Sexual and reproductive health and rights, HIV and migration in southern Africa: A rapid review

G Musuka,[1] DVM, PhD; **I Chingombe,**[1] MSc, PhD; **E Moyo,**[2] MB ChB, MPH; **T Chikava,**[1] LLBS (Hons), MSc; **B Moyo,**[3] MB ChB, MBA; **M Mapingure,**[1] MSc (Med); **H Musuka,**[1] BMedSci Hons; **T Dzinamarira,**[4,5] MPH, PhD

[1] *Innovative Public Health and Development Solutions, Harare, Zimbabwe*
[2] *School of Nursing and Public Health, College of Health Sciences, University of KwaZulu-Natal, Durban, South Africa*
[3] *AIDS and TB Programme, Ministry of Health and Childcare, Harare, Zimbabwe*
[4] *School of Medicine, Medical Science and Nutrition, University of Aberdeen, Scotland*
[5] *ICAP, Harare, Zimbabwe*

Corresponding author: *G Musuka (gmusuka@3ieimpact.org)*

Migration, a prevalent global phenomenon, significantly impacts health, particularly in low- to middle-income countries. This article presents a rapid review aimed at mapping projects, lessons and policies concerning sexual and reproductive health (SRH), HIV and migration in southern Africa. Utilising a population-concept-context framework, the review focuses on understanding the scope, nature and extent of interventions, identifying lessons learnt, and assessing existing policies and strategies. A comprehensive search strategy and screening process resulted in 19 studies and reports for inclusion. The review highlighted diverse projects across southern Africa, addressing SRH and HIV among migrants, refugees and asylum seekers. Projects ranged from peer-education interventions to community-based referral systems, aiming to improve knowledge, access and outcomes related to SRH and HIV. The lessons learnt emphasised the importance of community involvement, healthcare worker (HCW) training and inclusive policies to address migrants' diverse needs effectively. Additionally, projects facilitated cross-border collaborations and policy integration, enhancing access to SRH-HIV services and migrant health rights. Despite these efforts, challenges persist, including gender-based violence, financial barriers and xenophobic attitudes among HCWs. Limited access to comprehensive sexuality education and social protection for migrants underscores the need for further policy development and implementation. Nevertheless, existing policies, such as Botswana's inclusive HIV treatment policy and South Africa's National Strategic Plan for HIV, TB and STIs, demonstrate steps towards ensuring migrants' rights to healthcare.

Keywords: *migration, Southern Africa, SRHR, HIV, policy, review, Zimbabwe*

S Afr Med J 2024;114(8):e2011. https://doi.org/10.7196/SAMJ.2024.v114i8.2011

People move from one place to another through migration within and across national borders. Migration can be categorised as economic, sociopolitical, or voluntary.[1] In 2020, there were 281 million migrants globally, 3.6% of the world's population. Compared with the previous year's total of 272 million, this represented an increase of 3.5%.[2] About 48% of the migrants were women. A total of 21 million Africans were migrants to other African countries in 2020. Approximately 2.9 million international migrants were living in South Africa (SA) in 2020. SA continues to be the continent's most popular destination country.[2] The effects of migration on health are becoming more scrutinised as international migration rises in low- to middle-income countries. The study of the dynamics of migration and health ought to be a top priority for public health.[3] Additionally, as sub-Saharan African countries work to achieve universal health coverage, migratory populations need to be considered in health policy and planning.[4]

Migration and health have a complex relationship. Migration's effects on health vary across migrant populations based on several variables, including past medical issues, travel experiences and the migrants' sex. Determining the direct consequences of migration on health is challenging since the health state of migrants may differ from that of non-migrants before, during and after the migration.[5] The circumstances of the migrants' migration may affect their health and intensify their vulnerabilities and risky behaviours. The stress of moving or frequent movements are some of the factors contributing to the adverse health effects of migration.[6] Migrants are frequently exposed to various social, environmental and health situations after relocating. Due to their legal status, migrants may confront various health access challenges.[6] Migration may jeopardise a person's ability to receive healthcare and maintain continuity of care, especially if they have a chronic illness. Migrants' health-seeking behaviours might be inhibited due to informational gaps, language barriers and unpleasant encounters with healthcare workers (HCWs). Migrants frequently face difficulties such as not knowing where to get healthcare or the workings of local health systems.[6] Immigrants frequently encounter stigma, xenophobia, or discrimination when obtaining healthcare services. Illegal immigrants often do not have prospects for higher-paying jobs, which limits their capacity to pay for healthcare.[7] In some instances, HCWs have been reported to request illegal payments from migrants, even in countries such as SA, where healthcare is theoretically provided free of charge. However, access to free healthcare services in SA may be contingent upon migrants being able to demonstrate proof of legal immigration status within the country.[7] This scenario creates a potential barrier to healthcare access for migrants, particularly those who may face challenges in obtaining or presenting the required documentation. Therefore, while healthcare services are ostensibly available without charge, the reality for migrants, especially those without legal status, can be more complex owing to such requirements imposed by HCWs.[7]

Additionally, migrants' access to free and subsidised medical treatment is frequently restricted to primary or emergency care

interventions. Furthermore, sick illegal immigrants typically do not seek medical attention because they worry about being turned over to the authorities for deportation. Numerous migrants' precarious financial situations may make them more susceptible to prevalent infectious diseases such as tuberculosis and diarrhoea.[6]

