



Health care access and challenges: A case study of women migrant labourers in Newcastle, KwaZulu-Natal

By

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DECLARATION

I Mlungisi Lungisile Ntshangase declare that:

1. The research reported in this thesis, except where otherwise indicated, and is my original research.
2. This thesis has not been submitted for any degree or examination at any other university.
3. This thesis does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
4. This thesis does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:
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Student name: Mlungisi Lungisile Ntshangase

Signature: 

Signature Date: 31 July 2023

DEDICATION

Special dedication to my family the Ntshangase clan, my wife, and sister for the unwavering support throughout my academic life. A special dedication to the Almighty God for the strength, wisdom and courage, He placed in me.

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I am greatly indebted to the late Elma Nell, (may her soul continue to rest in peace), whom I have worked with at Madadeni Thuthuzela Care Center and to the entire facility staff for the time and opportunity I had working with the municipality. My sincere gratitude also extends to the municipality and the ward council of ward 24, Mr. S. Shabangu. I cherish your generous support in preparing a suitable ground for my field work.

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LIST OF ACRONYMS

AFP	African Health Placements
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
AU	African Union
CARISA	Cancer Research Institute of South Africa
CD4	Cluster of Differentiation
CoRMSA	Consortium for Refugees and Migrants in South Africa
CTOP	Chocie on Termination of Pregnancy
DFID	Department for International Development
EC	Emergency Contraception
FC	Female Condom
FP	Family Physician
FP	Family Planning
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
HTS	Health Testing Services
IILS	International Institute for Labour
ILO	International Labour Organization
IOM	International Organization for Migration
MC	Male Condom
MDG	Millennium Development Goals

NCD	Noncommunicable Diseases
NDoH	National Department of Health
NHI	National Health Insurance
NSP	National Strategic Plan
OAU	Organisation of African Unity
OI	Opportunistic Infections
PHC	Primary Healthcare
PMTCT	Prevention of Mother to Childhood Transmission
PRPs	Permanent Resident Permits
SACU	Southern African Customs Union
SADC	Southern Africa Development Community
SAMP	Southern African Migration Project
SAPS	South African Police Services
SDH	Social Determinants of Health
SLF	Six Livelihood Capitals
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
TB	Tuberculosis
TOP	Termination of Pregnancy
TRPs	Temporary Resident Permits
UKZN	University of KwaZulu-Natal
UN	United Nation
UNDP	United Nations Development Programme
VIA	Visual Inspection with Acetic Acid

WHO

World Health Organizations

ABSTRACT

Extreme economic disparity, both within and between nations, as well as unequal national political settings, characterize Southern Africa. “In 2019, 272 million people worldwide were international migrants” (Jinnah, 2020). Different types of cross-border mobility take a pivotal role in the livelihoods of both individuals and households in these circumstances. Historically, formal male migrant labour had dominated intra-regional labour mobility, particularly in the mining industry in South Africa (SA). Even now, the major destination is still South Africa, but over the past 20 to 25 years, political and economic shifts have led to a greater diversity of intra-regional migrant flows by location, temporality, and demography, including gender. Additionally, migrants' jobs and means of support now cover a diverse range of formalities, industries, and security. Female migrants often work in feminized labour, such as domestic and care work, but they also engage in a variety of service sector jobs and informal cross-border trading. Their presence in the labour market puts them in confusing and contentious relationships with South African citizens, who also deal with high unemployment and insecure employment rates. As a result, immigrants face xenophobia, gender and employment vulnerability and are accused of "taking jobs" from South African citizens.

There is a great heterogeneity and history to migration in Southern African Development Community (SADC), including but not limited to, forced migrants fleeing conflict; individuals moving in search of improved livelihood opportunities; asylum seekers and refugees; traders and seasonal workers displaced within their own countries or moving cross-border - some have legal documents while others are without (Crush et al., 2005). In cases of labour migrants each situation may create and respond to its own set of health concerns, dependent on part upon where migrants work and live, the duration and conditions of their stay, and whether and when they return home (Preston-Whyte, 2006:33).

Various interrelated factors account for migrant health, including behaviour, health-seeking behaviour and care-seeking decisions. Some behaviours are born of vulnerability, such as risky sex to procure food security, and some vulnerabilities are born of discrimination. Furthermore, health is not solely a physical condition that should be attained or maintained, but one that also incorporates mental health, which can be damaged through trauma, torture or depression, and ultimately causes much detriment to the well-being and the ability to adapt to a new environment (IOM, 2013; UNAIDS, 2014). The behaviour of health professionals has similarly

been indicated as one of the two factors that most determine the use or non-use of health services by immigrant communities.

Studies suggest that these professionals frequently present a limited knowledge of legislation and/or its applicability and act in accordance with social stereotypes (Wolffers & Fernandez, 2003 and Dias et al., 2010), not responding to the effective needs of the users. In addition, they tend to have no cultural competencies necessary to relate with users from other nationalities, and do not know their specific characteristics (Pusseti et al., 2009).

The South African legislative framework advocates for the universal acquiring of health services and the basic determinants of health. The National department of health has committed to providing efficient, equitable and accessible health services to all people residing within the country regardless of their identity status. Inaccessibility of healthcare service not only violate women migrants' rights, but also may results in increasing the prevalence rate of Human Immunodeficiency Virus (HIV); Sexually-transmitted Infections; Prevention of Mother-to-Child Transmission (PMTCT); Non-communicable diseases and Child mortality rate. This may also threaten the women labour migrants' lives if they had not taken necessary precautions. Women labour migrants from Southern Africa, working in the Newcastle Municipality textile industry, are also not immune to the challenges of healthcare accessibility. This study examines the experience of women migrants labourers from Southern Africa to determine their accessibility to healthcare services given their working conditions, culture shock, language barrier and their socio-economic conditions.

This is an empirical qualitative study that adopted in-depth interviews for the data collection of women labour migrants' views and experiences regarding access to healthcare services within Newcastle Municipality in KwaZulu-Natal Province. The in-depth interviews were purposively conducted with 35 participants from Newcastle textile firms, and these comprised 7 key informants. The sample was only limited to women labour migrants from Southern Africa working in the textile industries within Newcastle Municipality. The analysis of the *datum*, which was intended to give meaning to the conundrum of women labour migrants' access to healthcare services, adopted a thematic analysis that capitalized on structured themes throughout the analysis process.

The study employed the theories of intersectionality feminism, the health capability approach thus including capabilities of gender inequality, access to health care, and the social exclusion theory. This study found out that within the transnational space, women experienced overt and

covert issues regarding access to health-care services on transition and during their stay whilst working in the textile industry. However, there were some factors that influence their utilisation of healthcare facilities within the Newcastle Municipality area, these include culture, degree on basic education, the number of years stayed in the area and spoken language.

TABLE OF CONTENTS

DECLARATION.....	ii
DEDICATION.....	iii
ACKNOWLEDGEMENTS	iv
LIST OF ACRONYMS	v
ABSTRACT.....	viii
TABLE OF CONTENTS	xi
TABLES' LIST	xvi
LIST OF FIGURES	xvii
CHAPTER 1: INTRODUCTION AND BACKGROUND.....	1
1.1 Introduction	1
1.2 Background of the study.....	1
1.3 Problem statement.....	5
1.4 The significance of the study	6
1.5 Research objectives	7
1.6 Key questions	7
CHAPTER 2: LITERATURE REVIEW AND THEORETICAL FRAMEWORK	10
2.1 Introduction	10
2.2 Theoretical framework	10
2.2.1 Intersectional feminist approach.....	10
2.2.2 The health capability approach.....	14
2.2.3 The social exclusion theory	19
2.3 Literature review	22
2.3.1 Historical trends of migration	22
2.3.2 Migration as a global phenomenon.....	23
2.3.3 Labour migration within the South African context.....	28
2.3.4 Migration system in South Africa	32
2.3.5 The rights to migrants/refugee as per UN Convention	33
2.3.6 Migration trends in Southern Africa	34
2.3.7 South African Immigration Act	38
2.3.8 Morbidity and the spread of HIV/AIDS.....	38
2.3.9 Gender migration and feminization of migration	39
2.3.10 Access to healthcare services	40
2.4 Conclusion.....	49

CHAPTER 3: RESEARCH METHODOLOGY	50
3.1 Introduction	50
3.2 Research design	50
3.3 Research methodology	50
3.4 Data collection method.....	51
3.5 Sampling procedure	53
3.6 Study site	54
3.7 Population of the study	54
3.8 Background data of the study participants	55
3.8.1 Participants' profiles	55
3.9 Ethics-related matters.....	69
3.10 Data sources	70
3.11 Data analysis	70
3.12 Limitations of the study	70
3.13 Self reflexivity	72
3.14 Positionality.....	73
3.15 Summary	74
CHAPTER 4: BACKGROUND ON WOMEN LABOUR MIGRATION INTO THE NEWCASTLE AREA.....	75
4.1 Introduction	75
4.2 The context of Newcastle Municipality	76
4.2.1 Description of the study area	76
4.2.2 Newcastle area health sector	77
4.2.3 Newcastle area population	78
4.2.4 Newcastle area cultural background	78
4.3 Women labour migration in the Newcastle Municipality.....	79
4.3.1 Economic opportunities	79
4.3.2 The role of social networks	81
4.3.3 Women labour migrants in transit.....	82
4.3.4 Poor living conditions at the destination	83
4.3.5 Violence, abuse and exploitation	84
4.4 Migrants working conditions at the Newcastle textile industries	87
4.5 Conclusion.....	89
CHAPTER 5: MIGRANT WOMEN HEALTHCARE NEEDS AND ACCESS TO HEALTHCARE SERVICES	91

5.1 Introduction	91
5.2 Factors that influence health care for women labour migrants in the textile industry	91
5.2.1 Governance.....	95
5.2.2 Structural determinants and socio-economic position	96
5.2.3 Gender	97
5.2.4 Ethnicity	97
5.2.5 Nationality	98
5.2.6 Education.....	99
5.2.7 Occupation	100
5.2.8 Income (urban livelihood activities).....	100
5.2.9 Migration status.....	101
5.2.10 Xenophobia.....	102
5.3 Health care needs of women labour migrants and psycho-social needs.....	103
5.3.1 Family planning	105
5.3.2 Male and female condoms.....	108
5.3.3 Emergency contraception	110
5.3.4 Human Immunodeficiency Virus counselling and testing	112
5.3.5 Prevention of HIV/AIDS	113
5.3.6 The National guidelines on PICT	115
5.3.7 Cervical cancer screening	119
5.3.8 Prevention of mother-to-child transmission.....	120
5.3.9 Post exposure prophylaxis	121
5.4 The knowledge of women migrants on health care services in the Newcastle area	123
5.5 Exploring socio-cultural influences on women migrants accessing healthcare services.....	127
5.5.1 Cultural patterns in health-seeking behaviours	129
5.6 Conclusion.....	132
CHAPTER 6: CHALLENGES ENCOUNTERED BY WOMEN MIGRANTS IN ACCESSING HEALTHCARE SERVICES AND THEIR COPING STRATEGIES..	133
6.1 Introduction	133
6.2 Facility-level policy decisions	135
6.2.1 Language barriers	136
6.2.2 Negative attitude of healthcare workers.....	138
6.3 The external factors	143

6.4 Coping strategies, various aspects of livelihoods capital and how they influence women labour migrants coping and adaptation mechanism	144
6.4.1 The livelihood capitals of coping and adaptation of migrant women.....	144
6.4.2 Human capital.....	146
6.4.3 Social capital	149
6.4.4 Economic capital.....	151
6.4.5 Political capital.....	153
6.4.6 Cultural capital.....	155
6.4.7 The available livelihoods	155
6.5 Conclusion.....	156
CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS.....	158
7.1 Introduction	158
7.2 Summary of the study's findings	160
7.2.1 Migrant women health-seeking behaviour and socio-cultural influence with regard to access to healthcare needs	162
7.2.2 Challenges encountered by women labour migrants in accessing healthcare services in the Newcastle area.....	164
7.3 Possible interventions in the area of women migrants' access to healthcare services: Recommendations.....	168
7.4 Key contributions of the study	170
7.5 Suggestion for future research	173
8. REFERENCES.....	175
9. APPENDICES	196
Appendix 1: Interview Guide	196
Appendix 2: Informed Consent Form	197
Appendix 3: Gatekeeper's Letter.....	203
Appendix 4: Ethical Clearance	204

01 August 2018

Mr Mlungisi L. Ntshangase 216077015
School of Social Sciences
Pietermaritzburg Campus

Dear Mr Ntshangase

Reference number: HSS/0135/018D

Project title: The experiences of women migrant labourers from Southern Africa: A conundrum of accessing health care services in Newcastle Municipality, KwaZulu-Natal Province.

Full Approval – Full Committee Reviewed Application

With regards to your response received on 29 July 2018 to our letter of 28 March 2018, the Humanities and Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.


Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully


.....
Prof S Singh (Chair)
/px

cc: Supervisor: Dr Janet Muthuki
cc: Academic Leader Research: Prof Maheshvari Naidu
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TABLES' LIST

Table 5. 1. A description of the structural causes of health disparities and the experiences of female labour migrants working in the textile industries in Newcastle	93
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LIST OF FIGURES

Figure 4. 1: Newcastle Map	76
Figure 6. 1: Livelihood capitals framework.....	145

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

Access to healthcare services for women migrant's labourers can come with a lot of challenges and benefits. This study seeks to determine the accessibility to healthcare services given the migrant workers' working conditions, cultural shock, language barrier and their socio-economic conditions. To the knowledge of the researcher, there have been no explicit studies focusing on international women labour migrants in the textile industries in Southern Africa. This study seeks to identify the challenges not covered by existing literature and inform new policies and strategic frameworks to ensure equitable, efficient and effective access to healthcare services for women labour migrants from Southern Africa. The research chapter presents the background that would place the study into context.

The background and a problem statement are provided to contextualize the study. The study's objectives and important questions have been examined, as well as the concepts upon which this study is based. The study found that women labour migrants' access to healthcare services was largely determined by their familiarity with locations where they could obtain health care and the number of years they had worked in South Africa (SA), as well as their comfort with speaking the local languages and English. The significance of the study is explained in this chapter. Finally, the chapter outlines the dissertation's breakdown and organization.

1.2 Background of the study

Globally, 272 million individuals migrated internationally in 2019, according to Jinnah (2020). This applies to people who are migrating for work, travelers, students, and other individuals. The persistent anxieties following Western operations in these countries can be linked to more recent forced migration patterns from Syria, Libya, and Iraq into Europe. War, threats, or insecurity resulted in the forcible displacement of 71 million people from their homes in 2019. The majority of individuals, 41 million, are still considered internally displaced people and are still living in their home countries, while the 30 million have fled their country and are now refugees. In Europe and North America, there have been the most reported refugees. Ten percent of all refugees worldwide are housed and protected in Uganda, Sudan, Turkey, and Pakistan. Access to social welfare and health services is critical for the wellbeing of migrants as these are fundamental principles of human rights especially for women labour migrants.

Discrimination, physical remoteness from resources, a lack of knowledge diffusion, and other factors can all contribute to women labour migrants' lack of acquiring health services (Vearey & Nunez, 2010). Migrants frequently have legal rights to treatment for Human Immunodeficiency Virus (HIV) and other chronic conditions, but many are either uninformed of these rights or choose not to use them because of discrimination, as was previously highlighted. While the migrant-labour system was clearly implicated in the early transmission and spread of syphilis, tuberculosis (TB), and HIV, especially in relation to the ongoing systems of labour migration associated with the mines in SA, these dynamics have changed over time, and the association between migration, mobility, and health in the region is complex, according to Vearey & Nunez (2010). For individuals who relocate, both within and beyond borders, determining, testing, and treatment programs for Noncommunicable Diseases (NCDs) and common communicable diseases across the Southern Africa Development Community (SADC) member states must be consistently available.

The insufficient care of chronic illnesses for people who relocate was a major problem in 2014. This has detrimental effects on the well-being and the economical productivity of individuals who move about a lot, as well as on the health systems and family structures that must deal with the expenses of delayed healthcare seeking. The likelihood of catching or spreading HIV changes with increasing or risky sexual behaviour, (between generations, during transactions, etc.), but there are other contexts for this behaviour outside the correlation between migration and risky sexual behaviour. Sexual behaviour may be directly impacted by vulnerabilities (such as hunger), in some cases intimacy is utilized as a transaction to ensure safety or food security. Additionally, migrant workers who split from long-term spouses are more likely to have relationships with new partners, which puts them at greater danger (Lurie et al., 2003). Changes in sexual behaviour could also put immobile population at risk, as in the case of spouse of migrants who remain at their home country (Kishamawe et al., 2006).

For instance, Lopes (2007) confirmed in the study with a group of immigrants who were HIV-positive and seeking obstetrics services at a hospital in the Lisbon region, that the medical staff was not particularly helpful in their contact with the users and gave them very little information about HIV. Dias et al. (2010) claim that health technicians' ignorance of cultural characteristics of immigrants' sexual and reproductive behaviour affects both the number of women experiencing pregnancy, childbirth, parenting as well as how they use health services. A study on family planning concerns among Timorese female immigrants to Portugal by Manuel

(2007), revealed that the indigent ways of life and the situations in which the Timorese women found themselves after arriving in Portugal affected their attitudes toward reproduction.

A development strategy in Sub-Saharan Africa has identified migrant access to healthcare as a component. Gonah, Corwin, January, Shamu, Nyati-Jokomo, and Van der Putten (2016) made the following argument in a journal article: "Although language barriers, mistrust of, and fear of discrimination from healthcare workers are often the main factors impeding access to healthcare, they are not always the case." This may also be reinforced by the idea that migratory populations may be more susceptible to illness and encounter obstacles while trying to get medical care. Therefore, it is crucial that populations of migrants take into account potential obstacles to receiving healthcare services before migrating. World Health Organization (WHO) contends further that the majority of migrants from Sub-Saharan Africa frequently leave without giving adequate thought to any potential obstacles to receiving health needs they may encounter while residing in host countries. It has been established that language, service costs, health insurance, and the degree of illness among migrants have a greater impact on their decision regarding a healthcare provider than other factors. The most common barriers to accessing healthcare services are those related to language and communication, from which the majority of other hurdles were found. Baah-Boateng et al. (2013) validated the existence of these barriers.

Argued by Samantha (2018), migrants run the risk of being excluded from universal health coverage (UHC) as internal and international migration expand in breadth and complexity. The Sustainable Development Goals acknowledge UHC as supporting and balancing all health targets in recognition of the connections between health and development (WHO, 2015). In order to adjust UHC to local demographic, epidemiological, and technical conditions, frequent monitoring of progress is necessary (World Bank, 2015). The UHC ensures that everyone has access to cheap, high-quality, essential health services.

According to Ponce et al. (2006), one of the main hinderances to accessing health care is a lack of language proficiency in the host nation, which deters immigrant women from seeking assistance in the event of an illness or pregnancy. Most of the time, language translators are not available in health facilities, therefore, women are forced to use their partners or other family members as language translators due to non-availability of translators within the health care facilities, this then becomes an impediment for the migrants workers to confidently express their most private problems (United Nations Population Fund, 2006). From a different

perspective, in cases of domestic violence, this dependence may prevent victims from informing the authorities about the incident. It is crucial to emphasize that pregnant victims of violence have greater health issues than non-victims do, especially during the second trimester (Morewitz, 2004). Furthermore, some female immigrants experience discomfort and even disrespect as a result of the application of some medical acts, such as medical assistance by male doctors or the requirement to expose private body parts during clinical observation, because of the traditional norms of their countries of origin, which are deeply rooted in conservatism and the patriarchy (Mestheneos et al., 1999 apud Dias et al., 2009).

Barriers to service accessibility in the healthcare setting were also listed in the 2016 National Adherence Guideline Strategy for HIV, TB, and NCDs by the South African Department of Health. The impediments that have been found include organizational, socio-demographic training, medical, family and social support, behavioural, cognitive, affective, and communication issues. While some of the obstacles are patient- and social-environment-related, others are provider-related. While analyzing the experiences of women labour migrants' access to healthcare facilities in Newcastle municipality, it is imperative that the researcher also align himself with the generally recognized barriers.

The Southern Africa Development Community, in line with the UN objective, has declared access to health care for everybody. In South Africa, primary healthcare services are accessible for free. This study focuses on the accessibility of healthcare services by migrant women in the Newcastle area. The area attracts the highest number of women labour migrants from Southern Africa as the municipality has a number of textile industries. Newcastle municipality has a total of 85 textile industries which employed about 7000 people by the year 2012. A new bill in the year 2012 passed by the bargaining council for textile industries prompted the employers to consider employing migrant labourers as they could not afford to amend the adopted minimum wage for South African labourers. Newcastle Municipality attracts the highest number of migrant labourers from Southern Africa in the KwaZulu-Natal province.

This Industry attracts women migrants from Southern African countries as there is no strict application of the Employment Act. However, without statutory regulations in place, employees may be exploited. Access to medical care for women has been declared a priority area by the United Nations Organization. Research findings by International Labour Organization (ILO) in a paper presented in Geneva in 2003 has proven that women labour migrants are exploited, abused and discriminated. Inaccessibility of healthcare service not only

violate women migrants' rights, but also may results in increasing the prevalence rate of HIV/AIDS, STIs, PMTCT, Non-communicable diseases and Child mortality rate. This may also threaten the women labour migrants' lives if they had not taken necessary precautions. In most instances, migrants do have legal rights to HIV treatment and other chronic diseases but are either unaware of these rights or prejudice against them and therefore do not seek out care. Vearey & Nunez (2010) have also indicated that a large body of evidence acknowledges that the relationship between migration, mobility and health in the region is complex. Similarly, migrant workers separated from permanent partners are more likely to engage in relationships with other partners, exposing themselves to heightened risk (Lurie et al., 2003). Changes in sexual behaviour may also pose a risk factor to non-mobile persons, such as the partners of migrants who remain at their home countries (Kishamawe et al., 2006).

1.3 Problem statement

In many developing countries, women constitute the majority of emigrants as they vacate their homes in search of a better income in industrialized cities or countries. Approximately, about half of all migrants in the 21st century is female (Ehrenreich and Hochschild, 2002; FIDH, 2009). Women heading households and women in need of greener pastures find it imperative to migrate to bigger cities in search for better paying jobs and economic opportunities. Migration has also been a mode for survival in the face of increasing poverty and economic marginalization.

Historically, labour migration has been associated with men as they had, through the patriarchal system, been the heads and family providers, more especially from rural areas. Nowadays, women find themselves migrating to bigger cities, industrial sites and better developed areas in search for employment to be able to provide for their families after being neglected by husbands or in cases where the husband or bread winner has passed on. Some of those migrating to bigger cities are able to find jobs while most of them become exploited and abused in transits and in places where they have settled during their stays as labour migrants.

The study seeks to explore and examine the relationship between the women labour migrants and place of host, by assessing the levels of access to healthcare services as well other challenges. The study also explores women labour migrants' coping mechanism within Newcastle municipality as well as the access to primary healthcare services, while exploring their knowledge and understanding regarding services available for HIV/AIDS, STI's and TB. The area has a significant number of textile factories that attract mostly women labour migrants

from the SADC region countries like Lesotho, Eswatini, Botswana, etc. The mobility for women labour migrants within the area is limited due to the fear of being identified as migrants, deported, and stigmatized, thus resulting in poor decision-making regarding issues concerning health care and psychosocial support. Furthermore, the level of violence is high compared to other provinces, especially sexual abuse. The area has also been listed, on the HIV index districts, as one of the areas with high HIV/AIDS prevalence rate within the province. Thuthuzela Care Centre (Victim Support Center) has been prioritised for such areas because of the high sexual assault rates mostly directed to women by men, nevertheless, there have been incidences where sexual assault violence is directed to men by women.

1.4 The significance of the study

The study is significant as it seeks to uncover if indeed the country's legislative and legal framework provides everyone with the universal access to health care and the basic determinants of health. This also identifies if there is a commitment by the health department in providing efficient, equitable services and medical care to the population residing within the borders of the country regardless of their identity status. Inaccessibility of healthcare service not only violates women migrants' rights but also results in increasing the prevalence rate of HIV/AIDS, STIs, PMTCT, Non-communicable diseases and Child mortality rate. This also threatens the women labour migrants' lives if they had not taken necessary precautions.

Newcastle municipality is a sub district within Amajuba district in KwaZulu-Natal, northern part of the province. Women labour migrants flock to the city in search for jobs and life opportunities in local factories and shops, but they end up residing in areas closer to town as they cannot afford staying in the city.

Women labour migrants from Southern Africa working in the Newcastle Municipality textile industry are also not immune to the challenges of healthcare accessibility. The study examines the experience of women migrant labourers from Southern Africa to determine their accessibility to healthcare services given their working conditions, cultural shock, language barrier and their socio-economic conditions.

The study is significant because it firstly shares the views of women labour migrants regarding access to healthcare services as this is a human right issue and their rights are protected through the health international convention which South Africa is a signatory to. Secondly, the researcher was interested in identifying barriers to access to healthcare services by women

labour migrants and identifying possible means of improving such accessibility. These have been identified and possible recommendations have been listed as well.

1.5 Research objectives

The objectives for this research are as follows:

- 1) To explore women migrant labourers' healthcare needs.
- 2) To investigate the knowledge of women migrants on healthcare services available to them.
- 3) To explore socio-cultural influences on women migrants accessing healthcare facilities.
- 4) To examine challenges encountered by women migrants in accessing health care.
- 5) To explore possible interventions in the area of women migrants' access to healthcare services.

1.6 Key questions

- 1) What are the healthcare needs of women migrants working in Newcastle textile factory industries?
- 2) What healthcare services are women migrants labourers aware of within the Newcastle municipality area?
- 3) How does the women labour migrants' socio-cultural background influence their access to healthcare services?
- 4) What are the challenges encountered by women labour migrants in accessing health care?
- 5) What could be the possible interventions in improving access to health care services for women labour migrants?

1.7 The Structure of the thesis

This work is comprised of seven chapters.

Chapter One: Introduction

The study's background, significance of the study, research objectives, essential research questions, problem statement, study justification, and dissertation format are all presented in this chapter.

Chapter Two: The Literature review and theoretical framework

The current literature on this topic was thoroughly reviewed in accordance with the study questions for identifying the study gap that the researcher seeks to address. The chapter's purpose is to identify the research gaps by presenting the literature on women labour migrants with an emphasis on their access to healthcare services. The focus of the review is on the topic of access to healthcare for female labour migrants. The researcher focuses on women labour migrants, migration internationally, contextualization of migration in Africa, and migration in South Africa as a phenomenon.

Chapter Three: Research methodology

In order to address the primary questions that serve as the study's compass, this chapter describes the methodology employed to conduct the investigation. The chapter consists of data collection method, sampling procedure, sampling size, study sites, and population of the study. The research further discusses the background information about the interviewed participants, ethical consideration, data sources and analysis. The limitation of the study, self reflexivity, positionality and the conclusion of the chapter is discussed.

Chapter Four: Background on women labour migration in the Newcastle area

The chapter presents the background on women labour migration in the Newcastle area. The chapter provides the contextual background on women labour migrants in the Newcastle textile industries as well as factors influencing women labour migrants in the textile industry with focus on social networks, and poor living conditions at destination exploring violence, abuse and exploitation. Factors influencing women labour migrants migrating to Newcastle area migrants and working conditions that labour migrants are exposed to within the Newcastle textile industries.

Chapter Five: Migrant women health-seeking behaviour and socio-cultural influence regarding accessing health needs.

The chapter outlines the healthcare needs of the migrants in relation to family planning, prevention of mother to child transmission, cervical cancer screening, emergency

contraceptive, post-exposure prophylaxis and HIV/AIDS. The chapter also discusses the psychological aspects for women labour migrants and their health-seeking behaviour with focus on the influence of the social cultural norms, ethnicity, nationality, gender, educational level, poverty, etc. Moreover, the chapter discusses the knowledge of access to healthcare services by women labour migrants within the Newcastle area.

Chapter Six: Challenges encountered by women labour migrants in accessing health care services in the Newcastle area

The chapter discusses the challenges that are encountered by women migrants in accessing health services within the area. Challenges relating to language barrier, negative attitude by healthcare providers, facility level policy discussion and the six livelihoods capitals that women labour migrants could have possibly used to enhance ability to influence decision regarding choice to access healthcare services. The six capital livelihoods are, human capital, education capital as a factor, health as a capital factor, knowledge and skills, social relation of trust and mutual support influence on accessing healthcare services.

Chapter Seven: Conclusions and recommendations

The entire study is summarized in this chapter. The findings for this research are reviewed while keeping in mind the overall goals of this study. The research contributions to the body of knowledge are listed here. Finally, the researcher offers suggestions on further research based on this study's contributions and conclusions.

CHAPTER 2: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter provides the framework for understanding how the chosen theories by the researcher are applied to the study of female migrant workers. In ensuring the laying of the groundwork for the study and close any gaps in the literature, this chapter investigated the theories on labour migration and determinant of repercussions on gender and migration in transnational space. In doing so, the researcher provides explanations for the study and stresses on how easily women labour migrants can receive medical care. The chapter also reviews previous research on the obstacles faced by female labour migrants in accessing healthcare services and other difficulties they face throughout their journey while also identifying any gaps in the prior research.

2.2 Theoretical framework

The theoretical framework that guides this study is discussed below. It is followed by the reviewed literature relevant to this study.

2.2.1 Intersectional feminist approach

Intersectional analysis for the study is important, as Crenshaw's (1989, 1991) foundational analysis of legal redress of violence against Black women in the United States revealed, to ensure that African American women would not fall through the cracks of laws and policies that implicitly assumed that women were generically white or Black people were generically male. As a demographic that is easily identified as being less significant than the indigenous population, the intersectional approach, as an analysis, is crucial when examining the access to health services for women labour migrants. As argued by Stasiulis, Jinnah & Rutherford (2020) that almost all of the original intersectionality writers were women, the topics of analysis were almost exclusively oppressed women or less frequently women who were privileged due to their respective positions in connections and discourses of race/whiteness, class, sexuality, etc. Thus, the application of the intersectional feminist approach is critical for the purpose of this study.

Access to healthcare has been identified as a problem by the medical community, including feminist health care. Evidence-based information is required to integrate diversity of healthcare practices and healthcare services obtained by female labour migrants in the most possible effective way. Although most conventional healthcare conducted studies indicated that its

diversity-sensitivity incorporates one or two social/identity categories, feminist scholarship recognized the necessity to conceptualize diversity and accessibility to health care in terms of intersectionality. While intersectionality has certain advantages, there are drawbacks as well. The difficulties lie in figuring out which subjects are assumed to be overlapping, how power relations may be taken into account, and how complexity can be managed.

The intersectional feminist method is used in the study. The intersectional feminist perception is that people social economic status, race, class, gender, and sexual orientation can be affected by systems of discrimination like colonialism and globalization (Canadian Research Institute for the Advancement of Women, 2006: 7). A thorough theoretical framework for examining the various ways that Social Determinants of Health (SDH) influence women's health throughout their lives is provided by feminist intersectionality theory. McGibbon and Etowa's (2007) study of the health effects of the SDH's intersection with identities including race, social class, and gender advanced the concept of intersectionality by incorporating the ways that geographic factors might contribute to poor health outcomes.

A unique method of conceptualizing differences as they relate to a variety of identities is called "intersectionality" (Brah and Phoenix, 2004, Collins, 1991; 1998; Crenshaw, 1989; Lorde, 1984; Phoenix, 1998; Smith, 1998; Stewart and McDermott, 2004; Williams, 1997; Yuval-Davis, 1997). The theory has its roots in criticisms of second wave feminism that claim it ignores or minimizes distinctions and treats many forms of oppression as the sum of their separate, distinct forms, with some forms being significantly important in comparison with the rest (Mann and Huffman, 2005). According to the intersectionality theory, many oppressions are concurrent (for example, 'race', 'gender', 'class,' etc.), inseparable (for example, 'ethnicity' and 'sex' combined in their impact on daily life) and interwoven. The focus switches from a woman's social position with regard to various specific social groupings to their social position relatively to junction of a complex array of social identities.

According to Crenshaw (1989), intersectional feminism defines women's rights in a manner that highlights the variousness of political and social women's realities while focusing on the experiences of all women, particularly those whose social circumstance have received the least attention from political movements in terms of writing, research, or change. A human rights perspective on healthcare access was strengthened by McGibbon's (2009) intersectionality lens proposal. The SDH as outlined in the Toronto Charter, states that race, class, and gender, as well as the geographic or geographical settings of oppression are three areas at the intersections

of which she said health inequities might be properly described (Raphael, 2004). For instance, while experiencing housing or food insecurity separately can lead to specific identifiable effects and mental health pressures, women who go through both at once are affected in a manner that flout a straightforward additive analysis.

The Intersectional in this context is relevant as the study deals with a population of women labour migrants who are economic deprived of opportunities from their countries of origin. They are also geographically isolated as they hardly interact with the community due to ethnicity differences. Healthcare services are a vital part of women's health. The study examines their experience regarding access to healthcare services within the area where they reside. Their social status can also influence their attitude and behaviour regarding healthcare access.

2.2.1.1 Diversity and intersectionality

The narrowest understanding of diversity only considers racial and ethnic variety. A more constrained, but still constrained, perspective also considers gender. Diversity can refer to a wide range of social characteristics including those related to sexual orientation, age, physical or mental disabilities, categories, and in some circumstances, life philosophy (Nkomo and Cox, 1997). As they identify regions of resemblance and differences, these categories are regarded to have a significant role in issues of impartiality, personal entitlement, and social justice. Diversity is frequently used to describe the situation of minority groups.

However, it is significant to note that membership in distinct interest groups is assumed to influence one's perception of personal identity (both who one is and who one is not), and as a result, has broad consequences for one's day to day activities (Phoenix, 1998; Rummens, 2003). As circumstances changes, the relation between the social categories were rather naively conceptualized as independent or possibly additive. It is clear that majority of individuals recognize themselves or are identified by others as belonging to many different social groups over the course of their lifetimes. The human sciences' hierarchical legacy usually places emphasis on a particular, presiding identity or social location such as the characteristics of men and women as socially constructed or nationality (Donaldson & Jedwab, 2003; Wilkinson, 2003). Though, a number of frameworks have been used to comprehend numerous, distinct identities (Rummens, 2003). For a stacking approach, each social identity is regarded as a distinct layer of a person's overall personal identity. It accommodates each identity as independent of the others and disregards the significance of each identity for the individual.

Similarly, a radical approach desists from postulating any linkages among collective characters or changes in their salience through time and circumstance, placing a person in the base with diverse social identities spreading out from the core like spokes on a wheel. A centrifugal approach, which is the last, positioning a core-self that is surrounded by a number of separate social identities. The social identities nearest so as to near the center as the most significant, however, like the other two techniques, no linkages between the social identities are presumptively made. In contrast, an intersectional approach embraces the view of intersecting identities/social locations in the context of minoritization and is hence more advantageous for analyzing the relationships between identities (Rummens, 2003). Additionally, it presents a concept of power conscious diversity that might be used to both traditional and feminist healthcare systems. As a result, it guarantees a crucial diversity approach.

Intersectionality theory, which focuses concentration on the dissimilarities within the groups associated with a given category such as "racial" or gender groups, notably fundamentally been a concern in relation to the study of women, aboriginal people, immigrants, and people of colour (Wilkinson, 2003). Even though credit to diversity is abundant in the Social and Health Sciences, its roots are in African women's studies, which held that understanding black women's lives solely from a "race" or a "gender" perspective was inadequate. However, the term "intersectionality" first appeared in Crenshaw's (1989, 1991) analysis of how "race" and "gender" intersect in relation to violence against women of color. Collins (1991) used the term "matrix of domination" to describe convergence of "race" and "gender" at roughly the same time however has since accepted the term "intersectionality" (Collins, 1998). Diversity and the availability of healthcare for labour migrants cannot be considered simultaneously; these components are connected. Therefore, it is essential to look at both phenomena at once.

The study focuses on disadvantaged group that works within unbearable working conditions notwithstanding the fact that some may have been in the country illegally, thus making their movements restrictive as they are unaware of their rights. The study further focuses on examining difficulties encountered by women migrants in obtaining healthcare services. The role played by socio-cultural influence towards creating a need for women labour migrants to access healthcare service informs to study the needs and the role that might be a cause of gender disparities towards access to health care.

2.2.2 The health capability approach

Human development is a narrative of an individual's wellness. Historically, human beings move to search for better jobs or better life. Once they succeed, they escalate the socio-economic scale, whether as evaluated by income or by capabilities. Assistance of fundamental potential, at most within the areas of health, is key to enabling such upward mobility. Furthermore, individuals' dreams influence the kind of attempts, yet dreams become impossible to attain due to poverty, inequality, or social exclusion. Mobility can also cause difficulties to human development, ranging from overcrowded cities to widening inequality, as some get left behind. Advancing traditional obstacles frequently impede economic and social mobility and put in place a kind of social distance.

According to Sen (1993), "the health capability approach is a wide normative framework for the assessment of individual well-being, social arrangements, the design of policies, and proposals about social change in society". In examining the experience of international women labour migrants, the researcher evaluates the capability approach at the personal level, identifying the potential for individuals to act as agents of their own health. This includes the realm of subjective health psychology's self-control, efficacy, and motivation to achieve desirable health outcomes. In acting as an agent of own health, the focus is on one's capability in obtaining and extracting health information, knowledge, skills to preserve health and develop a set of habits, and conditions to prevent to the extent possible, the onset of morbidity and mortality.

Whilst examining the external and internal factors affecting women labour migrants from Southern Africa when accessing health care, the researcher explores their health care needs and investigating their knowledge about healthcare services available to them around Newcastle municipality. The research considers individual activities, empowerment, multidimensional poverty and assessment of health and social care services. The external factors emulating the accessibility to the healthcare facilities, socio cultural influences on women migrants accessing healthcare facilities and examining challenges encountered by women migrants in accessing health care. Internal emulating the working hours, employee wellness programs, flexibility of accessing healthcare services, moral support etc. Physical activities being individual lifestyles, behaviour; individual empowerment seeking to consider any form of support from either employer or facility providing service.

Humans can be pushed by dreams to move which can be viewed as influential drive of progress. Therefore independent', household', or communities' pursuit of their aspirations translates into improvements in their capabilities and functionings, however, it is a further question. Understanding people's aspirations and their capabilities to aspire, is critical in order for them to receive healthcare services.

