mitigated in part by services provided by charitable and religious organisations. The role of churches in assisting asylum seekers and refugees was

[†]Securitisation is the process of state actors transforming subjects into matters of “security”: an extreme version of politicisation that enables extraordinary means to be used in the name of “security”.

highlighted in our research. It would be interesting to explore further the place of these types of organisations in providing SRH services for women, and whether this can be considered a feasible alternative to State provision, or whether, on the contrary, the existence of such organisations merely serves to absolve States from their responsibilities in this regard. There are also questions regarding the way in which religious organisations might or might not be suitable to provide SRH services, given the sometimes very strict normative views which they hold in this area.

Finally, it is important to stress that women are made vulnerable because of their social, political and economic circumstances, and are not innately vulnerable or victims. The women that we met during this research project demonstrated enormous reserves of courage and had devised coping strategies to try and overcome the multiple barriers to health and well-being that they faced.

Ensuring their right to health is not a question of education or transformation of socio-cultural practices, but of addressing the persistent political, legal and economic inequalities and discrimination which place them in these situations of vulnerability and insecurity.

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Résumé

Les réfugiées et demandeuses d'asile font face à d'immenses difficultés relatives à leur santé et leurs droits sexuels et reproductifs. Dans cet article, nous étudions les déterminants structurels de la vulnérabilité de ces femmes en Afrique du Sud à un mauvais état de santé sexuelle et reproductive et se centre particulièrement sur les structures politiques, juridiques et économiques qui les fragilisent. Sur la base d'une étude qualitative réalisée à Durban, Afrique du Sud, nous avançons qu'il est essentiel de dépasser les analyses qui donnent la priorité aux obstacles socio-culturels pour la santé et les droits sexuels et reproductifs des demandeurs d'asile et des réfugiés, et qu'il faut tenir compte des politiques et législations nationales et internationales plus larges qui créent des obstacles aux droits de ces femmes à la santé sexuelle et reproductive.

Resumen

Las mujeres que buscan asilo y las refugiadas enfrentan enormes retos relacionados con su salud y derechos sexuales y reproductivos. En este artículo examinamos los determinantes estructurales de la vulnerabilidad a mala salud sexual y reproductiva (SSR) para estas mujeres en Sudáfrica, y nos enfocamos en particular en las estructuras políticas, legislativas y económicas por las cuales son vulnerables. Basándonos en un estudio cualitativo realizado en Durban, Sudáfrica, argumentamos que es vital ir más allá de los análisis que priorizan las barreras socioculturales a SDSR para las mujeres que buscan asilo y las refugiadas, y considerar la legislación y políticas nacionales e internacionales que crean obstáculos para que las mujeres ejerzan su derecho a SSR.