The majority of migrants are in the reproductive ages of 15 - 49 years.[2] As they strive to meet their necessities and find methods to continue their trips, migrant girls and women travelling alone or through illicit channels are vulnerable to sexual exploitation and abuse while in transit.[8] Compared with non-migrant women, studies have indicated that migrant women use fewer contraceptives, experience more intimate partner abuse, have higher rates of abortion and abortion complications and have higher HIV prevalence.[9-11] Recent International Organization for Migration (IOM) Zimbabwe reports found that female migrants, especially pregnant women, travel through unofficial channels to neighbouring nations primarily to take advantage of the better healthcare systems there.[12] Government responses to non-nationals accessing maternity services in receiving countries vary across southern Africa. SA recently released rescinding circulars requiring fees for persons accessing maternity and other services, creating confusion at the service delivery and community level for migrants.[13] Children and unmarried female migrants are more susceptible to risks and vulnerabilities related to sexual and reproductive health (SRH) because they frequently lack the means to negotiate for safe and protected sex, especially when travelling alone.[14] Asylum seekers and refugees are particularly susceptible to sexual assault.[6] Barriers to sexual and reproductive health and rights (SRHR) services among migrants are similar to those they experience when accessing other healthcare services.[15]

In sub-Saharan Africa, migrants are regarded as a high HIV risk category due to their higher HIV prevalence rates and increased HIV risk behaviours compared with non-migrants. One of the key elements in the transmission of HIV is mobility.[16] People who have left their communities engage in riskier behaviours. Migration may make it easier for both migrants and the partners they leave behind to find new companions because of the time they spend apart.[16] Owing to limited access to HIV prevention services, including pre-exposure prophylaxis, post-exposure prophylaxis and HIV testing, migrants are also more likely to contract HIV. Migrants who are HIV-positive have challenges initiating treatment and ensuring treatment continuity owing to limited access to healthcare services. As a result of these challenges, migrants are more likely to default on HIV treatment and develop drug resistance compared with non-migrants.[1] This rapid review aimed to map literature available on (*i*) projects being implemented in southern Africa (proposals and reports); (*ii*) lessons and best practices; and (*iii*) available policies and strategies on SRHR/HIV and migration, comprehensive sexuality education, livelihoods and social protection of migrants and vulnerable young people.

Methodology

A rapid desk review was conducted. The review loosely adhered to the preferred reporting items for systematic reviews and meta-analysis protocols (PRISMA-P) guidelines[17] and the Centre for Reviews and Dissemination (CRD) guidance for undertaking systematic reviews in healthcare.[18]

Table 1. Population-concept-context framework for the desk review

Criteria	Determinants
Population	Migrants
Concept	Sexual and reproductive health, HIV
Context	Southern Africa

Research question and study eligibility

The population-concept-context (PCC) framework (Table 1) was used to set the eligibility criteria for the review question following recommendations from the Joanna Briggs Institute.[19]

This review addresses the following research questions:

(*i*) What is the scope, nature and extent of projects being implemented in southern Africa on SRHR of migrants, including HIV?

(*ii*) What are the documented lessons and best practices in implementing SRHR for migrants?

(*iii*) What are the existing policies and strategies on SRHR/HIV and migration, comprehensive sexuality education, livelihoods and social protection of migrants and vulnerable young people in southern Africa?

Literature sources

A comprehensive search was conducted on PubMed and Google Scholar electronic databases, grey literature, reports from ministries of health of the respective countries, newspaper articles and the World Health Organization (WHO) and IOM websites for articles reporting on SRHR, HIV and migration.

Search strategy

A comprehensive search strategy was co-developed and pilot tested with the assistance of a senior health science librarian. The strategy was tailored for each database to ensure retrieval of the most relevant studies. A complete search strategy with PubMed and Google Scholar findings is presented in appendix Table 2 (https://www.samedical.org/file/2265). The search strategy includes medical subject heading (MeSH) and text-word searches. The search encompassed articles and reports published within a specified timeframe, ranging from 1 January 2017 to 31 December 2022. Both peer-reviewed literature and grey literature were considered eligible for inclusion. The language criterion was set to include studies published in English, reflecting the predominant language of scholarly communication in the region. Additionally, publication status was not restricted, allowing for the inclusion of both published and unpublished reports.

Title, abstract and full-text screening

Two independent reviewers screened the titles, abstracts and full-text articles for eligibility. Studies identified through database searches were exported to EndNote (Clarivence, USA). Duplicate articles were removed. Studies were then exported from EndNote to the Covidence (Covidence, USA) systematic review management platform. This desk review followed the reporting items for systematic reviews and meta-analysis protocols guidelines.

Data abstraction and analysis

We employed a standardised pre-piloted form to extract data from the included articles. The extracted information included the following: author name and publication year, country, a description of the populations, including regions where migrants/refugees originate, regions where migrants/refugees migrate to, scope, nature and extent of projects implemented, documented lessons and best practices, policies and strategies on SRHR/HIV and migration, comprehensive sexuality education, livelihoods and social protection of migrants and vulnerable young people, and other key findings.

The relevant outcomes and predefined themes for analysis were derived from the objectives of the rapid review, focusing on key areas such as SRH interventions, HIV prevention strategies, access to healthcare services, and policy implications. Predefined themes were established based on the PCC framework, ensuring a systematic approach to data synthesis and analysis. Through NVivo version 12 software package (Lumivero, USA) qualitative data were coded and categorised according to these predefined themes, facilitating the identification of patterns, trends and key insights relevant to the review objectives. Narrative synthesis,[20] a systematic approach to searching for and reporting evidence, explored relationships within and between study findings. Results were presented as a narrative synthesis of the conclusions of the included reviews, structured around the research questions. A synthesis of the qualitative results was presented in a narrative format.