2.2.2.1 The capabilities approach and its usefulness and access to healthcare services

According to Sen (1993), capabilities-based approach is an outcome of a long-term critique of the prevalent utilitarian approaches to evaluating welfare used in economics and development studies. John Rawls' concepts, as they were developed in his 1973 Theory of Justice, had a significant influence on how he came up with these ideas. In addition to being opposed to the notion that other members of society should have to give up privileges for the benefit of society as a whole, Rawls was a fierce opponent of utilitarian methods of evaluating welfare. According to his theory, social and economic disparities ought to be "organized" to mostly benefit the least advantaged.

Rawls argued that every citizen should have access to the "primary social 9 goods," ones that any rational person would choose, and that this list would include, but not be limited to, income. This position was similar to (though clearly developed independently) that of basic needs as a development strategy mooted in the 1970s. Sen, on the other hand, raised concerns with the definition of "primary goods" in his claim that the standard should not be the availability of material "goods" or wealth, but rather the wellness of individuals. He also criticises Rawls for failing to take into account interpersonal disparities in need (such as the possibility that some people may have physical or mental impairments) and his inability to transform commodities into well-being (Sen, 2007). According to Sen (2007), these interpersonal differences have a significant impact on social policy.

Sen's capabilities approach holds that policies should instead be assessed based on how well they enable people to perform socially acceptable functions rather than how well they can satisfy utility or increase money. The difference between capacities and functionings is crucial for our objectives. A person's "beings and doings" are referred to as their "functionings," while their "different combinations of [valued] functionings" are referred to as their "capabilities." As a result, proficiency is regarded as a troupe of utility tracks that reflect an individual's flexibility to lead any kind of life (Sen 1992: 40). Therefore, in terms of reproductive health, capacities would include things like the capacity to survive pregnancy and adulthood without

experiencing early death, whereas rates of maternal mortality would serve as an equal indicator of poor functioning.

In considering the function of human agency, the contrast between capabilities and functionings is particularly significant. When one person fasts for religious reasons and the other is a famine victim, they may both be similarly deficient in terms of functioning (such as enough nutrition), but they will not be equally capable because the hunger victim has no other options. Similar to how a person with HIV/AIDS in England has very different capacities than someone with HIV/AIDS in Bangladesh, a successful woman who has access to abortion has quite different talents than a poor woman. Sen would examine how these differences are explained using the capacity approach, taking into consideration not only inequalities in wealth but also social structures and norms.

2.2.2.2 Capabilities approach by Nussbaum

Based on Sen's theories, Martha Nussbaum's work from 2000 is a pioneering attempt to apply Universalist notions of justice to gender equality in non-Western contexts while ostensibly remaining sensitive to regional specificities. The widespread prejudice against women in the majority of developing nations and the fact that "considerations of justice for women have been disproportionately ignored in many conversations about international development" are two of Nussbaum's principal concerns (Nussbaum, 2000).

By creating a list of capabilities on which there can be cross cultural agreement, Nussbaum goes far further than Sen (who never created a list of fundamental capabilities and utilized them exclusively for cross-country comparisons). These include, among other things, right to life, bodily integrity, health, and participation in politics and the workforce. Nussbaum diverge from many development practitioners in this argument by criticizing both ethnic relativism in general and the categorization of any attempt to advance universalist concepts of women's rights as cultural imperialism. She claims that this trend fails to take into consideration the dynamism within and interpenetration between cultures and communities in a globalized society, as well as the history of protesting gender inequality within cultural and religious traditions outside of the West.

However, the researchers' goal is not to examine the justifications for and against creating such a comprehensive list, but rather the value of the general strategy. Nussbaum (2000) recognizes that Rawls' list of "basic goods" and her conception of capabilities are remarkably similar. But

Nussbaum adheres to Sen's position that welfare should be measured in terms of people rather than things, hence she rejects the recognition of the significance of any kind of commodity.

Nevertheless, Nussbaum (2000) addresses the "family" to examine what happens when principles of equality between the sexes conflict with competing claims from relatives and in-laws in recognition of feminist assertions that Rawls' conception of justice does not sufficiently take into account people's needs for belonging and affection. She is steadfast in her belief that, contrary to Rawls like Charles Taylor would contend, it is everyone's capacities that must be protected above everything else. According to Nussbaum (2000), there are benefits to considering issues pertaining to women's status and well-being in developing nations in terms of capabilities rather than concepts of rights. The next section describes the fundamental components of the reproductive rights framework before expanding on these concepts.

2.2.2.3 Capabilities and gender inequalities

The capacities framework can be especially helpful for examining issues of gender inequality, but to the researcher's knowledge, there hasn't been any application concerning reproductive health (except for Harcourt 2001). According to Robeyns (2003a), while capabilities are ontologically individualistic, in that they place a strong emphasis on the well-being of the individual, they are not. In contrast to the assertions of many of their detractors, they are ethically individualistic because they recognize the value of communal relationships, care, and cultural norms. According to Robeyns, "This is appealing for feminist study since ethical individualism rejects the concept that women's well-being may be subsumed under larger entities such as the household or the community, while not dismissing the impact of care, social relations, and interdependence" (Robeyns, 2003).

Given that reproductive health naturally emphasizes relative processes of sexuality and reproduction while emphasizing the well-being of individual women, this paradigm is likely to be especially useful in analyzing reproductive health. A further benefit for analyzing health outcomes is that this approach takes into account doings and beings in both market- and non-market settings (Robeyns, 2002). Health outcomes are not always improved by addressing issues like income, poverty, or access to health care in isolation from broader contextual parameters. By abandoning wealth and utility as the standard, we may reject instrumental strategies that prioritize reducing fertility or building up human capital at the expense of women's health while also recognizing how poor reproductive health can affect people from all socio-economic backgrounds.

The historical experience of maternal mortality in the UK provides an intriguing illustration of the latter point. Early in the 20th century, higher class women were more likely to die during childbirth because they tended to rely on doctors who frequently interfered with childbirth needlessly and to be hospitalized when hospitals lacked effective infection control. In contrast, the lower classes relied on traditional midwives who had extensive experience handling problems and gave birth at home (Loudon, 2000). The capacities approach, however, places issues of social justice, ethics, and distributional problems at the forefront of the discussion and offers a normative framework that is expressly founded on a theory of justice rather than general directives. Therefore, one would anticipate that such a strategy will offer the crucial link between broad-development discussions and focused health sector actions based on biological models of health.

2.2.2.4 Sen and Nussbaum on health

Sen and Nussbaum make references to the basic idea, in both of their writings, that health is a capability with inherent value and is necessary for other capabilities. The article "Why Health Equity?" asks this question. Sen contends: "Health equity may very well be a part of a larger framework of overall equity, but there are some 16 particular concerns relating to health that need to be forcibly incorporated into the evaluation of overall justice." (Sen, 2002: 663). He continues by arguing that evaluating questions of health equity by their very nature requires a multidisciplinary approach and that health equity depends on more than just how health care is distributed, which is the main point of contention in much of the international discussion about health inequality. Sen frequently criticizes the so-called "libertarians" "procedural" views to justice, which place the emphasis on just methods regardless of the results (Sen, 1999: 19).

He acknowledges that procedures matter and not simply results (functioning) matter in the context of health, as in other issues of social justice. Therefore, regardless of the outcome, discrimination in health care is a significant concern (Sen, 2002). He makes the argument that, despite the fact that women in most populations tend to have longer life expectancies than men, we should not favour males in terms of access to health services because processes as well as outcomes are crucial. On her list of essential skills, Nussbaum adds two items that are pertinent to reproductive health. The first is "bodily health" – the capacity to have excellent health including reproductive health, to be sufficiently fed, and to have a suitable environment to live in.

The second is "bodily integrity" which is defined as being free to move around; having one's physical boundaries respected; being safe from attacks as well as sexual violation, child sexual abuse, and domestic violence; and having access to opportunities for sexual fulfillment and reproductive choice (Nussbaum, 2000). Nussbaum wonders whether states should in this situation aim for functionality rather than capability and restrict choice in some ways by providing the underlying nature of health capabilities (Nussbaum, 2000: 91). Neither Sen nor Nussbaum provides a comprehensive examination of how such capacities may be treated methodologically or even of the complexity of policy in this area, beyond highlighting the inherent and instrumental contribution of health capabilities in terms of social justice. Without addressing the flaws or systematic biases against women in the healthcare system, it is common to make the implicit assumption that access to health care is always "positive."

More theorizing of this domain of social interactions can reveal how, for instance, education can also be a site of capability deprivation, as Unterhalter (2002) emphasizes in reference to their work on education. She takes on the use of education to advance the goals of the apartheid government in South Africa as an example, as well as the rampant abuse of schoolgirls that is currently taking place in the same nation, to demonstrate how education can be disempowering in some situations. Similar evidence exists in the discipline of health and family planning, showing that women seeking medical attention, especially impoverished women, are frequently treated disrespectfully and their basic needs are unmet. In the worst-case scenario, individuals become the casualties of unscrupulous behaviour, such as not getting informed consent, or even assault (Sen, Germain and Chen 1994; Kabakian-Khasholian et al 2000; Cottingham and Myntti 2002). Therefore, not only is there a problem with access to healthcare, but also with the nature and procedures of healthcare itself. While the study focuses on the health needs of female labour migrants, women's core healthcare needs are connected to their sexual and reproductive health. The understanding of the healthcare services that women labour migrants have access to in Newcastle municipality will also be a factor in this.

2.2.3 The social exclusion theory

According to the social exclusion theory, there are barriers that block some people from fully taking part in society or from enjoying a reasonable living level (Social Exclusion Unit, 2003). Social exclusion is most frequently attributed to monetary poverty, although there are other factors that might cause someone to be excluded, such as a disability, poor educational opportunities, substandard housing, and membership in an ethnic minority, unemployment, old

age, and poor transportation. The line between the causes, motivators, and social exclusion effect is frequently blurry (Bradshaw et al. 2004).

According to the social exclusion theory, developing social policies that precisely address the origins of these people's disadvantages is a better method to "include" them than simply giving them more money. Women labour migrants may experience isolation due to their work environment, ethnicity, and socialization status, which may lead to an inadequate allocation of health resources or attention from health officials since this may not be a major concern. Women who work as migratory labourers could also struggle to get essential services. This may involve having access to necessities like power and water supplies for the home, as well as to social isolation, a lack of civic engagement, and healthcare services.

2.2.3.1 Global dissemination of the social exclusion discourse

A more uplifting argument for the concept of social exclusion's rising popularity is that it was seen to offer unique intuition to the identity, roots and impact of poverty, deprivation, and discrimination. Several commentators believed in new direction to corrective policies and actions focusing attention at the procedures that underlie inequality, power relationships, agency (exclusion by whom?), the multidimensionality of disadvantage and the connections between various forms of deprivation (exclusion from what?). According to Sen (2000), "...we must try to evaluate major qualities of the current literature on social exclusion rather than conceptual departure" (Sen, 2000: 8).

The notion that the concept could provide a novel viewpoint on social reality, its primary emphasis on labour market relationships, and its 'fit' with the then-dominant neo-liberal politics may help to explain why, starting in the early 1990s, the discourse of social exclusion started to spread outside of Europe. The International Labour Organization (ILO) seems to have initially taken the initiative in advancing the idea into aid and development strategies in low-income nations. The idea may have connected with ILO's historic concerns of social cohesiveness, labour market participation, social fairness, and social organizations (specifically trade unions).

The aim of the investigator is deconstructing the utilization thereof the phrase social exclusion in European policy debates and to fashion a notion of social exclusion which is not Eurocentric while relevant globally, in a large scale of country settings. The ultimate intention was to clarify the interrelationships between poverty and social exclusion and to assess the potential usefulness of the research (Gore & Figueiredo, 1997:3).

The out of work, the aged, underage, and those with low levels of education were among the groups in the EU27 who were most at risk of poverty in 2007 (Eurostat, 2010). These so-called "vulnerable populations" are more susceptible to the unfavorable living situations that lead to health disparities. In reality, several of these populations are known to bear a disproportionately higher exposure to death as well as illness (EC, 2009). Poor health can also lead to poverty and social exclusion, particularly when using services ends in catastrophic and expensive medical costs (discussed more in the subsection on financing). People who have HIV and mental illnesses are also stigmatized and excluded, which can worsen health inequities.

Any of the four categories' social exclusion can cross with exclusion in others. A prime example of this is discrimination. It has a connection to the empirical differences on the physiological attributes and dimension but can also impact political, social, and economic dimensions. In one view on the prejudice within the EU, participants were asked how comfortable they would feel living next to different minority groups, with "1" denoting extremely uncomfortable and "10" denoting completely at ease. When a neighbour was Roma, the degree of solace with having a neighbour from a different ethnic background declined to 6.0 from 8.1 (EC, 2008).

There is evidence of discrimination towards Roma in several contexts (such as employment and education). Moreover, it was not surprisingly that the destitution rates among Roma were substantially greater than those of the general population and other socially excluded groups, given the widespread prejudice they face (Alam et al., 2005). Roma people might anticipate surviving ten years less than the majority population in some nations as a result of such complex exclusion.

Additionally, gender inequality interacts with other forms of inequality to produce exclusion in all four dimensions. Women continue to work more part-time than males do and at most working in undervalued occupations and industries, earn less money on average, and hold fewer positions of authority across the European Region. Remuneration disparities gap in the EU continues to exist (17.5% on average in 2007) in part because of sex segregation in the labour market (Eurostat, 2010). Women are more likely to work part-time and take time off from their careers to care for their families, which can have a detrimental impact on their earnings, chances for promotion, and accrued pension entitlements. Women tend to live longer lives, but they may not always be healthy due to the resulting financial and career uncertainty (WHO, 2010). Women's higher rates of sickness are observed at high- and low-income

countries, demonstrating that despite their potential for longer lifespans, overall women are rarely healthier than men (Sen & Stlin, 2010).

Inequalities in education, money, and work can make it harder for women to receive the resources they need and restrict individual capability to safeguard own health (WHO, 2010). A United Nations Development Programme (UNDP) regional human development report examines social exclusion focusing on triple dimensions of economic exclusion, exclusion from social services, and civic barring whilst resulting in numerous and collectively reinforcing deprivations in middle and south-eastern Europe, the Russian Federation, the Caucasus, and central Asia. According to the report, access to health care has become more unequal throughout this time of transformation, with inefficiency for the underprivileged, the elderly, and minorities (especially Roma), as well as between urban and rural areas (UNDP, 2014).

Significant increases in private spending, unofficial payments made out of pocket and fees for goods and services all appear to have been substantial contributors to the expanding inequality. Given the working conditions and social status of the women labour migrants, the study examines the challenges encountered by the women labour migrants, in an effort to explore and propose possible interventions. Encountered challenges could be issues linked to cultural barriers, language or ethnicity. While the majority of women labour migrants have completed secondary and higher education, Zimbabwean women labour migrants in South Africa mostly work in low-skilled and low-paying occupations due to the host country's bias towards foreign education and the non-recognition of their foreign credentials. Deskilling is a purposeful act of discrimination as well as a technique for the host nation to address labour shortages by utilizing the inexpensive labour of these migrants. If they have access to education, some migrant women can eventually upskill themselves to host country's requirements in order to acquire occupations they are qualified for.

2.3 Literature review

2.3.1 Historical trends of migration

Human history has always included people manoeuvre in reaction to demographic expansion, climatic change, and economic requirements. Migrations, both voluntary and forced, have been a result of war and the establishment of nations, governments, and empires. However, the development of European nation-states, colonization, and industrialization from the fifteenth century onward resulted in a sharp increase in non-native citizens (Cohen 1988; Cohen & Stewart 1995; Moch 1992). Europeans were sent abroad to work as seafarer, soldiers, farmers,

traders, priests, and administrators throughout the colonial era. Indentured labourers who were transferred across great distances inside colonial empires later replaced forcible African slave migration (about fifteen million between the fifteenth and nineteenth centuries). Industrialization within Western Europe resulted in landlessness and poverty, which sparked a wave of migratory movement to other continents. An estimated 30 million people immigrated to the United States between 1861 and 1920, which was a critical period for economic development and nation-building. In Western Europe's industrializing nations, migrant workers were widely employed. For example, the Irish were employed in Britain, Poles in Germany, and Italians in France (Noiriel, 1988: 308–18).

Between 1918 and 1945, migration decreased as a result of political unrest and economic stagnation. In the USA, "nativist" groups argued that people from the South and Eastern Europe were "unassimilable" and posed risk to the country's ideals and public order. After the National Origins Quota Act was passed by Congress, mass immigration ceased until the 1960s. During this time, France was the only nation to hire foreign labour, Italian and Polish colonies suddenly increased along the heavy industrial towns of the North and East, while Spanish and Italian agricultural communities appeared in the Southwest. Due to mass deportations during the 1930s slump, there were 500,000 fewer foreign residents by 1936 (Cross, 1983).

2.3.2 Migration as a global phenomenon

Moving temporarily from one political or administrative unit to another is known as migration (Boyle et al., 1998: chapter 2). Internal migration is defined as a process of movement from one region (a province, district, or municipality) to another inside a single country. International migration is the term describing the movement across the roughly 200 countries in the world. According to many scholars, domestic and international migration are connected phenomena that should be examined in conjunction with one another (Skeldon, 1997: 9–10). Noting that rigid distinctions can be misleading, although international migration can occur over long distances and between culturally different people, internal migration can occur over short distances and connect with approximately similar cultures (as in the case of the movements of the Uighar 'national minority' people from western provinces of China to cities in the east). Therefore, it is worth noting the importance that in other circumstances at times borders 'migrate' as opposed to people, transforming domestic migrants into foreign migrants. For example, the old Soviet Union fell apart, multitudes of previous immigrants became outsiders in the succeeding countries. However, this article focuses mostly on international migration because of its links to globalization and significance in creating multiethnic societies.

Border crossings typically have little to do with migration. Short-term visitors, either on vacation or for business, make up the majority of travelers. The act of migrating involves relocating for a predetermined period of time, such as six months or a year. Most countries' migration statistics and regulations can be divided into several groups. Australia, for instance, makes a difference between long-term temporary immigrants and short-term temporary visitors. The temporal immigrants for long term may remain for a period of twelve months, frequently for job, business, or study while short-term temporary visitors can stay for less than twelve months. However, Australia is recognized as a "classical country of immigration" due to its history of using immigration to build nations, thus almost all public discourse centers on permanent immigration. Other countries favour the mostly transitory perspective on immigration. It is worth noting as well that during the time just after the German Federal Republic initially started hiring the so-called "guest workers" in the 1960s, some were given one-year visas while others could only come as "seasonal employees" for a precise period of time. The enforcement of such stringent residence rules got harder over time. Residents consequently received permits for 2 years or 5 years, then ultimately indefinite terms of time.

Such differences serve as a harsh reminder that migration criteria are not objective, rather, are seen as the results of state policies that were put in place in order to respond to public attitudes, political and economic purposes. When residing in their own countries is in accordance viewed as a standard and moving is viewed as a deviation, international migration is bound to occur. Migration is typically viewed as a problem that needs to be handled and limited because it may lead to unanticipated changes. Issues with comparability arise not just as a result of different statistical categories, but also as a result of the fact that these changes really reflect discrepancy in the communal importance of migration in diverse contexts. It is important to note that this has been cauterized in the following ways to control the migration process.

Males and females who move abroad for a short period of time (from a few months to many years) to work and bring money home are known as short-term migrant workers. At times referred to as temporal workers or international contract workers.

Exceptionally skilled and business migrants are people who relocate inside the easily accessible employment markets of multinational firms and international organizations or who look for employment through international work markets for rare skills. They may have degrees in a related subject or as managers, executives, professionals, or technicians. Many countries have specific "skilled and business migration" initiatives of enticing such people to immigrate.

Undocumented migrants are people who enter a country unlawfully and without the necessary paperwork, typically in search of employment. Known as irregular or illegal migrants. The majority of labour migration movements frequently consist of undocumented immigrants. Several migrant-receiving countries allegedly favor such migration due to the capacity to deploy labour to suit economic demands without incurring social costs or taking efforts to protect migrants.

Forced migration is defined broadly to encompass not just refugees and asylum seekers but also persons displaced due to natural disasters or construction industry (for instance; new factories, roads or dams).

Refugee referred to a person who lives outside of their kingdom or state of nationality but is impotent or reluctant due to "well-founded fear of persecution due to race, religion, nationality, membership in a particular social group, or political opinion," as defined by the 1951 United Nations Convention relating to the Status of Refugees. By enabling them to enter and granting them temporary or permanent residency status, signatories to the Convention commit to protecting refugees. There is a distinction among refugees and migrants, yet they do have a lot of similarities like social requirements and cultural repercussions in their new home (UNHCR, 1997).

Asylum seekers are known as people who cross borders in pursuit of refugee status even if they do not meet the precise requirements outlined by the 1951 Convention. It might be challenging to distinguish between individuals fleeing due to personal persecution and the ones leaving because economic and social infrastructures needed for survival were destroyed in many modern crisis scenarios in less developed countries. The generalized and pervasive violence brought on by quick decolonization and globalization under conditions set by rich countries is linked to both political and economic reasons for migration (Zolberg et al., 1989).

2.3.2.1 Causes of migration as a global phenomenon

The causes of migration are the subject of a sizable empirical and theoretical literature discussed in length (see Boyle et al. 1998, chapter 3; Castles and Miller 1998, chapter 2; Massey et al. 1993, Skeldon 1997). Globalization may be defined as the spreading, deepening, and accelerating worldwide interconnection in all facets of contemporary social life, includes international migration as a key component (Held et al., 1999: 2). Rapid rise within cross-border movement of all kinds: finance, trade, ideas, pollution, media products, and people is the primary sign of globalization. Multinational network may draw transnational enterprises,

worldwide retails, international governmental and nonprofit organizations, wide range criminal syndicates, or transnational cultural communities, is the primary organizing framework for all these flows. The internet, better phone connections, and inexpensive air travel are all important examples of contemporary information and communications technology (Castells, 1996). The owners of economic and political power typically welcome the flow of capital and goods, although a large number of governments and political movements want to stifle it because migration as well as ethnic diversity are perceived as possible threats to national sovereignty and identity. However, in practice, population mobility is intricately linked to other cross-border fluxes.

Inconsistency of wealth, jobs and social well-being between various locations is the most evident reason for migration. Differences in demographic trends related to labour force growth, age-structure, mortality, and fertility are also significant (Hugo 2005). Neo-classical economic theory holds that individuals' attempts to maximize their income by relocating from low-wage to high-wage economies are the primary drivers of migration (Borjas 1989). International migration's root causes, however, are frequently highly nuanced. While states' control of boundaries presents hurdles to market forces, variations may be started and regulated by strong institutions (Portes & Böröcz, 1987). "New economics of labour migration" (Stark, 1991), which contends that migration cannot simply be explained by income differences between two countries but also by factors like prospects for stable employment, capital accessibility as entrepreneurial activity, and the need to manage risk over extended periods, offers an alternative economic approach. Not simply individuals make migration decisions; but they frequently reflect family plans to increase income and chances of survival (Hugo, 2005). Only a "whole-household economy" perspective will allow individuals to completely comprehend how remittances are used for investment and consumption (Taylor, 1999: 64).

As a result, there is no straightforward connection between poverty and emigration. Since people lack the financial means to travel; the cultural awareness necessary to see means somewhere else as well as the social capital (or networks) necessary to successfully locate employment and adapt to a new environment, departures from the very poorest communities may be uncommon. However, the poorest people may as well be compelled to migrate usually in very difficult circumstances including war or environmental degradation that eliminates the bare necessities of subsistence. As a result, migration can be regarded as a cause and an effect of development. Migration results from development because people are more equipped to look for better possibilities abroad because of advancements in education and the economy.

According to research, middle-class populations in emerging countries are more likely to leave. Emigration generally tends to drop as earnings rise (UN Working Group on International Migration, 1998).

"Migration systems theory" offers a valuable method for examining the numerous emigration-causing factors (Kritz et al., 1992). Two or more nations that trade immigrants with one another make up a migration system. Examining both ends of the flow is vital, as is researching all connections (cultural, economic, political, military etc.) between the locations in question. Migration flows are typically the result of historical connections between sending and receiving nations, such as colonialism, political sway, marketing, investment, or cultural relations. In an example, the Caribbean migrants have a tendency to go to their respective previous colonial power: for instance, from Surinam to the Netherlands, Jamaica to Britain, and Martinique to France. The French colonial presence in Algeria led to the migration of Algerians to France, whereas Germany's administered labour recruitment of Turks during the 1960s and early 1970s led to their presence there. American military participation in the nations of origin is the cause of both the Korean and Vietnamese emigration to the country.

The beginning of migratory chains is typically caused by an outside force such as military duty or recruitment as well by the inceptive movement of young (mostly male) pioneers. Once a movement is developed, the migrants mostly travel along "worn tracks" (Stahl, 1993) with the assistance of friends and family who have already immigrated to the region. System, on ground of family or a shared place of origin, can aid with housing, employment, administrative support, and assistance with personal challenges. For the migrants and their families, the social networks make the migration process safer and easier to handle. Once the set-up networks begin, migratory movements develop into self-sustaining societal systems. Some migrants and non-migrants alike become migration facilitators. A "migration business" made up of employment agencies, attorneys, agents, smugglers, and other middlemen is growing. These individuals may aid migrants while also taking advantage of them. Governments' attempts to regulate or halt migrations have frequently been thwarted by the formation of the transhumance sector with a strong stake in the continuance of migration.

The ties between the immigrant population and its home country may last for many generations. Even while remittances decrease and home visits become less frequent, cultural and familial ties do not. People maintain relationships with their home communities and may look for marriage partners from back home. The large exodus of former Yugoslavs to Germany as

refugees in the early 1990s, followed compatriots who had immigrated as workers 20 years earlier, demonstrated how migration continues through existing chains and can rise drastically at times of crisis. Long-term migration may result in global communication networks that impact economic linkages, social and political institutions, as well as the national identities and every culture involved (Basch et al., 1994).

2.3.3 Labour migration within the South African context

In a study published by Dinbabo & Nyasulu (2015), about the "pull" causes for international migration to South Africa, it is stated that the problem of immigration from abroad has a lengthy history that dates back to several centuries. Cross (2000) opines that international migration to South Africa origins can undoubtedly be connected to colonial control, which was established after hundreds of thousands of Europeans. Moreover, the discovery of substantial diamonds together with gold mines situated in Kimberley and on the Witwatersrand in the late 19th and early 20th centuries attracted large flows of labourers from nearby countries including Mozambique, Lesotho, and Zimbabwe. These events were followed by the start of large sugar cane fields in Natal that captivated considerable flows of immigrants, particularly from India. A substantial number of labour migrants added a significant portion of South Africa's population from the start of the early 20th century. In actual fact, this category of people immigrated to the nation permanently throughout the 19th century due to white settlement. In addition, the development of substantial gold and diamond mining sites over Kimberley and on the Witwatersrand in the late 19th and early 20th centuries drew considerable numbers of employees from a variety of neighbouring nations, notably Mozambique, Lesotho, and Zimbabwe. The establishment of vast sugar cane fields in Natal (also known as KwaZulu-Natal), which attracted large numbers of immigrants, mainly from India, came after these events. From early 20th century, a considerable stock of foreign immigrants made up a sizeable share of South Africa's population.

The 1911 Census showed that 6% of South Africa's population was made up of immigrants from nearby nations. The overall number of foreign migrants reached eight hundred and thirty-six thousand by 1961 (Peberdy, 1997). According to Ayala et al. (2013), there are at least four recognized international immigration routes in the country's history, in spite of the fact that no credible source with regard to the actual number of immigrants, particularly during the pre-Apartheid era. The above mentioned comprised of temporal workers in the mines, unauthorized immigrants hired to work in the service and construction industries, Mozambican conflict

refugees, and white "asylum seekers" from nearby nations. Furthermore, there are also women labour migrants in the Newcastle city to solicit employment in the textile industries.

The establishment of a system of white supremacy (Apartheid) in South Africa by the year 1948 had a significant impact on the country's immigration policy (Peberdy and Crush, 2001). A policy of racial preference for white immigration was pursued by succeeding Apartheid regimes, while restrictions on black/African and later Jewish immigration were also in place. Successive Apartheid regimes understood the need for inexpensive foreign labour to work on the mines and farms, they only promoted restrictions on unauthorized immigration by the nearby nations and prevented foreigners from obtaining either temporary or permanent residency in South Africa. However, between 1960 and 1980, in order to increase the white population in South Africa, citizenship was extended to white immigrants fleeing political unrest in newly established African nations like Zambia, Kenya, and Zimbabwe (Peberdy, 1997; Peberdy & Crush, 1998). The aforementioned scholars point out that substantial colonial and Apartheid-era restricting migration legislation were enacted in 1913, 1930, 1937, and 1991.

Post the years of the end of undemocratic government and the subsequent beginning of the new era (democratic dispensation) in the nation in 1994, the African National Congress-led administration has continued to pursue a more stringent immigration policy (Crush & Peberdy, 2001). The South African government has traditionally showed minimal interest in immigration, with the exception of a few amnesties granted to those seeking political asylum and refugees from a few Sub-Saharan African nations. Since the implementation of more stringent rules, it has been more challenging for companies to get work permits for foreign contract workers, hence legitimate labour migration into the country has been declining since the early 1990s (Crush & McDonald, 2003). However, in Adepoju's (1998) views, international migration into South Africa has increased despite these tight immigration laws. The bulk of immigrants are from Sub-Saharan African nations, and they mostly came to this regional economic superpower in quest of employment and other opportunities (Adepoju, 1998). The largely poor and jobless segments of the indigent population, who view migrant's job seekers as direct contender for work within the core areas of the economy, have periodically responded hostilely to the expansion in economic activities of migrant's job seekers and workers, primarily from neighbouring countries. This animosity culminated in violent xenophobic attacks in May 2008, when groups of South Africans destroyed many small businesses, mostly run by immigrants from Zimbabwe, Mozambique, and Malawi throughout multiple cities (Friebel, Gallego, and Mendola; 2013), and more recently in August 2019.

According to Klotz (2000), hundreds of thousands of migrants from all over the world enter South Africa each year, both legitimately and illegally, in quest of political and socio-economic opportunities. These influxes of migration are divided into three categories by Kok et al. (2006): labour mobility, refugees, and permanent migrants.

As per Stats SA (2012), an estimation of about 7 million to 8 million foreigners lives in South Africa. This represents roughly 5.7% of the 51 million people who make up the entire population of the nation (Stats SA, 2012). Although there is some disagreement over the precise number of illegal immigrants, this cannot be said of the figures of foreigners who are lawfully residing in the country. The majority of labour migration consists of women. When democracy first began in South Africa, there was more freedom of movement, and residents from the majority of neighbouring nations moved there in search of greener pastures. Some women looked for work as domestic helpers, while others looked for jobs in the textile sectors. Newcastle municipality was not exempt because it has a lot of textile businesses that contributed to the "pull factor."

According to statistics from South Africa, the Department of Home Affairs issued a total number of one hundred and forty-two thousand, eight hundred and thirty-three time-related resident permits (TRPs) and permanent resident permits (PRPs) to foreign people in 2012. The majority of the TRPs forty-five percent (45.6%) went to citizens of other nations (mostly Republic India, Republic of China, Pakistan, as well as Britain), whilst fifty-four percent allocation was for the citizens of the African continent (Zimbabwe, Nigeria, Democratic Republic of the Congo, and Lesotho). On the other hand, individuals from foreign nations made up forty-six per cent (46.8 %) of PRPs, while those from the African continent made up fifty-three per cent of all PRPs granted in year 2012 reported, (Stats SA; 2013). According to the aforementioned description and other accessible material, experts appear to be in broad agreement that economic concerns are what primarily drive immigration to South Africa. For instance, according to the United Nations Development Programme (UNDP), the majority of African migrants who move to South Africa do so because the situation in their home countries has deteriorated beyond what they can tolerate. The large number of international migrants residing in in the country is a good illustration. The organization also emphasizes that the main forces for migration are the "push" of extreme poverty in their home countries and the "pull" of opportunity in the destination country (Crush & Frayne, 2007). Adepoju (2000) noted that socio-economic instability, extreme poverty, and unemployment in some rural areas of Africa

have changed what might have been domestic emigration to urban centers into international emigration to nearby, developing countries like South Africa.

Although it can be argued that economic forces push migrants out of their home countries, less is known about the macroeconomic forces that draw migrants to the country and their experience in accessing healthcare services. The majority of research projects on the topic that have been carried out in the nation to date (Lucas, 1987; Bhorat et al., 2002; Wocke and Klein, 2002; Bhorat, 2004; Waller, 2006; Landau and Segatti, 2009; Crush and Williams, 2010; Friebel et al., 2013; Mayda et al., 2013) appear to concentrate primarily on migrants tendencies and migration effects on the labour market, but no gain on health care for women labour migrants. In light of this, it is obvious that there is a significant information vacuum about the experiences of women labour migrants in accessing healthcare services from South African public health facilities, the challenges they experience as well as their knowledge with regard to sexual reproductive healthcare services.

A significant number of foreign nationals left behind their loved ones, friends, and homes in the sometimes-hopeless pursuit of jobs, hundreds or even thousands of kilometers away from home. It is conceivable to assume that the majority of these migrants start from rural to urban areas, from poorer to richer countries, and from places with low unemployment to those with high employment. There is more research on the history of migration in Southern Africa and it is extensively documented to academic topics (Crush, et.al 2000: 13). The depth of research on this subject was not surprising given the institutional contexts in which labour migration takes place in Southern Africa and into South Africa as well as the importance of population movement on the maturing of South African economy (see, for example, Nattrass 1976; Crush, Jeeves and Yudelman 1992).

The movement of people between South Africa's rural and urban areas was facilitated by a number of state initiatives to organize and manage black labour. For instance, all black labour migrants who were 16 years of age or older had to register as job seekers with a local labour bureau and carry passes in order to visit 'white' districts. Black foreign contract workers were subject to the same restrictions on employment and relocation. These contract workers are eligible for repatriation at least twice every two years under South African labour law. Should their labour services ever be required in the future, they would have to re-attest (Spiegel, 1980: 115). These labour migrants were prohibited from bringing their husbands and families to their

places of employment, just like many other black labourers from South Africa's Bantustans or rural areas.

Locals routinely turn over employment that unqualified, uneducated, and occasionally very young migrants frequently receive. Migrants usually have fewer options than risky prostitution, domestic work, illegal trading, transportation, and agricultural industries. The rising percentage of women among migrant workers is referred to as the "feminization of migration" trend. Poor, uneducated women are commonly desperate for jobs when faced with challenges such as HIV/AIDS, ravage communities, murder or disable partners, fathers, or brothers. Because of stigma, people with HIV typically leave their communities in search of employment or health care far from friends and family.

2.3.4 Migration system in South Africa

The regional migration trend in the country changed significantly from the period of 1994. By 1995, the New South African government had revoked the majority of the aforementioned restrictions. Nevertheless, their status as refugees under the United Nation Refugee Convention, forced or economic migrants, or even job seekers, a significant number of migrants destined for South African country at the present are from neighbouring African countries. Given that many individuals think South Africa has a strong economy and that European asylum laws are becoming more restrictive, South Africa is frequently cited as the sole viable option. During Apartheid, foreigners were prohibited from entering South Africa due to the Aliens Control Act. The phrase "Control Act" alone indicates that the government's major objective at the time was to regulate immigration into the nation. But it was rather clear that the government's approach prior to 1994 was mostly based on racism. Its immigration policy acted as an overt and blatant tool of white racial superiority or dominance. Individuals could only relocate to South Africa if their lifestyle accorded with South Africa's criteria, according to component 4 (1) of the Aliens Control Act, which was unambiguous in its declaration. So as to fit the formal criteria of an immigrant, assimilation into the white community was necessary. By description, Africans were ineligible for immigration. Not that South Africa would not take more Africans from its neighbors and far from it, but they were only allowed in as migrant labourers, and admission was very restricted.

These foreign workers were hired prior to 1994 in accordance with agreements negotiated between the governments of the countries that supplied them and the hiring company, which was frequently one of the major mining conglomerates. The majority of contracts had a two-

year duration, after which the workers were sent back to their home nations collectively. Foreign workers in South Africa were only allowed to go around the workplace and were not allowed to have their families with them. The majority of the countries in the region provided labour to South Africa for its mines and farms. Undocumented immigrants, who were subject to stringent limitations and definitely supplied the mines and fields with cheap labour, were these workers. The majority of African countries stopped using this labour force after achieving independence. Although the South African government allowed approximately a total number of 350 000 Mozambicans who had been dislocated by civil war to enter the country in the 1980s, it never formally recognized them as refugees.

It is uncertain how many people have immigrated into South Africa from other African countries more recently. Cross border migration from other African countries increased during the 1990s (McDonald, 2000). According to official data on illegal immigrants given by the South African Police Service, there may have been more than five million to eight million undocumented immigrants living in South Africa in 1995. In that same year, the Ministry of Home Affairs estimated that there may have been 4 million immigrants without documents in the country. However, neither set of estimates was considered reliable because they lacked any methodological details (Crush, et.al 2000:61). A significant portion of recent study on migration into South Africa challenges preconceived notions about non-native citizens and conducts a critical analysis of that country's migration strategy from the angles of human rights and regional development. A reliable and comparative study of attitudes about and experiences with cross-border migration in the region was the goal of the Southern African Migration Project (SAMP), which was founded in 1996 (McDonald, 2000: 3).

2.3.5 The rights to migrants/refugee as per UN Convention

The definition of a refugee in the Refugees Act is quite generous and inclusive. It incorporates OAU definition in addition to the United Nation Convention similar to the status of refugees, broadening the scope of the UN definition. Additionally, it offers family members of the primary applicant a derivative status. The Act also grants refugees a wide range of fundamental rights, similar to those granted to South Africans under that country's Bill of Rights (except for those citizenship's rights such as voting and standing for political office). In addition, South Africa is one of the few nations in Africa that permits refugees and asylum seekers to travel freely throughout the nation. In reality, South Africa has no refugee camps. However, it must be noted that for one to obtain a working Visa permit if the person flees their country due to

economic hardship, they must be providing a scarce skill of which women labour migrants working in textile industry are not categorised under such skills.

As soon as a person requests asylum, they are able to look for work and live in housing. They are also given similar rights to basic health care, emergency treatment, and education as South African citizens. These are undoubtedly highly progressive regulations, but refugees still have a very difficult time turning their legal protection into reality. Hence this results in the illegal crossing for employment opportunities.