Results

The initial search retrieved 219 930 articles from peer-reviewed literature and 105 from grey literature and hand searching. A total of 219 947 articles remained following de-duplication. Following title screening, 46 were eligible for abstract screening. Seventeen articles were excluded at the conceptual screening stage because they did not meet the set inclusion criteria, leaving 29 for full-text screening. Ten articles were excluded at the full-text screening stage.[21-30] A total of 19 studies and reports were included in this review. More details are presented in Fig. 1.

Projects implemented in southern Africa (proposals and reports)

Among the 14 retrieved articles on proposals, reports and projects implemented in southern Africa, one was from Angola,[31] one from Botswana,[32] one from Namibia,[33] seven from SA,[34-40] two from Zimbabwe,[41,42] and two were multinationals covering Eswatini, Lesotho, Malawi, Mozambique, SA and Zambia.[43,44] Eight of the articles were reports,[29-31,35,36,39,41,44] four were published research articles[32-34,38] and two were proposals.[36,40]

The proposals focused on the provision of information about sexual health and access points;[36] reminding HCWs of universal access to reproductive healthcare, including for migrants,[37] and increasing access to SRHR services.[39] The reports on projects revealed that the projects being implemented varied by country. In Angola, the project included setting up women-friendly spaces in refugee camps where girls and women received information on SRHR. In this project, 15 refugees were hired and trained as social mobilisers. These mobilisers raised awareness of refugees' human right to live free of violence, and helped connect survivors of gender-based violence to supportive services. The United Nations Population Fund also supported the Matabeleland provincial Department of Health with the training of nurses and other health workers to sensitively treat survivors of sexual and gender-based violence and provide reproductive healthcare,[31] while in Botswana, a project focused on empowering sex workers to gain skills to prevent HIV infection.[32]

A Namibian project supported poultry projects run by refugees and asylum seekers to improve their livelihoods. There were 32 poultry projects which the Office of the United Nations High Commissioner for Refugees funded at the Osire refugee settlement.[33] In SA, the projects focused on peer-education intervention to improve knowledge of sexually transmitted infections (STIs) and HIV, and increase safer sexual practices among male hostel residents, who included migrants,[37] and clubs where foreign migrant adolescent girls and young women discussed SRHR and HIV issues.[39] Research conducted in SA in the published articles explored the experiences of migrants in accessing SRHR services and the challenges they faced.[33-36,40] One Zimbabwe project focused on providing SRH services to refugees, migrants and deportees.[41] A multinational project that was conducted in Eswatini, Lesotho, Malawi, Mozambique, SA and Zambia focused on improving SRHR-HIV-related outcomes, mainstreaming SRHR-HIV rights, including migration in national policies and cross-border co-ordination for the provision of SRHR-HIV services among migrants.[43] Over 1 000 'change agents' were deployed through the communities to engage with people through door-to-door and community dialogues. The change agents supported counselling, testing, referrals and guidance in scheduling appointments at health facilities, monitoring antiretroviral treatment and home visits.[43] The initiative has reached >650 000 beneficiaries with comprehensive SRHR-HIV information and services through community-based referral systems. This project helped >70 000 migrants, sex workers and young people to receive services ranging from HIV testing, family planning, initiation of HIV antiretroviral treatment (ART) and services for survivors of sexual and gender-based violence. The project also sensitised over 700 duty bearers, including health and non-health service providers, faith leaders

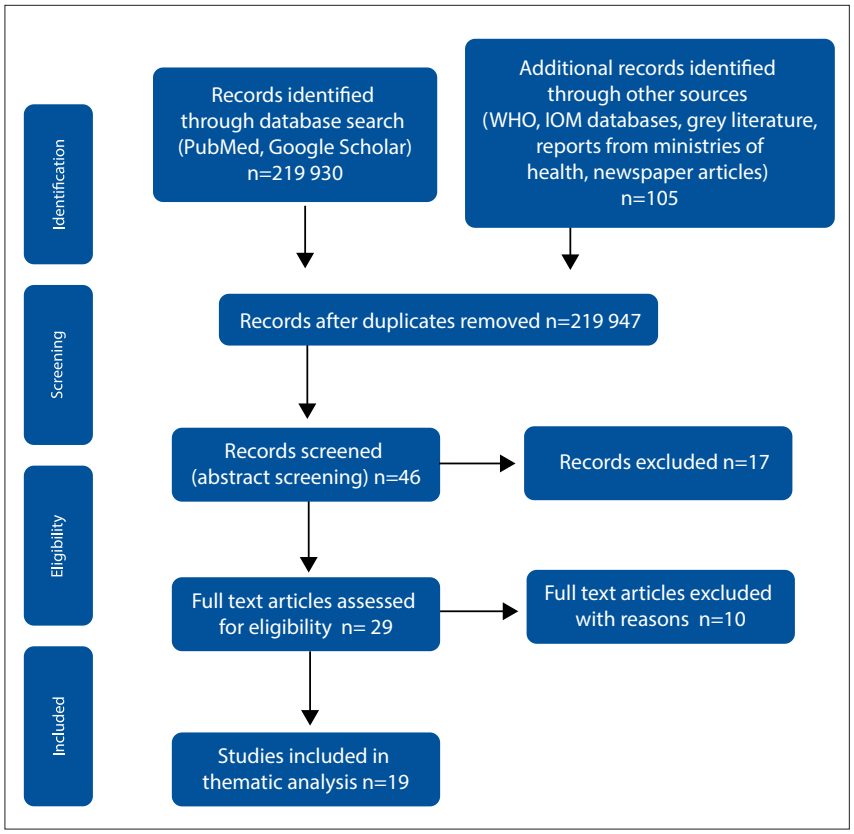

Fig. 1. PRISMA (preferred reporting items for systematic reviews and meta-analyses) flowchart. (WHO = World Health Organization; IOM = International Organization for Migration.)

and traditional structures, on beneficiaries' human and SRH rights while following a rights-based approach to service provision.[43] More details are presented in appendix Table 3 (https://www.samedical.org/file/2265).