Legal status determines the type and quality of health services and social protection available to migrants. Most often access is poor, although Uganda offers refugees access to health services equal to that of the native-born population, together with free primary education and a plot of land. In some countries, reception is less welcoming. Temporary foreign workers may be returned to their countries of origin when they become ill or injured on the job, compelling their families, communities, and local health authorities to absorb the economic and social costs. Barriers to care often persist despite legal rights. Fearing detention or deportation by health authorities, undocumented asylum seekers and labour migrants often depend on services provided by civil society. Labour migrants residing with their employers may rely on them to access health services. Obtaining sexual and reproductive health services can be problematic for women (Spitzer, Torres, Zwi, Khalema & Palaganas, 2019: 1-4).

2.3.6 Migration trends in Southern Africa

The International Organization for Migration through the United Nations had profile the trends of migrants across Southern Africa eras and events.

Colonial era and structured labour migration systems: 1869–1910

Migrant labour was increasingly formalized and colonially exploited at this time. Mozambique, Lesotho, Eswatini, Botswana, Malawi, and Zimbabwe, provided the majority of the miners.

Kimberley, South Africa, experienced extensive migration as a result of the discovery of diamonds in 1869.

1885 - The German colonial authority in Tanzania implements systems of (forced) migrant labour that preserve linkages to communities of origin.

1880s - Final period of indentured migration of Indians to Mauritius.

In order to formalize a system of (forced) migrant labour in Southern Africa, the Rand Native Labour Association was founded in 1901.

In the Congo Free State, colonial mechanisms were developed in 1906 to enable labour mobilization for diamond mines and railroads.

The Southern African Customs Union (SACU), which includes South Africa, Namibia, Swaziland, Lesotho, and Botswana, was founded in 1910 and is amongst the earliest customs union enacted in the world.

1906 – Colonial systems established to support the labour mobilization for diamond mines and railroads in the Congo Free State.

1910 – Establishment of the oldest customs union in the world, the Southern African Customs Union (SACU) among 5 countries, South Africa, Namibia, Swaziland, Lesotho and Botswana.

Apartheid era: 1948 to 1990

During this time, extensive civil conflicts were waged over several decades in a number of Southern African governments, notably Angola, Mozambique, and Zimbabwe (then Rhodesia). Under the apartheid system, black people were generally repressed in South Africa, former Rhodesia, and Namibia. Beyond the Kimberley and Witwatersrand mines in South Africa, migrant labour networks also reached Zambia and Botswana. 1948 – Apartheid began in South Africa.

Migrant labour was attracted to Zambia in the 1960s by copper mining, in Botswana by the discovery of diamonds in the 1970s, while in Rhodesia, a protracted rebellion between white settlers and the native population started in 1972.

From 1975 to 2002, the Angolan civil war caused widespread displacement and forced migration.

From 1977 to 1992, the Mozambique civil conflict uprooted thousands of people, many of whom flee to South Africa.

In order to give an economic and political alternative to apartheid, the Southern African Coordinating Conference (SADCC), which was later changed to SADC, was established in 1980.

Between 1980 and 1990, during the Rhodesian Bush Wars (Zimbabwe's independence struggle), numerous migrants left the nation.

1960s – Copper mining in Zambia drew migrants to Zambia.

1970s – Diamonds discovered in Botswana also attracted migrant labour,

1972 – Protracted insurgency began in Rhodesia between white settlers and local population.

1975–2002 – Angolan civil war led to mass displacement and forced migration.

1977–1992 – Mozambique's civil war displaced thousands; many flee to South Africa.

1980 – SADCC, forerunner to SADC, was formed in order to present economic and political counterpoint to apartheid South Africa.

1980–1990 – Rhodesian Bush Wars (Zimbabwe's war of independence) – many migrants flee the country.

Regional unrest and significant changes to the political landscape have occurred recently. The continuous conflict in Democratic Republic of the Congo, which led to significant and prolonged displacement, had the biggest impact on children (ACERWC, 2019). Since 2000, there has been an upsurge in the number of migrants coming to South Africa from Zimbabwe, primarily because of political upheaval and economic difficulties (IOM, 2018, 2011). In the year 2000, an increase was recorded on women travelling to South Africa to work in low-skilled jobs, and in 2006, 30% of migrant Basotho workers in South Africa were females (IOM, 2013). Tropical Cyclone Eline and Tropical Storm Hudah severely damaged Mozambique, South Africa, Botswana, and Zimbabwe, causing the destruction of agricultural regions and the movement of more than a million people (FAO, 2017).

- 1992 - The SADC Treaty created Southern African Development Community (SADC).
- African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa has been approved by only six governments in Southern Africa (Kampala Convention) as of 2009 (AU, 2015).

The rules governing labour migration and free movement within SADC have advanced significantly in recent years, despite the fact that there is still no actual free movement of people. According to current predictions, climate change will have a significant impact on Southern Africa (Intergovernmental Panel on Climate Change (IPCC), 2018). The northeast

part of the region is projected to see a strong wetting tendency, but the southwest was reported drying and warming at a rate twice the global average (IPCC, 2018). Water stress has been highlighted as one of the key migration triggers (Ionesco et al., 2016). It is possible that significant parts of Namibia, Botswana, and South Africa will not be suitable for cultivating grain crops in the next 60 years (DEA, 2016: 42). These climate changes will have a significant influence on livelihoods and the availability of food, which could become a major factor in regional migration. With observations, farming was the primary source of income for 60% of the people in Zimbabwe and Zambia, and for 80% of the people in Mozambique and Madagascar (USAID, 2019; IPR, 2018; Ionesco et al., 2016). The small islands of Seychelles, Comoros, and Mauritius also suffer the risk of losing their fishing businesses and coastlines, which would stress the local inhabitants and possibly drive them to go abroad in search of employment.

Namibia, Botswana, northern Zimbabwe, and southern Zambia will experience more frequent and severe droughts as a result of Southern Africa's warming, which is happening twice as fast as the rest of the world, according to the IPCC (2018). There are currently few records of the effects of the drought on displacement in the region (Internal Displacement Monitoring Centre (IDMC), 2019). But in 2019, the number of people who suffered food insecurity increased by 28% to 41.2 million across 13 nations in the area (SADC, 2019). Recently, Namibia, Lesotho, and Botswana declared a state of drought calamity, after Botswana faced its worst drought in 30 years (Meeting Professionals International (MPI), 2015). Zambia, Zimbabwe, Eswatini, Mozambique, and the Democratic Republic of the Congo are nations with a high risk of food insecurity. Chronic child malnutrition is becoming an issue in twelve states, including the Democratic Republic of the Congo, Mozambique, Angola, and Madagascar (SADC, 2019). This may also help to explain why female labour migrants moved to Newcastle's textile industries.

Migration, the security for occupancy of land, gender dynamics, and water shortage are all connected (Curran and Meijer-Irons, 2014). In the face of shifting environmental conditions, residents with insufficient tenure rights are less likely to make long-term investments in their land, such as climate change adaptation. Thus, when arable land is exhausted, migration is the only risk-diverse approach left. Women are often less able to restore their land and means of livelihood following a disaster as a result of unstable, informal, or unrecognized land rights.

In the past, droughts, floods, storms, and food and water shortages have forced out thousands of residents from their homes. These challenges might promote further integration, but they might also incite protectionist behaviour on the part of member nations.

2.3.7 South African Immigration Act

The primary law governing foreigners' admission is the Immigration Act of 2002. In general, this Act welcomes applications for residence from immigrants who can add to the diversification of South Africa's economy. Likewise, applications from competent people in professions where there is a scarcity in the nation are encouraged, but especially those from industrialists and other company owners who want to move their present operations or start new ones in South Africa. Anyone who plans to retire in South Africa is allowed to demonstrate if they have a net worth of a sum established by Minister of Home Affairs.

South Africa has clearly prioritized its immigration policy, and anyone coming to the country to work must demonstrate that their intended field of employment is not one in which there are already enough workers to meet the country's needs. Only a small portion of immigrants entering South Africa are of this sort. You are invited to immigrate to South Africa if you have remarkable abilities and can contribute to the economy. As a result, South Africa is open to accepting professionals and qualified employees, but it is obviously uninterested in hiring unskilled labour. It might be said that the Immigration Act encourages a very restrictive approach to immigration. This then leads to undocumented migrants for labour purposes as they are not catered for as per the legislation and this is the gap in literature.

In the past, men made up the majority of labour foreign nationals. In the 1990s, there was a noticeable increase in female internal labour migration, even though males were still twice as likely as women to migrate in 1999. It is worth noting that there are no specific studies that have attempted investigating the experiences and needs for women labourers in South Africa and Southern Africa. The rural household has instead often been depicted as "a cohesive entity in which all members were unified in maximizing resources and rejecting threats to its integrity" (Walker, 1990: 177).

2.3.8 Morbidity and the spread of HIV/AIDS

The International Organization for Migration has identified four significant connections between migration and the development of HIV/AIDS (IOM, 2018). Mobile individuals frequently engage in risky or vulnerable conduct. Young males, for instance, usually spend a lot of time without their wives or partners. This makes it difficult to provide health education,

testing, condoms, or treatment. Opportunities for sexual networking made possible by mobility may be a driving force behind migration to metropolitan areas. Significant studies have been conducted in respect to male labour migrants as they constituted a large portion compared to female labour migrants, this has resulted in a limitation of information with regard to female labour migrants in Southern Africa.

Mobile communities have high rates of HIV/AIDS prevalence due to pervasiveness of social, economic, and political marginalization in these populations. To further illustrate the linkages between mobility and HIV/AIDS, further instances could be employed. The incidence of HIV is typically higher in regions close to roadways and other major transportation routes because they act as arteries, conveying not just people and goods but diseases as well. The highest rates of HIV/AIDS tend to be found in Southern African countries with relatively high levels of wealth (such as South Africa and Botswana), effective transportation networks, strong economies, and significant amounts of international migration. People with HIV/AIDS may relocate to seek medical care, escape stigma or discrimination, or both. Some people might go outside of their own nation to care for HIV positive family members. Furthermore, people make the decision to migrate for economic and many other reasons. The driving factors are obvious money and employment. People may leave their areas due to internal political or economic unrest. For instance, years of hyperinflation and persistent unemployment in Zimbabwe have prompted many individuals to cross the border into South Africa and other nations in quest of finer life.

2.3.9 Gender migration and feminization of migration

The decision to move has been portrayed as a community and a familial affair by most institutions, which is influenced by gender hierarchies and cultural expectations toward a moving population. The decision is also influenced by the migrant's obligation to provide for the family, he or she left behind in the home country, by sending money home in the form of remittances. According to Lalonde & Topel (1997), the family will keep sending members abroad in order to increase their net income through remittances from abroad. However, this sending raises the possibility of a gendered migration, in which the migrant women are simply sent and cannot decide to migrate on their own. However, important work by Van der Velde & Naerssen, (2016) emphasizes that women can migrate in their own right and, more importantly, they can move alone within the transnational area, however, less emphasis looking into migrant labourers within the textile industries in South Africa has been made.

One might also make a case for the social network theory viewpoint since it maintains that migration is a social activity that involves decisions that are influenced by the connections people have with one another rather than being an individual action. According to the social network theory, migrants have connections in the transnational area that tell them about the hazards involved, opportunities in the destination country, and the expense of Oishi, (2002:7). Such knowledge, when combined with financial support from ties to the diaspora, may make it easier for women to migrate alone or even to rely on their families to help them make a decision to move. These connections, which provide knowledge about what to expect in the target country, allow the migrants to plan and foresee the actions they will do before traveling to a new place (Mahler and Pessar, 2008).

For instance, Lopes (2007) confirmed in his study with a group of immigrants who were HIV-positive and seeking obstetrics services at a hospital in the Lisbon region that the medical staff were not particularly helpful in their contact with the users and gave them very little information about HIV. Dias et al. (2010) claim that health technicians' ignorance of cultural characteristics of immigrants' sexual and reproductive behaviour affects how several women experience pregnancy, childbirth, and parenting as well as how they use health services. The cultural component, along with the circumstances in which the Timorese women found themselves after arriving in Portugal, had an impact on the Timorese women's attitudes toward fertility, according to a study by Manuel (2007) about family planning issues in female Timorese immigrants to Portugal.

2.3.10 Access to healthcare services

Various factors, including discrimination, physical separation from resources, and a lack of information distribution, can affect women labour migrants' opportunities to health care (Vearey & Nunez, 2010). Most of the time, immigrants do have legal rights to treatment for HIV and other chronic conditions, but they are either uninformed of these rights or choose not to seek care because of discrimination, as was already discussed. According to Vearey & Nunez (2010), a substantial body of research recognises the complexity of the relationship between migration, mobility, and health in the area. While the migrant labour system was clearly linked to the early transmission and spread of syphilis, tuberculosis (TB), and the human immunodeficiency virus (HIV), particularly in relation to the ongoing systems of labour migration linked to the mines in South Africa (SA), these dynamics have changed over time and the link between movement and the spread of communicable diseases is less pronounced today. For persons who relocate, either within or beyond borders, prevention, testing, and

treatment programs for NCDs and common communicable diseases in the SADC must be consistently available. The insufficient care of chronic illnesses for people who relocate was a major problem in 2014.

This has detrimental effects on morbidity and mortality for a population that moves about a lot, as well as on the health systems and family component that must deal with the expenses of delayed healthcare seeking. The likelihood of catching or spreading HIV changes with increasing or risky sexual behaviour (between generations, during transactions, etc.), but there are other contexts for this behaviour outside the correlation that connects migration and risky sexual behaviour. Sexual behaviour may be directly impacted by vulnerabilities (such as food insecurity), where sex may be utilized as a means of securing safety or food. Similarly, migrant workers who are divorced from their long-term partners are more inclined to date other partners, which puts them at greater danger (Lurie et al., 2003). Changes in sexual behaviour could also put immobile people at danger, such as the partners of migrants who stay home (Kishamawe et al., 2006).

The framework for guaranteeing that South Africans obtain access to high-quality SRH throughout their lives is established by Integrated SRHR Policy of 2019. Sexual reproductive health includes holistic aspects of individual health, such as availability and accessibility of contraception, fertility, the decision to end a pregnancy, sex or unhealthiness, and the health effects of violence that may or may not be directly related to reproduction. People who reach criteria for Sexual and Reproductive Health and Rights (SRHR) have satisfying, secure romantic relationships and are free to choose whether, when, and how to start families.

This legislation seeks to acknowledge the diversity of SRHR services while also emphasizing the interdependence of reproductive health, human rights, individual autonomy, and reproduction. Particularly the burden of disease on South Africa's health and socio-economic systems, as well as social determinants of health and socio-cultural norms that have an impact on these systems and services, this policy aims to raise awareness of the short falls and seek solutions for the complex nature of SRHR service delivery. However, it is simpler to implement the different efforts due to the distinct norms that form the basis of this policy. While respecting each person's choice, on making SRH decisions, a rights-based approach helps organize and deliver high quality of Sexual Reproductive Health services. It is impossible to achieve SRHR which are essential to social justice, long term development, and public health. This is due to relationships between sexuality, gender, and the economy. With the guidance of National

Department of Health (NDoH), this policy was established with the goal of assisting the South African people. The integrated SRHR Policy should be used as a clear guidance by implementers, line managers, and health professionals who dedicate their professional efforts to improving health outcomes for all South Africans.

For instance, Lopes (2007) confirmed in his study with a group of immigrants who were HIV-positive and seeking obstetrics services at a hospital in the Lisbon region that the medical staff were not particularly helpful in their contact with the users and gave them very little information about HIV. Dias et al. (2010) claim that health technicians' ignorance of cultural characteristics of immigrants' sexual and reproductive behaviour affects how several women experience pregnancy, childbirth, parenting as well as how they use health services. According to a study by Manuel (2007) on family planning difficulties among female Timorese immigrants to Portugal, the cultural context in which these females' encounter once they arrived in Portugal had an impact on their conceptions of fertility. Below are sexual reproductive health services for women and men.

2.3.10.1 Condom utilization

Even though South Africa reportedly distributes 400 million male condoms (MCs) each year, this number is still insufficient. Despite an increase in distribution, the Department of Health's distribution of MCs to men aged 15 and older remained low in 2007/2008, at 12 condoms per male per year. Western Cape, which has the lowest prevalence of HIV, distributes the most condoms, over 40 per male per year, while five provinces (Eastern Cape, Northern Cape, Northwest, Free State and Western Cape) report MC distribution rates below eight. Stock-outs of male condoms occurred in 2009 and 2010, allegedly as a result of delays in issuing the national condom tender in late 2008. Since 1999, the female condom (FC) program in South Africa has grown, and more than 4 million FCs are currently provided annually, primarily through the public sector. In contrast to male condoms, FCs are not offered at all locations that offer family planning services, hence there are fewer distribution sites available. Only 3.6 million FCs, approximately, were supplied at public health facilities in 2008, according to Plus News.

In the year 2008, 62% of respondents to a national survey who had recently experienced a sexual encounter reported using a condom. In particular, compared to 73% of women, 87% of males aged 15 to 24 reported using a condom during their most recent sex. Individuals should

receive a minimum of 100 condoms a year, according to WHO recommendations. It is obvious that there needs to be a significant increase in condom supply.

According to the research by Crush, Frayne and Grant (2006), millions of workers from both within and outside of South Africa are extremely mobile in that country. Given that a sizeable grown-up population fraction (up to 80% in Lesotho, for instance) has lived abroad as a migrant, such international movement may have an impact on the disease transmission in such nations' surroundings.

Although there is statistical evidence that emigration labour system contributed to the early transmission and spread of syphilis, tuberculosis (TB), and the human immunodeficiency virus (HIV), particularly in relation to the ongoing systems of labour migration associated with the mines in South Africa (SA), these dynamics have not changed over time, and the link between movement and the spread of communicable diseases still exists today. This has also been demonstrated by some of the participants' behaviour in this study. Nevertheless, NCD prevention, testing, and treatment programs in the SADC must always be accessible to people who relocate, both inside and across national boundaries. The insufficient care of chronic illnesses for people who relocate was a major problem in 2014. This has detrimental morbidity and mortality effects on the population that moves a lot including the healthcare systems and family structures that must deal with the expenses of delayed healthcare seeking. Additionally, or hazardous sexual behaviour (inter-generational, transactional, etc.).

The reasons for this behaviour must be understood in the context of factors other than how migration and risky sexual behaviour are related. This behaviour undoubtedly alters the likelihood of developing or transmitting HIV. Sexual behaviour may be directly impacted by vulnerabilities (such as food insecurity), where sex may be utilized as a means of securing safety or food. Similarly, migrant workers who are divorced from their long-term partners are more inclined to date other partners, which puts them at greater danger (Lurie et al., 2003). Changes in sexual behaviour could also put non-mobile people at danger, such the partners of migrants who stay home (Kishamawe et al., 2006).

2.3.10.2 Emergency contraception

Like all other hormonal contraceptives, emergency contraception (EC) pills work to prevent pregnancy largely by delaying or slowing ovulation and by blocking fertilization. The EC was accessible as of November 2000 within public facilities, furthermore it is now accessible in pharmacies without a prescription as well. This approach is also available in the public sector.

In 2003, only 0.6% of women had used this approach in the public sector. Health care providers must encourage their patients to use a variety of ways, and a client's right to choose their preferred method is a crucial aspect of that right. Because of insufficient advertising, several technically feasible solutions are underutilized. Healthcare professionals are reluctant to recommend or prescribe EC due to worries that it would be overused or utilized as an abortifacient. The latter is likely based on a misunderstanding because EC does not actually cause pregnancy; it merely prevents it from happening.

Making male and female condoms, EC, and other measures accessible to both men and women can help with the right to prevent pregnancy and disease. Better counseling, longer clinic hours, and increased community accessibility, including in schools, key business districts, and integration with other services, are also necessary. Little progress has been made in terms of expanding the accessibility of other methods or services, particularly industrial regions, with the exception of enhanced condom availability, improved counseling in the public sector, availability of safe abortion service and post-abortion care. In order to guarantee wider accessibility of pregnancy termination, the Choice on Termination of Pregnancy (CTOP) Amendment Act was passed in 2004. Unusually, none of the interviewees said there were termination of pregnancy (TOP) services offered by medical facilities in their communities.

The World Health Organization's 90-90-90 targets were set to be met by 2020, since Human Immunodeficiency Virus counseling and testing have been identified as services that South Africans want and need to minimise the spread of HIV/AIDS. To ensure that 90% of the population is aware of their status, the first '90' promotes HIV testing. This strategy takes into account the fact that women labour migrants are legally the responsibility of the South African government and that, if they engage in risky behaviour, there is a strong likelihood that the epidemic will become unmanageable. In order to stop the epidemic, 90% of South Africans must be aware of their health status, 90% must start treatment, and the final 90% must adhere to the medication and have the virus suppressed. As a result, the transmission of the HIV/AIDS virus in South Africa will be stopped. With the National Health Act's amendment allowing trained healthcare professionals, including counselors and retired healthcare professionals, to conduct blood draws for HIV testing, the national HIV Counseling and Testing (HCT), now known as the Health Testing services, is now done in healthcare facilities (HTS).

According to Coffee, Lurie and Garnett (2007), migration has a greater impact on the transmission of HIV by promoting irregular and risky sexual behaviour than by bridging high-

and low-risk locations. When combined with higher sexual risk behaviour respondents said that they do not practice safe sex; frequent return of migrants is a significant risk factor that raises the possibility of STI transmission. Further, they contended that, despite the fact that it may be more challenging to identify these people, South African intervention programs must especially target the sexual behaviour of temporary migrants.

2.3.10.3 The National guidelines define PICT

All patients visiting medical institutions are routinely offered HIV counseling and testing as a basic part of medical care by healthcare professionals. At any health facility, including antenatal and postnatal clinics, TB facilities, Integrated Management of Childhood Illness (IMCI) Centers, Family Physician (FP) clinics, STI clinics, centers providing treatment for opportunistic infections (OIs), domestic or gender-based violence/trauma services, and post-exposure prophylaxis, provider-initiated counselling and testing (PICT) should be made available to all adults, youth, and children. Clients may "opt out" of receiving PICT, which can be routinely offered. As a result, more people will receive HTS, access to improved care and support, HIV and STI treatment, prevention continuum comprehensive care and HIV therapy. The plan was that 90% of HIV-positive individuals must have received treatment, care, and support by 2020, according to NSP 2012-2016, a collective response to South Africa's AIDS epidemic. Currently, South Africa has the largest antiretroviral (ARV) program in the entire world. As of November 2009, the South African government stated that almost 920 000 people were receiving treatment, or 56% of adults and children in need of antiretroviral therapy (ART). The disparity between those who require therapy and those who are receiving it, though, persists and varies by province. Achieving near-universal coverage in a short amount of time is a huge undertaking given this gap and the probable obstacles to its completion. To ensure the 2021 and future targets are met, the NSP has recently undergone a review that resulted in a number of suggestions. These include expanding province and district-level resources, the requirement for a rolling annual implementation plan, and funds for surveillance. For more affordable and successful programs, more efficient supply chains and medicine procurement are also required.

2.3.10.4 Cervical cancer screening

The most prevalent type of cancer detected in South Africa is cervical cancer. Every year, about 7 000 South African women are diagnosed with cervical cancer. Cervical cancer screening and care are not well covered, despite the existence of standards and a policy, and this problem affects the entire population, not only the women who work as migrant workers. Older women

have more likelihood of developing cervical cancer, and the disease takes time to spread. This justification underpins the national cervical screening policy in South Africa, which is based on WHO recommendations for screening in nations with little resources. While not ideal, screening women who are not HIV-positive every 10 years from the age of 30 would have the biggest population-based impact on lowering significant morbidity and mortality from cervical cancer among women in the nation.

The Cancer Research Institute of South Africa (CARISA), 2015 estimates that only around 23% of South African women have regular access to pelvic exams, and that between 56% and 60% of women have never had one. Even more concerning is the fact that the age group of women who are most at risk for cervical cancer screening rates are notably low (between 45 and 54 years). The demands of cytology-based screening technologies represent a substantial obstacle to the introduction and sustainability of mass cervical cancer screening in South Africa. This demands a relatively complicated laboratory infrastructure and are labour- and resource-intensive. Further research is needed on quick, cutting-edge screening methods like visual inspection with acetic acid (VIA), which does not need a pathologist, samples to be chilled, or a microscope.

2.3.10.5 Mother-to-Child Transmission Prevention

The health of South African women and children will improve with enhanced PMTCT, including postnatal care. The primary prevention of HIV infection in women, of unintended pregnancies in women living with HIV, of transmission from women living with HIV to their infants, and the provision of care, treatment, and support for women living with HIV including their families are generally regarded as the four main strategies that make up PMTCT.

The implementation of antiretroviral treatment, including highly active antiretroviral therapy (HAART) for mothers at particular risk and, more widely, as combined therapy increasingly replaces individual antiretroviral therapies, are some strategies to stop mother-to-child transmission. These include the amendment of the policy and standard operation procedures on HIV testing services, encouragement to share HIV status with partners and family, skilled supervision of labour and delivery with an eye toward minimizing invasive procedures, for women to develop optimal newborn feeding and reduce any stigma associated with feeding preference, and also health worker support is required. The risks of exposure to contaminated settings outweigh the risks of HIV transmission through breastfeeding in the majority of impoverished populations. Antiretrovirals can significantly lower breastfeeding transmission

when given to nursing infants or lactating mothers. The updated South African treatment recommendations, which match with WHO recommendations, call for ART for all HIV-positive children younger than one year old and ARVs for HIV-positive pregnant women with a cluster of differentiation 4 (CD4) count of 350 or higher at 14 weeks as part of the PMTCT program.

Intriguingly, 17% of the participants attended antenatal care during their first trimester, which is in accordance with the recommendations, and they were able to attend until they gave birth, even though they had to travel to a facility in town. This demonstrates their awareness of the significance of making sure they attend antenatal care for protection of the unborn child from contracting the HIV/AIDS virus.

2.3.10.6 Post-Exposure Prophylaxis (PEP)

PEP is a brief antiretroviral therapy used to lessen the risk of HIV infection following potential exposure, such as one acquired through sexual contact or occupational exposure. Since 2002, PEP coverage has been required for victims of sexual assault.

2.3.11 Barriers in accessing healthcare services

Access to healthcare for migrants in Africa South of the Sahara has been noted as a component of a development strategy. In a journal article published in 2016, Gonah, Corwin, January, Shamu, Nyati-Jokomo, and Van der Putten stated that although language barriers, distrust of, and fear of discrimination from healthcare personnel are often the key issues impeding access to healthcare, the idea that migrant communities may be more susceptible to illness and face access challenges to healthcare may also support this. Therefore, it is crucial that migrants take into account potential obstacles to receiving healthcare services before migrating. The World Health Organization contends this by saying majority of migrants from Sub-Saharan Africa frequently leave without giving adequate thought to any potential obstacles to receiving health services they may encounter while residing in host countries. It has been established that language, service costs, health insurance, and the degree of illness among migrants have a greater impact on their decision regarding a healthcare provider than other factors. The most common obstacles in accessing health services are those related to language and communication, from which the majority of other hurdles were found. Baah-Boateng et al. (2013) validated the existence of these barriers.

According to Ponce et al. (2006), one of the main hindrances at receiving health care is a lack of language proficiency in the host nation, which deters immigrant women from seeking

assistance in the event of an illness or pregnancy. Most of the time, translators are not available in health facilities, or women are forced to use them in the company of their partners or other family members due to ignorance of their existence, preventing them from openly expressing their most private problems (United Nations Population Fund, 2006). From a different perspective, in cases of domestic violence, this dependence may prevent victims from informing the authorities about the incident.

It is crucial to emphasize that pregnant victims of violence have greater health issues than non-victims do, especially during the second trimester (Morewitz, 2004). On the other hand, some female immigrants experience discomfort and even disrespect as a result of the practice of some medical acts, such as care from male doctors or the requirement to expose private body parts during clinical observation, because of the cultural norms of their countries of origin, which are deeply rooted in conservatism and the patriarchy (Mestheneos et al., 1999 apud Dias et al., 2009).

2.3.11.1 Cultural patterns in health-seeking behaviours

More linguistic and cultural hurdles affect foreign nationals from obtaining healthcare in the United States. According to Fenta et al. (2007), immigrants frequently obtain medical care that is not appropriate for their culture or face several obstacles to receiving it. Additionally, because of cultural variations in how people view disease, how they seek out healthcare, and how accessible services are, the resultant use of healthcare services is also constrained. The most prevalent type of barrier, when looking at the difficulties faced by female labour migrants, is language. As a result, there is a need to comprehend how cultural differences affect how people use healthcare services in order to enhance service delivery, cost, accessibility, and life outcomes, such as morbidity and death rates. Research frequently ignores the influence of cultural variables on the health condition and use of health services among female labour migrants. Therefore, further research on the influence of culture on women labour migrants' health would help practitioners, policymakers, and service providers in creating programs and services that are more accessible, appropriate, and acceptable from a cultural perspective (Lai & Surood, 2008). Ivanov and Buck (2002) contend that policy pertaining to refugees and migrants should take into account the difficulties that various migrant groups have in obtaining healthcare services.

2.3.11.2 Culturally competent healthcare services

Previous studies have identified that acculturation and a person's education level have an impact on how they use healthcare services. However, other academics contend that acculturation levels are erratic indicators of the use of healthcare services (Ivanov & Buck, 2002). On how refugees use healthcare, there is a dearth of empirical research (Fenta et al., 2007). Ivanov and Buck (2002) had earlier clarified that, however, the few studies that have concentrated on the usage of healthcare services emphasized on how crucial it is to deliver culturally competent healthcare in order to enhance health outcomes. To better administer healthcare services to people from different cultures, healthcare providers must therefore determine both healthy and unhealthy behaviours as defined by the interested refugee culture. Furthermore, there is a wealth of information showing that immigrants frequently suffer numerous hurdles to care or obtain care that is not appropriate for their culture. Additionally, a review of the research on healthcare-use-patterns has shown that, in comparison to the general population, ethno-visible minorities are less likely to use healthcare services and experience more access challenges (Lai & Surood, 2008). The available research is limited to women labour migrants within the textile industry.

2.4 Conclusion

The chapter discussed the theoretical framework that the study drew its conclusion from. The intersectional feminist approach, diversity and intersectionality, capability approach, diversity and its usefulness, access to healthcare services, the Nussbaum approach to capabilities gender inequalities, and lastly the social theory had also been discussed. The chapter explored literature review on the history trends of migrants, migration as a global phenomenon and the cause of migration. The chapter has reviewed writings on Southern Africa labour migration history and the South African existing migration systems especially the rights for migrants as per UN chapter. Lastly the chapter reviewed morbidity and the spread of HIV/AIDS, gender migration and feminization of migration, access to healthcare services as well as cultural pattern in health-seeking behaviour and culturally competent health needs.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

The interpretivism research paradigm was used to carry out this investigation. According to research, this is a phenomenological technique where the researcher identifies the “essence” of participants’ reported human reactions to an event (Cresswell, 2003:15). The researcher must engage in self-reflection since meaning-making is a shared process that involves both the researcher and the participants. In better understanding the experiences of female labour migrants in the textile sector and their access to healthcare in the Newcastle area, the study used a qualitative research technique. The researcher also examined how well-informed women labour migrants are on major health issues, such as TB, HIV/AIDS, STIs, and gender-based violence. Their perceptions, due to their level of information, may have an impact on how they feel and act about using healthcare resources. In order to address the study’s guiding question, this chapter focuses on the methodology employed to carry out the investigation. The chapter also discusses the methods used to acquire the data, ethical issues taken into account, how the data were analyzed, and the study’s shortcomings. The study also examines the demographic data of the participants in order to comprehend the backgrounds of the research subjects.

3.2 Research design

Research design is the overarching way of thought that directs the steps to be taken while conducting a specific study (Newman & Benz, 1998). The researchers’ conduct of the study is guided by their philosophical outlook (Creswell, 2007; Babbie, & Mouton, 2010). This work used an interpretivist research paradigm to interpret the phenomena of the women labour migrants since the nature of this study necessitates a flexible and relative worldview. In contrast to positivism, which takes a rigorous approach, the interpretivist research paradigm allows for relative observation and interpretation of data to produce meaning. The interpretivist paradigm asserts that the research subjects are complex beings with unique perspectives and experiences of a particular occurrence, not merely inert objects.

3.3 Research methodology

The systematic approach of collecting data and interpreting it in accordance with a set of paradigms and theories is referred to as research methodology (Babbie, & Mouton, 2010; Hill, 2012; Maree, 2007; Newman 2011; Rebeck et al., 2001). It involves a series of steps and methods that the researcher uses to direct the study (Rebeck et al., 2001). A qualitative research methodology was used for the study, due to the purpose of the study, which was to learn how

women labour migrants in the Newcastle municipality experienced obtaining healthcare facilities. In order to understand migrants' experiences, which rely on their socioeconomic level, behavioural pattern, cultural influences, and educational background, it was essential to develop the appropriate approach for the study. Adopting a qualitative approach was inevitable because it was more likely to present people's actual experiences in a particular environment. Although a qualitative approach would be the most effective way to learn more about the experiences of a particular group of people, the results of the study cannot be free from the researcher's and participants' prejudices and biases based on their own social, economic, and political circumstances. More importantly, the small sample of cases examined cannot be used to represent other situations because the researcher and the participants have opposing viewpoints and environments that might have a varied impact on them, as opposed to a quantitative method where the outcomes are independent of the aforementioned circumstances.

According to Newman (2011), the qualitative research methodology is a strategy for describing and explaining a social phenomenon. On the same note, Silverman (2006) contends that the use of qualitative research methodologies provides access to participant's experiences through a thorough process of data collection. This methodology, which enables the comprehending of the realities on the ground, was appropriate given the study's focus of the experiences of women migrant labourers in the textile sector. Since the qualitative methodology is a naturalistic approach that helps the researcher to understand reality in a specific situation, it was pertinent to this study, as Maree (2007) points out.

3.4 Data collection method

For this study, an extensive interviewing methodology was used. Semi-structured interview questions were appropriate for this work due to their open-ended character and relevance to the goals the study aimed to accomplish. According to Mathers and Schofield (1998:2), exploratory questions give the interviewer and the subject of the interview the chance to go into further detail about some subjects. In-depth interviews between the researcher and the subjects were used to get the appropriate data. In order to fully comprehend their sociocultural life, knowledge of health care services, types of services offered at health facilities, and prior experiences, the researcher utilized free narration about the participants' former lives in between the two countries, South Africa and country of origin that they alternated. The main benefit of in-depth interviews, according to Boyce & Neale (2006), is that they offer a lot more specific information than what can be obtained through other data collection approaches. This strategy worked well for this study. Due to the open-ended questions utilized during the in-

depth interview, the researcher was able to reformulate the topic so that the participants would comprehend it. Open-ended interview questions, according to Hill (2012:87), could boost data output because they encourage the participant's experiences, thoughts, ideas, and feelings in a liberating and judgment-free environment.

On the other hand, the interviewees had some latitude to provide additional material that was not covered in the question but was nonetheless crucial to the study. The researcher was able to examine their actions and demeanour while they spoke about access to healthcare difficulties that included some painful experiences for others. The researcher being a qualified social worker with experience dealing with trauma issues, the interview occasionally took longer than anticipated, and the researcher would provide counselling support to help them deal with their unhappy memories.

Responses of the research participants were audio-recorded throughout the interviews using an Android phone for data storage. In order to later maintain track of events, a notebook with thorough notes about what happened in the field was kept.

A deeper memory of some elements, such as participant behaviours, which were not recorded by the audio recorder was made possible by the field note-taking system that was available. Writing down the researcher's thoughts on the notes allowed the researcher to reflect on several significant themes and topics that kept on coming up. These reflections were used in the analysis, which took a thematic approach. Keeping a diary is advised throughout research, according to Borg (2001) and Newburry (2001), this is because it allows the researcher to reflect on their work while also keeping track of ideas, thoughts, and events.

A research plan was used to keep the interviews on topic without straying too far from the main points of the investigation. The research guide's semi-structured interview questions focused on the needs for healthcare among women labour migrants, their understanding of the services that are available, socio-cultural factors, and the obstacles that they may face in getting access to health care. The researcher asked additional questions (probed) based on the informants' responses in order to clarify anything that was not clear because of the questions asked and the concerns that arose. The probing presented a difficulty in that it took longer than anticipated since some participants wanted to talk more about topics related to the difficulties they encountered as migrants and in the textile industry. The average amount of time spent on each interviewee was therefore between 60 and 80 minutes. The researcher probed each participant during the interviews in order to fully comprehend the concerns that were coming to light. The

respondents who knew more about the data the study was focusing on, were further questioned to better comprehend what they said.

3.5 Sampling procedure

Sample refers to the collection of comparatively fewer individuals chosen from a population for research purposes, according to Alvi (2006). According to Maree (2007:79) Sampling is the method used to select a portion of the population for the study. For this investigation, non-probability sampling was employed. Non-probability sampling, in contrast to random selection of the population to be studied, relies on an arbitrary attempt to select a sample that can yield the required data (Battaglia et al., 2008). In this instance, the researcher was free to firmly choose the sample that could produce the information relevant for the purpose of the study. Purposive sampling was used for the study because, according to Battaglia et al. (2008) and Tongco (2007), “with purposive sampling, one identifies what needs to be known and set out to find people who can and are willing to offer information by virtue of expertise or experience.” Because the researcher was looking for a group of women labour migrants with a particular set of characteristics, other sampling techniques were inappropriate for this study. As a result, the subjects questioned for this study were identified and provided with alibis using the snowballing sampling technique. The gatekeeper’s letter from the ward counsellor did not provide the researcher with a free pass to the women labour migrants; however, the researcher already knew seven informants who occasionally doubled as interpreters to help with the recruiting process and to set up the interviews. The snowballing method was therefore suited for that reason.

There were 35 research participants in the study. These were female labour migrants who had lived in the Newcastle municipality for at least a year and worked in the textile sector. They were between the ages of 21 and 50 and still in relationships with dependents. According to various writers, 35 is a suitable quantity for chosen research methodology. According to Francis et al. (2010:1229), the sample size in qualitative studies is justified by speaking with participants until “data saturation,” beyond which no more information would be forthcoming. Dezin & Lincoln suggest 30–50 interviewees; Creswell suggests 20–30 participants; and Morse suggests 20–30 interviewees (Marshall et al., 2013; Francis et Al., 2010:1229; Creswell, 2003). Despite these differences in opinion among researchers, 30 seems to be the overlap point for the saturation number argued by Marshall et al. (2013).

3.6 Study site

The researcher chose Newcastle municipality which had a total of 85 textile industries, employing about 7 000 people by the year 2012. A new bill in the year 2012 passed by the bargaining council for textile industries prompted the employers to consider employing migrant labourers as they could not afford to amend the adopted minimum wage for South African labourers, by its textile industries. This is the appropriate site for the study as the area is also near to Lesotho, Swaziland and Botswana. Textile Industries attract women migrants from Southern African countries as there are no strict application of the employment act. However, without statutory in place employees may be exploited. Accessing of health care needs for women has been declared a priority area by the United Nations Organization.