Lessons and best practices

Different lessons were learnt from the implemented projects and the conducted studies. In Angola, it was revealed that gender-based violence among refugees continued in the refugee camps and settlements.[31] Refugees and asylum seekers who participated in the poultry projects in Namibia became self-reliant, making it possible for them to pay for their healthcare services, including SRH services.[33] A study conducted in SA revealed that active participation of the affected communities and training of HCWs to deliver quality and relevant SRH services are essential for the success of SRH service programmes.[37] One study conducted in SA revealed that, for countries to reduce HIV infection among foreign migrant adolescent girls and young women, they should prioritise action to address the specific determinants of their HIV risk, and formulate inclusive policies that recognise migrants' heterogeneity based on gender and age.[39]

Studies conducted in SA also revealed that a lack of financial independence among migrant women exposed them to sexual violence and transactional sexual relationships, which exposed them to high risks of HIV and other STIs. However, many of the women were unable to access SRH services owing to a lack of documentation and money, and xenophobic attitudes and behaviour of HCWs.[34,35] Migrant sex workers faced maltreatment, and were over-charged and abused by HCWs when seeking healthcare services. Sometimes, migrant workers were denied SRH services, including HIV treatment, at public healthcare facilities. As a result of these challenges, migrant women preferred to use private healthcare, which is more expensive.[40] Of interest was that HCWs who would have refused access to state institutions may be available to migrants through personal networks such as churches. Churches and religion played a crucial role in providing emotional, instrumental and informational support to pregnant women in preparation for childbirth.[36] In addition, informal social networks, especially fellow migrants, influenced the participants' health and help-seeking behaviours, attitudes and perceptions towards antenatal care and the public healthcare system.[36]

In Malawi, the SRHR-HIV Knows No Borders Project team's efforts in national-level technical working groups provided a platform for advocacy on migration and migrant health, resulting in the incorporation of these issues in the country's 2018 - 2022 national strategy on SRH.[44] In Eswatini, owing to the project, the Ministry of Health included consideration of migrant health in its SRH policy. It introduced a client information management system that enables migrants to access SRH and other services throughout the country. The project also increased the number of migrants who tested for HIV and knew their status.[45] Three cross-border collaboration initiatives that started during the SRHR-HIV Knows No Borders Project led to a cross-border referral system and improved continuity of care for migrants and members of mobile populations living with HIV. Cross-border programming was most feasible where bilateral agreements existed among neighbouring countries, since bilateral agreements are less political than multilateral approaches.[44] The involvement of traditional leadership was also productive in addressing environmental barriers to SRH-HIV service access by members of target groups, including migrants. Moreover, the dialogue was used as an enabling tool at all levels of the programme, to articulate and understand the policy and sociocultural drivers of access and use of SRH-HIV services and needs of the target groups, communicate these to those with power and influence to deliver programme changes and provide feedback to and from beneficiaries.[44] More details are presented in appendix Table 4 (https://www.samedical.org/file/2265).

Available policies and strategies on SRHR/HIV and migration, comprehensive sexuality education, livelihoods and social protection of migrants and vulnerable people

Although there are few national SRHR-HIV policies specifically for migrants in most countries in southern Africa, the rights of migrants to access SRHR-HIV services are embedded in these countries' constitutions and national SRHR-HIV policies. Botswana extended HIV treatment to non-citizens in 2019. The policy requires healthcare facilities to provide treatment to all people living with HIV in the country.[46] The Kingdom of Lesotho's National HIV and AIDS Strategic Plan (NHASP) 2018/19 - 2022/23 stipulates that a combination of HIV prevention strategies should reach all vulnerable populations, including migrants and mobile populations.[46] The SA National Strategic Plan for HIV, TB and STIs 2017 - 2022 goal 3 aims to reach all key and vulnerable populations with customised and targeted interventions, including mobile populations, migrants and undocumented foreigners. Migrants and undocumented foreigners are identified as vulnerable populations for HIV and STIs. The plan also encourages HCWs to provide services in a compassionate and non-discriminatory manner, and civil society organisations and community networks to support key and vulnerable populations. The plan also aims to strengthen cross-border collaborations with neighbouring countries and other stakeholders to provide SRHR-HIV services.[47] The SA Constitution also stipulates that all SA residents, including migrants, have a right to access healthcare services, including SRHR-HIV services.[48] The Kingdom of Eswatini's SRH policy considers the SRH of migrants. Through the Ministry of Health, it has been partnering with neighbouring countries to ensure that migrants have equal access to health services. The country has established clinics along the border to ensure that truck drivers and sex workers can access SRH programmes to prevent STI infection.[44,49] No policies or strategies on comprehensive sexuality education, livelihoods and social protection of migrants and vulnerable people were retrieved. More details are presented in appendix Table 5 (https://www.samedical.org/file/2265).