Research findings by ILO in a paper presented in Geneva (2003) has proven that women labour migrants are exploited, abused and discriminated. Women migrant labourers have turned to prefer factories around Newcastle area as they are always having employment opportunities and lifestyle is said to be affordable compared to bigger cities and more developed areas. They argue that in those areas one can still find a rental room for at least R350.00 and share with a friend to cut cost. All the interviews were conducted outside the workplace, in places where these migrant women were residing. These places included Mabhodini, Madadeni sections 3, 5, 6 and 7. The researcher was very fortunate as the participants did not mind interviews being conducted where they stayed. These participants were working in different textile industries within the Newcastle area. The participants were interested in the interviews as they had never been part of such and they believed that perhaps their views could be heard, and change achieved in terms of accessing health care, attitude from healthcare providers and perhaps other means for them obtaining healthcare services and access to justices could be explored.

3.7 Population of the study

All of the research subjects are referred to as the “study sample” (Yount, 2006). Women labour migrants who had worked in the Newcastle textile sector for at least a year were the study’s target subjects. For the study this were women labour migrant aged between 21 and 50 years old. The study aimed at interviewing women labour migrants from Southern African countries with the purpose of documenting their experiences regarding obtaining healthcare services in the area and to investigate their knowledge regarding health services further exploring the influence their socio-cultural beliefs have on them accessing healthcare services. There were a lot of women labour migrants who were showing interest in being interviewed, however, the researcher had already reached the set limit.

It was learnt during the interviews that some of the women were raped and could not even seek recourse through the justice system as they feared to be questioned about their identities and end up being deported. The rape victims were also scared to visit the clinic for any help as the police would be involved in such cases as they are treated as sensitive cases. The researcher thus, employed pseudonyms in this study due to the sensitivity of the individuals, their positions, and the need to maintain their secrecy.

3.8 Background data of the study participants

Interviews comprised of 35 women labour migrants working in the Newcastle textile industries for a period of more than a year. The participants were from three different countries, these countries were Lesotho with 15, Botswana with 8 and Swaziland now known as Eswatini with 12 participants. The researcher is fluent in speaking Siswati and average in both Sesotho and Setswana. The following are not their real names but pseudonyms. The informants would intervene where there was a bit of misunderstanding, this was just a mere portion as most of them were able to converse in English, there and there.

3.8.1 Participants' profiles

Malefu

Malefu is from Lesotho, she is a 27-year-old single parent with three children. She studied until grade 9 and dropped out of school because she was pregnant. Two of her children belong to the same father and one she got from here in South Africa. At home she is the second born, and non-among her family members is working. They are a family of six without parents, hence, she decided to migrate to South Africa to be able to support her children and the family member left home. The children are staying in Lesotho with the maternal aunt and Malefu supports them together with her siblings. She had hoped that she would have made her breakthrough by coming to South Africa, however, not all her expectations were met. She has been working in the Newcastle textile industry for 2 years with some break ins and outs. She travels home once every month. Her focus now is on her children and she has stopped having relationships as she complains that men impregnate her and dump her with the children, without supporting them. She visited health care facility during her antenatal care visits for her last born only. She preferred the clinic in town as she said it would not be full compared to the local clinics, however, she does not like visiting healthcare facilities. She had once tried family planning contraceptive and stopped as she said it caused her to gain a lot of weight.

Mofeng

Mofeng is from Lesotho, she is a 28-year-old single parent with three children. She studied until grade 9 and dropped out of school because she was pregnant. All her children belong to different fathers with two born of South African fathers and one of a Lesotho father. The two from South Africa stay with their relatives and the other one stays in Lesotho. She is the second last born with six siblings, only her mother is still alive. She decided to migrate to South Africa to be able to support her children and the family members she left home. She supports both her child, mother and siblings back home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Have been employed in the Newcastle textile industry for 3 years with some break ins and outs. She travels home once every month. Her focus now is her family back home. She does have casual relationships here and there. She has visited the health care facilities during the antenatal care for her last two children, she preferred the healthcare facility in town as she said it is always not full.

Matshediso

Matshediso is from Lesotho and is a 28-year-old single parent with two children. She studied until grade 10 and dropped out of school because she was pregnant. All her children belong to the same father who is in Lesotho. She is the fifth born out of eight children with both of her parents deceased and non-among the family members is working a stable job. Hence, she decided to migrate to South Africa to be able to support her children and the family members she left home. The children are staying in Lesotho with their paternal grandparents. She supports both her children and her siblings back home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Employed in the Newcastle textile industry for a period of 2 years with some break ins and outs. She travels home once every month. She visits health facility every month for family planning, however, she does have casual relationships.

Lekeledi

Lekeledi is from Lesotho, aged 28 years and a single mother with three children. She studied until grade 10 and she dropped out of school because she was pregnant. Two of her children belong to the same father and one she got from here in South Africa. She is the third born out of five children and non-among the family members is working. Hence, she decided to migrate to South Africa to be able to support her children and the family members she left home. The children are staying in Lesotho with her siblings and they all depend on her. She had hoped

that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Employed in the Newcastle textile industry for 3 years with some break ins and outs. She travels home once every month. Her focus now is on her children and she has stopped having relationships. She never visited the healthcare facilities around Newcastle as she prefers self-medication.

Busisiwe

Busisiwe is from Swaziland/Eswatini aged 29 years old single mother with two children. She studied until grade 11 and she dropped out of school because her parents could not afford paying for her fees and her twin sister's fees since they were proceeding to the same grade. All her children belong to different fathers in Swaziland. She is the second born out of four children, with one parent remaining and non-among the family members is working. Hence, she decided to migrate to South Africa to be able to support her children and her family members. Her children are staying in Swaziland with their maternal grandparent and she is the bread winner. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. She has been employed in the Newcastle textile industry for 2 years with some break ins and outs. She travels home once every 2 months. She does have casual relations now and then and visits the healthcare facility for collection of her chronic treatment and for family planning.

Busi

Busi is from Swaziland/Eswatini and is 29 years old, she is a single mother with one child. She studied until grade 11 and she dropped out of school because her parents could not afford paying for her fees and her twin sister's fees since they were proceeding to the same grade. She is the second born out of four children, with only one parent remaining and only one of her family members is working. Hence, she decided to migrate to South Africa to be able to support her child and her family members. The child is staying in Swaziland with their maternal grandparent and she supports both her child and her siblings. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Employed in the Newcastle textile industry for 2 years with some break ins and outs. She travels home once every 2 months. She does have casual relations now and then and she visits the healthcare facility for collection of her chronic treatment and for family planning.

Matlatsi

Matlatsi is from Botswana and she is a 27-year-old single parent with two children. She studied until grade 11 and she dropped out of school because she was pregnant. Both of her children belong to the same father who is in Botswana. She is the forth born out of seven children with both of her parents deceased and non-among the family members is having a stable job. Hence, she decided to migrate to South Africa to be able to support her children and her family members. The children are staying in Botswana with their paternal grandparents. She supports both her children and her siblings and travels home once every month. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. An employee of the Newcastle textile industry for 2 years with some break ins and outs. She visits health facility every month for family planning and she does have casual relationships.

Ntlaki

Ntlaki is from Botswana and she is a 37-year-old single parent with two children. She studied until grade 10 and dropped out of school because she was pregnant. All her children belong to the same father who is in Botswana. She is the second born out of five children, with both of her parents deceased and non-among her family members is having a stable job. Hence, she decided to migrate to South Africa to be able to support her children and her family members. The children are staying in Botswana with their paternal grandparents and she supports both her children and her siblings, therefore, she travels home once every month. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Employed the Newcastle textile industry for 4 years with some break ins and outs. She visits health facility every month for family planning and does have casual relationships. She fell into tears when she narrated how she was sexually assaulted by someone whilst hiking from Bloemfontein to Newcastle and she was infected with HIV/AIDS virus.

Thantazile

Thantazile is from Swaziland/Eswatini and is a 33-year-old single mother with two children. She studied until grade 11 and dropped out of school because her parent could not afford paying for the next grade. Both her children belong to the same father. She is the fifth born out of seven children, with one parent surviving and non-among the family members is having a proper job. Hence, she decided to migrate to South Africa to be able to support her children and her family members. The children are staying in Swaziland with her siblings and they all depend on her, therefore, she travels home once every month. She had hoped that she would

have made her breakthrough by coming to South Africa, however not all her expectations were met. Has been an employee in the Newcastle textile industry for 3 years with some break ins and outs. She visits the healthcare facilities around Newcastle for family planning.

Thando

Thando is from Swaziland/Eswatini and is a 29-year-old single mother with one child. She studied until grade 11 and dropped out of school because she was pregnant. Her child stays in Swaziland with her mother. She is the second born out of five children, with her mother surviving and non-among the family members is working a stable job. Hence, she decided to migrate to South Africa to be able to support her children and her family members. The child is staying in Swaziland with her mother and she supports her child, mother and her siblings. Therefore, she travels home once every month. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. An employee in the Newcastle textile industry for 2 years with some break ins and outs. She visits health facility every month for family planning and does have casual relationships.

Siphiwe

Siphiwe is from Swaziland/Eswatini and is a 30-year-old single parent with one child. She studied until grade 11 and dropped out of school because her parent could not afford paying for her fees for the next grade. Her child stays in Swaziland with her mother. She is the third born out of seven children, with her mother surviving and non-among the family members is working a stable job. Hence, she decided to migrate to South Africa to be able to support her child and her family members. The child is staying in Swaziland with her mother and she supports them and her siblings, hence she travels home once every month. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Has been an employee in the Newcastle textile industry for 2 years with some break ins and outs. She visits health facility every month for family planning and does have casual relationships.

Tanele

Tanele is from Swaziland/Eswatini and is a 33-year-old widowed single parent with two children. She studied until grade 11 and dropped out of school because she was pregnant. Her children are staying in Swaziland with her mother. She is the second born out of six children, with her mother surviving and non-among the family members is working a stable job. The

children are staying in Swaziland with her mother and they together with her siblings fully depend on her. Hence why she travels home once every month. Hence, she decided to migrate to South Africa to be able to support her children and the family members back home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. An employee in the Newcastle textile industry for 3 years with some break ins and outs. She visits health facility for family planning and collection of her chronic treatment and does have casual relationships.

Ntswaki

Ntswaki is from Botswana and is a 35-year-old single mother with three children. She studied until grade 10 and dropped out of school because she was pregnant. All her children belong to the same father who is in Botswana. She is the third born out of six children, with both of her parents deceased and non-among the family members is working a stable job. Hence, she decided to migrate to South Africa to be able to support her children and her family members. The children are staying in Botswana with her siblings and she supports both her children and her siblings, hence why she travels home once every month. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Employed in the Newcastle textile industry for 3 years with some break ins and outs. She visits health facility every month for family planning and does have casual relationships. She also is one of the participants who were recruited by a friend.

Angel

Angel is from Botswana and is a 36-year-old single mother with three children. She studied until grade 10 and dropped out of school because she was pregnant. All her children belong to the same father who is in Botswana. She is the second born out of four children, with one parent surviving and non-among the family members is having a stable job. The children are staying in Botswana with her siblings and she supports all of them, therefore, she travels home once every month. Hence, she decided to migrate to South Africa to be able to support her children and the family members. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. An employee in the Newcastle textile industry for 4 years with some break ins and outs. She visits health facility every month for family planning and does have casual relationships. She was recruited by a friend to participate in this study.

Ncobile

Ncobile is from Swaziland/Eswatini and is a 34-year-old single parent with two children. Her children are from different fathers with one born from a South African. She studied until grade 11 and dropped out of school because she was pregnant. One of her children stays in Swaziland with her mother and the other one stays with relatives within the area. She is the first born out of five children, with her mother surviving and non-among the family members is working a stable job. Hence, she decided to migrate to South Africa to be able to support her children and her family members. She supports both her child and her siblings back home, so she has to travel home once every month. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Worked in the Newcastle textile industry for 3 years with some break ins and outs. She visits health facility for family planning and collection of her chronic treatment and does have casual relationships.

Phindile

Phindile is from Swaziland/Eswatini and is a 36-year-old single parent with two children. Her children are from different fathers with one born from a South African. She studied until grade 11 and dropped out of school because she was pregnant. Both her children are staying in Swaziland with her parents. She is the first born out of six children, with both parents surviving and non-among the family members is having a stable job. She supports her children, parents and her siblings back home. Therefore, she travels home once every month. She decided to migrate to South Africa to be able to support her children and her family members. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Employed in the Newcastle textile industry for 4 years with some break ins and outs. She visits health facility for family planning and collection of her chronic treatment and does have casual relationships.

Pontso

Pontso is from Lesotho and is a 34-year-old single mother with two children. Her children are from different fathers with one born from a South African. She studied until grade 11 and dropped out of school because she was pregnant. Both her kids reside in Lesotho with her mother. She is the third born out of six children, with her mother surviving and non-among the family members is working a stable job. Hence, they all depend on her, she travels home once every month. She decided to migrate to South Africa to be able to support her children and her family members. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Employed in the Newcastle textile

industry for 2 years with some break ins and outs. She visits health facility for family planning and collection of her chronic treatment and does have casual relationships.

Dimakatso

Dimakatso is from Lesotho and is a 33-year-old single parent with two children. Her children are from different fathers with one born from a South African. She studied until grade 11 and dropped out of school because she was pregnant. She came to South Africa hoping to continue with studying. One of her children stays in Lesotho with her mother. The other one stays with relatives within the area. She is the first born out of four children, with her mother surviving and non-among her family members is working a stable job. Hence, she decided to migrate to South Africa to be able to support her children and her family members. She travels home once every month. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. An employee in the Newcastle textile industry for 3 years with some break ins and outs. She visits health facility for family planning and does have casual relationships.

Moeletsi

Moeletsi a 33-year-old single mother with two children from Lesotho. Her children are from different fathers. She studied up to grade 11 and dropped out of school because she was pregnant. She came to South Africa hoping to continue with studying. Both kids stay in Lesotho with her mother. She is the third born out of six children, with her mother surviving and non-among the family members is having a stable job. Therefore, she travels home once every month. Hence, she decided to migrate to South Africa to be able to support her children and her family members. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Employed in the Newcastle textile industry for 3 years with some break ins and outs. She visits health facility for family planning and does have casual relationships.

Tsosane

Tsosane is from Lesotho and is a 32-year-old single parent with two children. Her children are from different fathers. She studied up to grade 11 and dropped out of school because she was pregnant. She came to South Africa hoping to continue with studying. She is the second born out of seven children with both parents surviving and non-among the family members are working a stable job. Hence, she decided to migrate to South Africa to be able to support her

children and the family members back home. She travels home once every month. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. An employee in the Newcastle textile industry for a period 3 years with some break ins and outs. She visits health facility for family planning and does have casual relationships.

Selloane

Selloane is from Lesotho and is a 32-year-old single parent with two children. Both children have different fathers. She studied until grade 11 and dropped out of school because she was pregnant. She came to South Africa hoping to continue with studying. She is the first born out of five children, with both parents surviving and non-among the family members is working a stable job. Hence, she decided to migrate to South Africa to be able to support her children and the family members back home. She travels home once every month. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. An employee in the Newcastle textile industry for 3 years with some break ins and outs. She visits health facility for family planning and does have casual relationships.

Mamasoko

Mamasoko is from Lesotho and is a 30-year-old single parent with one child. She studied until grade 11 and dropped out of school because she was pregnant. She came to South Africa hoping to continue with studying. She is the second born out of six children, with both parents surviving and non-among the family members is working a stable job. She decided to migrate to South Africa to be able to support her child and her family members back home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Has been employed in the Newcastle textile industry for a year. She travels home once every month. She visits health facility for family planning and does have casual relationships.

Maseabata

Maseabata is from Lesotho and is a 29-year-old single parent with one child. She studied until grade 11 and dropped out of school because she was pregnant. She came to South Africa hoping to continue with studying. She is the third born out of seven children, with both parents surviving and non-among the family members is working a stable job. She has to travel home

once every month. She decided to migrate to South Africa to be able to support her child and her family members back home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Employed in the Newcastle textile industry for 3 years. She visits health facility for family planning and does have casual relationships.

Thoko

Thoko is from Swaziland/Eswatini and is a 30-year-old single parent with three children. She studied until grade 6 and dropped out of school because no one amongst the family member was keen and supportive towards her attending school. She was raised by both her parents who were traditional healers and had not attended any school. They all passed on when she was on her early twenties. She is a fourth born from a family of seven. Her children are all in Swaziland staying with her siblings and she visits them every end of the month. She does not believe in western medicine hence she does not consult any clinic around and back home. She only visits clinics when she is about to give birth and does not have any relevant knowledge about women's health and family planning. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. She has been employed in the Newcastle textile industry for 4 years with some break ins and outs.

Manaledi

Manaledi is from Lesotho aged 28 years and a single mother with three children. She studied until grade 7 and dropped out of school because her parent did not believe that a girl child should attend school and they could not afford the school uniforms and books. She is a last born from a family of five with both parents deceased. Her children are in Lesotho with her siblings. She has not consulted in a health facility around Newcastle she prefers to consult back home. She does not use family planning services as she believes she will gain weight. She does not attend church around the area and after work, she is always with her home girls and they routinely go where they stay for socializing. She does have casual relationships around the area and she does not insist on using a condom. She travels home once every month. She decided to migrate to South Africa to be able to support her children and the family members she left home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. She has been employed in the Newcastle textile industry for 3 years with some break ins and outs.

Nomusa

Nomusa is from Swaziland/Eswatini and is a 36-year-old widow with four children. She is now cohabitating. She studied until grade 6. Her parents were not keen in encouraging a girl child to go to school, they believe that educating a girl was a waste as they will ultimately be married and start their own families. She is a second last born from a family of seven with both parents deceased. Her children stay in Swaziland with her siblings. She does not believe in western medication, therefore, she had only been to hospital when giving birth. She does not attend church around the area and after work she is always with her home girls and they routinely go where they stay for socializing. She does have casual relationships around the area and she does not insist on using a condom. She travels home once every month. She decided to migrate to South Africa to be able to support her children and her family members back home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Employed in the Newcastle textile industry for 4 years with some break ins and outs.

Nthabiseng

Nthabiseng is from Lesotho and is a 30-year-old single parent with three children. She studied until grade 6 and dropped out of school because her parent did not believe that a girl child should attend school and they could not afford the school expenses. She is the last born from a family of eight with both parents deceased. Her children are in Lesotho with her siblings and she visits home once every month. She has not consulted any health facility around Newcastle as she prefers to consult clinics back home. She does not use family planning services as she believes she will gain weight. She does not attend church around the area and she is always with her home girls. After work they go where they stay for socializing. She does have casual relationships around the area and she does not insist on using a condom. She decided to migrate to South Africa to be able to support her children and the family members back home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Hired in the Newcastle textile industry for 3 years with some break ins and outs.

Mokgadi

Mokgadi is from Botswana age 29, she is a single parent with three children. She studied until grade 8 and dropped out of school because her parent did not believe that a girl child should attend school and they could not afford the school uniforms and books. She is the second last born from a family of seven with both parents deceased. Her children are in Botswana with her

siblings and she travels home once every month. She has not consulted in a health facility around Newcastle as she prefers to consult clinics back home. She does not like to use family planning objects. She does not attend church around the area and is always with her home girls. After work they go where they stay for socializing. She does have casual relationships around the area and she insists on using a condom. She decided to migrate to South Africa to be able to support her children and her family members back home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. She has been working in the Newcastle textile industry for 2 years with some break ins and outs.

Eva

Eva is from Lesotho and is a 31-year-old single mother with three children. She studied until grade 7 and dropped out of school because her parents did not believe that a girl child should attend school and they could not afford the school resources. She is the last born from a family of nine with both parents deceased. Her father had two wives. Her children are in Lesotho with her siblings, therefore, she travels home once every month. She has not consulted any health facility around Newcastle as she prefers to consult clinics back home. She complains that she cannot communicate in IsiZulu and she feels as if the nurses have got attitude against migrants. She said she observed when accompanying a friend. She does not use family planning services as she believes she will gain weight. She does not attend church around the area and is always with her home girls. After work they go where they stay for socializing. She does have casual relationships around the area and does not insist on using a condom. She decided to migrate to South Africa to be able to support her children and her family members she left home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. Employed in the Newcastle textile industry for 4 years with some break ins and outs.

Temavungadze

Temavungadze is from Swaziland/Eswatini and is a 28-year-old single parent with three children. She studied up to grade 8 and dropped out of school because her parents could not afford paying for her fees for the next grade. She is the last born from a family of seven with her mother surviving. Her children are in Swaziland with her mother and siblings, and they all depend on her. So, she travels home once every month. She does consult in a local health facility for family planning services. She has casual relationships around however she insists

on the use of a condom. She does not attend church around the area and is always with her home girls. After work they go where they stay for socializing. She decided to migrate to South Africa to be able to support her children and the family members back home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. She was recruited by a friend whom she is staying with. She has been working in the Newcastle textile industry for 2 years with some break ins and outs.

Jabulile

Jabulile is from Swaziland/Eswatini and is a 34-year-old divorcee with three children. She is now cohabitating. She studied up to grade 7 because her parents were not keen in encouraging a girl child to go to school, they believe that educating a girl was a waste as they will ultimately be married and start their own families. She is the last born from a family of eight with both parents deceased. Her children stay in Swaziland with her siblings, therefore, she travels home once every month. She does not believe in western medication and had only been to hospital when giving birth. She does not attend church around the area and is always with her home girls. After work they go where they stay for socializing. She does have casual relationships around the area and she does not insist on using a condom. She decided to migrate to South Africa to be able to support her children and the family members back home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. She has been working in the Newcastle textile industry for 3 years with some break ins and outs.

Mahlatse

Mahlatse from Botswana is a 32-year-old with three children and is cohabitating. She studied up to grade 5 and dropped out of school because her parents did not believe that a girl child should attend school and they could not afford the school resources. She is the last born from a family of 11 with both parents deceased. Her father had 3 wives. Her children are in Botswana with her siblings and she visits home once every month. She has not consulted with a health facility around Newcastle as she prefers to consult with clinics back home. She complains that she cannot communicate in IsiZulu and she feels as if the nurses have got attitude against migrants. She said she observed when accompanying a friend. She does not use family planning services as she believes she will gain weight. She does not attend church around the area and is always with her home girls. After work they go where they stay for socializing. She does have casual relationships around the area and she does not insist on using a condom. She

decided to migrate to South Africa to be able to support her children and the family members back home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. She has been working in the Newcastle textile industry for 4 years with some break ins and outs.

Grace

Grace a 34-year-old widowed single mother with four children from Botswana. She studied up to grade 5 and dropped out of school because her parents did not believe that a girl child should attend school and they could not afford the school resources. She is the last born from a family of seven with both parents deceased. Her children are in Botswana with her siblings, so, she travels home once every month. She has not consulted any health facility around Newcastle as she prefers to consult clinics home. She complains that she cannot communicate in IsiZulu and she feels as if the nurses have got attitude against migrants. She said she observed when accompanying a friend. She does not use family planning utilities as she believes she will gain weight. She does not attend church around the area and is always with her home girls. After work they go where they stay for socializing. She does have casual relationships around the area and she does not insist on using a condom. She decided to migrate to South Africa to be able to support her children and the family members back home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. She has been an employee in the Newcastle textile industry for 4 years with some break ins and outs.

Happy

Happy, a 31-year-old single parent with two children from Botswana. Her children are from different fathers with one born from a South African. She studied up to grade 11 and dropped out of school because she was pregnant. She came to South Africa hoping to continue with studying. One of her children stays in Botswana with her mother and the other one stays with relatives within the area. She is the first born out of four children, with her mother surviving and non-among the family members is having a stable job. She visits home once every month. She decided to migrate to South Africa to be able to support her child and the family members back home. She had hoped that she would have made her breakthrough by coming to South Africa, however not all her expectations were met. She has been an employee in the Newcastle textile industry for 3 years with some break ins and outs. She visits health facility for family planning and does have casual relationships.

3.9 Ethics-related matters

According to Neuman (2011: 143), ethical considerations or issues are the uncertainties, disputes, and worries that surround the right approach to conduct research. The investigator acquired ethical clearance from the University ethical committee prior to conducting the interviews and further ensured confidentiality of shared information between researcher and respondents during the write up. Informed consent, voluntary participation, and anonymity were guaranteed. Study respondents were briefed about the purpose of the research to ensure that they were informed about the intentions of the researcher and were made aware of the rights to discontinue the interview or participation at any given time when they felt uncomfortable.

To earn the participants' trust, the research method started with an explanation of the study's objectives. Participants were then interviewed and assured of the research's strict confidentiality throughout. The Ward Councillor provided the researcher with the gatekeeper's letter, which permitted the researcher to interview the participants, albeit there was still a need for the informants to help with participant identification and appointments arrangement. Prior to the interviews, instead of keeping the audio recorder hidden in the pocket out of a concern that the participants would withhold from providing information that was sensitive to them, the researcher sought permission from the participants concerning the recording of any information they provided and made sure they were comfortable with it. The research subjects were fine with having their audio recorded, but they requested that their identities be protected because they did not even have work permits or asylum papers and they were worried about being deported if the information reached the police or Home Affairs.

The informed consent protocol was followed to ensure that the respondents felt at ease throughout the interviews; in fact, the majority of them were happy to find that their information was being recorded. After being assured of their confidentiality, several of them said it was fine to quote them without disclosing their identities.

The respondents were also told that they could stop the interview if they felt uncomfortable; at least four people expressed interest in participating but then withdrew out of fear of having their identity revealed. Before starting the interviews, the researcher made an introduction and justified the relevancy of the research.

It was explained to them why the researcher was conducting the study and how it would be advantageous for them to participate. They were convinced by the researcher that the data they

produced would remain anonymous and private. This was done by reassuring them that the data would be presented using pseudonyms and that the information they provided would be deleted once the research report has been produced.

3.10 Data sources

The women labour migrants employed in the Newcastle area's textile sector were the primary sources for the data. Informants facilitated contacts with the women labour migrants that provided sufficient data to ensure the completion of the study. That is, these informants from Botswana, Lesotho and Eswatini created easier path for the researcher to approach other participants as they would have already briefed the participants during the time of interviews and would have arranged time slots for their interviews. Hence accessing the participants was not that much of a hustle hence opted for the purposive sampling. Secondary data for the study was gathered through conference papers, books, theses, and journal articles.

3.11 Data analysis

According to Babbie and Mouton (2010: 64), data analysis refers to the methods and techniques used to carry out a research design or research plan. The acquired data was analyzed using straightforward frequencies. According to developing themes based on the research questions, the study used a thematic analysis to group the data it had gathered. For the purpose of identifying trends and determining the results of the empirical study, the data was organized, examined, and analyzed (De Vos et al., 2005).

The transcription of the voice recordings from the audio recorder over the course of two months was the first step in the data analysis process. The transcribed data was 203 pages long with 1.5 line spacing. Because the material needed for the analysis is made available in writing, transcription, according to Hill (2012), is an essential task during the research process. After going word-by-word through the transcribed material, the primary themes were discovered.

3.12 Limitations of the study

The challenge that the study posed was the constant changing of the participants as some had travelled home for family emergencies and some pulled off during interview session as they felt uncomfortable. What the researcher noticed was that there were traumatic experiences that the participants might have encountered either from their country of origin or after they migrated to SA of which they did not want to talk about. Along the interview there were questions that triggered emotional trauma such as rape incidences. Given the immediate outburst the researcher would also immediately stop the interview and provide trauma post

counselling. This was a challenge as the researcher had to immediately deviate from being an interviewer to being a social worker. Some of the traumatic experiences would need exploring their support systems and encouraging them to stay focused and empower themselves.

Women labour migrants interviewed by the researcher were employed without following the South African Labour law hence the impediment of the researcher interviewing them within their work environment as this will have resulted in the employers being arrested and fined. This meant that an informant identifies and recruit participants for the purpose of this study. It might have benefitted the study if the researcher was able to conduct the interviews within their work environment.

3.12.1 Experience encountered during the study

The researcher intended to share experience encountered during the collection of data in this study. This is important for the researcher as he was dealing with a difficult population to access, given that the population itself was at risk of being deported as most of them were undocumented labour migrants. This as well exposed the contravening of the labour relation act as it requires employees to register employers with the department and implement the minimum wage policy.

Language barrier was not much of an issue as the researcher is multilingual (speaking IsiSwati, a bit of Sesotho and Setswana) and most of the participants could also speak a bit of English. Where an interpreter was needed the informants would intervene. It was also easier for the investigator to be culturally sensitive given his academic background. The researcher did anthropology until level three and his profession entails that he should always be culturally sensitive and be aware that people beliefs and challenges will never be the same so individuals must always be treated as individuals. It was easier for the investigator to create sense of trust and rapport with the participants and some felt comfortable to talk almost about everything which made it easier to gather as much information as possible, and this benefitted the study.

There were no cultural and religious barriers encountered in this study, almost all the participants grew up as Christians even though when they migrated they have never been to any church around the area. This might have also been what contributed to some of the issues they encountered relating to isolation, because they go in groups everywhere especially when they have got their salaries. Amongst the participants there were those who think that healthcare facilities are only for sick. Services like family planning and normal health checking were not what they will visit a healthcare facility for, hence they would not even visit one. There were

those who would prefer to return home for treatment when not feeling well than visiting health facilities that were local, these was because they were worried they might be asked to produce their South African Identity document or passport, and they feared being deported.

The researcher had also intended to interview some of the participants telephonically, however, it did not materialize as most interviewees preferred face to face interviews, some did not even have reliable phones but could not change to smart phones as people using this kind of phones were mugged.

3.13 Self reflexivity

According to Waigajo (2017), a qualitative research approach entails the researcher deriving significance from a given phenomenon, the outcome of which depends on the perspectives of both participants and the researcher. Therefore, the idea of self-reflexivity cannot be disregarded in the research process due to the researcher's prejudices and biases because it aids the researcher in reflecting on how variables like belief systems, politics, clan systems, religion, age, education level, and stereotypes toward participants have an impact on the data collection, interpretation, report writing, and recommendations (Hill, 2012; Lambert, Mruck & Breuer, 2003; Roller, 2012). Hill (2012) contends that due to researcher prejudice, any knowledge derived from the research cannot be objective. In order to address such a gap, the researcher must be aware of its repercussions and take appropriate action. A sincere examination and discussion of oneself in connection to the research are the goals of self-reflexivity. It is a challenging process because self-reflection and self-discussion are difficult. The researcher therefore considered how certain social settings (language, gender, nationality, education, and so on) could affect data collection and thesis writing in order to produce an objective research result devoid of the researcher's prejudices and biases.

Being a resident of the Newcastle municipality and worked in the healthcare facilities where cases of abuse of women labour migrants were referred to the researcher it was going to be easier for one to be biased on the subject and it was advantageous for the researcher as he could understand all the languages and speaks IsiSwati fluently. For the participants it would always be a matter of diverting their responses to ensure that they suit the intended outcome. Hence it was important to always keep on checking that they do not interfere with the study during the interviewing period. There was an interesting pattern with these women labour migrants, with all of them being recruited by a friend, or friend of a friend, or a family member. It was a chain because it would continue like that with the recruited also recruiting another friend. Commonly

was that they were mostly from incomplete families, and they were forced by economical needs to migrate so as to fend for those left at home and amongst all they were non-that had completed matric.

The migration journey had traumatic experience for these migrants. If by any luck one had not been exposed to the place of host, the women migrants' labourers were subjected to such trauma. They had been made targets especially the new arrivals, hence they adopted a strategy of doing things in groups of more than two. Those who had affairs with locals were subjected to physical abuse and at a later stage they would even be thrown out of the house where they were staying hence, they did things in groups and advise each other against staying with a local male partner as they might be exposed to abuse.

Despite carefully following the research instructions, the researcher enabled the research subjects to describe their prior lives, which resulted in a wealth of data for the study. Their weeping was accompanied by passionate displays that completely overpowered the researcher. The nature of the researcher's work exposes him to scenarios like these virtually every day. For the sake of this study, participants were given post-traumatic support in this circumstance and were encouraged to cry if necessary because doing so is a necessary step to the process of coming into terms with the situation.

3.14 Positionality

Positionality refers to the researcher's awareness of his or her status as a participant in the research, such as whether the researcher is an insider who shares the same experiences as the group being studied or an outsider who is unaware of the group's circumstances. This investigation was carried out by an outsider researcher. The researcher benefited from conducting his research from the outside since he was able to see things that insiders would normally take for granted but were crucial to the study (Maqubela, 2013). Given that the researcher is familiar with the situation and has previously collaborated with migratory women. This assisted in positioning himself correctly and being able to direct the study. Moreover, given that the respondents were women, the researcher was always mindful of his position. The fact that participants are from different cultural background and nationality (positioned as an outsider from their culture), in some instances that was essential for acknowledgment and for the researcher to be aware not to step overboard. Considering that the researcher had been a resident within the municipality and worked with cases of women labour migrants had worked to the advantage of this study.

3.15 Summary

The research approach, methodology, which was utilized in this study, was covered in this chapter because it allows the researcher to infer meaning from a given phenomenon. This study concentrated on the experiences of female labour migrants who worked in the textile industries in the Newcastle region in order to better comprehend the data. The methodology used to collect the study's data, how the data were evaluated, ethical concerns, and the study's limitations were all discussed in this chapter. Finally, a comment on the fieldwork that discusses the researcher's experience and the challenges he faced is also included.

CHAPTER 4: BACKGROUND ON WOMEN LABOUR MIGRATION INTO THE NEWCASTLE AREA

4.1 Introduction

The chapter presents the contextual background on women labour migrants within the Newcastle textile industry with focus to the health care aspects, population and cultural background. Study explores the feminization of women labour migrants with factors influencing labour migrants moving to the Newcastle textile industry. The chapter also looks at the prospects for women labour migrants in the Newcastle area, the impact of social networks on migration, the living situations at the destination, and the challenges faced by women labour migrants both in transit and at the final destination.

This chapter also presents the background on women labour migrants in the Newcastle area, the textile factory industry. The textile industry attracts the highest number of women labour migrants from Southern Africa from countries namely Lesotho, Swaziland and Botswana as the municipality has a number of textile industries. Newcastle municipality had a total of 85 textile industries, employing about 7 000 people by the year 2012. A new bill in the year 2012 passed by the bargaining council for textile industries prompted the employers to consider employing migrant labourers as they could not afford to amend the adopted minimum wage for South African labourers, by its textile industries. It attracts the highest number of migrant labourers from Southern Africa in the province. These factories are operated by the Chinese community, who also operate in the countries mentioned above. Thoko, one of the participants from the Kingdom of Eswatini (Swaziland) alleged that most employees knew about these factories within the Newcastle area through the rotation of staffs by the employers. She said she was one of many other employees who were rotated to work in the Newcastle factory site, “I was working in Matsapha textile factory owned by the relative of this owner of the factory I am currently working for here at Newcastle textile factory”.

These industries attract women migrants from Southern African countries as there is no strict application of the employment act. However, without statutory in place, employees might be exploited. Accessing health care for women has been promulgated by the United Nations Organization. Research findings by ILO in a paper presented in Geneva (2003) has proven that women labour migrants are exploited, abused and discriminated. Inaccessibility of healthcare service does not only violate women migrants’ rights but also may results in increasing the prevalence rate of HIV/AIDS, STIs, PMTCT, Non-communicable diseases and Child mortality rate. This may also threaten the women labour migrants’ lives if they had not taken necessary

precautions. In most cases, migrants do have legal rights to HIV treatment and other chronic but are either unaware of this right or, discriminated against and therefore do not seek out care. Vearey & Nunez (2010) has also indicated that a large body of evidence acknowledges that the relationship between migration, mobility and health in the region is complex. Likewise, migrant workers separated from permanent partners are more likely to engage in relationships with other partners, exposing themselves at heightened risk (Lurie et al., 2003). Changes in sexual behaviour may also pose a risk factor to non-mobile persons, such as the partners of migrants who remained home (Kishamawe et al., 2006).

4.2 The context of Newcastle Municipality

4.2.1 Description of the study area



Figure 4. 1: Newcastle Map

As of the 2011 census, Newcastle, a city in KwaZulu-Natal province, South Africa, had a population of 363,236 residents. The majority of these residents—56,144—lived in Newcastle West, while the remaining people were spread out among the two major townships that make up Newcastle East: Madadeni and Osizweni. Newcastle is one of the key industrial hubs of the nation which is below the Drakensberg Mountains along the Ncadu River in the province's northwestern region. The town is number ten biggest city in South Africa, with a municipality of 188 square kilometers (73 square miles), thirty-one municipal wards, and a population growth rate of 0.87%. Connected to the N11 Corridor and the R34 roads. Newcastle serves as

both the local municipality's and the Amajuba District Municipality's seat. The census that was provided did not include workers moving in and out of the city.

The smallest of the three industrial estates, Newcastle Textile Industry, formerly known as the Madadeni Industrial Estate, was built in 1983 and is located next to Madadeni Township, 17 kilometers from Newcastle. The majority of the factories on this estate are involved in the production of beds and bedding, apparel and textiles and there is one of the three largest plants in South Africa that manufactures fibers. The industries provide employment opportunities for more than 8 000 people. Some of the factories are now dilapidated, with poor enforcement of municipal bylaws and supervision from labour department. This is supported by the fact that whenever a raid is done, in all most instances, the raided factory closes operations as there are a lot of non-compliant issues identified.

4.2.2 Newcastle area health sector

As presented in the Department of Health website, Amajuba District Municipality in Newcastle, information from the District Health System (DHS) presents that the district uses the Primary Health Care (PHC) strategy to offer health services to the populace, just like other facilities at various levels of healthcare. The district's residents are served by three gateway clinics, one private fixed clinic, three provincial hospitals (Madadeni, Newcastle, and Niemeyer Memorial), one private hospital, six (24-hour) clinics, twelve (10-hour clinics), nineteen provincial fixed clinics, two municipal clinics, seven mobile clinics, and nineteen fixed private clinics. Race and disability were taken into consideration when structuring the district's employee complement in accordance with the Employment Equity Act. The public service principles of Consultation, Service Standards, Courtesy, Access, Information, Openness and Transparency, Dealing with Complaints, as well as Giving Best Value are followed by all facilities within the health district when providing services.