Discussion

This review revealed that proposals and projects were being implemented in countries in southern Africa. The main aims of the projects were to provide information on SRHR services and access to migrants and refugees, provide SRH services, train HCWs on dealing with the SRH needs of migrants and refugees and strengthen cross-border co-ordination.[37,38,41-43] Similar projects are also being carried out on other continents. Australia's Multicultural Centre for Women's Health supports migrant and refugee women's SRH through advocacy, research, training and multilingual health education and information. Its work includes cross-cultural professional development and training of HCWs on providing SRH services to migrants and refugees. It also has free nationwide access to its health information catalogue and library.[50] To improve the sexual health of migrants and refugees in Europe, the Europe and Global Challenges Financing Initiative funded a project in 2017. The project aimed to identify and put relevant and efficient public policy responses into practice. Through preventing and controlling sexually transmitted illnesses (STIs), the project sought to enhance the SRH of migrants and refugees.[51]

The present review revealed that migrants and refugees face several challenges when accessing SRH-HIV services in their host country.[34-36,40] These findings concur with a study conducted in Uganda and a systematic review of SRH knowledge, experiences and access to services among migrants, refugees, displaced girls and young women in Africa.[43,52] The study in Uganda revealed structural barriers and discrimination affecting access to SRH services among migrants.[52] The systematic review reported sexual violence against refugees in refugee camps. Lack of information on where to access SRH services, language barriers and discrimination at healthcare facilities were identified as factors hindering access to SRH services.[53] These challenges are not unique to southern Africa. In Australia, a survey of men with immigrant and refugee histories found that many of the men were uninformed on the variety of SRH services that were available to them, including where to get an HIV test, how sexual health consultations work and how to get access to specialised SRH services. Barriers to accessing SRH services for migrants included language, finances, literacy and fear of prejudice and stigma.[54] Another study conducted in Sweden among migrant youths reported that some of the youths refrained from seeking SRH services owing to a lack of knowledge about the Swedish health system and available SRH services, language barriers, long waiting times and the cost of care.[55] The education status of migrants also affects their utilisation of SRH services. A study in six southern African countries revealed that migrant women who utilised SRH services such as modern contraceptive methods had higher education and comprehensive knowledge about SRH, including HIV, compared with those who did not utilise SRH services.[15] It is, therefore, important that migrants are informed about available SRH services and where they can be accessed in the regions where they live. Migrants and refugees should have access to a wide range of contraceptives, including other SRH services such as abortion and sterilisation. Refugees are usually traumatised owing to the conflicts they have experienced. As a result, they are unlikely to open up to HCWs about their health unless they feel comfortable with the HCWs. Refugee camps and settlements should ensure that they provide all SRH services in a friendly and professional way, considering the refugees' experiences.

A study conducted among Lesotho migrants working in SA revealed that ~25% of the participants defaulted on their HIV treatment mainly because of failure to get back to Lesotho to collect their medication. There was also a lack of transfer letters from Lesotho to SA healthcare facilities to facilitate their care and treatment in SA.[56] It is, therefore, important that the region offers continuity of care to migrants living with HIV, and this can be achieved through co-ordination among countries in the area. Migrants living with HIV should not only have access to ART, but they should have access to all HIV services, such as viral load testing and switching their treatment whenever there is an indication, wherever they are in the region, regardless of their status. These services will ensure that no migrants are left without HIV care, allowing the countries in the region to achieve the Joint United Nations Programme on HIV and AIDS 95-95-95 targets. Migrants in the area should also have access to all HIV prevention services, including HIV testing, voluntary medical male circumcision, pre-exposure prophylaxis and post-exposure prophylaxis. Providing HIV prevention and care services to migrants will ensure that local communities are not exposed to HIV, since mobile populations are usually associated with a higher prevalence of HIV.

Programmes for SRH for migrants and refugees must engage all stakeholders and be attentive to the needs of the migrants and refugees if they are to be effective. Participatory community accountability systems should exist because they help people understand and assert their SRHR. For people to use SRH services, environments for private, non-stigmatising discussions regarding SRHR must be created. Leaders from various stakeholders should be chosen to participate in the creation and execution of the interventions.[52] To lessen provider prejudices and foster trust, HCWs should also receive training on providing welcoming services to migrants. This is important because migrants who feel supported and comfortable with their healthcare providers are more likely to adhere to their antiretroviral medication. A positive HCW-patient relationship is therefore important for the continuity of care among migrants. To guarantee that SRH services are accessible to all targeted migrants and refugees, flexible outreach strategies should also be used.[57] Programmes funded over a more extended period will benefit from continuity and higher success rates. Additionally, SRH services for migrants should be incorporated into the nation's current SRH programmes, because doing so will prevent discrimination against immigrants.[52] Although certain southern African nations have rules requiring that migrants have access to SRH services at healthcare institutions, this usually does not occur because some HCWs still discriminate against them. To guarantee that HCWs follow national policies, there should be an improvement in the oversight and monitoring of HCWs.[15]

Countries in the southern African region need to use the lens of the right to health/universal health access to address migrants' HIV and SRH prevention and treatment needs. Although Southern African Development Community (SADC) countries have domesticated regional and international resolutions promoting universal health access, they must move from policy to practice. Considering the challenges migrants face in accessing SRH services, we recommend that they receive comprehensive SRH education to ensure that they make informed decisions about their SRH. Projects and programmes targeting migrants and refugees will also need to address individual-level barriers such as lack of/inadequate awareness of health services in the various countries in SADC. SRH services and policies should consider the culture of migrants so that they are comfortable accessing the services. Cross-border co-ordination of SRH services should be strengthened to make sure that migrants receive the services anywhere they are in the region, regardless of whether they are documented or not. Healthcare facilities near the borders should have enough HCWs and consumables for SRH services such as condoms and contraception medications to cater to migrants, who are usually not included in budget planning for the facilities. There is an urgent need to monitor and evaluate SRH services for migrants in the region. The collected data should be shared among countries in the region, international organisations and non-governmental organisations to improve the services. More research is also needed to understand the SRH needs of migrants in different settings.

Finally, the universal challenge of poverty and livelihoods, although less directly related to health, needs addressing, because this is a crucial driver of unplanned migration, and exposes individuals, especially young women and girls, to gender-based violence and unprotected sex, resulting in HIV acquisition. Another factor is climate change, which destroys livelihoods in rural and marginalised areas. There is a need for governments to come up with effective countermeasures.

Limitations

Our search strategy had limitations, including the fact that only a few databases were used, making it possible that some relevant articles were missed. Another limitation was that only articles published in English were reviewed, potentially introducing a language bias.

Conclusion

Refugees and migrants face difficult social, political and economic circumstances that jeopardise their fundamental right to health, particularly SRH-HIV. Some migrants frequently have their SRHR severely restricted or ignored by their host governments owing to their status. Access to

SRH services such as maternity care, contraception, abortion care and management and prevention of STIs, including HIV, is frequently limited. Several SRH projects for migrants are being implemented in the southern African region. For the programmes to succeed, there is a need for stakeholder involvement, training of HCWs on the provision of SRH services without discrimination and cross-border co-ordination on the provision of the services. There is also a need for high-quality, context-specific research based on local and regional priorities to adequately address the varying problems and SRH needs of migrants and refugees. Finally, critical regional documents such as the SADC protocol on health must be updated to prioritise migration SRHR issues, especially considering that there are many migrants in the region.

Data availability. Available on request from the corresponding author.

Declaration. None.

Acknowledgements. None.

Author contributions. Conceptualisation: GM and IC; writing: original draft preparation, GM and TD; writing: review and editing, IC, EM, TC, MM and HM. All authors have read and agreed to the published version of the manuscript. EM: Writing of original draft.

Funding. The International Organisation of Migration, Zimbabwe.

Conflicts of interest. None.