Every health facility in a Newcastle area has a method for receiving compliments, a box for suggestions, and an "open-door" policy where patients can voice their reservations about the services provided to them. Although the study looks at the difficulties faced by female labour migrants in accessing healthcare services in the Newcastle municipality, it is based on an intersectional feminist framework that examines how colonialism and globalization can affect how an individual socialization or economic status, race, class, gender, and sexual orientation are all combined (Canadian Research Institute for the Advancement of Women, 2006: 7). A thorough theoretical framework for examining the various ways Social Determinants of Health

(SDH) influence women's health throughout their lives is provided by feminist intersectionality theory. McGibbon and Etowa's (2007) study of the health effects of the SDH's intersection with identities including race, social class, and gender advanced the concept of intersectionality by incorporating the ways that geographic factors might contribute to poor health outcomes.

4.2.3 Newcastle area population

The largest single ethnic group is the Zulu tribe. Precisely its heritage, Newcastle has a sizable population of individuals of British descent, Afrikaners, and Indians. The outskirts of the town are home to numerous places of worship and spiritual groups. Chinese nationals have been moving into the city since the middle of the 1980s. Although they only make up a fewer portion of Newcastle's population, they have made significant economic contributions through the textile sector. It is worth noting of the contribution within the Newcastle Township, making it a leader in the textile and plastic manufacturing industries, with some 200 Chinese-owned enterprises. The Chinese School and Mediation Center of the Buddhist Light Association have been built off Victoria Road after Apartheid was abolished. Since 1995, immigrant nationals from India, Pakistan, and Africa have poured into the town in quest of a better life, and they now call Newcastle their home. The population of 363 236 was counted in the 2011 Census. The majority of these residents (56,144) live in Newcastle West, while the remaining people are spread out among the two major townships that make up Newcastle East: Madadeni and Osizweni.

4.2.4 Newcastle area cultural background

Although the area is composed of different nationalities, ranging from Chinese, Pakistan, Dutch, Arabs and Zulus, the most dominant tribe is the Zulus. This is in exclusion of the undocumented labour migrants and this was initially from the inception of the city. Census 2011 has also identified the racial composition with fifty-two per cent of the black African, with four per cent coloureds, nineteen per cent Indians, twenty-three per cent whites and one per cent belonging to other tribes. The Zulu culture is the most dominant culture. Most of the women labour migrants are unfamiliar with the Zulu culture except the SiSwati speaking as they are all from the Nguni Clan. Women labour migrants may somehow feel unrepresented or as outsiders due to the cultural practices and lifestyle that they are not used to. These may present restrictions in one's social life. It must also be noted that in areas where different cultures exist, it is common that they borrow practices from one another, for example young Zulu women may find the Indian traditional attire more appealing to them and as a result they

may prefer it over the Zulu traditional attire, this does not mean that they are overlooking their own culture. The participants in this study are from Basotho, Batswana, and Swazi cultural backgrounds.

The cultural background of the respondents in this study might assist in perhaps advancing the women labour migrants' stance when it comes to cultural practices as this may also inform their interaction within the area. This also assists in addressing issues of socialization and cultural integration as it is known that culture helps in determining one's sense of belonging. In accordance with the intersectionality feminism lens, this addresses issues around population of women labour migrants who are economically deprived of opportunities from their countries of origin. They are also geographically isolated as they hardly interact with community due to ethnicity difference. Healthcare services are an essential component of women's health. The study examines their experience regarding access to healthcare services within the area where they reside.

Women labour migrants' social status can also influence their attitude and behaviour regarding healthcare access. In the interviews, majority of female labour migrants mentioned that they had to organize some resources to fund their lengthy and perilous travel to South Africa. A few of them also had specific places they planned to stay in mind as well as people who might be able to accommodate them. Although some employees will arrive with the employer's confidence that they will be cared for. A significant number of immigrants come to South Africa because of the opportunities there, particularly in the textile industry. When people think of their neighbours back home, they typically picture those who are wealthier than they are. However, such can be caused by the reality that, in contrast to South Africa, their countries provide them with no economic opportunities. In this way, the cognitive perspective contributed to the construction of the images of South Africa that led to the planning of their travel to live up to their expectations.

4.3 Women labour migration in the Newcastle Municipality

4.3.1 Economic opportunities

Women labour migrants in the study's context have previous experience working in the textile industry and some started by assisting with cleaning, packing and doing other rounds. The economy and opportunities from their countries of birth are scarce presenting them with the only opportunity to migrate to South Africa and work at the textile industries. Majority of them relocated to better their lives and support other family members left behind in their home

countries. Women are migrating in search of better areas to find career possibilities and be able to take care of themselves and those left behind at home due to economic effects and climate change resulting in drought and poverty. Malefu described this occurrence by saying that:

“I migrated from Lesotho Butha-Buthe for employment opportunities in Newcastle textile industry so that I can be able to support my siblings and my three children. I had hoped that if I can come to South Africa and work in the Newcastle textile industry, I will be able to live my dream life”.

This has therefore served as a viable option for many of those left behind at home hence the number of them migrating for opportunities in the textile industry has increased. However, the industry has also been dealt with a blow by imports from China and other countries, in abroad shipping clothes at a cheaper price. Despite this, female labour migrants in the textile industry have continued to pursue their economic goals, maximize their earnings, and provide financial assistance for their family back home through remittances.

Women labour migrants from Swaziland working in the textile industry recruit each other based on work experience gained from factories operating in that country. They believe that in the Newcastle textile industry, they are receiving better remittance in comparison to what they are paid in their country of origin. It is easier for them to survive as the dominant language in the area is almost similar to their indigenous language (Siswati). The other influence for them migrating was based on the ability to at least understand the local language. The improvement of living conditions and support for those left behind were the main goals of the migration. Gundel (2002:256) notes that remittances from abroad contribute more to livelihoods than any other source, including international gifts and state development initiatives put together. Busisiwe expressed similar views:

“I came to Newcastle textile industry when a friend of mine who knew someone working this side told her about opportunities this side and better payment compared to Matsapha textile industry. We shared her space until me and my friend got first payment and we secured our own backroom shack here at extension 7. I am not having difficulties in hearing local Zulu but for the deep Zulu I am struggling. It is much better this side compared to that side. At least if I save money for 2 months I can manage to visit home. It is much better visiting home after that time given that I will have saved enough money to support them for that period”.

Women labour migrants have huge responsibilities of supporting their families left behind. Most of them have left children, some parents, and siblings behind. Their desire to migrate to

work in the textile business stems from a desire to fend for those remaining at home. However, on arrival, they can have trouble getting healthcare services, and some choose to go back home instead. Migrants' health has a significant impact on whether or not they can proceed to care for themselves and support their families. They should therefore make access to healthcare a top priority, yet this is rarely the case.

In the Southern African Development Community, transhumance is extremely diverse and has a long history. Examples include forced migrants fleeing conflict, people moving in search of better job opportunities, asylum seekers and refugees, traders, and seasonal workers who are either internally displaced or crossing international borders (Crush et al., 2005; Agadjanian, 2008; Olivier, 2009). Depending on factors such as where workers live and work, how long they stay, the conditions of their stay, and whether and when they return home, each situation involving labour migrants may give rise to and need a different set of health problems (Preston-Whyte, 2006:331). The physical health of migrants is as a result of a number of interconnected elements, including behaviour and care-seeking behaviour. Some behaviours, like hazardous sex to ensure food security, are born out of vulnerability, and some vulnerabilities are born because of discrimination.

Notwithstanding wars, and other drivers for women labour migrants, economic opportunities and advancement in life prospects has been the driving force for women labour migrants within the textile industries. Although there is a very minimum portion that migrated because they wanted to be closer to their partners and for security reasons.

4.3.2 The role of social networks

Social ties were a major driving force behind women's migration, notwithstanding the possibility of other variables pushing female labour migrants to travel abroad. According to social network theory, it is simpler for migrants to acquire support and information before setting out on their journey because of their interpersonal connections (Borgatti, et al., 2009; Jennisen, 2007). The majority of those surveyed claimed that friends and family helped them travel to South Africa by giving them accurate information about their destination. Ntswaki said:

"I come from Botswana. I asked my neighbour to hook me with opportunities to come to South Africa and work. She told me about the Newcastle textile industry and how we can go. I was just fortunate that she came with me and accommodated me. That is why I am able also to

assist other neighbours who ask about opportunities this side. I have seven that I recruited although three have left this side. I don't know where they are working now".

It is as well worth noting that social ties are considered the drivers of migration as migrants are lured by the exorbitant lifestyles migrant's presents with when they have visited their places of residents. They are seen as being able to afford and support their families thus that presents them to be seen as dependable hence most women will engage them on plans of relocating to the assumed opportunities.

4.3.3 Women labour migrants in transit

The United Nations Human Rights Commission (2016) noted in a report that migrants encounter physical and environmental dangers, malnutrition, ill health, and trauma exposure while travelling. Many times, the displaced community in transit are unable to legally work, rent housing, or are in need of basic amenities like healthcare and education. Where illegal immigration is punishable by law, migrants in transit live in continual fear of being discovered and mistreated. Many migrants are healthy when they set out on their journey. However, many migrants may experience poor well-being outcomes due to the difficulty of the migratory journey, the conditions of travel, and an inaccessibility of health care. Moving through dangerous terrain and enduring physically taxing travels through deserts are regular challenges for migrants. Those who are vulnerable in particular majority of them were infants and young children, pregnant women, the elderly, and people with impairments. High risks of mortality and morbidity are connected to this stage of the migration cycle. Temavungadze described her voyage from Eswatini to Newcastle in the following manner when questioned about it:

"We cross the Piet Retief border but we don't use the formal border crossing, we cross on the side. It is not safe especially when you are a female alone. That's why we prefer to go in pairs. One-time early March 2009 my friend had promised me that we will meet at the station so that we cross together unfortunately she didn't come. I waited and it was starting to be a bit late, I decided to cross alone, in the middle a man from nowhere appeared just in front of me carrying a panga forced me in the forest and raped me. I was helpless cried after the ordeal running away until when I was helped by a passing car. I ensure that when I am going at least I go month end Friday mid-morning to afternoon as there are many people crossing. I decided not to go the clinic although I had been advised. I realised that if I go to the clinic the police will be involved then I will be arrested as I was in the country undocumented".

All immigrants are entitled to full protection for their health regardless of their status. International Commission on the development, social, and cultural rights safeguards everyone's right to the highest level of physical and mental health. All migrants must obtain same access to prevention majors, cure, and palliative health services regardless of their legal standing and documents as per the established structure on Economic, Social, and Cultural Rights. The right to health of migrants while they are in transit countries is particularly hampered by the management of chronic illnesses like diabetes and cardiovascular disease, the treatment of behavioural and mental health conditions, as well as basic access to healthcare. Numerous migrants face terrible events connected to their travels, such as detention and physical and mental abuse, which calls for mental health care. Women labour migrants are more likely to steadfastly turn to self-medication or rely on unofficial medical procedures to treat their health issues if they do not have access to adequate services. The special health requirements of migrant women and girls are routinely met. Gynaecological examinations and services for sexual and reproductive health may not be provided to migrants obtaining medical care while they are on the road. Ntlaki when asked about the transit journey she just broke in tears as she narrated the ordeal of how she was raped by a man who had given her a lift between Bloemfontein and Ladysmith whilst destined for Newcastle. Ntlaki said:

“The journey of coming and going is not easy because I use illegal entry and it is not safe. I at least club when going home end of the month. There was once one incident when I was hiking from Bloemfontein to Ladysmith, a male gave me a lift, it was about 5 in the afternoon, along the way he pulled off and raped. My whole body was in pain. I had severe rash all over my body in the morning and decided to go to clinic. When I narrated what happened I was referred to Madadeni Thuthuzela care centre where I was tested for HIV/AIDS, for the first time I tested positive. After medical examination and provision of treatment. I was informed that police were on their way to assist with opening of a case. I decided to immediately go because I was scared police will question my citizenship and arrest or deport me”.

4.3.4 Poor living conditions at the destination

Women labour migrants most on arrival are accommodated by close friends. In a case where the movement was facilitated by the employer, women labour migrants are then accommodated in the factory where they will be working. The living conditions inside the factory are inhuman, unhygienic, and squalor. This was revealed through a raid in one of the textile industries in the year 2017, where a number of women migrants were rescued and taken to Madadeni Thuthuzela Care Centre for medical examination before deported back to their country of

origin. For those accommodated by close friends, normally it is shack dwellings or a place of poor maintenance hence the rent is normally, less than R400.00 rand and four will be sharing that small place. Social connections helped migrants find housing and jobs in the textile industry in addition to allowing them to enter the host country. Oishi (2002:7) contends that immigrant groups frequently assist their fellow men and women to immigrate, obtain employment, and adapt to a new environment. The new immigrants have a way of recognizing the help they receive from their friends when they first arrive.

“I came with my friend from Swaziland, we were helped by a friend who has moved to work at the Newcastle textile industry a year ago. She told us not to worry about accommodation as it is taken care of by the employer. We then embarked on the journey she was assisting us on the directions until we arrived in Newcastle textile area where she collected us. On arrival we went in the factory, just behind the factory there were storerooms that were turned to domes. The place was very dirty looked dilapidated with poor hygiene. Sharing one dirty toilet whilst we were more than 30. We were advised not to move around or move out as we might be deported given that we had no documentation. We were there forced to work more than 12 hours. We will then only go to town on Sunday when paid to buy food, whilst saving to go home at the end of the month. We were then removed by police taken for medical examination and deported and the factory was closed in 2016. We then did means of coming back and looking for a job in another factory, we are now renting a shack which is a backroom at extension 5”.

4.3.5 Violence, abuse and exploitation

Women labour migrants frequently run the risk of being harmed, tortured, abused, and exploited while in transit. For instance, more than half of the women labour migrants examined were reported experiencing violence, abuse, and exploitation at their jobs and in the areas around them. There were instances where women labour migrants were sexually or physically assaulted. All of the interviewees had a phobia about them being migrants, they felt that they were at risk by the fact that they were migrants. In a study by Jinnah (2017) that looks at exploring labour strategies for Zimbabwean farm workers in Musina it is evident that labour migrants are easily exploited and for labour migrants there is a disregard for equity and implementation of labour laws to protect the rights of migrants workers by employers and critical social welfare facilities. This is what some had to say:

Ntlaki said: *“The journey of coming and going is not easy because I use illegal entry and it is not safe. I at least club when going home end of the month. There was once one incident when*

I was hiking from Bloemfontein to Ladysmith, a male gave me a lift, it was about 5 in the afternoon, along the way he pulled off and raped. I had severe rash all over my body in the morning and decided to go to clinic. When I narrated what happened I was referred to Madadeni Thuthuzela care centre where I was tested for HIV/ AIDS, for the first time I tested positive. After medical examination and provision of treatment. I was informed that police were on their way to assist with opening of a case. I decided to immediately go because I was scared police will question my citizenship and arrest or deport me”.

Maseabatha said: *“I came with a friend who later got a boyfriend and moved out from the shack we had hired behind the house. The owner stayed with her son. The granny had allowed us to rent the shack and she was staying with the son. Mid-May 2014, when I came from work the son immediately followed me and pull-out a gun locked the door raped me the whole night. In the morning he told me that if I go to the police they will immediately deport me and when he is out on bail he will kill me. Fearing for my life when I reached my workplace, I told my friend who immediately advised that I visit the clinic. I was referred to a Thuthuzela Care Centre where I was examined given treatment when asked if I want to open a case I said yes, but immediately I collected my treatment a sneaked out of the place scared that I will be jailed as I crossed the country illegal. I also left the place until I came back 2018. However, I haven’t seen the perpetrator and I stay far away from where the incident happened”.*

While traveling to South Africa, women are exposed to gender-based violence from those who offer them services like border checks, lodging, and transportation in exchange for sex. It is crucial to note that, while seeking out better pastures, female labour migrants fall victims to sexual, gender-based violence and human rights violations at their destination. The environment is perceived as very hostile, by the women labour migrants, coupled with the inhuman working conditions hence at times the local authority will conduct inspections with luck of a few being relieved. However, given their economic circumstances they will find their way back. Women labour migrants argue that the hardship they encounter in the Newcastle work environment is better off than the hardship they are faced with from their country of origin. The courage emanate from the comfort of being able to buy food for the ones remaining at home.

According to research, women labour migrants are ineluctably prone to experience sexual abuse from authorities, police officers, other officials, criminal gang members, and other male migrants. Most women labour migrants interviewed were undocumented, meaning they were

scared to associate themselves with the community in fear of being deported. However, there are still certain factors influencing them to seek access in healthcare services within the area, but are unable to. This was expressed by Phindile:

“I was working extra hours and caged at industrial or workstation. Here, for us who had ones stayed inside the factory, you work from early morning until late with no extra benefits. Before I rented here, we were staying in the factory on arrival from Swaziland, we stayed 2.6 months, before police raided the factory, we were taken to Madadeni hospital for check-ups and late deported, this was July 2015. The other frustrating part is that in the clinic the nurses speak to you in their local language I couldn’t hear a thing, the nurses also tried using English but I was struggling also in hearing English as due to the fact that I dropped out of school very early. I then decided to come back with my friend to look for work in another textile factory at least here we are renting and it is much better compared to then”.

It has been demonstrated that migrant and refugee women are disproportionately susceptible to domestic violence in intimate relationships. Studies already conducted have shown how migration alters gender power dynamics and how migrating women encounter additional challenges in accessing services and support in their new countries (Kiwanuka, 2009). While they are traveling, migrant women frequently face violence.

According to reports, migrant women frequently encounter violence when they try to enter South Africa from nearby nations (Human Rights Watch, 2009b; Médecins Sans Frontières (MSF), 2009). The Southern African region confirms the rising global patterns in female migration (Perbady and Dinat, 2005; Lefk o-Everett, 2007). The UN’s participation through the UN Convention and its strategic partners in developing and campaigning for the right of women is necessary because this is regarded as contravention of individual human rights.

It is important to note that experts generally concur that economic concerns serve as the primary impetus for immigration to the Newcastle region. For instance, according to the United Nations Development Programme (UNDP), the majority of African migrants who move to South Africa do so because the situation in their home countries has deteriorated beyond what they can tolerate. The large number of immigrants who are currently residing in South Africa is a good illustration. The organization also notes that the main forces for migration are the “push” of extreme poverty in their home countries and the “pull” of opportunity in the destination country or city (Crush & Frayne, 2007). According to Adepoju (2000), socio-economic instability, extreme poverty, and unemployment in some rural areas of Africa have turned what could have

otherwise been domestic movement to urban centers into international emigration to nearby, more developed countries like South Africa.

Although there is an agreement that economic forces push migrants out of their home countries, less is known about the macroeconomic forces that draw people to South Africa. The majority of research projects on the topic that have been carried out in the nation to date (Lucas, 1987; Bhorat et al., 2002; Wocke and Klein, 2002; Bhorat, 2004; Waller, 2006; Lindau and Segatti, 2009; Crush and Williams, 2010; Friebel et al., 2013; Mayda et al., 2013) appear to concentrate primarily on migration trends and effects on the labour market, but not on its macroeconomic. In light of this, it is obvious that there is a significant information vacuum about the important macroeconomic factors influencing cross border migrants which have influenced the foreign incomer's inflows into the nation during post-Apartheid regime. All of the women labour migrants in this study who were interviewed moved to Newcastle's textile sector to better their lives and the lives of others around them. Thando from Swaziland said:

“Coming to work in the textile industry I had trusted that I will change my life for the better and for my sibling left at home, I am managing to send money home every month and visiting them after every two months, if I had not come to work here in Newcastle textile industry my siblings will be suffering of hunger and really don't know where I could have been by now. I am now used to the area, I visit the clinic at any time it is where I also do my family planning, collection of treatment. Although I feel a bit uncomfortable that when at the clinic admin request for my Identity number or passport I do not have because I am a labour migrant and I have used an illegal entry to migrate to the country for work”.

Ntlaki said: *“I had tried to look for employment from my country after dropping out of school as I could not afford to pay school fees. I spent more than 4 years without getting a job. I then decided to ask a friend who then recruited me to join her other friend to work in South Africa in the textile industry, (Newcastle area), that's how I came to this place. I am not comfortable in socialization within the area given that I can't speak the local language, people of here only speak their native language once you speak English language, they look at you somehow.*

4.4 Migrants working conditions at the Newcastle textile industries

This has also been discovered by Gonah, Corwin, January, Shamu, Nyati-Jokomo, and Van der Putten (2016) who stated that although language barriers, mistrust of, and fear of discrimination from healthcare personnel are often the key factors impeding access to treatment, these are not always the case. The idea that migrant communities may be more susceptible to illness and

face access challenges to healthcare may also support this. Therefore, it is crucial that populations of migrants take into account potential obstacles to receiving healthcare services before migrating. This finding, which was supported by the study, may have contributed to the reluctance of some female labour migrants to use the local medical facilities.

The setup of the textile industries is a distance within residing areas. As they recruit each other through social networks, the main challenge presented by women labour migrants is the places where they are accommodated. Majority of new arrivals are accommodated within the factory in a non-conducive environment as more than 20 people had to share a single toilet. Some choose to stay within the factory in trying to save money for rents whilst some stay because they are scared that they might be deported once they are seen outside the community.

Mofeng said: *“On arrival with my sister we stayed in the factory and only go out when we were going to buy food at a local retail. We were scared that if we frequently outside the factory we might be noticed that we are not local and be deported. After a while then we moved out of the factory to stay here at Emabhodini. I am still sharing rent with my sister. We are still scared around here, people are robbed, raped and killed”*.

Thantazile said: *“On arrival we stayed in the factory and worked even overnight. The environment was unhygienic some started getting sick. I don’t know how the local authority knew that we were in the factory. They raided the factory and found that we were not having documentations. We were then taken to hospital and later deported but I managed to come back although I am now working in another factory”*.

It is also worth noting that the employers physically and verbally abuse women labour migrants sometimes they are not paid their remittance if they happen to break a sewing machine or any equipment. It was not strange to learn that some women were physically assaulted by the employer when they have made a mistake on cutting or sewing as that cloth will be a waste and damaged goods.

Jabulile said: *“I once spent the whole day struggling to walk after my supervisor hurt me with a broom saying I have stolen money that I never did. The other day I made a wrong cut that day I was not paid my wage, the supervisor said that the wage will be a compensation for my mistakes”*.

Matshidiso said: *“The working conditions are not good as we are physically assaulted once we do mistakes or the machine you are working with gets stuck. In the other factory the machine*

I was working with was damaged, I immediate left the factory and never came back before the supervisor realised because I know I was gonna be physically assaulted and my wage be withheld until I have paid the full amount for fixing the sewing machine”.

Through the feminist intersectionality theory, one can argue that women labour migrants suffer several jeopardies that are not only gender based but also racially and nationality (foreign) based, all impacting the same women at the same time. Using the intersectionality framework, it's clear that the kind of stereotypes and abuse that these women labour migrants face within the transnational space is different from that of their male counterparts. Also, under intersectionality, it's clear that other women labour migrants who are able to speak the local language (IsiZulu) are perceived differently and in higher regard. This was expressed by Busisiwe who said:

“I have been working in the textile industry and considering that I am a Swati speaking person I can hear clear IsiZulu language and I am not having challenges in visiting local clinic for family planning and collection of my ARVs treatment. It is no longer a strange environment to me. Yes, we do experience abuse in the textile industry by supervisors at time the employer. I am now used to the treatment. One could say this place is like prison although I have never been to one. Most of the people from Swaziland are recruited by me”.

Furthermore, social ties were not only the means by getting into the host country, but it enabled the migrants to get into the community and relate with South Africans. In receiving countries, argues Oishi (2002:7), immigrant communities often help their fellow men and women to immigrate, find a job, and adjust to a new environment.

4.5 Conclusion

This chapter examined the background of women labour migrants within the Newcastle area focusing it to the Newcastle textile industry. Healthcare services within the area were also explored and the population cultural aspects as a detrimental factor to inspire women labour migrants to utilize available healthcare services. The chapter has also explored the feminization of women labour migrants with the textile industry as well as factors influencing them move to the Newcastle textile industry. Challenges encountered by women labour migrants in transit such as sexual violences, exploitation and gendered complexities during the migration process were also explored. Labour migration within the South African context was also reviewed.

The push and pull factors as discussed above are drivers for migration this is testament to women labour migrants within the Newcastle textile industry. Interviewed women labour

migrants travelled in an effort to change the economic living conditions and improve their social-economic situation at their homes.

In the next chapter, the study focuses on the women labour migrants' healthcare needs and services available to them, concentrating on the social determinants of health.

CHAPTER 5: MIGRANT WOMEN HEALTHCARE NEEDS AND ACCESS TO HEALTHCARE SERVICES

5.1 Introduction

This chapter focuses on migrants' health-care needs, health-care-seeking behaviour and access to healthcare services within the Newcastle municipality area. Gushulak and MacPherson (2000), Zimmerman and others (2011) argued that health of migrants can be considered at various stages of the migration process. Furthering that each stage of the migration processes: the pre-departure phase, the journey itself, arrival, adjustment at the place of destination and return to the place of origin is associated with a set of health parameters and influences, which impinge upon a migrant's health. These impacts can be both positive and negative. On the positive side, some migrants may have better access to healthcare services at the place of destination than at the place of origin. In this study, 35 women labour migrants were interviewed regarding their healthcare access, needs and challenges.

5.2 Factors that influence health care for women labour migrants in the textile industry

The women labour migrants were interviewed about their need to visit healthcare facilities around the area; their knowledge about the closest healthcare facilities; the main reason they visited the healthcare facilities, and so on. A total of 20 respondents out of the 35 interviewed respondents visited the local health care regularly for family planning and a total number of 6 visited healthcare facilities for antenatal care, the last total number of 9 participants preferred to return to their countries of origin and consult there rather than visiting local clinic. Amongst those who visited the healthcare centers in the area were those who went for antenatal care services, some to collect their treatment care and some for family planning needs.

The intersectional feminist theories, which consider how systems of discrimination like colonialism and globalization can affect a person's combination of social or economic status, race, class, gender, and sexual orientation, are likewise supportive of this (Canadian Research Institute for the Advancement of Women, 2006: 7). This theory offers a thorough framework for examining the various ways that Social Determinants of Health (SDH) influence women's health throughout their lives. McGibbon and Etowa's (2007) study of the health effects of the SDH's intersection with identities including race, social class, and gender advanced the concept of intersectionality by incorporating the ways that geographic factors might contribute to poor health outcomes. There is a concern that HIV/AIDS risks increase due to separation from

regular sexual partners for those migrating and left behind – with those migrating possibly desiring intimacy and connection in new environments. Amongst the women labour migrants who had left partners back home, there were those who are also involved on casual relationships in the place of destination and some would not insist on the use of a condom or any other method of family planning, for instance, Nthabiseng had this to say:

“I am Nthabiseng from Lesotho, 30 years old with three children and I’m single. I studied until grade 6 and left school because my parent did not believe that a girl child should attend school since they couldn’t afford the school expenses. I am from a family of eight with both parents deceased as the last born. My children are home in Lesotho with my siblings. I do not consult in a health facility around Newcastle as I prefer to consult at home. I do not use family planning as I believe I will gain weight. I do not attend church around the area. I am always with my home girls and the exercise are the same, after work we go where we stay that’s where our socialization circle ends. I do have casual relationships around the area and I do not insist on using of a condom. I decided to migrate to South Africa to be able to support my children and the family members left at home. I have hoped that I would have made my breakthrough by coming to South Africa, however not all my expectations were met. I have worked in the Newcastle textile industry for 3 years with some break ins and outs. I travel home once every month”.

The health capability approach was used in the study as a theoretical foundation for the methodology. The researcher’s thoughts on the data gleaned from the interviews are shown in the table below. The health capability approach is a comprehensive normative framework for assessing social structures and personal well-being, designing policies, and making suggestions for societal change (Sen, 1993). The researcher assesses health capability at the individual level by evaluating the experience of the female labour migrants and determining how effectively people can be their own health’s agents. This covers the areas of self-control, efficacy, and motivation to attain desired health goals in subjective health psychology. The ability to acquire and apply health-related information, knowledge, and skills to maintain health and create a set of habits and conditions to prevent, to the greatest extent feasible, the onset of disease and mortality is the focus of acting as one’s own health agent.

Table 5. 1. A description of the structural causes of health disparities and the experiences of female labour migrants working in the textile industries in Newcastle

Factors affecting the distribution and exposure to social determinants of health for women labour migrants: structural determinants of health inequality	Structural factors and the socio-economic status of female labour migrants	Social factors that affect health: social factors that affect the health of migratory workers
Political and socio-economic environment	socio-economic status and structural factors	<p>Local government is one of the intermediary determinants of government.</p> <p>Norms and the political system macroeconomic regulations (labour market structure)</p> <p>Public guidelines (labour, housing, land, health, education, social protection, immigration policy, refugee policy)</p> <p>Documentation and legal standing</p> <p>the values of society and culture (how health is valued, how migration is valued and viewed)</p> <p>epidemiological circumstances</p> <p>Social status and structure (in destination; inclusion, exclusion, ntegrationion)</p> <p>Gender\s Ethnicity</p> <p>Nationality</p> <p>Education\s Occupation</p>

		<p>Income (urban livelihood activities)</p> <p>Urbanization history and migration status (migration experience, place in the city)</p> <p>Significant circumstances (living and working conditions, food availability, access to secure tenure, access to social grants, household structure, environmental conditions, access to basic services)</p> <p>mental and social aspects (fear of police, detention and deportation, safety, fear of violence, experience of trauma, stress, dependents, hunger)</p> <p>behavioural and biological aspects</p> <p>health system</p>
<p>In order to ensure equity in the provision of healthcare services for migrant women labourers, governance (including the role of health care providers and various domains of government, including local government) Policies and community organization</p> <p>macroeconomic regulations (labour market structure)</p> <p>Public guidelines (labour, housing, land, health, education, social</p>	<p>Social position and structure (in destination; inclusion, exclusion, integration)</p> <p>Gender\s Ethnicity\s Nationality</p> <p>Education, Employment, and Income (urban livelihood activities)</p> <p>state of migration.</p>	

protection, immigration policy, refugee policy)		
Documentation and legal standing the values of society and culture (how health is valued, how migration is valued and viewed) epidemiological circumstances	Social capital and social cohesion Bridging, connecting, and linking capital; social cohesiveness and integration	

Table 5.1 is discussed in detail below and how it is linked to this study.

Studies reveal that as more and more women migrate, intra-African female migration has become a more common occurrence. For instance, since 1994, migrant women from different regions of Sub-Saharan Africa have poured into South Africa, and the percentage of female migrants in Sub-Saharan Africa has increased from 46.4% in 2005 to 47.5% in 2019. Due to discrimination on the basis of gender, ethnicity, and race, migrant women are a particularly disadvantaged group that exacerbates already-existing problems in the general community.

Women labour migrants are breadwinners hence the reason for migration is for economic survival for their families and themselves. As mentioned in the above paragraph it is evident that women labour migration has increased significantly in comparison with the past figures. Hence the need not to neglect the conditions women labour migrants are subjected to whilst they advance for survival.

5.2.1 Governance

Ackerman and Gross (2005) defined governance as a proactive process through which public officials educate about and justify their plans of action, behaviour, and results, and are sanctioned accordingly. According to Ackerman and Gross (2005), accountability calls for public employees to be held accountable for carrying out their duties and to be given clear consequences if they fail to do so. There cannot be true accountability without punishments. Accountability is uncommon in most public health systems globally, despite how crucial it is to the efficient delivery of healthcare services (Brinkerhoff, 2004). In order to incite and maintain desirable behaviour, good governance also involves appropriate incentives at all levels of the health system, as well as standards for and information on performance. This may as well be the role of healthcare providers and different spheres of government, including local

government towards ensuring equity in the provision of healthcare services for migrant women labourers. There were no specific government structures that seek to provide health care specifically for women labour migrants populations. However, as the country is a signature to the United Nations, the commitment of provision of healthcare services to people in the country and advancement of human rights is enshrined within the constitution of the country.

Poor governance in healthcare systems is largely to be blamed for the ineffectiveness of service delivery, which in some circumstances results in no service at all. Poor provider performance can be caused by a lack of standards, information, incentives, and accountability. It can also result in corruption, or “the use of public office for private advantage” (Bardhan, 1997: 139). However, the distinction between bad leadership and corruption is frequently hazy. Is bad service a result of mismanagement or just plain corruption? In order to boost the effectiveness of health services, elevate performance, and eventually improve the health condition of the population, it is important to improve governance and, by extension, deter corruption in health systems.

However, recently there have been instances where government officials including MEC of health in the Limpopo province had sentiments that foreign nationals must pay for healthcare services rendered within the country in government facilities whilst it is not the same with the citizens of this country.

5.2.2 Structural determinants and socio-economic position

Social structure/social position include factors such as destination, inclusion, exclusion, and marginalization. All the respondents did not feel a sense of belonging within the environment where they find themselves at, they felt excluded from community activity as they had already defined themselves as outsiders. As argued by Sen (1993), defining the health capability approach that seeks to evaluate individual’s well-being and social arrangements incorporates defining design policies and proposal for social change. Through the structural determinants a socio-economic position women labour migrants have proven to be in a position to act as agents of change of their own health. These included individual ability to decide on the type of health services they needed and choosing the facility where to access the health services. Malefu said:

“When I was pregnant with my second baby, I have been attending antenatal services at Pro-clinic as it closes late and the service is good”.

Although a portion of women labour migrants were content with the provision of access to healthcare service in the Newcastle area, there has been a feeling of marginalization as some

of them have been sexually assaulted many a times. When they attempted to report the matter, they always had a fear that their resident status will be questioned, and they felt that it may even lead to them being deported, hence they prefer to suffer in silence. Given that they are females, immoral males will always perceive them as sex objects and they also felt powerless to defend themselves.

One's culture or upbringing has a huge influence on socialization decision making and influence on one's access to healthcare services. Some of the respondents did not believe in family planning methods and visiting a health facility, that is because of the way they were brought up.

5.2.3 Gender

The feminist intersectional approach is about the intersection of a person's social or economic status, race, class, gender, and sexual orientation and can be affected by systems of discrimination like colonialism and globalization (Canadian Research Institute for the Advancement of Women, 2006: 7). Participants were vulnerable since they were women immigrants; this consequently has an impact on some people's views toward using healthcare services. Apart from gender discrimination, cultural issues also influence the way women labour migrants conduct themselves. For example, women labour migrants were not able to exercise their sexual reproductive health rights because they wanted to bare a heir as it is expected of them to bare a heir to continue with their clan even though they had almost given birth to more than four children. These respondents had also highlighted that culture did not give them any form of power to go against their husbands' and in laws' wishes when it comes to destemming their sexual healthcare needs.

Grace when asked about how her socio-cultural aspect determines usage of healthcare services, she replied as follows: *"I don't think my culture influences the usage of the clinic. I don't use family planning because I need to have a son as a heir. What I can't do is aborting my child"*.

5.2.4 Ethnicity

The fact that all the respondents were non-South Africans and all of them without proper documentation, it was not that easy for them accessing healthcare services as they always had the fear of being deported. They did not have any sense of entitlement to the services provided at local clinics. The fact that most of them could not even speak the vernacular language in the area, had put them in an awkward position as some will be forced to converse in English

whereas others would act like they understand yet in many cases they did not. Manaledi and Nomusa expressed themselves as follows:

Manaledi said: *“I am unable to speak the local language and English. I had attended school until grade 7, that I didn’t even set for final exam due to that I became pregnant and dropped out of school. I couldn’t continue with school. I only understand Sesotho. I socialize with the people speaking my language hence I am scared even to visit a clinic. What if am deported?”*

Nomusa said: *“I am a swati speaking person from deep rural of Eswatini. I attended school until grade 6. I can hear a bit of Isizulu although I can’t converse on it. There is the deep Zulu that I can’t hear a thing at all. I am uncomfortable in speaking local language and visiting the clinic as I will easily be identified that I am not a local and be reported”.*

5.2.5 Nationality

These respondents were of different nationalities although some of the clans were still acknowledged in South Africa, the locals knew that they were not from South Africa given the nature of their job. Some were from Eswatini previously known as Swaziland, Lesotho, and Botswana. These are some of the factors that resulted from some of the participants – not at ease in visiting healthcare facilities; they would not even attempt to report any form of abuse to the local law enforcement officers as they would say their residential status will always come in question and these have resulted in some being deported and many returning home as they felt that after reporting the matter they will be deported; whilst some would argue that they do not have the time to pursue such they are here to work. As argued by Spitzer et Al. (2019), undocumented asylum seekers and labour migrants frequently rely on services offered by civic society because they are concerned about being detained or expelled by health officials. They may be the only source of health services for labour migrants who live with their employers. For women, getting access to sexual and reproductive health treatments can be difficult. Nthabiseng and Grace expressed themselves below:

Nthabiseng said: *“If I was home maybe I will think on visiting the clinic but here even if I am not feeling well, I asked the people I work with or home girls for same pills. I am not comfortable in visiting local clinic since I can’t speak English and the local language”.*

Grace said: *“I will not visit a clinic. I rather return home if I am not feeling well. I am scared I will be deported once I visit the clinic since they will ask for my ID or passport that I don’t have, given that I have crossed the border illegally. I am even worse since I can’t even speak Zulu or English”.*

In line with the diversity and intersectionality theory, individual nationality may as well be defined on race and ethnicity. This can as well be argued in the case of women labour migrants' interactions with healthcare providers. A more constrained, but still constrained, perspective also considers gender. Diversity can refer to a wide range of social characteristics, including those related to sexual orientation, age, physical or mental disabilities, class, and, in some circumstances, life philosophy (Nkomo and Cox, 1997). As they identify regions of resemblance and difference, these categories are regarded to have a significant role in issues of equality, individual rights, and social justice. As such, this may as well refer to the context of minority group status and this resulted in other women labour migrants' difficulties in making a decision on accessing healthcare services within the Newcastle area.

5.2.6 Education

The highest grade amongst the participants is grade 11 and the lowest is grade 5. Interestingly, most of the participants with grade 11 had an average of two children and they frequently use the health facilities for family planning services and collection of their chronic treatment. However, the participants with grades 5 to 8 were having an average of three children and amongst them were those who did not believe in western medication who sincerely relied on traditional herbs and some on self-medication. One could argue that the ones with grade 11 perceive healthcare needs much more seriously and necessary compared to the participants of lower grades and moreover they tend to understand the benefits linked to family planning services and adhered to any treatment provided to them.

Busisiwe said: *"I visit Pro-clinic for family planning and collection on my chronic medication. I don't have a problem in accessing health care in the area and I can hear and try to speak in IsiZulu. It is not difficult for me since I am also speaking Siswati"*.

Education, as claimed by Unterhalter (2002), can also be a place of capability deficit. She uses education as an example, to advance the goals of the apartheid government in South Africa as well as the rampant sexual abuse of schoolgirls that is currently taking place in the same nation, to demonstrate how education can be disempowering in some situations. In the field of health and family planning, there is undoubtedly enough literature to show that women seeking medical attention, and impoverished women in particular, are frequently treated disrespectfully and that their needs are not always taken into consideration. In the worst-case scenario, individuals become the victims of unethical behaviour, such as not getting informed consent, or even assault (e.g., Sen, Germain and Chen 1994; Kabakian-Khasholian et al. 2000;

Cottingham and Myntti 2002). Women labour migrants who were unable to communicate in the local language and English were uncomfortable in accessing health care in the Newcastle municipality. Therefore, language and financial status (monetary poverty) can also be viewed as barriers in accessing healthcare services for women labour migrants as argued by the social exclusion theory.

Manaledi said: *“I don’t visit any healthcare facility within the area, I don’t want to be judged that I can’t speak English and local language. I am scared, what if they recognize that I am not from South Africa and deport me since I am here without papers”?*

Social exclusion is most frequently attributed to monetary poverty, although there are other factors that might cause someone to be excluded, such as a disability, poor educational opportunities, substandard housing, and membership in an ethnic minority, unemployment, old age, and poor transportation. The line between the causes, motivators, and effects of social exclusion is frequently blurry (Bradshaw et al., 2004).

5.2.7 Occupation

All the participants were working in the industrial area as seamstresses and some packaging and cleaning. Their wages did not supplement the types of work they do. Some were cutting the fabrics whilst others will be sewing, in other cases they will take turns. Some who had earlier resided on site in other factories had also mentioned that the working hours were abnormal as in some cases they will work more than 12 hours a day and they would not be compensated for overtime work.

The interviewed women labour migrants had no professional background or career that they had studies from their countries of origin. The fact that they are undocumented presented them with challenges to register for any qualification that they might aspire within the places of work.

5.2.8 Income (urban livelihood activities)

They were paid very low wages; thus, the employer prefers them over locals even though they were hired in some sinister ways. They will recruit each other hoping to make ends meet and to support their families. The South African Textile Industry had set a minimum wage of R3,500.00 and now supplemented by the South African National Minimum wage hence the employers will always come over with employees from the nearby countries. The women migrant labourers are only paid R800.00 per fortnight under strict supervisions. Their other work times will only be recorded but never paid or supplemented.

The wages that women labour migrants earned were as a result of them being vulnerable as they come and work in the country without proper documentation, as such they were not protected by the labour laws of South African textile workers. It is believed they allow the system to exploit them.

According to WHO (2009), women also have a harder time obtaining the services and money they require, there are also disparities in work and education might make it harder for them to protect their health. In three dimensions—economic exclusion, exclusion from social services, and civic exclusion—a forthcoming United Nations Development Programme (UNDP) regional human development report examines social exclusion as the result of numerous and mutually reinforcing deprivations in central and south-eastern Europe, the Russian Federation, the Caucasus, and central Asia. According to the report, access to health care has become more unequal throughout this time of transition, with poorer access for the underprivileged, the elderly, and minorities (especially Roma), as well as between urban and rural areas (UNDP, 2010). This also applies to women who migrate to work in the textile business.

5.2.9 Migration status

The fact that these participants did not have any asylum, refugee or any legal documents, is what might have contributed to their exploitation, abuse and not being confident enough to demand access to health care and just basic human rights. These could also be the reasons why some of these textile industries could opt for women labour migrants as they will take anything as long as they will have means of surviving and sending some remittances to their immediate families. Respondents have also argued that the locals were not in any way accepting the wages and the working conditions under which they were working.

These patterns can also be seen in Crenshaw's (1989) work, which makes the case that intersectional feminism should be applied to highlight the variety of women's social and political realities, focusing on the experiences of all women, especially those whose social circumstances have received the least attention from the media, academic research, or political movements. A human rights perspective on health care access was strengthened by McGibbon's (2009) intersectionality lens proposal. The SDH as outlined in the Toronto Charter, states that race, class, and gender, as well as the geographic or geographical settings of oppression are three areas at the intersections of which she said health inequities might be properly described (Raphael, 2004). For instance, while experiencing housing or food

insecurity separately can lead to specific physical and mental health pressures, women who go through both at once are affected in a way that defies a straightforward additive analysis.

Pontsho said: *“I am not comfortable moving around the area and visiting the healthcare facility although I do go. I am scared that if I can be identified as a migrant, the authorities may deport me. The fact that I can’t even speak the local language makes things difficult for me as most people here don’t like speaking English and when you speak English, they look at you somehow”*.

It has been clear during the conduction of this study that these women labour migrants in the industrial sector in Newcastle area are geographically isolated as they hardly interact with community due to ethnicity differences, considering that these women labour migrants are from the Southern African countries. Their social status has also proven to influence their attitude and behaviour regarding healthcare access as they hardly socialize with locals as they felt being perceived as outsiders and some labelled as “hoes”. All the respondents were not participating in any form of religious or social gatherings that the locals were involved in, these resulted in a form of isolation and not seeing themselves as part of the local community.

5.2.10 Xenophobia

Harmonizing the attitudes and presumptions associated with African migrants is one of the key obstacles in handling the refugee issue and providing adequate protection to women labour migrants regarding access to healthcare services. African migrants used to receive a warm welcome since they were engaged in a liberation struggle against colonialism, but that welcome has dwindled and is quickly being replaced by xenophobic sentiments that hinder rather than helping labour migrants integrate into society. The emphasis shifted from advocating for a long-term solution for refugees, in which many were helped through local integration and were automatically granted citizenship, to advocating for temporary protection, with the idea that “refugees should leave when conditions in their country of origin are conducive to return.” Given the difficulties in accessing the documentation that will allow women labour migrants to seek for employment opportunities, employers opt to hire undocumented labour migrants to avert abiding by Employment Legislation and Employment Act, hence the unbearable employment conditions women labour migrants reported and the poor wages given as remittance.

A large portion of these prejudiced beliefs are blatantly xenophobic. According to a survey conducted by the South African Migration Project, 87% of South Africans thought their nation

was allowing in too many foreigners. In South Africa, xenophobia can take many forms, from blatant physical attacks on immigrants to the exploitation of women migrant labourers in terms of work and social relief programs and meaningful community participation. Several xenophobic manifestations unquestionably infringe a number of the rights for women labour migrants. The use of xenophobic and insulting terminologies, such as “*amakwerikweri*” and “gone with foreigners,” which make migrants labourers feel less than human, violate their fundamental rights to dignity. Additionally, such phrases can qualify as hate speech. Additionally, the direct attacks on migrants violate their right to life and arbitrarily deprive them of their freedom and security.

A major source for concern is the persistence of such xenophobic behaviour, particularly the rape, physical assaults on migrants and the notion that not enough is being done to investigate these events. Most recently public office bearers have also been seen condoning women migrants regarding access to healthcare facilities, as such thus infringe on an individual’s right to access healthcare services as per United Nation accord. There is a pressing need for the South African government to either take action to stop this plague or increase support for NGO efforts that are working in this area when labour migrants’ rights to access healthcare services, freedom, and security are threatened.

5.3 Health care needs of women labour migrants and psycho-social needs

Sexual and reproductive health is “a condition of total physical, mental and social well-being and not only the absence of sickness or infirmity, in all areas relating to the reproductive system and to its activities and processes,” according to the World Health Organization (2010). Also included in reproductive ill health are conditions related to pregnancy, the end of pregnancy, and puerperium, as well as ectopic pregnancy, spontaneous abortion, discomforts of pregnancy, pregnancy-induced hypertension, aggravation of pre-existing conditions, anemia, urinary tract infections, antepartum hemorrhage, infection, postpartum infection, depression, eclampsia, and obstructed labour.

Furthermore, sexual health is more than just the absence of sickness, malfunction, or infirmity; it is a condition of physical, emotional, mental, and social well-being in relation to sexuality. Sexuality is a fundamental aspect of being human throughout life and includes sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexual health necessitates a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion,

discrimination, and violence. Thoughts, dreams, desires, beliefs, attitudes, values, behaviour, practices, roles, and relationships are all ways that people feel and express their sexuality.

Even though sexuality might encompass each of these aspects, not all of them are always felt or expressed. Biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual elements all combine to affect sexuality. Sexual freedom and rights include all human rights, especially those that are currently enshrined in national legislation, international agreements, and other consensus statements. For example, seeking, receiving, and imparting information related to sexuality; sexuality education; respect for bodily integrity; choosing their partner; deciding to be sexually active or not; consensual sexual relations; consensual marriage; and deciding whether or not and when to have children. They also include the right of all persons to the highest standard of sexual health and access to sexual and reproductive healthcare services.

Women labour migrants' sexual reproductive health has been categorized as follows: These are the basics of women reproductive health needs; when the researcher was exploring the women healthcare needs with regard to access to healthcare services, there were the ideal expected healthcare needs that any women would have to acquire at some point in their life cycle especially within the child-bearing ages. The needs for access to healthcare services may vary from individuals. This can also be argued through the intersection feminist approach as explained by McGibbon & Etowa (2007), that women healthcare needs are shaped by the Social Determinants of Health (SDH) across their lifespan. This can be summed up to the impact globalization may have in one's social or economic status, race, class gender and sexuality. The SDH had a significant influence on the choices of women labour migrants' economic lifestyles hence they had to migrate to Newcastle Textile industry for work opportunities, moreover they had to adjust and navigate different cultural systems and change their lifestyles.

In terms of the choices they make in respect to their physical and psychological healthcare needs, women labour migrants' reproductive healthcare demands have also been related to individual health capabilities. These include a person's ability to build a set of habits and conditions to prevent, to the best of their abilities, the onset of morbidity and mortality. In addition, their ability to acquire and draw on health-related information, knowledge, and skills. The respondents described unsanitary working conditions, unusual working hours, a lack of

moral and emotional support from the company, as well as a lack of programs created to meet their healthcare needs as some of their concerns.

Women labour migrants' access to healthcare services has mostly been informed by the availability as some would prefer Pro-Clinic in town due to easy accessibility; whilst there were those who would prefer self-medication; and those who were accustomed to the local culture and were able to communicate with the local language therefore were able to visit local healthcare facilities for treatment, collection, family planning services and other conditions, although it was more prominent on those who had studied above grade 10. This may also be properly explained through the social exclusion theory, which also mentions that lack of enough money could disadvantage individuals in accessing necessary services. For instance, these migrants would prefer going to private doctors or hospitals, but due to not having medical aid schemes then they are bound to go to the public clinics where they might be discriminated. The work environment, ethnicity and socialization status of women labour migrants subjected them to isolation resulting in inadequate allocation of health services/attention given by health officials, as this might not be an area of great concerns.

Below are the basic healthcare needs per the World Health Organization and the reflection on the accessibility and utilization of healthcare services by women labour migrants within the textile industry:

5.3.1 Family planning

Increased access to family planning (FP) could aid South Africa in meeting the Millennium Development Goals (MDG) targets by lowering the rate of maternal deaths after childbirth (Goal 5) and by lowering the number of pregnancies and induced abortions, according to the National Strategic Plan 2012–2016. Furthermore, the targets could be met by lowering the proportion of high-risk births, the number of newborn and child deaths (Goal 4).

A review of health services, including FP provision, was undertaken by the Reproductive Health Steering Committee in 1994. This review found a lot of issues in the field of FP, particularly with access and care quality. In South Africa, non-governmental FP supply has historically been relatively insignificant, leaving government entities to provide FP for the vast majority of the population. A significant women's health conference that covered crucial SRH problems was also conducted in 1994. A forward-thinking contraceptive strategy that prioritizes the client's right to choose and the standard of care was introduced in 2001 and includes a thorough analysis of the development of FP in South Africa. Providers have been

trained and service delivery guidelines for the implementation of this policy have been prepared.

In this study 20 women labour migrants had visited the healthcare facilities within the Newcastle area for family planning methods. Although with some it was a once off, but with all who visited the facility for ART treatment also ended up requiring family planning services. All participants who reported having accessed family planning methods were also offered HIV counselling and testing services, STI and TB screening, as these come as a package.

When asked about what healthcare services they were aware of in the Newcastle area, this was their response, that there was a local clinic at section 3 and Madadeni hospital that they visited for Antenatal care, family planning and collection of ARV treatment. When asked about what were their health conditions that they were aware of?

Busisiwe indicated that: *“I know that there are HIV/AIDS, TB, Sexually transmitted disease, Hypertension, and Mental health”*. What do you mostly visit the healthcare Centre/Clinic for? *To collect my ARVs treatment.*

Thando, when asked what healthcare services are you aware of in the Newcastle area? She responded as follows: *“Local clinics and hospitals Antenatal care and family planning services. What services do you receive from these healthcare centers? She added: “I went to the clinic for antenatal care”*. What are health conditions that you are aware of? *“I know that there is HIV/AIDS, TB, Sexually transmitted disease, Hypertension, and Mental health”*. What do you mostly visit the healthcare Centre/Clinic for? She added: *“To collect my ARVs treatment”*.

Malefu, when asked what healthcare services are you aware of in the Newcastle area? She said: *“There is a clinic at section 3, and Pro-hospital in town, they provide family planning and HIV treatment”*. What services do you receive from these healthcare centers? She said: *“I went to the clinic for antenatal care”*. What are health conditions that you are aware of? *I know that there is HIV/AIDS, TB, Sexually transmitted disease, Hypertension, and Mental health”*. What do you mostly visit the healthcare Centre/Clinic for? She replied: *“To collect my ARVs treatment”*.

A total number of 20 participants who had gone to local clinics for family planning had studied until grade 11. This shows the impact education might have had in their way of thinking. Interestingly, they were also able to understand a bit of the local language or would speak English when consulting. There is still a proportion of 40% amongst the 20 that had also been

attending the local healthcare clinic for both family planning and ART treatment collection. Nevertheless, some were not consistent with the visits for family planning. Most of them were using depo injection as a form of family planning, meaning that they would normally get injections after every three months. It is also noted that when they visited the healthcare facilities it was not only family planning services they were offered, but it also extended to Tuberculosis and sexually transmitted diseases screening. During the interview time one could understand that they had a better understanding of healthcare services and preventions to ensure that they stay healthy.

For instance, Lopes (2007) confirmed in his study with a group of immigrants who were HIV-positive and seeking obstetrics services at a hospital in the Lisbon region that the medical staff were not particularly helpful in their contact with the users and gave them very little information about HIV. Dias et al. (2010) claim that health technicians' ignorance of cultural characteristics of immigrants' sexual and reproductive behaviour affects both the number of women experiencing pregnancy, childbirth, parenting as well as how they use health services. A study by Manuel (2007) on family planning difficulties among Timorese female immigrants to Portugal revealed that these women's attitudes toward reproduction were influenced by both the cultural aspect and the situations they encountered once in Portugal.

Through the study amongst the participants, the proportional figure that had visited healthcare facilities for various services proves that an individual can act as an agent of their own healthcare needs, thus proving that health capability approach theory. The knowledge of availability of healthcare services rendered at their identified healthcare centres, indicates their ability and desire to acquire healthcare services and the possibilities of a positive health-seeking behaviour. Although within their working environment the health awareness was not advocated for, this is proven by that there were no health activities/promotions within the workplace, no condoms available, and no n95 face masks provided considering that the nature of their work involves garments dust. This may as well be viewed as exclusion to healthcare services considering that the South African Environmental Labour Act promotes access to such services in a workplace. However, this could not be enforced by the employer as he was deliberately exploiting the employees given their background.

Given that the women labour migrants are experiencing economic deprivation of opportunities from their countries of origin; are geographically isolated as they hardly interact with community due to ethnicity differences; and some were sometimes kept against their will, this

is well explained through the intersectional feminist theory as it seeks to look into situations where women are deprived of opportunities. In this case, access to health care in the work settings could also be assessed. This has assisted the researcher in examining their experiences and the impact of such on their attitudes towards accessing healthcare services.

5.3.2 Male and female condoms

The South African government has created rules to ensure that both men and women have access to all healthcare facilities at public spaces. Health promoters are also in charge of distributing condoms among the communities. However, in order for women to be able to discuss condom use, there is still a need for their empowerment. They ought to freely talk about sexual orientation; gender-based violence; men's and women's comfort and knowledge with their anatomy; gender roles and expectations; and women's rights. Advocates for SRH and human rights must insist on having access to both male and female condoms as well as a thorough programming.

Even though South Africa reportedly distributes 400 million male condoms (MCs) each year, this number is still insufficient. Despite an increase in distribution, the Department of Health's distribution of MCs to men aged 15 and older remained low in 2007/2008, at 12 condoms per male per year. While the Western Cape, which has the lowest prevalence of HIV, distributes the most condoms over 40 per male per year other five provinces report MC distribution rates below eight. Stock-outs of male condoms occurred in 2009 and 2010, allegedly as a result of delays in issuing the national condom tender in late 2008.

Since 1999, the female condom (FC) program in South Africa has grown, and more than 4 million FCs are currently provided annually, primarily through the public sector. In contrast to male condoms, FCs are not offered at all locations that offer family planning services, hence there are fewer distribution sites available. Only 3.6 million FCs, approximately, were supplied at public health facilities in 2008, according to Plus News.

With 62% of respondents reporting using condoms during their most recent sexual encounter, in 2008, condom use statistics recorded in a national survey indicated a significant rise. In particular, 87% of males aged 15 to 24 reported using a condom during their most recent sex encounter, compared to 73% of females at the same age. According to WHO recommendations, people should receive at least 100 condoms a year. Clearly, there has to be a significant increase in the condom supply.

During the interviews, the researcher was able to identify that all of them were sexually active; some were involved in transactional sex; and some had more than one sex partner although they still maintained their relationships with their sexual partners back home. The participants indicated that they were aware of the benefits of using condoms, however, they relied mostly on the male to initiate the conversation on the use of condom during sexual intercourse and to bring along the condoms. This indicates the lack of knowledge on individual health advocacy and the consequences of having unprotected sex with multiple partners. Mokgadi said: *“When times are tough, I do sex work, and it is better when I don’t use a condom since I will have more customers, but I only do that on weekends when am off”*.

Manaledi said: *“I have two sex partners here who are married and I have my partner at home, they do help financially when I am in need and we don’t use a condom when having sex”*.

Nomusa said: *“I don’t use a condom because I am doing family planning, so I don’t need to use a condom”*. When asked if she was aware that a condom does not only prevent pregnancy, she said, *she was aware but she didn’t like a condom as it hurts her and she doesn’t prefer sex with a condom”*.

It is clear that given the environment, knowledge and the level of education the respondents are at, there is a need for health promotions, so that they can understand the need to practice a healthier lifestyle, the consequences of their sexual choices, and how it will impact on them in future. One could only imagine the effects if the respondents were HIV/AIDS positive and then they transmit the virus to their sex partners who also infect their wives and ultimately their prospective children at home.

According to a study by Crush and Williams (2005), millions of domestic and international labour migrants make up South Africa’s highly mobile population. The spread of disease in nearby nations where a sizeable fraction of older have lived as migrants in South Africa may be impacted by such international migration.

Although there is no doubt that emigration labour system contributed to the early transmission and spread of syphilis, tuberculosis (TB), and the human immunodeficiency virus (HIV), particularly in relation to the ongoing systems of labour migration associated with the mines in South Africa (SA), these dynamics have not changed over time, and the link between movement and the spread of communicable diseases still exists today. This has also been demonstrated by some of the participants' behaviour in this study. Nevertheless, NCD prevention, testing, and treatment programs in the SADC must always be accessible to people

who relocate, both inside and across national boundaries. The insufficient care of chronic illnesses for people who relocate was a major problem in 2014. This has detrimental effects on wellness and productivity of a population that moves about a lot, as well as health needs and the wellbeing of the family that must deal with the expenses of delayed healthcare seeking. Additionally, or hazardous sexual behaviour (inter-generational, transactional, etc.).

The reasons for this behaviour shall be understood in the context of factors other than how migration and risky sexual behaviour are related. This behaviour undoubtedly alters the likelihood of developing or transmitting HIV. Sexual behaviour may be directly impacted by vulnerabilities (such as food insecurity), where sex may be utilized as a means of securing safety or food. Similarly, migrant workers who are divorced from their long-term partners are more inclined to date other partners, which puts them at greater danger (Lurie et al., 2003). Changes in sexual behaviour could also put non-mobile people at danger, such the partners of migrants who stay back home (Kishamawe et al., 2006).

Whilst safer sex using condom is encouraged as part of HIV/AIDS prevention intervention within the World Health Organization, amongst the respondents it was clearer that they did not prefer having sex with a condom and the desire to advocate for condom was not identified during the interview. Looking at the individual capability to act as an agent of change one can argue that the environmental setting or work conditions this women labour migrants find themselves in, did not motivate them or practice a health seeking behaviour. The knowledge they had on the benefits of having protected sex was not enough to influence their behaviour. This may have resulted in infecting or being infected by sexually transmitted diseases and having unplanned pregnancies.

5.3.3 Emergency contraception

Like all other hormonal contraceptives, emergency contraception pills work to prevent pregnancy largely by delaying or slowing ovulation and by blocking fertilization. The EC was supposed to go offline in November 2000, but it is now accessible in pharmacies without a prescription. This approach is also available in the public sector. In 2003, only 0.6% of women had used this approach in the public sector. Access to EC is restricted, which violates human rights. Health care providers must encourage their patients to use a variety of ways, and a client's right to choose their preferred method is a crucial aspect of that right. Because of insufficient advertising, several technically feasible solutions are underutilized. Healthcare professionals are reluctant to recommend or prescribe EC due to worries that it would be

overused or utilized as an abortifacient. The latter is likely based on a misunderstanding because EC does not actually cause pregnancy; it merely prevents it from happening.

Making male and female condoms, EC, and other measures accessible to both men and women can help with the right to prevent pregnancy and disease. Better counseling, longer clinic hours, and increased community accessibility, including in schools, key business districts, and integration with other services, are also necessary. Little progress has been made in terms of increasing the accessibility of other methods or services, even in industrial areas, with the exception of greater condom availability, improved counseling in the public sector, access to post-abortion care, and safe pregnancy termination to ensure widespread access to abortion. It is worth noting at this juncture that the Choice on Termination of Pregnancy (CTOP) Amendment Act was passed in 2004. It is interesting to note that none of the participants mentioned termination of pregnancy services offered by healthcare facilities in their communities. The researcher asked the respondents if they knew that TOP was offered in the hospital and if they could opt for such a service. These were their responses:

Angel said: *"I don't want to kill an innocent child; I don't do abortions or promote it"*.

Ncobile said: *"My grandmother hates abortion she always says that I must rather give her the child"*.

Lekeledi said: *"A child is a gift from God, why should I kill him or her"?*

Mofeng said: *"Some women could kill to have a child why can I kill one"*.

Some of the healthcare services are associated with stigma from societies, and termination of pregnancy is amongst those. It is perceived as murdering an innocent soul. Non amongst the women labour migrants who happened to conceive whilst within the Newcastle area had opted for TOP. Women labour migrants who were pregnant, when asked about why they did not consider TOP if they did not need the child, they responded that it was against their belief. They belief every child has a right to life. Their understanding could have been limited by the knowledge they had on TOP and emergency contraceptive, which can also be informed by their socialization, religion and culture.

Whilst the study examined the knowledge women labour migrants had on TOP, it was evident that the individual choices were mostly cultural and religious informed. However, there was a knowledge gap regarding the process that may lead to TOP, the steps that are followed, and what may prompt TOP.

5.3.4 Human Immunodeficiency Virus counselling and testing

HIV counselling and testing has been regarded as a South African demand services the spread of the HIV/AIDS, hence the Ministry of Health in collaboration with WHO aim at attaining the set targets of 90-90-90 by the year 2020. The first 90 seeks to promote HIV testing in order to ensure that 90% of the population knows their status. This approach is inclusive of women labour migrants as they are constitutionally the responsibility of the South African government and in cases where they are involved in risky behaviour chances of the epidemic to be uncontrollable are high. As such for the epidemic to be arrested, 90% of people living in South Africa should know their status with 90% initiated to treatment and the last 90% for all initiated to be adherent and viral suppressed to treatment. This will therefore eliminate the spread of the HIV/AIDS virus in South Africa. The Provider-Initiated Counselling and Testing (PICT) is done at healthcare facilities with the amendment to the National Health Act allowing trained healthcare providers, including counsellors and retired healthcare providers to undertake withdrawal of blood for HIV testing and the national HIV Counselling and Testing (HCT) now known as the Health Testing services (HTS).

Siphiwe said: *“I was once or twice tested in the Clinic at Section 3 when I went for family planning.”*

Busi said: *“I have never gone specifically to test for HIV, sometimes when we are there, they will tell us about testing, it is then that I test”.*

Malefu said: *“I was tested positive for HIV when I went for antenatal care service and they gave me ARV and other pills”.*

HIV testing services are rendered to all clients visiting the healthcare centres, it is always at the point of entry to other services although it is a patient's choice. In the case of women labour migrants only 65% of the total participants who had visited the healthcare services were offered HTS. However, it must be done after almost six weeks in every sexually active person who is not on antiretroviral treatment or once tested positive. The respondents who fell within the category only tested so that they could get access to either family planning services or for Antenatal Care (ANC). None amongst the respondents had visited the healthcare facility for only HIV/AIDS testing services. This shows that they are less concerned about their well-being when it comes to knowing their HIV status and understanding of HIV/AIDS which can really put their lives at risk and may compromise their health in the process. The researcher has also noted that for all the respondents that had visited the healthcare facility for antenatal care

were tested and those found to be HIV positive were initiated into treatment, although they did not continue with their treatment after birth of the child.

Women labour migrants lacked the capacity to initiate or visit healthcare facility for HIV/AIDS testing services. Although this must be an individual responsibility, it is still the responsibility of the state where migrants are residing to ensure easy accessibility to healthcare services, moreover it is in the interest of any government to be able to improve access to ART treatment so that the transmission can be halt. The employer is also expected to promote access to healthcare services through the employee wellness programs. This can help in improving the employee capacity and knowledge on the importance of HIV/AIDS testing and adhering to treatment when found to be positive. This can as well help in preserving individual wellbeing and maintaining an array of routine with order to prevent, the extent possibility and the onset of morbidity and mortality.

5.3.5 Prevention of HIV/AIDS

Preventing new infections and AIDS-related deaths amongst young women in South Africa is crucial. Some of the main drivers of the epidemic are early sexual debut, gender-based violence and gender inequality, intergenerational sex, multiple HIV, and early treatment of symptomatic STIs which contributes directly to the reduction of the HIV incidence. Syndromic management of STIs is available through all public sector's – primary health clinics. Challenges experienced in decreasing the rate of STIs include partner notification, the fact that women are often asymptomatic and as a result this may affect them differently in contrast to the male counterpart. The study has noted that a portion of the participants visited the healthcare centres for collection of their treatment. However, others were unaware of their HIV status and were involved in sexual risky behaviours.

The participants' behaviour did not indicate any concerns about being infected by HIV/AIDS as some would not prefer using a condom when sexually involved, yet some had multiple partners whilst some were involved in transaction sex. The availability of condoms within the place of work was also identified as a concern although the women labour migrants who were more sexually active would not prefer carrying a condom. They perceive that as a responsibility for men.

While increased or risky sexual behaviour (inter-generational, transactional, etc.) undoubtedly changes the likelihood of contracting or spreading HIV, the reasons for this behaviour must be contextualized beyond aligning migration and dangerous sexual behaviour. Vulnerabilities

encountered (such as food insecurity) may directly affect sexual behaviour, where sex may be used as a transaction ensuring safety or food security. Likewise, migrant workers separated from permanent partners are more likely to engage in relationships with other partners, putting them at heightened risk (Lurie et al., 2003). Changes in sexual behaviour may also pose a risk factor to non-mobile persons, such as the partners of migrants who remain at home (Kishamawe et al., 2006).

Out of the total respondents, only 65 per cent knew their HIV/AIDS status. This means that there were those who were known HIV positives on treatment, those who were ones on treatment but defaulted, and those who last tested negative some years back with no intention of testing again. This might have resulted on stigma associated with being HIV positive, their knowledge regarding benefits and consequences of HIV testing, and the availability of the services to the women labour migrant population. A significant portion of them indicated to be sexually active and involved in a lot of casual sex/transactional sex. The study has also noted that the respondents who visited health facilities for collection of HIV/AIDS treatment were amongst those who have studied until grade 11 and those who could speak a bit of the local language. The portion of respondents who defaulted on HIV/AIDS treatment mentioned that it was because of long queues, changing of treatment collection points, and the time they take to access their medication. The 35 per cent of participants who did not know their HIV status had never tested and were reluctant to test for HIV/AIDS in fear of stigma. The researcher had also noted that amongst those who had said they use condom for HIV/AIDS protection when involved in casual sex, they were also not consistent in the use of condoms during sexual intercourse. Temavungadze had this to say: *“I sometimes use condoms only if the person am having sex with has it, if he doesn’t, I don’t mind having sex without a condom as I don’t like a condom”*.

Selloane said: *“I use condom if I have them, if I don’t, I don’t mind having sexual intercourse without it”*.

Coffee, Lurie and Garnett (2007) argued that foreign nationals’ relocation has an influence on the spread of HIV as this has an influence on increasing risky sexual behaviour, when connecting from areas of high risk and low probability. Frequent return of migrants is an important risk factor when coupled with increased sexual risk behaviour as it is mentioned by the respondents that they do not practice safe sex, this increases chances of STI’s transmission. According to Coffee, Lurie and Garnett (2007), planned interventions in country should focus

on mitigating risk associated with unhealthy behaviour of short-term migrants specifically, even though these individuals may be more difficult to identify. This is also visible when it comes to the lifestyle and information shared by the participants on sexual lifestyle choices ranging from condom utilization, multiple sexual partners, sexual transactions and reluctance in using condoms.

Women labour migrants as observed in this study were more vulnerable to poor health choices. One may argue that it was informed by the condition they find themselves in regarding advocating for safer sex and availability of condoms. However, the researcher has also noted that the participants did not show any sense of willingness in advocating for safe sex with their sexual partners as they assume the responsibility is upon the other sexual partner. This affected the individuals' capabilities to prevent being infected by STI's and having unwanted pregnancies. This might have been because of the limited knowledge the respondents had on the benefits of safer sex and prevention, which might have resulted from their upbringing, education and socialization. However, the responsibility may as well lie with the employer in ensuring that wellness programmes are put in place.

Given that employment environment is supposed to promote health and wellness programs which was not the case with the Newcastle textile industry, as a result, the women labour migrants are disadvantaged and they may have been behaving in a manner that might put their lives at risk without knowing, given the exclusion of the wellness service. The work environment, ethnicity and socialization status of women labour migrants as well subjected them to isolation that resulted in inaccessibility of health services that might improve their well-being and with less attention given by health officials as this might not be an area of great concerns. Women migrant labourers lacked access to basic health services like condom, TB screening, awareness campaigns, etc. This also include proper accommodation, socialization and being able to move around freely and acquire any service they may need such as laying a criminal charge after gruesome rape etc.

5.3.6 The National guidelines on PICT

HIV counselling and testing is initiated and recommended by healthcare providers to all clients attending healthcare facilities as a standard component of medical care. Provider-Initiated Counselling and Testing should be offered to all adults, youth and children at any health facility, including at antenatal and postnatal clinics, tuberculosis (TB) facilities, Integrated Management of Childhood Illness (IMCI) Centres, FP clinics, STI clinics and centers offering

treatment for opportunistic infections (Ois) and domestic or gender-based violence/trauma services, including post-exposure prophylaxis. The PICT can be routinely offered and clients can ‘opt out’ in delivery. This will substantially increase the number of individuals receiving HTS and improve access to care and support.

The Continuum of treatment, care and prevention for HIV and STIs, Comprehensive HIV treatment and care should be routinely offered. The NSP 2012-2016, an inclusive multi stakeholder response to South Africa’s AIDS epidemic, calls for treatment, care and support for 90% of HIV-positive people by 2020. South Africa currently has the largest ARV programme in the world: by November 2009, the South African Government reported nearly 920 000 individuals on treatment representing 56% of adults and children requiring ART treatment. However, the gap between people in need of treatment and those currently on treatment remains considerable and varies by province.

Given this gap and the potential barriers to its achievement, attaining near-universal coverage within a short time is an immense task. A recent review of the NSP produced a number of recommendations to ensure the 2021 and future targets are reached. These include increasing resources at provincial and district levels, the need for a rolling annual implementation plan, as well as surveillance funding. More efficient drug procurement and supply chains are also necessary for more cost-effective and efficient programmes.

The research findings indicated that more than 50% of the participants were attending the healthcare facilities for chronic medication, antenatal care and family planning. However, most worrying is that, about 20% were not interested in attending local healthcare facilities within the area and others were against the western medicine due to their beliefs. This can present setbacks in reducing the epidemic if they are involved in sexual risk behaviours. In cases where they are HIV positive, this might result in infecting their sexual partners and as such their sexual partners infecting others and it becomes a chain, hence women labour migrants within the textile industrial sector must be provided access to healthcare services in order to eliminate the HIV/AIDS epidemic and other diseases. Language barrier, facilities being overloaded hence increase in patient’s waiting time, and victimization regarding identity documents were challenges encountered during the facility visits by the women labour migrants. Perhaps one could also argue that visiting of healthcare facilities has also been common amongst women labour migrants who had studied until higher secondary level, this might have been influenced

by their knowledge regarding the importance of healthcare needs and access to their chronic treatments.

South Africa has the additional burden of a TB epidemic that is being fueled by HIV. As a result, women of reproductive age are disproportionally affected by the dual epidemics. Although some integration of TB screening, prevention and treatment services with HIV services has commenced at facility level, more targeted integration of TB, reproductive health, and maternal and child health services is required. The recent Lancet series on South Africa calls for improving TB cure and case detection rates, the integration of TB and HIV services and the identification and treatment of drug resistant TB. Recommendations that could result in improved TB cure and detection rates include: widespread utilization of lay counsellors and community health workers; rapid HIV tests; nurse-driven treatment and care; an electronic patient information system; and outreach support for nurses in the TB programme. Given the fact that TB has become more dangerous than HIV/AIDS whilst it is curable, it is shockingly that according to the women labour migrants they have never been screened for TB whilst they are working at high-risk environment and the worse part of it is that they are in a textile industry where there is a lot of dust, let alone the contamination, this really violates human rights.

Although South Africa follows an integrated primary healthcare model, health services related to HIV are provided in a largely vertical fashion. As a result, services such as FP, PMTCT, HIV, ARV, and other STI services are poorly integrated. Integrating SRH and HIV services can lead to improved efficiency and effectiveness of the healthcare system, as well as to improved reproductive health outcomes. These potential benefits include increased contraceptive prevalence or declines in unplanned pregnancies, maternal mortality, or in the incidence of HIV and other STIs. In addition, combining reproductive health services may improve efficiency by requiring fewer client-provider contacts, reducing duplication of services, ensuring continuity of care and training staff to perform multiple tasks. Linking services may also help to reach under-served groups such as women labour migrants. At present, there is a lack of clear policies on integration within South African health services. Further, studies in South Africa have found substantial barriers to providing an integrated service, due to on-the-ground realities of vertical service provision, logistical difficulties and the need for extensive re-training of healthcare providers.

Postnatal follow-up for HIV-positive mothers and their infants should be integrated with treatment services for HIV, as well as with treatment services for opportunistic infections such

as TB. Health monitoring of children born to HIV-positive women and of the women themselves should be closely allied to programmes to prevent mother-to-child transmission. The integration can be effective and more cost efficient than separate programmes. Prevention of infections acquired through unsafe injections, child sexual abuse and risky sex in older children and adolescents deserves more attention.

The PMTCT guidelines from the South African National Department of Health the correct time for visiting healthcare facility for antenatal care is before three months which is then referred as early antenatal care booking. This then ensures that in the case where the pregnant mother tests positive for HIV/AIDS she is given ART treatment to prevent infecting the unborn child. This is more effective when the booking is made within the first trimester of the pregnancy. None of the six women labour migrant respondents in the study had made a booking within the first trimester. Those reported booking visited healthcare facility after five to six months of their pregnancy. This might have been as a result of them being scared that they might be deported, they did not know the importance or did not find the need.

Demand for of health services provider among migrants has been recognised as stimulated at most by communication, price value of the system, health insurance and severity of illness amongst migrants. Language/communication challenges, from which most of other identified barriers emanated, are the often-mentioned barriers to access healthcare services. The impediments were confirmed by Baah-Boateng et al. (2013). As presented in the study that most of the women labour migrants who were pregnant preferred to use Pro-Clinic in town than the local clinics due to treatment and queuing systems. Furthermore, it is important to stress that pregnant women who are victims of violence present more health complications than non-victims, especially during the second trimester of pregnancy (Morewitz, 2004). On the other hand, some female immigrants, due to the cultural norms of their countries of origin which are deeply rooted in conservatism and the patriarchy, feel uncomfortable and even disrespected by the practice of certain medical acts, namely care from male doctors, or the need to show private body parts during clinical observation (Mestheneos et al., 1999 apud Dias et al., 2009). When the researcher asked about the experiences during pregnancy visit to healthcare facilities, the responses were as follows:

Dimakatso said: *"I don't belief in disclosing my pregnancy before six weeks it is a bad luck"*.

Angel said: *"I didn't visit the clinic until I was 7 months pregnant"*.

Malefu said: *"I went to Pro-clinic when I was 5 months pregnant"*.

Busisiwe replied: *“I worked until I was eight months, I then went back home to Swaziland”*.

Of all the respondents who happened to be pregnant whilst working in the Newcastle textile industry, none reported to the local healthcare facility within their first trimester as per PMTCT guideline. This might have been because of lack of information, and moreover not feeling the need to do so as they did not know the benefits and consequences. One can also argue that this might have been to the fact that they would miss work, and some might have needed money to attend Pro-Clinic. This is better explained by the individual capability approach theory as it puts more emphasis on subjective health psychology, desire to achieve health outcomes and the knowledge they might have regarding health care. This informs individual lifestyle choices and moreover conditions to prevent the extent of possible mortality and morbidity. This may as well have been informed by the socio-cultural influences as Thantazile indicated that per her culture, nobody must know about her pregnancy until the child is at least more than five months old (in her tummy), she indicated that it was a bad luck according to her grandmother.

The situations women labour migrants from the textile are faced with include economic deprived of opportunities from their countries of origin. The work environment set up deprives them of socialization with the local community. This can well be described by the intersectional feminist approach as it reflects on groups that are geographically isolated as they hardly interact with community due to ethnicity differences. Healthcare services form an integral part of women's health. Their social status has influenced their attitude and behaviour regarding accessing healthcare services.