1. Nicholas PK, Mfono N, Corless IB, et al. HIV vulnerability in migrant populations in southern Africa: Sociological, cultural, health-related, and human-rights perspectives. Int J Africa Nurs Sci 2016;5:1-8. https://doi.org/10.1016/j.ijans.2016.09.003
2. International Organisation for Migration. World Migration Report 2022. IOM, 2022. https://publications.iom.int/system/files/pdf/WMR-2022.pdf (accessed 13 March 2024).
3. Wickramage K, Vearey J, Zwi AB, et al. Migration and health: A global public health research priority. BMC Public Health 2018;18(987). https://doi.org/10.1186/s12889-018-5932-5
4. Vearey J, Orcutt M, Gostin L, et al. Building alliances for the global governance of migration and health. BMJ 2019;366:14143. https://doi.org/10.1136/bmj.l4143
5. Ginsburg C, Collinson MA, Gómez-Olivé FX, et al. Internal migration and health in South Africa: Determinants of healthcare utilisation in a young adult cohort. BMC Public Health 2021;21(554):1-15. https://doi.org/10.1186/s12889-021-10590-6
6. African Union. Migration and health: Addressing current health challenges of migrants and refugees in Africa – from policy to practice. African Union, 2022. https://au.int/en/documents/20220504/migration-and-health (accessed 13 March 2024).
7. Alfaro-Velcamp T. 'Don't send your sick here to be treated, our own people need it more': Immigrants' access to healthcare in South Africa. Int J Migr Health Soc 2017;13(1):53-68. https://doi.org/10.1108/IJMHSC-04-2015-0012
8. Brandon Chen Y. International migrants' right to sexual and reproductive health care. Int J Gynaecol Obstet 2022;157(1):210-215. https://doi.org/10.1002/ijgo.14149
9. Coast E, Norris A, Moore A, Freeman E. Trajectories of women's abortion-related care: A conceptual framework. Soc Sci Med 2018;200:199-210. https://doi.org/10.1016/j.socscimed.2018.01.035
10. Metusela C, Ussher J, Perz J, et al. 'In my culture, we don't know anything about that': Sexual and reproductive health of migrant and refugee women. Int J Behav Med 2017;24(6):836-845. https://doi.org/10.1007/s12529-017-9662-3
11. Raben L, van den Muijsenbergh METC. Inequity in contraceptive care between refugees and other migrant women? A retrospective study in Dutch general practice. Fam Pract 2018;35(4):468-474. https://doi.org/10.1093/fampra/cmx133
12. International Organisation for Migration. Flow Monitoring Report IOM Zimbabwe. IOM, July 2022. https://reliefweb.int/report/zimbabwe/flow-monitoring-report-iom-zimbabwe-july-2022 (accessed 13 March 2024).
13. Bornman J. Migrant mothers vs the state. New Frame, 2022. https://www.newframe.com/migrant-mothers-vs-the-state/#:~:text=Migrant%20mothers%20are%20asked%20to,as%20much%20as%20R25%20000 (accessed 13 March 2024).
14. Kwankye SO, Richter S, Okeke-Ihejirika P, et al. A review of the literature on sexual and reproductive health of African migrant and refugee children. Reprod Health 2021;18(81):1-13. https://doi.org/10.1186/s12978-021-01138-3
15. Chawhanda C, Levin J, Ibisomi L. Factors associated with sexual and reproductive health service utilisation in high migration communities in six southern African countries. BMC Public Health 2022;22(876):1-15. https://doi.org/10.1186/s12889-022-13308-4
16. Anglewicz P, van Landingham M, Manda-Taylor L, Kohler H. Migration and HIV infection in Malawi. AIDS 2016;30(13):2099-2105.
17. Shamseer L, Moher D, Clarke M, et al. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015: Elaboration and explanation. BMJ 2015;349:g7647. https://doi.org/10.1136/bmj.g7647
18. Akers J, Aguiar-Ibáñez R, Baba-Akbari A. Systematic reviews: CRD's guidance for undertaking reviews in health care. York: Centre for Reviews and Dissemination, 2009.
19. Dos Santos WM, Secoli SR, de Araujo Püschel VA. The Joanna Briggs Institute approach for systematic reviews. Revista latino-americana de enfermagem. 2018;26:e3074. https://doi.org/10.1590/1518-8345.2885.3074
20. Popay JRH, Sowden A, Petticrew M, et al. Guidance on the conduct of narrative synthesis in systematic reviews. A product from the ESRC methods programme. Lancaster: Lancaster University, 2006.
21. Correa-Agudelo E, Kim HY, Musuka GN, Mukandavire Z, Akullian A, Cuadros DF. Associated health and social determinants of mobile populations across HIV epidemic gradients in Southern Africa. J Migr Health 2021;3:100038. https://doi.org/10.1016%2Fj.jmh.2021.100038
22. Khanlou N, Haque N, Skinner A, Mantini A, Kurtz Landy C. Scoping review on maternal health among immigrant and refugee women in Canada: Prenatal, intrapartum, and postnatal care. J Pregnancy 2017;2017:8783294. https://doi.org/10.1155/2017/8783294
23. Spitzer DL, Torres S, Zwi AB, Khalema EN, Palaganas E. Towards inclusive migrant healthcare. BMJ 2019;366:14256. https://doi.org/10.1136/bmj.l4256
24. Madiba S, Ngwenya N. Cultural practices, gender inequality and inconsistent condom use increase vulnerability to HIV infection: Narratives from married and cohabiting women in rural communities in Mpumalanga province, South Africa. Glob Health Action 2017;10(Suppl 2):1341597. https://doi.org/10.1080/16549716.2017.1341597
25. Luiking M, Heckemann B, Ali P, et al. Migrants' healthcare experience: A meta-ethnography review of the literature. J Nurs Scholarship 2019;51(1):58-67.
26. Labys C, Dreyer C, Burns J. At zero and turning in circles: Refugee experiences and coping in Durban, South Africa. Transcult Psychiatry 2017;54(5-6):696-714.
27. Adedeji A. Accessing sub-Saharan African migrant group for public health interventions, promotion, and research: The 5-wave-approach. CMS 2019;7(30):1-13 https://doi.org/10.1186/s40878-019-0134-6
28. Majid Z, Welch C, Davies J, Jackson T. Global frailty: The role of ethnicity, migration and socioeconomic factors. Maturitas 2020;139:33-41.https://doi.org/10.1016/j.maturitas.2020.05.010
29. Mukumbang F. Pervasive systemic drivers underpin COVID-19 vulnerabilities in migrants. Int J Equity Health 2021;20(146):1-7. https://doi.org/10.1186/s12939-021-01487-2
30. Mutambara V, Crankshaw T, Freedman J. Assessing the impacts of COVID-19 on women refugees in South Africa. J Refug Stud 2022;35(1):704-721.
31. Skarstein T. Women-friendly spaces offer safe haven for Congolese refugees in Angola. Friends of Angola, 2018. https://friendsofangola.org/archives/tag/women-friendlyspaces#:~:text=Women%2Dfriendly%20spaces%20offer%20safe,find%20safe%20haven%20and%20support (accessed 13 March 2024).