5.3.7 Cervical cancer screening

In South Africa, cervical cancer is the most commonly diagnosed form of cancer. Approximately 7 000 South African women develop cervical cancer annually. However, despite the availability of guidelines and a policy, there is poor coverage of screening and care therefore, cervical cancer remains a challenge not only for the women labour migrants but for the entire population. Cervical cancer is more common among older women and takes a while to progress. This is the rationale behind the national policy for cervical screening in South Africa, based on WHO recommendations for screening in limited resource countries. Screening is done at 10-year intervals from the age of 30 years for women who are not HIV-positive, while not optimal, would have the greatest population-based effect in reducing cervical cancer-related serious morbidity and mortality among women in the country.

According to the Cancer Research Institute of South Africa (CARISA), 2015 about 23% of South African women have consistent and regular access to pelvic examinations and 51%-60% of women have never had a pelvic examination. Of even greater concern is the fact that screening levels are particularly low among the age cohort of women at greatest risk of developing cervical cancer (between 45 years and 54 years). A significant barrier to the implementation and sustainability of mass cervical cancer screening in South Africa is the requirements of cytology-based screening methods. These are labour and resource intensive and require relatively complex laboratory infrastructure. Fast, innovative screening tests such as visual inspection with acetic acid (VIA) that do not require a pathologist, refrigeration of samples or a microscope require further investigation. None amongst the participants reported to have done Pap smear screening in their lifetime or reported to have been offered such services. Most of them did not even know what that service was and if they must be provided with it. This indicates the knowledge gap that women labour migrants with regard to sexual reproductive health services.

If there are inadequate screening programmes or coverage, cervical cancer is often diagnosed at a late stage with associated sub-optimal outcomes. This is more concerning in HIV-positive women who are more likely to contract the disease, generally at a younger age and with increased severity as compared to uninfected women. As cancer of the cervix is an AIDS-defining illness, the consistent use of condoms can partially protect against human papillomavirus (HPV) and provide cheap protection against all STIs, including HIV, as well as unwanted pregnancy. However, amongst the respondents they reported inconstancy use of condoms during sexual intercourse with some relaying to accessibility and availability whereas some would not prefer having sex with a condom. Moreover, they felt no need to negotiate for condom use because they felt that should be men's responsibility. This puts their lives at a greater risk as not all men they have sex with will prefer having a condom. There is a greater need for programs that will empower women to understand the importance of safer sex and their responsibility towards own health, choices and use of a condom during sexual intercourse.

5.3.8 Prevention of mother-to-child transmission

Strengthening PMTCT including postnatal care will contribute to the health of women and children in South Africa. The PMTCT is widely regarded to comprise four key strategies namely primary prevention of HIV infection in women; the prevention of unintended pregnancies in women living with HIV; the prevention of transmission from women living with

HIV to their infants; and the provision of care, treatment and support for women living with HIV and their families.

Interventions to prevent mother-to-child transmission includes the introduction of enhanced HIV testing services, encouragement of sharing HIV status with partners and family, skilled supervision of labour and delivery with attention to minimizing invasive procedures, and the implementation of combination antiretroviral treatment, including highly active antiretroviral therapy (HAART) for mothers at particular risk and, more widely, as combined therapy increasingly replaces single-dose nevirapine regimens. Health worker support is necessary for mothers to establish optimum infant feeding and minimize any stigma related to feeding choice. In most poor populations, the hazards of transmitting HIV by breastfeeding are outweighed by the dangers of exposure to contaminated environments. The ARVs given to breastfeeding infants or lactating mothers can greatly reduce breastfeeding transmission and on the other hand assist in moving towards alignment with WHO recommendations. The revised South African treatment guidelines include ARVs for HIV-positive pregnant women with a CD4 count equal to or greater than 350 at 14 weeks as part of the PMTCT programme and ART for all HIV-positive children under one year.

Interestingly about 17% of the participants attended their second trimester antenatal care, which negatively affects the implementation of Health guidelines, although thereafter they were able to attend until they gave birth, utilizing the health facility in town. This shows their understanding of the importance of ensuring that they attend the antenatal care to protect their infants from being exposed to the HIV/AIDS virus.

5.3.9 Post exposure prophylaxis

Post-Exposure Prophylaxis (PEP) is a short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. The PEP provision has been policy for sexual assault survivors since 2002. However, challenges in service delivery still remain. The challenges include poor uptake among rape survivors, limited accessibility of services, lack of trained service providers and problems with adherence to a complete course of ART. For, instance within the participants, Dimakatso when asked,

What services do you receive in the healthcare centers? She replied: *“I went to the clinic after I was raped.”*

What challenges do you encounter in health services? She said: *“Language barrier as I relied on English which I also struggle with. I don’t like it that when you are at the clinic they will ask if you have an ID. I worry that they might report me to be deported. When I went for the rape incidence, they reported the matter to the police the perpetrator told me that Police will deport me, then I decided not to return to the clinic and to change address.”*

From the response of Dimakatso one could pick up that she did not take her treatment as per expectation. Knowing that you are provided a week treatment and you come again for monitoring of adverse events, thereafter you are provided with two weeks treatment and you present to the health facility until you take the treatment for full 28 days, Dimakatso did not complete the course! Hence these challenges are being noted also from the service provider’s point of view.

Prevention of mother to child transmission forms part of antenatal care, which is explained as the time a pregnant mother is expected to visit health facility before her trimester for vital checkups and to ensure that the unborn child gets the necessary vitamins. In a case where the mother is found to be HIV positive the first test is initiated into treatment, if not, she then tests for HIV every month she comes to the healthcare facility for checkups until the birth of the child, this is according to the South African Department of Health PMTCT guidelines. There were nine of the participants who had been pregnant whilst working within the Newcastle textile industry. Culture has also played a role towards them visiting health facility within the first trimester regardless of the conditions they are subjected to within those health facilities. Most of them belief that pregnancy was to be kept a secret until after six months, they believed that it was a bad luck for a pregnant woman if everybody knows about her pregnancy at an early stage. This might also impact badly during their pregnancy tenure and on the day of delivery resulting to morbidity or mortality. Some of the responses women labour migrants shared on pregnancy are as follows:

Matshediso said: *“When I was pregnant, I went to the clinic when I was seven months pregnant, I went to Pro-Clinic because I was not feeling well, I absconded from work”.*

Thantzaile said: *“I went to the clinic when I was about six months pregnant because I could feel my child kicking, so I assumed the worst”.*

Thoko responded: *“I went to the clinic when I was seven months pregnant before, I left for home I wanted to make sure that am well to go. I prefer giving birth at home, I hear stories here that children die in hospital or the mother may die while giving birth”.*

Mokgadi replied: *“When I was six months pregnant. I did not return back to work until I gave birth”*.

Malefu answered: *“I started going to Pro-Clinic when I was five months pregnant with my second born. I then decided to go on monthly per nurse’s instruction until I left for giving birth at home when I was 8 months pregnant”*.

It can be drawn from the respondents that most of them did not know the importance of visiting the healthcare facility within the first trimester of their pregnancy, to them it was a normal routine exercise hence most of them went to the clinic when they thought there was something wrong with their child. The research has identified a knowledge gap that might have informed their behaviour. This could as well have been addressed by the health and wellness program at work, however the employees did not have such. This is not only putting their lives at risk, but also of the unborn child. Although culture also had a huge influence in their choices, they should be aware that culture changes through knowledge sharing and it evolves over time.

5.4 The knowledge of women migrants on health care services in the Newcastle area

Amongst the 35 interviewed respondents only 26 found it necessary to visit the healthcare facilities. Although they visited the facility for a variety of reasons such as family planning, antenatal care and some for collection of chronic treatments. Nine of those did not want anything to do with visiting healthcare facilities around the Newcastle area. A portion amongst the nine would prefer to always consult back home when they were not feeling well or take self-medication. Amongst those also were those whom their beliefs were against them utilizing any of the western medications.

These were some of the responses given when asked, *“What health care services are you aware of within the Newcastle area?”* *“When pregnant, I always visit the clinic at the hospital monthly for antenatal care.”* Amongst others was, *“I visit the local clinic and hospital, Antenatal care, family planning and HTS”*.

Amongst the participants when asked, what services do you receive in these healthcare centers? Ntlaki answered: *“I went to the clinic after I was raped. I was advised and persuaded to open a case. I was uncomfortable in opening a case because I feared for my life and that if I open a case, I will end up being deported. I never returned to the facility for my next visit”*. Amongst the participants there were those who visited healthcare facilities after sexual assault incidence. However, this was a once-off visit as they indicated that they felt compelled to press charges

against the perpetrators of which they were advised by friends not to go on with the case as this might have resulted in them being deported since they had no asylum or work permits for them to be in South Africa.

The researcher has noted that regardless of the working condition and health hazards their working environment might have posed the concerns to those participants who would visit healthcare facilities either for family planning, antenatal care or collection of chronic treatment. The infection that they might have had because of working conditions were not of health concerns and the exposure to Tuberculosis diseases as they were working with garments and the dust within the environment. It is noted that if amongst them anyone could have had TB, it might have spreaded to almost every one of them. There were none amongst them who did mention that they visit the health facility for Pap smear or cancer screening, this might have been influenced by their level of educational background and health education availability to them.

The behaviour of health facilities staff has similarly been indicated as one of the two factors that mostly determine the use or non-use of health services by immigrant communities. Studies suggest that these professionals frequently present a limited knowledge of legislation and/or its applicability and act in accordance with social stereotypes (Wolffers & Fernandez, 2003 apud Dias et al., 2009), not responding to the effective needs of the users. Conversely, they tend to not have the cultural competencies necessary to relate to users of other nationalities, and do not know their specific characteristics (Pusseti et al., 2009).

The healthcare field (including feminist health care) has noted access to health care as a concerning. Research information becomes critical in incorporating diversity into healthcare practices, on how best to conceptualize accessibility to healthcare services for women labour migrants. The approach as it addresses issues of power relations, this can be seen from the employee and employer perspective. In this case, women labour migrants when they are supposed to visit healthcare facilities, their employers do not allow them, if they persist, they end up having salary deductions or being expelled from their positions of responsibilities. This is what Maselaelo said: *“I ended up stopping collection of my treatment at the clinic because of queues, at times I would spend the whole day thus resulting on salary deducted and threats of being expelled from work due to absconding”*. These were the same sentiments shared by Happy. She said: *“I was constantly missing my appointments at the clinic when I was pregnant*

because if I had to visit the clinic it meant I was not going to have salary for that day until I went back to Swaziland when I was eight months pregnant”.

The power relations between the employer and employee are evident as in this case women labour migrants were at the lower position of power compared to the employer who had to put a condition of no work no pay. These women labour migrants are not covered by the South African Employment Act since they are working without work permits, some were in the country through illegal ports of entry, whilst others their documents of stay in the country had expired.

Intersectional feminist approach examines the extent of systems resulting to intolerance, such as colonialism and globalization can impact the combination of a person's social or economic status, race, class, gender, and sexuality (Canadian Research Institute for the Advancement of Women, 2006: 7). In this study women labour migrants have relocated from their country of origin to seek employment opportunities in the Newcastle textile industry thus placing them at the lower position of power and subjects them to suppression. As it has been discovered during the data collection process that some participants were locked in one of the factories where they were then rescued by police and the Department of Home Affairs.

Whilst, Crenshaw (1989), argue that Intersectional feminism seeks to define women's rights in a way that it calls attention to the diversity of women's social and political reality, centralizing in the experience of all women, especially the women whose social conditions have been least written about, studied, or changed by political movements. McGibbon (2009) proposed an intersectionality lens to strengthen a human rights perspective on healthcare access. Arguing that disparities influenced by health needs are described as intersections of three areas: the SDH as laid out in the Toronto Charter indicate race, class and gender, geographic or spatial contexts of oppression as Social Determinants of Health. For instance, food alternatively housing insecurity create certain physical and mental health stresses, women who experience both struggles at the same time are impacted in a way that defies a simplistic additive analysis. Women labour foreign nationals are prone to inappropriate social leaving conditions, discriminated because of their places of origin and subjected to physical and sexual assaults and poor health as reflected on some of the respondents' experiences.

The study employed the health capability approach as an inclusive descriptive foundation of the assessment for an individual well-being and social arrangements, the design of policies and proposals about social change in society as argued by, Sen (1993). In examining the experience

of the women labour migrants, the researcher evaluated the potential at the individual level, identifying how well individuals can act as agents of their own health. This included the realm of subjective health psychology's self-control, efficacy, and motivation to achieve desirable health outcomes. In acting as an agent of own health focuses on one's potential in acquiring and draw on health-related information, knowledge, and skills to preserve health and to develop a set of habits and conditions to prevent, to the extent possible, the onset of morbidity and mortality.

Whilst looking at the external and internal factors for women labour migrants from Southern Africa accessing health care, the researcher explored women migrants labourers' healthcare needs and investigated the knowledge of women migrants on healthcare services available to them around Newcastle municipality. External factors emulating the accessibility to the healthcare facilities and socio-cultural influences on women migrants accessing healthcare facilities and examining challenges encountered by women migrants in accessing health care were raised. Internal factors emulating the working hours, employee wellness programs, flexibility of accessing healthcare services, moral support, etc were reviewed. Physical activities being individual lifestyles, behaviour; Individual empowerment seeking to consider any form of support from either employer or facility providing service. These were the responses from the respondents when asked how often they visit the local healthcare facility:

Thantazile responded: *"I was one of the employees who were found locked at one of the factories although is closed now. We were taken to Madadeni Thuthuzela Care Centre for examination and later deported to our countries. I was taken to Swaziland through the Oshoek border gate"*.

Selloane replied: *"When I visit a clinic is to collect my medical treatment and family planning"*.

Malefu answered: *"I last visited the clinic when I was pregnant. It has been now about six months without me visiting a local clinic"*.

Mahlatse retorted: *"I only visit the clinic when I am not feeling well"*.

Nomusa said: *"I don't visit health facilities, I prefer self-medication"*.

A few examples of hurdles include disability, lack of educational opportunities, subpar housing, membership in an ethnic minority, unemployment, age, and lack of transportation, while income poverty is the most frequently mentioned reason for social exclusion. There may be difficulties to differentiate between the causes, motivators, and effects of social exclusion

(Bradshaw et al., 2004). Because they were in the nation illegally, women labour migrants had less opportunity to take advantage of resources that could have helped them because they had no educational possibilities open to them for growth. The employer took that advantage of exploiting them whilst maximizing on profits and paying them less money without also putting policies in place to promote their health and well-being. Women migrant labourers might also find themselves lacking access to basic services.

5.5 Exploring socio-cultural influences on women migrants accessing healthcare services.

The study focused on the social and cultural factors that affect how easily immigrant women can receive medical treatment. The participants in the interviews were able to discuss the potential impact that culture might have on various forms of health-seeking behaviour. According to Gushulak and MacPherson (2000), it is critical to take into account any disparities existing between migrants and the place of residing in the country, not limited to social upbringing, dialect, age, socio-economic level, and financial conditions. However, determining these differences is very difficult, as many migrant groups are invisible in standard data collections.

Amongst those interviewed were those who expressed that they always consult with health facilities for variety of reasons such as family planning, and collection of their chronic medication. A pattern amongst these participants was that all of them were educated enough to know the benefits of health-seeking behaviour. However, those with lower grades were not willing to visit a health facility as some argued that they did not believe in western medication whilst some did not necessarily have the confidence in visiting a healthcare facility and rely on self-medicating. Below are some of the responses provided:

How does your socio-cultural aspect determine usage of healthcare services?

Malefu attested: *“My grandmother who raised me never wanted us to use contraceptives she will say we either give the children to her than to use family planning methods”*. What impact does your culture have in accessing healthcare services? She added: *“It has resulted in me having unplanned pregnancies”*.

How does your socio-cultural aspect determine usage of healthcare services?

Mofeng opined: *“I don’t think my culture influences the usage of the clinic, I am able to access family planning services although the queue is very long and antenatal care for my last born.*

It's just that the local clinics are always full, it's better when you go to town at Pro-clinic. What I can't do is aborting my child. What impact does your culture have in accessing healthcare services? She added: *"I don't really rely on culture in accessing healthcare services. I just do what works for me".*

How does your sociocultural aspect determine usage of healthcare services?

Matshediso pronounced: *"I don't think my culture influences the usage of the clinic, I am able to access family planning services although the queue is very long and antenatal care for my last born. It's just that the local clinics are always full, it's better if you go to town at Pro-clinic. What I can't do is aborting my child".* What impact does your culture have in accessing healthcare services? She added: *"I don't really rely on culture in accessing healthcare services. I just do what works for me".*

How does your sociocultural aspect determine usage of healthcare services?

Lekeledi answered: *"I don't think my culture influences the usage of the clinic, I am able to access family planning services although the queue is very long and antenatal care for my last born. It's just that the local clinics are always full, it's better if you go to town at Pro-clinic. However, I also take the child for cultural practices.*

According to a study by Ejike (2017), the culture of migrants makes it difficult for people to ask for assistance. The researcher who studied the cultural influences on health service and its uses, among these migrants, noticed that these migrants' decisions about how to use healthcare services were influenced by their social and cultural origins. According to Leclerc, Jensen, and Biddlecom (1994), cultural disparities in disease, help-seeking behaviour as well as a lack of knowledge were the main factors limiting the use of professional healthcare. The behaviour of women labour migrants regarding access to health care and lifestyle may as well results in increase in morbidity due to differences in disease prevalence, for instance, they were working with garments which accumulate dust, but they did not have personal protective clothing like n95 masks etc. Physical and psychologically effects of relocation, and the adaptation to new social and physical environments may as well result in poor health outcomes for women labour migrants. Moreover, given the conditions they migrate under, the social living was mostly poor conditions with considerable economic barriers relative to access and utilization of medical care as some had to travel to Pro-Clinic for efficient healthcare support during antenatal care.

Individual perceptions and attitudes towards choices are at most informed by their way of life, environment, cultural background and at most the circumstances they find themselves in. The researcher has identified that amongst the respondents were those who understood their role and capability of acting as an influence of change to their own health. Hence among the participants were those who were taking ARV treatment consistently and adhering and there were those who were able to access family planning services. The researcher had also noted that positive health behavioural patterns were mostly common among those who could speak a bit of the local language and amongst those who have studied until grade 11. One may also argue that their behaviour may as well have been informed by the amount of knowledge they had from school and the ability to read.

The set of women labour migrants who stay within the Newcastle isolate themselves from the community in most cases, hence it is difficult for them to easily socialize within the society. There is a group amongst the participants who had at some point been held hostage by the employer, provided them with food and working abnormal hours until they were rescued by the local municipality, SAPS and Home Affairs and later deported although they returned given that they saw opportunities this side of Newcastle compared to their places of birth. This is more explained by the social exclusion theory as it indicates that there are barriers that block some people from fully taking part in society or from enjoying a reasonable living level. For instance, monetary poverty is one of the inhibiting factors mentioned by the social exclusion theory. Therefore, this theory emphasizes on ensuring social policy development specifically formulated to include and address migrants' challenges.

This has been clear in the study that the work environment, ethnicity and socialization status of women labour migrants subjected them to isolation which resulted in inadequate allocation of health services/attention given by health officials as this might not be an area of great concerns. Whilst culture adaptation may have improved the ability to make informed decision about health choices, this may as well be the results of women labour migrants who are economic deprived of opportunities from their countries of origin. Whilst geographically isolated as they hardly interact with the community due to ethnicity differences.

5.5.1 Cultural patterns in health-seeking behaviours

When trying to access healthcare services in the US, immigrants face higher linguistic and cultural difficulties. According to Fenta et al. (2007), immigrants frequently encounter numerous hurdles to care or receive medical attention that is not acceptable for their culture. In

addition, due to differences in how disease is seen across cultures, how people seek out healthcare, and how accessible services are, the resultant use of healthcare services is also constrained. Language barriers were the most prevalent type in this study, which is significant when considering the difficulties faced by these female labour migrants. As a result, there is a need to comprehend how different cultural perspectives affect how people use healthcare services in order to improve service delivery, cost, accessibility, and life outcomes, such as morbidity and death rates.

Research frequently ignores the influence of cultural variables on the health condition and use of health services among female labour migrants. Further research on the influence of culture on these migrants' health would help practitioners, policymakers, and service providers create programs and services that are more accessible, appropriate, and acceptable from a cultural perspective (Lai & Surood, 2008). Ivanov and Buck (2002) contend that the policy pertaining to refugees and migrants should take into account the difficulties that various migrant groups have in obtaining health services.

According to past study, acculturation and a person's education level have an impact on how they utilize health services. However, other academics contend that acculturation levels are erratic indicators of the use of healthcare services (Ivanov & Buck, 2002). On how refugees use healthcare, there is a dearth of empirical research. Ivanov and Buck (2002) had earlier clarified that, however, the few studies that have concentrated on the usage of healthcare services emphasized on how crucial it is to deliver culturally competent healthcare in order to enhance health outcomes.

To better administer healthcare services to people from different cultures, healthcare providers must therefore determine both healthy and unhealthy behaviours as defined by the interested refugee culture. There is also a ton of information showing that immigrants frequently suffer numerous hurdles to care or obtain care that is culturally incorrect. Additionally, research regarding health services consumption similarities has shown that, in comparison to the general population, ethno-visible minorities are less likely to use health services and experience more access challenges (Lai & Surood, 2008).

Although amongst the respondents with higher educational background the visits to healthcare services were consistent this might have been to the fact that they understood the benefits and the need to access such services regardless of the anticipated challenges like language barrier, cultural sensitivity, etc. It is also noted in this study that women labour migrants with lower

levels of education neither used healthcare facilities nor relied on self-medicating until they will return home and consult there. Whilst there were also those who did not believe in western medication and utilization of healthcare facilities. Below are responses captured from women labour migrants regarding the influence culture has concerning their health lifestyle.

How does your socio-cultural aspect determine usage of healthcare services?

Malefu responded: *“My grandmother who raised me never wanted us to use contraceptives, she would say we either give the children to her than to use family planning methods”*. What impact does your culture have in accessing healthcare services? She added: *“It has resulted in me having unplanned pregnancies”*.

How does your socio-cultural aspect determine usage of healthcare services?

Mofeng answered: *“I don’t think my culture influences the usage of the clinic. I don’t use family planning because I need to have a son as a heir. What I can’t do is aborting my child”*. What impact does your culture have in accessing healthcare services? She answered: *“I know for me to be married I must bear a son as a heir. I think that is what makes me to continue trying to have children”*.

How does your socio-cultural aspect determine usage of healthcare services?

Busi replied: *“I don’t think my culture influences the usage of the clinic, I am able to access family planning services although the queue is very long and antenatal care for my last born. It’s just that the local clinics are always full, it’s better if you go to town at Pro-clinic. The cultural part when it must be done for the children it does happen. What impact does your culture have in accessing healthcare services? She added: “I don’t really rely on culture in accessing healthcare services. I just do what works for me”*.

How does your socio-cultural aspect determine usage of healthcare services?

Thantazile responded: *“When I feel sick, I rely on natural herbs. At home when growing up we were not much taken to clinic when we are not well because my mother and grandmother were traditional healers”*. What impact does your culture have in accessing healthcare services? She added: *“I don’t believe on western medication we treat ourselves when we are not feeling well”*.

Culture is a way of life, notwithstanding that it revolves over time. Although there is that significant part of culture that cannot holistically change over time. This may include the traditional medicine practices although it does no longer happen in a large scale. About 20 per

cent of the respondents preferred traditional medicine when not feeling well. This shows that although civilization has influenced the kind of health care to prefer, there is still some part of the population that relies on traditional medicine. How women labour migrants conducted themselves in relation to women health care significantly was an influence of culture. For example, Jabulile, responded that the reason she did not prefer family planning methods was because her husband wanted a heir hence they keep on trying for a male child although they had females. This shows the cultural significance of having a male child as it is believed that they remain the heir of the family whereas the females will be married to a new surname. Africans are culturally family oriented, hence even from the participants, majority were constantly visiting home to look after their families when they were paid their wages so as to provide for them.

According to studies by Mestheneos et al. (1999) and Dias et al. (2009), it is common for female immigrants to feel uneasy and even disrespected by the practice of some medical acts, such as receiving care from male doctors or being required to expose private body parts during clinical observation. This is because of the deeply ingrained conservatism and patriarchy in their countries of origin. Though it was less obvious in the case of women labour migrants, there was some resistance to attending local facilities for antenatal care; instead, some of them would choose to go home when they were ready to give birth.

5.6 Conclusion

The chapter discussed factors that influence healthcare needs for women labour migrants in the textile industry and their healthcare needs including psychosocial support. The chapter explored the knowledge of women labour migrants on healthcare services within the Newcastle municipality. Socio cultural influences on the utilization of healthcare services within the area had also been discussed within this chapter as well as cultural patterns in health-seeking behaviour for women labour migrants.

CHAPTER 6: CHALLENGES ENCOUNTERED BY WOMEN MIGRANTS IN ACCESSING HEALTHCARE SERVICES AND THEIR COPING STRATEGIES

6.1 Introduction

This chapter focuses on the challenges that female labour migrants must overcome in order to receive healthcare services and potential solutions. South Africa has passed additional legislation to ensure that labour migrants have access to legal health care, including free basic healthcare and free ART for both refugees and asylum seekers with or without a permit (NDoH, 2006). However, accessing healthcare and other services is difficult for refugees and those seeking asylum; protective policies have not evolved into protective practices (for example, see Preston-Whyte et al., 2006; Vearey, 2010; IOM, 2011; Moyo, 2010; Consortium for Refugees and Migrants in South Africa).

Furthermore, everyone has "access to healthcare services," according to the South African Constitution. According to the Constitution, "the state shall adopt reasonable legislative and other measures, within its resources, to effect the progressive realization of each of these rights." No one may, unequivocally, be denied emergency medical treatment, it adds. According to South African law and jurisprudence, all residents of South Africa, including migrants, are entitled to access health services. The right to access health services for all has been developed and given content by the South African Constitutional Court. According to the National Department of Health (NDoH), "refugees and asylum seekers with or without a permit should be assessed according to the current means (test) as applied to South African citizens when accessing public healthcare." Here are some of the difficulties the respondents experienced as the study sought to uncover the difficulties faced by female labour migrants inside the Newcastle textile sector.

The Migrant Rights Monitoring Project (MRMP) survey found that 30% of people who reported to medical facilities in need of care and needed assistance in doing so, had difficulties trying to obtain public healthcare services (n = 396). The most frequent difficulties include being treated unfairly by a nurse; language difficulties; being denied care due to issues with documentation; and being denied treatment due to "being a foreigner". The majority of foreign migrants without papers and asylum seekers had the highest likelihood of reporting difficulties (such as study and work permits). In metropolitan South Africa, refugees were the group that was least likely to experience difficulties when attempting to obtain public healthcare services.

The challenges experienced by women labour migrants are also affecting locals as they always complain of clinics being full and spending more time at the clinic. However, challenges relating to language barrier and some in relation to residential permits are only prone to the migrant workers.

Similarly, in cases of displacement due to conflict or flight from natural disasters, people are unprepared and ill-informed about how to reach a safer destination for themselves and their families. Women are particularly vulnerable to sexual violence during the journey, displacement or refugee camps, from militia, and hostile local populations as women and girls go about their roles in fetching water, firewood collection or small market commerce. Illegal labour migrants usually try to remain invisible to escape deportation, so in this sense men may be at a disadvantage in that they tend to work in more visible sectors. As seen in the study where women labour migrants were kept inside the factory so that they avoid being seen to eliminate chances of being deported as per their employer accounts to such events.

Although individual capability level may inform his/her choices on access to healthcare services challenges such as stigma and low self-esteem, poor advocate of individual rights may influence his/her ability to seek medical care. This affects an individual's ability to act as an agent of change of own health. For instance, condoms outlets are mostly in public busy places, if one is staying in a place that has not been identified as a condom outlet, she may feel scared to approach such places and collect condoms as she may feel intimidated as she is not a local. The approach by any health official determines whether the person receiving the service may return in future or not. As in the case of women labour migrants, the most fear is being discriminated and deported/arrested. This may be a relief if the employer was to source some health services from local facilities such as condoms or screenings so that they may easily be accessible to the employees.

The economic status of the women labour migrants may have played a part in them being able to access healthcare services without being discriminated or fearing to be deported. If they could afford a private medical-care services or had a medical aid, this could encourage them to seek medical care whenever they feel without fear of discrimination. The treatment of patients in public and private healthcare facilities is different. There is more of a business sense in private health facilities as they rely on the user payer principle than government facilities that are subsidised for everything hence the clientele treatment is poor. The work environment, ethnicity and socialization status of women labour migrants may also subject them to isolation

which may result in inadequate allocation of health services/attention given by health officials as it is not viewed as an area of great concerns.

The geographical set up women labour migrants find themselves staying at compels them to mostly isolate themselves from the locals. They hardly interact with community due to ethnicity differences as they are either from Lesotho, Botswana or Swaziland. Healthcare services are an integral part of women's health, this has been evident in the study that it influenced participants' utilization and choices of access to healthcare services.

Migrants may leave their villages in the hope of finding a better life, but they rarely do, especially if they have HIV or become infected with it. According to UNAIDS (2014), Africa is a home to roughly 66 per cent of the world's AIDS cases but only 1.3 per cent of the worldwide healthcare personnel. Migrants may have a very difficult time getting the medical care and treatment they need since they are cut off from their home communities, frequently face linguistic, cultural, and even xenophobic difficulties. Foreign nationals who work illegally in a new nation will have no or very restricted access to medical care.

It will be challenging for everyone to get care, including those who are employed lawfully. On farms, mines, or construction sites, migrants frequently work in solitary conditions with little access to medical amenities. A lot of other migrant employment, including formal or contracted ones, do not cover doctor's visits or even the most basic care, despite recent improvements in health care from South African mining firms. Men with money, few leisure alternatives, and a lack of family ties may engage in unsafe sex, which makes migrant work frequently a favourable environment for the spread of illness. According to an IOM investigation, the risks of contracting HIV surpassed the feelings of despondency that are stressful, high-risk jobs caused among migrant farm workers on the border between South Africa and Mozambique. When forced to barter sex for visas or licenses to cross borders, female migrants may be exposed to the greatest hazards while in transit. Unfortunately, very few programs and regulations focus on the unique demands of mobile employees. However, one IOM initiative provides both education and care to farm workers in South Africa.

6.2 Facility-level policy decisions

One major issue is that some public health facilities have been found to create their own rules and regulations that go against national law, and they nevertheless require South African identity cards and refuse admission to international migrants (CoRMSA, 2009; Vearey, 2008a). Another issue is that many foreign labour migrants with lesser levels of education are unable

to obtain the requisite papers to enter South Africa legally because of the country's restrictive immigration laws and the way they are being implemented (Landau ; 2008, et.al).

In addition, all foreign migrants, including refugees and asylum seekers, have difficulty obtaining documentation through the Department of Home Affairs (Landau, 2011). They appear to be treated with disrespect when it comes to respecting their access to healthcare services, just like in the case of female labour migrants in the Newcastle area. This can be determined by their communication style and demeanor towards them. The researcher made a note during the interview that during some of the consultations, women labour migrants' rights to fair access to healthcare services were violated.

6.2.1 Language barriers

There are issues with the language. Communication can be challenging when cross-border migrants do not speak the same language as their native country people. Furthermore, some cross-border migrants disguise themselves as South Africans and do not know any of the local languages, according to healthcare professionals. Because of this, language is frequently used to identify those who belong and those who do not. Migrants are portrayed as outsiders from the very beginning of their interactions. Forged paperwork and false identities notwithstanding the fact that the law does not need the existence of documentation in order to give care, front line staff nonetheless need documentation to identify the patient (CoRMSA, 2009; Vearey, 2008a). Due to their ignorance of the law, undocumented immigrants may utilize phony identification documents (Moyo, 2010). The connection between healthcare professionals and cross-border migrants is then framed in shock and terror, which causes a number of issues (Moyo, 2010). Lekeledi had this to say about language barrier:

“Language is a barrier as I relied on English which I also struggle with. I don’t like it that when you are at the clinic they will ask if you have an ID. I worry that they might report us to be deported. When I went for the rape incidence, they reported the matter to the police, the perpetrator told me that Police will deport me then I decided not to return to the clinic and to change address”.

Grace: *“I don’t like going to the clinic because they are mean, the fact that I cannot speak the isiZulu and English they will make you feel like you are less human. I went there once, everybody working at the clinic was called to try and hear what I was saying, and I could see that they were making fun of me like it was for the first time they hear a person speaking*

Tswana. I couldn't hear a thing what they were saying to me. This is after I was raped on my way to Newcastle”.

Language had been a hindrance for some women labour migrants in accessing desired health service from local facilities around Newcastle area. Although for some who could at least hear and understand the local language could tolerate the painful experience that narrated to be encountered at the healthcare facility that they could not speak or hear proper the local language or either English, this they said would result in them asking the same questions more than once or asking for it the same information to be repeated more than once, hence resulting in the healthcare service provider being irritated or giving them an attitude. This as well resulted in some deciding not to consult, only to attend health care when it was an emergency or preferring self-medicating or returning back home for treatment care. Culturally, the Southern African countries where women labour migrants in this study originated from are respectful nations, women still strive under a heavy patriarchal system, their attitude towards someone mean to them will always be retreating and maintaining the level of respect or one may say level of shyness.

All the interviewed participants did not know that accessing healthcare service was their basic human right. Some felt uncomfortable seeking healthcare services within the area due to language barriers and for some it was due to their socio-cultural beliefs and lifestyle choices. They were those women labour migrants who constantly visited healthcare facilities for mainly family planning, antenatal care and some for collection of chronic treatment. However, this was more common with women labour migrants that were able to speak English especially those who had studied until grade 11 and also amongst those who could speak and hear a bit of Zulu language.

Ntswaki is from Botswana, she said: *“I attended school until grade 9, challenges I encountered at Madadeni Crisis Centre (Thuthuzela Care Centre) was language barrier as I relied on English language which I also struggle with. I didn't like that when you are at the clinic they will ask if you have an ID. I worry that they might report me to be deported. But I do go after every two months to collect my treatment. When I went for the rape incidence, they reported the matter to the police, I was then told by co-workers that Police will deport me then I decided not to return to the clinic and to change address, I now use section 3 Clinic”.*

Pontso said: *“Challenges I encounter at the clinic are long queues, the bad attitude from the staff, language has not been a barrier as such since I speak English and can speak a bit of Zulu and I understand it”*.

Dimakatso said, *“I visit pro clinic to collect my ARVs treatment and for family planning. I can speak English and understand a bit of Zulu although I struggle a bit but am learning. The long queues are tiring and bad staff attitudes”*.

6.2.2 Negative attitude of healthcare workers

In other cases, the staff's workload, a lack of materials and human resources, and the providers' negative attitudes toward cross-border migrants serve to further exacerbate this problem (Moyo, 2010). There is a belief that the "local" population should be given preference in a situation with scarce resources. In addition, senior healthcare managers and professionals openly criticize migrants in some healthcare facilities in Johannesburg. If interrogated about their work with migrant clients, they may do this out loud in front of those clients as well. This sends the message that "It is OK to mistreat cross-border migrants," which sets a bad precedent for the entire health system. Additionally, it has been stated that frontline healthcare workers, such as receptionists and clerks, determine whether a cross-border migrant qualifies to receive healthcare based on their own assessment of the severity of the health issue (for example, see Moyo, 2010). This was especially apparent when female labour migrants who worked in the textile sector attempted to get medical care at the nearby medical institutions. Below are a few experiences highlighted.

Siphiwe said: *“The receptionist will give you an attitude after asking you to give her your identity number or card after realizing that you don't have, even the nurses after checking your file and realize that you don't have an ID number or place of origin is outside South Africa they will start mentioning how you are wasting taxpayer money and increasing the capacity of the facility and even mentioning that we also stop taking ARV treatments without informing them and disappear”*.

An attitude of a health care provider plays a huge role on the consistence utilization of healthcare services, and if the attitude does not encourage the patients to visit facility for consultations it affects individual capability in making the right choices for their health. The attitudes of healthcare providers towards women labour migrants in accessing healthcare services impacted on their decision for continuous seeking of healthcare services when in need.

This may result in perpetuation of morbidity and mortality within the Newcastle area considering their sexual lifestyles.

International migrants still face many obstacles when trying to access public health services in South Africa, despite the recently developed protective policy guidelines and frameworks. This is because protective policy has not been effectively translated into protective practices (Amon & Todrys, 2009; CoRMSA, 2009; Human Rights Watch, 2009a, 2009b; Landau, 2006b; Pursell, 2004; Vearey, 2008a). "One must also acknowledge how little public policy has an impact on daily life. State policy of any kind is unlikely to have the desired consequences, whatever they may be, with insufficient implementation capacity and widespread corruption among borders and police officers (Landau & Wa Kabwe-Segatti, 2009: 2).

In place of worries about citizenship, legitimacy, entitlement, and a healthcare system with limited resources, the public health justification for providing healthcare to foreign migrant populations is frequently disregarded (Amon & Todrys, 2008; Grove & Zwi, 2006; Harper & Raman, 2008; McNeill, 2003; Worth, 2006). The public healthcare system in South Africa offers free primary healthcare (PHC) at the point of use, however there are various limitations with regard to defining geographic limits and governance responsibilities that have impacted the equitable delivery of PHC services (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009).

Through this study the researcher has identify that women labour migrants in the Newcastle textile industry encounter variety of challenges regarding access to public healthcare services. Overcrowding was one of the challenges highlighted, this had led to patients in need of health services resorting to travel to a distant facility in order to access quick and efficient health care. This has been more prevalent in the cases of antenatal care service where pregnant women labour migrants preferred Pro-hospital in town than local clinics. The other challenge raised was the communication barrier as some of the women labour migrants could not speak either English or any of the local languages.

Moreover, there was a fear of deportation since in the health facility they would need one's ID number or asylum documents for administration. However, for those women labour migrants who could communicate in local languages they were able to access desired healthcare services, although there was a challenge of long queues resulting in them to choose between work and access to health care since in their work environment, there were no sick or annual leaves. The researcher probed if there were any incidences where any of the women labour

migrants within the textile industry was deported after visiting healthcare facility, they acknowledged that there was no one that they knew of, it was just their fear. This may as well be the result that none of them had ever given birth within the local health facility, they rather prefer going back home as soon as they are due. Some of the participants managed to access their ART treatment within the local facility although they ended up missing their appointments as they travel back home, and some end up prolonging their stay and scared to return back to the facility to collect their packages.