32. Sisonke-Botswana, BONELA. Botswana CEDAW Shadow Report. Global Network of Sex Work Projects (NSWP), 2019. https://www.nswp.org/resource/member-publications/botswana-cedaw-shadow-report (accessed 13 March 2024).
33. United Nations Namibia. 2021 UN Country Annual Results Report Namibia. Geneva: UN, 2022. https://namibia.un.org/en/download/115482/197937 (accessed 13 March 2024).
34. Chekero T, Ross F. 'On paper' and 'having papers': Zimbabwean migrant women's experiences in accessing healthcare in Giyani, Limpopo province, South Africa. Anthropol South Afr 2018;41(1):41-54.
35. Freedman J, Crankshaw T, Mutambara V. Sexual and reproductive health of asylum seeking and refugee women in South Africa: Understanding the determinants of vulnerability. Sex Reprod Health Matters 2020;28(1):1758440. https://doi.org/10.1080/26410397.2020.1758440
36. Makandwa T, Vearey J. Giving birth in a foreign land: Exploring the maternal healthcare experiences of Zimbabwean migrant women living in Johannesburg, South Africa. Urban Forum 2017;28(75-90):1-16. https://doi.org/10.1007/s12132-017-9304-5
37. Scorgie F, Vearey J, Oliff M, et al. 'Leaving no one behind': Reflections on the design of community-based HIV prevention for migrants in Johannesburg's inner-city hostels and informal settlements. BMC Public Health 2017;17(Suppl 3):S482. https://doi.org/10.1186/s12889-017-4351-3
38. Sonke Gender Justice. Sonke Gender Justice launches its #undertheblankets campaign: Refugees' and migrants' access to sexual health in South Africa. Sonke Gender Justice, 2022. https://genderjustice.org.za/news-item/sonke-gender-justice-launches-its-undertheblankets-campaignrefugees-and-migrants-access-to-sexual-health-in-south-africa/ (accessed 13 March 2024).
39. Temin M, Milford C, Beksinska M, van Zyl D, Cockburn J. Inclusive HIV prevention in South Africa: Reaching foreign migrant adolescent girls. Front Reprod Health 2021;3:629246. https://doi.org/10.3389/frph.2021.629246
40. Walker R, Vearey J, Nencel L. Negotiating the city: Exploring the intersecting vulnerabilities of non-national migrant mothers who sell sex in Johannesburg, South Africa. Agenda 2017;31(1):91-103.
41. Médecins Sans Frontières. Our activities in 2021 in Zimbabwe. MSF, 2021. https://www.msf.org/zimbabwe (accessed 13 March 2024).
42. Population Services International. PSI ensuring SRHR for all in Zimbabwe 2022 - 25. Openaid, 2022. https://openaid.se/en/activities/SE-0-SE-6-14481A0101-ZWE-12220 (accessed 13 March 2024).
43. International Organization for Migration. Sexual and reproductive health and rights remain a priority to IOM's work in southern Africa. IOM, 2021. https://southafrica.un.org/en/124582-sexual-and-reproductive-health-and-rights-remain-priority-ioms-work-southern-africa (accessed 13 March 2024).
44. International Organization for Migration. SRHR-HIV Knows No Borders (KNB) project: A synthesis report of the regional, national, and community dialogues. Migration Health Research Portal, 2020. https://migrationhealthresearch.iom.int/srhr-hiv-knows-no-borders-project-synthesis-report-regional-national-and-community-dialogues (accessed 13 March 2024).
45. Kingdom of Lesotho. Lesotho HIV Strategic Plan: 2018 - 2023. National AIDS Council, 2018. http://nac.org.ls/wp-content/uploads/2019/06/Lesotho-HIV-Strategic-Plan-2018-2023.pdf (accessed 13 March 2024).
46. Joint United Nations Programme on HIV and AIDS. Botswana extends free HIV treatment to non-citizens. UNAIDS, 2019. https://www.unaids.org/en/resources/presscentre/featurestories/2019/september/20190924_Botswana_treatment_non-nationals (accessed 13 March 2024).
47. South African National AIDS Council. South Africa's National Strategic Plan for HIV, TB, and STIs 2017 - 2022. Pretoria: Republic of South Africa, 2017. https://www.gov.za/sites/default/files/gcis_document/201705/nsp-hiv-tb-stia.pdf (accessed 13 March 2024).
48. International Organization for Migration. Migrants right to health in southern Africa. IOM, 2017. https://www.migration.org.za/wp-content/uploads/2017/08/Migrants-Right-to-Health-in-Southern-Africa.pdf (accessed 13 March 2024).
49. Kingdom of Eswatini. Voluntary review report on the status of implementation of the global compact for migration in Eswatini – 2022. Migration Network, 2022. https://migrationnetwork.un.org/system/files/docs/Eswatini%20-%20Voluntary%20GCM%20Review.pdf (accessed 13 March 2024).
50. Multicultural Centre for Women's Health. Sexual and reproductive health. MCWH, 2019. https://www.mcwh.com.au/project/sexual-and-reproductive-health/ (accessed 13 March 2024).
51. Institute of Social and Preventive Medicine. ISPM Bern's Sexual and Reproductive Health group collaborates on newly awarded grant to improve the sexual health of migrants and refugees. ISPM, 2017. https://www.ispm.unibe.ch/about_us/news/collaborate_to_improve_the_sexual_health_of_migrants_and_refugees/index_eng.html (accessed 13 March 2024).
52. Arnott G, Otema C, Obalim G, Odallo B, Nakubulwa T, Okello SB. Human rights-based accountability for sexual and reproductive health and rights in humanitarian settings: Findings from a pilot study in northern Uganda. PLoS Glob Public Health 2022;2(8):e0000836. https://doi.org/10.1371/journal.pgph.0000836
53. Ivanova O, Rai M, Kemigisha E. A systematic review of sexual and reproductive health knowledge, experiences and access to services among refugee, migrant and displaced girls and young women in Africa. Int J Environ Res Public Health 2018;15(8):1583. https://doi.org/10.3390/ijerph15081583
54. Mengesha Z, Hawkey AJ, Baroudi M, Ussher JM, Perz J. Men of refugee and migrant backgrounds in Australia: A scoping review of sexual and reproductive health research. Sex Health 2022;20 (1):20-34. https://doi.org/10.1071/sh22073
55. Baroudi M, Nkulu-Kalengayi F, Goicolea I, Jonzon R, San Sebastian M, Hurtig A. Access of migrant youths in Sweden to sexual and reproductive healthcare: A cross-sectional survey. Int J Health Policy Manag 2022;11(3):287-298.
56. Faturiyele I, Karletsos D, Ntene-Sealiete K, et al. Access to HIV care and treatment for migrants between Lesotho and South Africa: A mixed methods study. BMC Public Health 2018;18(1):668. https://doi.org/10.1186/s12889-018-5594-3
57. Davidson N, Hammarberg K, Romero L, Fisher J. Access to preventive sexual and reproductive health care for women from refugee-like backgrounds: A systematic review. BMC Public Health 2022;22(1):403 https://doi.org/10.1186/s12889-022-12576-4

Received 7 March 2024; accepted 27 May 2024.