Those with lower grades at most, did not attempt to visit healthcare facilities. Women labour migrants within the industry are still exposed to modern day slavery. In an article by the Mercury newspaper dated 20 February 2019 quoted, “The South African Clothing and Textile Workers Union (SACTWU) says the discovery of 100 foreigners working in conditions resembling “modern-day slavery”, at textile factories in Newcastle yesterday, was nothing new as the union has been battling against the scourge for more than a decade. KwaZulu-Natal Economic Development MEC Sihle Zikalala made the discovery yesterday during his department’s operation to check whether businesses were complying with regulations”.

Lekeledi is from Lesotho, she said: *“I have never visited any health facilities around Madadeni, I prefer self-medication if I feel worse, I normally go back home. My friend told me about the long queues, the bad attitude from the staff, language barrier since I can’t speak English and Zulu languages”.*

Mahlatse who is 32 years old from Botswana said: *“I went to the clinic when we were rescued by police in a factory. We were assumed, kept against our own will, that’s when also our identities and entrance were questioned. We ended up being deported. I could make sense of words in isiZulu and English during the consultations. Nothing much happened except clinical physical assessment. We were then deported although I returned after a few weeks. When I feel sick, I rely on natural herbs. At home when growing up, we were not much taken to clinic when we are not well because my mother and grandmother were both the traditional healers. I don’t visit local clinics”.*

Grace from Botswana said: *“I only went to the clinic ones when I was raped. I couldn’t hear well what they were saying I only hear Sotho and a bit of Zulu. My friend told me that when you are at the clinic they will ask if you have an ID. I worry that they might report us to be deported. When I went for the rape incidence, they reported the matter to the police and the*

perpetrator told me that Police will deport me then I decided not to return to the clinic and to change address. I prefer using clinics at home. When I am very sick, I go home”.

In 2016, more than 80 women labour migrants were also rescued and referred to Madadeni Thuthuzela Care Center for medical checkups before arrangements for deportation. This has been now a syndicate to extort cheap labour from vulnerable population given their economic circumstances. In the above-mentioned case, ever since they arrived in the factory, they had never been to any healthcare facility for medical checkups or chronic medication collection. One of the victims the researcher spoke to indicated that they were held under false pretense that if they were to stay out of the factory they would be locked up and charged as criminals as they were in the country illegal. That was the ‘modus operandi’ used against this vulnerable women labour migrants. When recruited, they are given hope that their economic situation will change as they will also be able to support their families, only to realize that they would not even have access to basic healthcare services. These were cases of criminal injury and human trafficking. Thoko from Swaziland (Kingdom of Eswatini) said: *“I went to the clinic when we were rescued by police in a factory. We were assumed, kept against our own will, that’s when also our identities and entrance were questioned. We ended up being deported. I don’t believe on western medication, we treat ourselves when we are not feeling well. I don’t visit the clinic at all”.*

Mahlatse who is 32 years old from Botswana said: *“I went to the clinic when we were rescued by police in a factory. We were assumed, kept against our own will, that’s when also our identities and entrance were questioned. We ended up being deported”.*

The respondents for this study were all women labour migrants between the ages of 28 and 34, thus reflecting on the desire to improve their lives through employment opportunities and independence. The highest grade attained by the respondents has been ‘form 4’ known as ‘grade 11’ and the lowest being ‘standard 4’ known as ‘grade 6’ both in the South African education system. They have a minimum of two children and a maximum of four. One could argue that their lack of information and ignorance may have been a result of them having more children hence now they find themselves having to work in such kind of environments. Their educational background may also have influence on the use of the healthcare center. This statement can be supported by the fact that not all the interviewed respondents happened to know or wished to use the family planning methods although the accessibility has also been

not much. There were only a few cases where culture had an influence in them giving birth to more children as they were trying to have a heir.

Out of the 35 interviewed respondents, 9 never visited the clinic for any service, when they are not well, they would rather return home to their nearest clinic. Six visited healthcare center for antenatal care and a total of 20 respondents visited the health center for variety of healthcare services. Commonality with those who visited the health center is that they mostly have a maximum of two children thus attributing to the proper usage of family planning. Mostly ended in grade 11, this could also have influenced their lifestyle choices. It is noted that most of them, their socialization skills were a bit improved and being able to understand the local language. However, with the respondents who struggle with understanding of local language, the socialization was restricted to their colleagues and home girls. All of the respondents were not attending any socialization group including a church. This could also reflect their socialization skills and struggling with the sense of belonging.

During the conduction of the study the researcher observed that the data had a portion of women labour migrants who visited the facility for Antenatal care and in most cases those participants who visited the health facility would all prefer a health facility in town by the name of Pro clinic where they argued that the service was more efficient and the facility was not always packed compared to local facilities closer to place of their work or where they resided. This was 6 of the participants of 35. This demonstrated the individual ability to take care of their own health as outlined by the health capability approach. If one could further consider that these women labour migrants could consider spending on transport to a health facility in town one could understand how they valued the healthcare services for their unborn babies.

Twenty of the respondents visited the local healthcare facilities for family planning, collection of chronic treatment, etc. They were provided with the services although they were arguing that the facilities were fully packed, they would spend almost the whole day queuing for the services. This has also been confirmed by the Department of Health, hence the introduction of the universal healthcare coverage system. This had also illustrated the women labour migrants' desire to take care of their own health and ensuring that they correctly take their chronic treatment and access services like family planning. Although a portion of them would not consider using a female condom and mostly were also not empowered to negotiate the use of a condom with their sexual partners, given their gender powers. This may have also been contributed by the fact that their own status as migrants had made them vulnerable and

worsened by the fact that they also had no work permits, refugee or asylum documentations. Interesting also is that they were health conscious, meaning they knew the impact of unhealthy behaviour practice and most of them were exposed to higher education with minimum having standard 8 (grade 10) and they were having at the most, a maximum of two children.

The last identified category was of those participants who preferred not to visit local healthcare facilities. This total to nine participants. They would rather go over the counter when they were not feeling well or to go back home so as to visit their healthcare centres. This was attributed to the fact that some were scared of being deported and some had language barriers. Amongst them were also those whose beliefs were against the usage of western medicines. Interestingly, all of them had a minimum of three children and their education ended at a lower primary level. They were not health conscious, not using any family planning services or visiting healthcare facilities for other services. They would prefer buying medication over the counter when they had headache or stomachache rather than visiting a healthcare facility. The need for them to visit a healthcare facility back home was when they were not feeling well. This indicates a lack of health awareness and self-empowerment.

6.3 The external factors

As argued by Sen (1993), the external factors emulated from accessibility to the healthcare facilities, socio-cultural influences on women migrants accessing healthcare facilities and examination challenges encountered by women migrants in accessing health care. Internal emulated from the hours, employee wellness programs, flexibility of accessing healthcare services, moral support, etc. The physical activities they focused on were the individual lifestyles, behaviour; and individual empowerment willingness to consider any form of support from either employer or facility providing service. Participants when asked how socio-cultural determined their usage of healthcare services and what impact does it have on them accessing health services etc., they responded as below. The researcher decided to pick one common from those who attended health facility mostly for antenatal care; those who attended healthcare facility for chronic treatment and family planning; and those who did not attend healthcare facilities because they preferred buying medication over the counter and returning home for healthcare services.

The study had identified that respondents who visited the healthcare centers for antenatal care did not associate their lifestyle choices with culture, even when the researcher further probed their lifestyle choices, they were at most responding to their individual needs. However, what

was commonly raised among those who were not visiting healthcare facilities within the area/country of work and those who visited healthcare facilities were the unresponsiveness of their working condition and environments towards healthcare needs. Noted they did not have face mask covers to block the dust, not having access to condoms in the workplace and there were no employee wellness programs. In cases where one might have attended healthcare facilities, they would not be paid for that day or they would literally abscond.

The researcher also noted that respondents with lower education were still cultural conscious as one can see with 'Jabulile' who was persistent in trying to bear a son so that he can serve as a family heir. This is supported by the health capability approach that individual external factors might have influence towards their health behaviour as one could attest with the conditions the women labour migrants in the textile industry were exposed to.

6.4 Coping strategies, various aspects of livelihoods capital and how they influence women labour migrants coping and adaptation mechanism

The Six Livelihood Capitals

According to the Red Cross Annual Report (2011), livelihoods are made up of the capabilities, livelihood capitals, and activities needed to earn an income and be able to earn a long-term livelihood. Sustainable livelihoods refer to people's ability to earn and maintain their livelihoods and improve their own well-being, as well as those of future generations (Krantz, 2001). A viable livelihood is supposed to make people cope and bounce back from shocks and stress. Six capitals, namely human, economic, social, physical, cultural and political capitals, represent the livelihoods that people need to have access to. In this study, the six capitals will be discussed intensively.

6.4.1 The livelihood capitals of coping and adaptation of migrant women

The livelihood capitals are useful in the explanation of the coping and adaptation of migrant women in the host countries. According to Bebbington (1999), the community capital strengths should be analysed to ascertain how they may be converted into positive livelihood outcomes in preparation for specific disasters. According to Chambers and Conway (1992), it is critical to assess the people's levels of resilience by measuring their capital strengths. Livelihood capitals are the core of the livelihood analysis and in this instance the livelihood capital factors (resilience) will be derived from the livelihood capitals. It is imperative to look at the coping and adaptation mechanism for migrant women by applying the livelihood capitals, according

to Chambers and Conway (1992) and Flora et al. (2004), as grouped into six categories, namely human, economic, social, physical, political and cultural livelihood capitals.

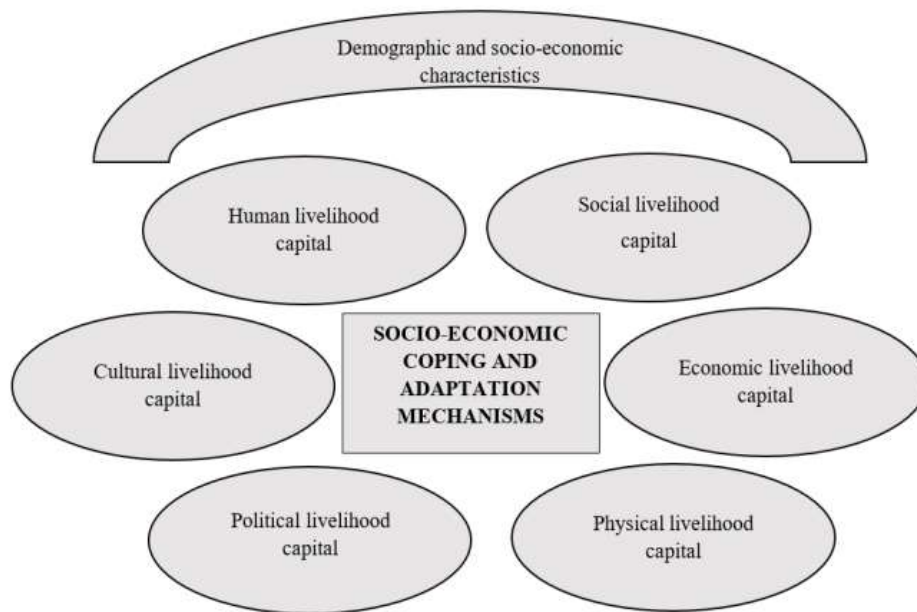


Figure 6. 1: Livelihood capitals framework

In an ideal situation, all people need to have adequate capitals in order to live a life they desire. They need all the livelihood capitals in order for them to be resilient in the face of any disasters or hazards (Sen, 1984). Figure 6.1 above represents the availability of all the capitals to the people depicting a zero vulnerability so that people can withstand any hazardous situations that may befall them. However, this is not usually the case considering that not all people in this world have access to a complete basket of resources to live the life they desire (Sen, 1984). People try and balance the resources that are at their disposal. In other instances, they go without many things they dream about just to survive or consider the opportunity cost of having one capital at the expense of others (Igoe, 2006). Women labour migrants interviewed had a survival mechanism so as to remain in the area and work to be able to send money home. Most of the interviewed participants shared accommodation with some accommodated within their workstations. This enables them to survive and being able to support those remaining behind at their home countries. Siziwe shared her experience of coping and adapting in Newcastle.

Siziwe said: *“On arrival in the Newcastle area, I have been staying within the factory as there are dormitories that we are allowed to stay in, this helps in being able to save money for*

sending those remaining at home as accommodation is expensive and at least here your safety is better guaranteed”.

In the case of this study women labour migrants were able to utilize available accommodation to save on money for rents whilst ascertaining their security given their level of vulnerability as they were undocumented labour migrants as such they could easily be exploited. This enables them to socialize amongst themselves and build strong networks for protection, dependency and support for each other.

6.4.2 Human capital

According to Loomis and Rodriguez (2009), human capital is described as the knowledge, skills, capabilities and qualities in individuals that enable the formation of personal, social, and economic well-being of the individual. Human capital is the most important capital in enhancing resilience as all the other capitals depend on it (Becker, 2009). Promotion of human capital is essential for the maximisation of the other capitals (Goodwin, 2003). People with different capitals can combine them and be able to live a life they desire (Sen, 1984). Examples of human capitals that are the backbone of people’s livelihoods, include but are not limited to skills, knowledge, experience, good health and ability to labour (DFID, 2000).

Women labour migrants who had experience in working in the textile industry had easier chances in securing a job; advantageously they were those with skills and able to communicate in English, this placed them at a better position than those without experience and skills of working within the sector. Experienced women labour migrants within the textile industry had an advantage as their wages were more in comparison to those without experience.

Selloane said: *“When I started working here I had a bit of experience working in the textile industry. I think the fact that I can hear a bit of English has assisted me in getting the job of the supervisor. I had worked for two months and the boss started noticing me. He used to give me instructions to tell the team. The following month he announced that I was a team leader, I was very excited because he added some few bucks on what I was already earning. This was an achievement for me. I remember I even called home to share the good news”.*

a) Education as a human capital factor

One human capital that has been proven to be necessary in people’s prosperity is the education level of the population (Bergheim, 2006). It is also stated that education is the key engine of growth in any society (Almendarez, 2013). Most successful economies such as India, China

and Malaysia have made heavy investments in education which is manifesting in the growth of their economies (Bergheim, 2006). The quality of education in any country has a bearing on the availability of skills needed in a country for development, as well as for individuals, with the skills to cope and adapt at any given time and place in the face of challenges.

The view that a strong educational base is vital for development, is supported by the studies carried out by Barro (1997) in India when it was discovered that the economic growth from the period 1960 to 1995 was positively related to secondary and higher levels of education.

The level of their education assisted in being able to enhance their knowledge in accessing healthcare services and communication as they would be regarded as mediators by the employer with some allocated a supervisory role within the factory. The desire to further their studies and acquire qualifications was demonstrated during the interview sessions. Southern African countries have a challenge when it comes to human capital development, especially the educational-driven aspect (Mills and Herbst, 2014). According to Ramdas (2009), in South Africa, this problem has escalated since the dawn of independence in 1994. Basically, when human capital in a community is poor, it will affect the livelihoods of the people, for example low education and limited skills will affect development and economic empowerment (Tilak, 2002). The identified human capital factors are education, health, knowledge and skills that are inherited or acquired through education and training, and the capacity to work.

Tsosane said: *“Being able to speak English helps in the textile industry because it is easier for you to become a team leader especially if you are the only one that the bosses speak with, you are automatically given the position of a team leader or supervisor. As I indicated that I do visit eMadadeni clinic for sexual reproductive health services, it is easier for me because when I go to the clinic, I am able to speak English as well although they respond in Zulu which at times, I can’t hear a thing. I assume what the nurse was saying, but I do sometimes meet good people at the clinic who are able to properly help me”.*

b) Health as a human capital factor

Human capital can also be accumulated not only in terms of educating individuals, but also through medical and public health advances. Access to health services is essential to building a sound human capital base. The health status of a person or a group of people should be improved to enhance the human capital of people. The life expectancy of people in a country, or community, availability of health facilities and incidences of diseases such as cancer, diabetes and HIV/Aids can be determinants of the level of the human capital of any society.

Other determinants are the proportion of the population that is covered by the public healthcare system (World Health Organization [WHO], 2008). A good example is the public health system of South Africa that many participants praised for its accessibility and affordability to them as well. However, there is a bit of attitude amongst health workers in providing health services for women labour migrants as they are perceived as draining the system.

It is worth noting that if the healthcare system neglects a certain segment of the population due to circumstances around documentations and profiling, the HIV/AIDS epidemic and other non-communicable diseases may never be overcome as per the National Developmental Plans vision. Through the study, it was noticeable that women labour migrants who frequently use the health facility either for collection of chronic medication or family planning, did not experience health complications or reported often not feeling well at work. If women labour migrants may not be provided with healthcare services, chances of them being unable to protect themselves and their partners would be high and this may result in more people being infected if the individual has been infected and is not on treatment.

Maseabata said: *“At school we learnt about reproductive health services and its benefits. Given that I already had a child. I have been constantly visiting the clinic at section 3 for family planning and other things. I don’t want to be infected with HIV/AIDS as I am involved in casual relationships”.*

c) Knowledge, skills and capacity to work

Working within the textile industry requires skills especially for those sewing and taking the measurements and cutting. Women labour migrants with experience migrated to Newcastle for work due to factor closures and economic hardship in their respective countries. The experience and skill set them at an advantage compared to their counterparts hence it was easier for them to be hired.

Siziwe said: *“I came here at Newcastle already having the experience of using sewing machine since I was working for the same employer at Eswatini. This as well makes it easier for me to get another job within the textile industry. We are rewarded better given that we are sewing as compared to those cutting and packing”.*

Through education and training, individuals acquire knowledge and skills (Alan, Altman and Roussel, 2008). According to the Global Agenda Council on Employment report (2014), skills are an essential necessity for businesses, countries and individuals as the imbalance in skills

may have an impact on development in any economy. Skills development is fundamental to improving productivity of individuals and, thus, productivity is imperative in improving living standards and the general well-being of people (ILO, 2008). It is, therefore, essential for the migrant women to possess some knowledge, skills and the capacity to work in the host countries in order to cope and adapt. Knowledge and skills can also be acquired through individual experiences. These skills result in individuals increasing their productivity, hence their capacity to work, as well as better coping and adaptation (Sidorkin, 2007). Highly productive individuals are preferred employees and also have better livelihood capacities than low productive employees.

6.4.3 Social capital

Social capital is defined as a measurement of community immaterial resources such as networks, cultural quests, trust, connections, and commitment to local well-being and shared morals and values (Beeton, 2006). Social capitals are social resources upon which people rely for their livelihood outcomes (DFID, 1999). With social capital, a community can be able to absorb shocks, exploit opportunities and positively look towards the future. Social capital facilitates the social cohesion and coordination of economic activities of people (Goodwin, 2003). Social capital enables individuals and groups to act collectively and can enhance coping and adaptation mechanisms of migrant women in host countries. The social livelihood capital factors consist of social resources, networks and connections, patronage, neighbours, reciprocity, kinship, relations, trustworthiness, formal and informal groups, leadership, collective representation, and sanctions and rules governing the people's cooperation and support (International Fund for Agricultural Development [IFAD], 2003; Kollmair and Gamper, 2002).

In host countries, migrant women can depend on one another for both material and moral support as this has been a case for the Newcastle textile industry women labour migrants. According to Drabek (2005) each of the above types of social capitals are important in times of disasters, need or mishaps. This is also supported by Thoko's experience:

"I shared accommodation with my home girl who was renting a backroom shack at section 3 on my arrival. Because it's someone I grew up with, we have been staying together and we are somehow related. This has helped me to adapt in the area since I joined her, she was already knowledgeable about the area and work environment".

a) Networks and relationships as components of social capital

In the immediate aftermath of Hurricane Mitch in Honduras, the town of Choluteca depended on its resilient family members and neighbours to deal with the disaster (Barrios, 2014). The only thing that makes most communities resilient in the face of adversity is cooperation and camaraderie among its members. Unity is another factor that helps to relieve the load on impacted community members. For instance, when a funeral is held in a community, some people may go from house to house collecting mealie meal and veggies and present them to the grieving family as a gesture of support (Mataranyika, 2010). Locals from the neighborhood will also help with the grave digging, water fetching, and firewood gathering.

Although women labour migrants were not at ease to integrate with the community, their social network amongst themselves assisted them in coping within the Newcastle area with some staying inside the factory whilst some had rented within a place called embodini with some staying at section 7. The desire and behaviour of an individual was as a result of the influence they got from the person who had influenced their decision to migrate in search for prospective employment. Network and connections had assisted women labour migrants who were able to reach out for healthcare services as some had routine checkups and felt a sense of belonging in the community.

Nqobile said: *“I have been working in this area for four years now. It has been easier for me to socialize since the church I attend at home Eswatini is also here in Newcastle, I have found sisters and brothers. I also don’t have a problem in visiting the clinic. I used to attend the clinic on a monthly basis, but now I only attend after three months for collection of my chronic medication and family planning”*.

Grace said: *“I spend most of my time with my home girl if I am not working. We only go out of the house when we are going to buy essentials. This helps in creating a sense of security amongst us as we are all immigrants”*.

b) Relations based on mutual respect and trust

The ability of people to work together and have faith in one another, as well as official and informal membership groups, can lead to mutual trust and agreement on matters that concern a specific community. Therefore, mutual agreements among a group of individuals can encourage cooperation, win favour, and provide unofficial safety nets (UNDP, 2014).

These social capitals are interconnected; for instance, belonging to a group or association can provide one with access to and influence over other institutions, fostering trust between those

of the same kinship or nationality (Williams and Durrance, 2008). These formal institutional mechanisms that control community relations are represented by these structures and processes. These institutions and procedures may enhance people's feeling of well-being by fostering their sense of identification and belonging, which results in the social capital that the individuals have (DFID, 2000). The social capital of the immigrant women will be what they use to strengthen their resilience, coping, and adjusting in the host country. The social capital factors are networks and connections, relations of trust, formal and informal groups and collective representation.

In the case of this study women labour migrants formed mutual support and relations with the person that had influenced them or assisted them with finding a place to stay and a job within the Newcastle textile industries and with few coworkers. They depend on each other for support and guidance as they easily associate with each other given their social status, this might have been informed by the guarantees of staying with each other as they always hope from one employer to the next.

Phindile said: *“I think because I am a good-looking lady and that I can hear a bit of Isizulu it has made it easier for me to find friends around whom I sometimes spend times with. I do visit the clinic for services. I don’t regret coming here. I do see some people I work with are struggling to cope here, as they are anti-social. I also do attend the local Zion church and am part of the choir”*.

One can also argue that within the same interaction circle women labour migrants were able to refer some of their colleagues to services like health care, shopping centers and better residential places (for those who had rented in informal settlements as places of residence), etc.

6.4.4 Economic capital

Economic capital, according to Carney (1998), refers to the financial resources that people and households have access to, such as savings, earnings, and incomes, lines of credit, remittances, and informal financial facilities that provide chances for the pursuit of various livelihood options. Economic capital aspects are seen to be the most flexible of all capitals since they can be employed to create any sort of capital or to support any essential way of life (Kollmair and Gamper, 2002). Even though it is crucial, economic capital is not always accessible to the less fortunate sections of society, migrant women included (Kollmair and Gamper, 2002). The indicators of economic capital are savings, earnings, incomes, and marriage.

The only source of economic capital women labour migrants relied on was the wages they received from their employer. Some women labour migrants would not return to their workplace given the nature of the job and the working environment as this could have not been what they have anticipated for when they were embarking on the journey, but the financial capital in a form of a wage remained a motivation for them to embark on the return journey.

Mokgadi said: *“Here the source of income I rely on is the wages I receive from the job I do. But I know with some they also do other plans to get extra money, like my home girl, she recruited me to be involved in Escort along the main drive corridor”.*

a) Savings/wages and incomes

Wealthy households can utilize ex-ante planning to protect themselves against obstacles by using savings as one risk-coping approach (Dercon, 2002). People who need money would turn to wealthy households during a disaster, while people with jobs make use of their income and wages. People who have insurance, file claims and begin to rely on insurance payouts to survive, while people who lack savings, are unemployed, or do not have insurance will begin to lose their tangible assets. As a result of these behaviours, the population becomes more susceptible to challenges in life, and migration emerges as a means of coping and adapting.

Through the study it has been evident that women labour migrants travelled to South Africa Newcastle textile industry in search for economic opportunities and survival. The survival means were for themselves and their dependants left back home. The nature of the work women labour migrants do, compels them to save money for at least two months for them to be able to visit their homes. The migration was propelled by the economic difficulties their countries have been through; the remittance served as a motivation.

b) Marriage

Marriage is categorized under the economic capital elements because, according to Becker (1974), who outlined two principles, the theory of preferences and the market in marriages concept, women may marry for financial gain. The majority of people, including migratory women, marry, and the selection of partners is based on money, education, and other characteristics, this is consistent across contexts, according to Becker (1974). Marriage is another coping and adaptation strategy used by migrant women in South Africa. In South Africa, many respondents said they viewed marriage as a coping and adaptation tool. A few interviewed women labour migrants were involved in casual relationship in hope for marriage

with some indicating that getting married can as well help them in accessing citizenship and be able to access many benefits.

Tanele said: *“I am involved in a relationship with someone around hoping that he will marry me and I can be able to obtain citizenship as well and have more opportunities to study and perhaps secure a better job”*.

c) Stokvels and burial societies

Stokvels are unofficial social groups formed by individuals with a shared bond, such as friends, family, neighbours, or coworkers, with the intention of jointly saving money over a set period of time (Moloi, 2011). Women labour migrants were members of stokvels and burial societies in their countries. In South Africa, the focus was on saving money and returning home and provide for dependants left behind. The stokvels they were involved in were with those whom they come from the same village, as mentioned it was on a month-to-month basis. This was a missed opportunity for them to empower each other on healthcare needs and access to healthcare services.

d) Credit facilities

Studies in Sub-Saharan Africa nations with middle- and low-income levels revealed that selling assets and borrowing money were some of the coping mechanisms used by communities. These tactics were chosen specifically to deal with unforeseen medical bills that required urgent care (Amendah, Buigut and Mohamed, 2014). In these situations, legal and informal loans of credit are employed, and migratory women use them to get by. However, migrant women do not have easy access to official credit loans.

6.4.5 Political capital

In a public setting, there are two ways to look at political capacity. A person's political capital may be either a quality or a resource (Bennister and Worthy, 2012). This is a reference to politicians who are able to mobilize people for their own goals and harness the power of their constituents. Bennister & Worthy (2012) as well argue that may also refers to the influence and connections that individuals have as a result of their interactions with politicians. Politicians use this tool when they need to persuade people to act in a certain way or when they want to help communities resolve contentious issues. Political capital, according to Bourdieu (1986), can be thought of as a substitute for social capital. The credit for this alternative social capital is given based on belief recognition. When viewed from the standpoint of the community,

political capital refers to the capacity of the citizens or community members to convert social capital into material advantages. Political capital, according to Syed and Whiteley (1997), is a type of social capital that operates vertically in the social order rather than horizontally and is also a product of relationships between the public and the government. Political capital affects a person's access to resources, ability to influence events, and perception on an individual level (Srensen and Torfing, 2007). Using the political resources and contacts at her/his disposal, a person with the capacity can use this capital to empower herself/himself. The following distinction was established by Srensen and Torfing (2007):

Political capital, on the other hand, refers to the individual political powers that are developed via involvement in interactive political processes. Social capital, on the other hand, refers to the trust-building through social interaction in civil society.

The political capital that underpins political power is fundamentally reliant on resources. Access to these resources is granted to those with political influence. By forming political ties with officials and leaders in their communities and elsewhere, individuals can amass political capital. Relationships with political leaders, political networks, encounters with politicians, and commercial ties to politicians make up the study's list of political capital variables. One has a probability of obtaining a better job if they have close personal ties to influential political figures since politicians "make things happen". Migrant women can use their political influence as individuals or as a collective by contacting various parties to ask for help for them to survive in their new countries. To effectively use their political capital in the host nations, migrant women must be aware of it (Bennister and Worthy, 2012).

According to Flora et al. (2004), not all members of a community may have access to political capital, making those who do feel excluded and giving rise to the "us versus them" mentality. The migratory women ought to be aware of or have a working knowledge of the political capital at their disposal. They may decide to do things "their way" if they feel excluded from the community as a result of being discriminated against because of their nationality. Losing political clout could make someone angry, frustrated, and lose faith in the government (Putnam, 1995). Social capital has a significant impact on political capital (Jacobs, 2007); it may be decreased if political capital is reduced. As an illustration, consider the American village of Louisiana, which was decimated by a storm (Czajkowski and Done, 2014). As a result of the community's mistrust of the government and sense of neglect, they had low political capital.

Links and networks with political authorities, both in the home and host nations, as well as economic relationships with politicians, fall under the category of political capital elements.

6.4.6 Cultural capital

Collective identity is referred to as cultural capital. People employ cultural capital to bring individuals together and mentor the next generation (Jacobs, 2007). It is also clear that cultural capital influences how people's lives, families, faith, histories, and ethnicities are shaped. Due to their improved understanding of one another under shared themes that can be honoured during festivals, this makes the people special (Jacobs, 2007). These persons may be culturally related because they were born from the same ethnic group. Daskon (2010) contends that culture can be effectively preserved, passed down, and utilized across generations to improve the chances, results, and viability of these people's lives. It has also been identified during the study that women labour migrants easily associated with individuals who shared the same culture. This is well visible during recruitment and socialization groups.

Conflicts in communities can result from cultural differences. Sometimes individuals choose to collaborate with those who share the same cultural backgrounds with them in order to achieve positive results (Guiso, Sapienza and Zingales, 2006). In this case, culture affects economic capital. When two different people live together who have different ancestries, histories, and aspirations, there may be a presence of cultural capital. New immigrants or a minority tribe can contribute to the cultural capital of a community if that community values diversity and coexistence (Jacobs, 2007). Women labour migrants who integrated with the community have a different experience to those who isolated themselves. For instance, the experience for women labour migrants who utilised healthcare services is different from the experience of those who have not utilised healthcare services, this can be argued on the frequency to access healthcare services. Finding out what kinds of cultural capital are present in a community helps to strengthen social bonds, promote harmony, and foster the future growth of community identity. Gender difficulties, conventional ideas, work ethics, and respect for authority are major cultural capital factors. Programs that promote access to healthcare services and educate the public about health care should be centered on culture.

6.4.7 The available livelihoods

Capitals can be seen as a community store with six facets, according to Jacobs (2007). Every single one of the six dimensions human, social, physical, economic, political, and cultural—exists inside the community's members at different levels. Depending on how the persons

decide to use them, the capacities, strengths, and degrees of these capitals can all be utilized. As these capitals have a tendency to affect one another, they are complimenting one another. It is necessary for people to use the capitals in their host countries in order to adapt and cope. To prevent morbidity, it is essential to use medical services as a way to promote healthy lifestyles and decisions. Women labour migrants who utilize healthcare services within Newcastle area did presents with inability to report to work due to health complications.

Tsosane said: *“I visit health clinic for sexual reproductive health services and whenever I am not well. This helps me in remaining healthy, I have not missed a day due to not feeling well the only time I did not report for duty is when I did not return home”*.

The SLF claims that even within the same context, communities or groups of individuals exhibit differences in the structure and size of their livelihood capitals. For instance, the migrant women might not have access to material resources when they arrive in the host nation. Although their physical and financial resources may be quite limited, local hospitals and clinics offered free medical care to female labour migrants, despite their low financial and physical resources. Some women also went to the Pro clinic for prenatal care. The examination of the various capitals will show how the capitals complement one another, and consequently, how the migrant women in South Africa are coping and adapting. According to Krantz (2001), it is important to evaluate how much access individuals have to these various capitals because their resilience levels will have an impact on how well they cope and adapt. Carney (1998) emphasized once more that people can take advantage of institutional frameworks since they have access to and control over capital. It is crucial to keep in mind that the same variables that can help migrant women adapt in the short term (their capitals, institutions, and policies) may also be those that limit their adaptation in the long term (Hugo, 2005). Such things may affect how they cope and adjust. In South Africa the constitution detects universal accessibility to health services for all people residing in the country regardless of migration status, these are some of the opportunities that some women labour migrants utilized.

6.5 Conclusion

The chapter discussed the challenges encountered by women labourers in accessing healthcare services. The focus is on the challenges experienced by women labour migrants at facility policy implementation level and the language barriers. Negative attitude of healthcare workers towards women labour migrants as well as external and internal factors influencing access to healthcare services were discussed. The study has also explored the coping mechanism for

women labour migrants focusing on various aspect of livelihood capital and how they influence women labour migrants' coping and adaptation mechanism and the livelihood capital factors.

CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

This work was an analytical study on women labour migrants' access to healthcare services, these women work in the textile industry. The study was located in Newcastle municipality KwaZulu-Natal province. Newcastle municipality has a significant history in textile industries. The municipality is boosted with a number of textile factories. Due to unregulated imports and illegal dumping of clothes from China and Indonesia, those factories' production has now been hindered. In cognizance of the healthcare needs, given the migration process and health care access, socio-cultural influence and knowledge relating to healthcare access within the area, the study was an intersectional analysis.

The literature reviewed revealed the depth of labour migration the in the global context, African context zooming into the South African context with focus on women labour migrants' access to healthcare services, influence of socio-cultural beliefs, and their knowledge on sexual reproductive health services with their experience in accessing healthcare service. Also, the migration phenomenon for women in the workplace focusing on migrants' experiences in the transnational space from an intersectional perspective was revealed. A literature gap has been identified regarding to women labour migrants. As more research has been conducted on the subject migration and the focus being on men only. A gap on a study relating to access to healthcare services for women labour migrants was identified, however, available literature mostly focused on the migration phenomenon. This study explored the individual influence of culture and health influence with further exploring the influence of education towards influence on lifestyle choices and decision making. Through the literature the subject on women labour migrants' access to healthcare services, their healthcare needs, experiences and cultural influence had a gap. Largely available literature had focused on the migration journey and challenges women labour migrants encounter. The focus of the study has been exploring the needs and access to health care by women labour migrants through the feminist intersectional perspective. In establishing the experiences of women labour migrants within the textile industry, the researcher employed the intersectional feminist approach for effectively exploring the healthcare needs and women labour migrants' experiences and accessing healthcare services and needs within the Newcastle area. Intersectionality Theory, which focuses on identifying the contrast amongst the groups associated with a given category, such as "racial" or gender groups, been primarily a worry with regard to the research of women, about, immigrants, and people of color (Wilkinson, 2003), even though evidence to diversity are

abundant in the Social and Health Sciences. Its roots are in African women's studies, which held that understanding Black women's lives solely from "race" or "gender" perspective was inadequate. However, the term "intersectionality" first appeared in Crenshaw's (1989, 1991) analysis of how "race" and "gender" intersect in relation to violence against women of colour.

In establishing the experiences of women labour migrants' healthcare needs, the study has employed the healthcare capability framework. The health capability framework is mostly understood as a comprehensive normative framework for assessing social structures and personal well-being, establishing policies, and making suggestions for societal change (Sen 1993). The researcher assesses the health capability at the individual level while looking at the experience of women labour migrants in the Newcastle area, determining the extent at which they may act as agents of their own health. This covers the areas of self-control, efficacy, and motivation to attain desired health goals in subjective health psychology. In order to maintain healthier and establish a regular way for practices and conditions to prevent, to the greatest extent possible, the onset of illness and mortality, one must act as an agent of one's own health. This involves learning and applying health information, knowledge, and skills. Individual activities, empowerment, multidimensional poverty, and an evaluation of social and health services are all taken into account in the research. The external elements that simulate the accessibility to medical services, socio-cultural influences on how easily women migrants may access medical facilities, and an examination of the difficulties that women migrants have in doing so are discussed. Internal modeling of working hours, wellness initiatives for employees, access to healthcare providers with flexibility, morale-boosting measures, and so on, were taken into consideration. Individual empowerment, wanting to consider any sort of support from either an employer or an institution offering service; and physical activities representing individual lifestyles were taken into account.

Extensively, the researcher had employed the social exclusion theory that focuses extensively on challenges that may prevent some people from fully participating in society or from enjoying a reasonable level of living (Social Exclusion Unit, 2003). Social exclusion is most frequently attributed to monetary poverty, although there are other factors that might cause someone to be excluded, such as a disability, poor educational opportunities, substandard housing, and membership in an ethnic minority, unemployment, old age, and poor transportation. The line between the causes, motivators, and effects of social exclusion is frequently blurry (Bradshaw et al., 2004). The researcher concluded that one of the inhibiting

factors for the women migrant labourers to access descent healthcare services is the lack of enough funds to pay for medical aid, since they do not earn much from their workplaces.

7.2 Summary of the study's findings

Background on women labour migration in the Newcastle area

The chapter presents the background on women labour migration in the Newcastle area. The chapter concentrates on the contextual background of women labour migrants in the Newcastle textile industries as well as factors influencing women labour migrants in the textile industry with focus on social networks, poor living conditions at destination, exploring violence, abuse and exploitation. Factors influencing women labour migrants moving to Newcastle area, and migrants' working conditions at the Newcastle textile industries are taken into consideration. Women labour migrants in the study's context already have working experience in the textile business, while others start out by helping with cleaning, packing, and other errands. Their only option was migrating to South Africa and work in the textile industries because their home economies and employment options are limited. To improve their lives and help their dependents back home, they all moved to SA in search of employment. Women have migrated as a result of the whims of the economy as well as climate change, which have manifested in drought and poverty, as they seek out better locations to find career possibilities and be able to take care of themselves and those left at home. The study has revealed that women labour migration in the Newcastle area has been influenced by the economic breakdown and growing levels of poverty in other Southern African countries. Which resulted in a large increase in the number of women migrating to South Africa, these sentiments have been argued by Crush et al., (2015) as well. As a result, more people have left their homes in search of employment prospects in the textile sector, which has led to a rise in migration. However, the business has also suffered from cheaper clothing imports from China and other nations. Despite this, female labour migrants in the textile industry have continued to pursue their economic plans, maximize their earnings, and send money home to support their families.

Based on their prior employment history in factories located in Swaziland, women labour migrants working in the textile industry said it was easier for them to secure employment opportunities. In their opinion, remittances received by workers in the Newcastle textile sector are higher than those received by workers in their home countries. Since the region's primary language is nearly identical to their native tongue (Siswati), it is simpler for them to live. The improvement of living conditions and support for dependants left home were the main goals of

the migration. Gundel (2002:256) notes that remittances from abroad contribute more to livelihoods than any other source, including international gifts and state development initiatives put together. Busisiwe, one of the participants, expressed similar views.

It has as well been established from the findings that health relations for migrants is affected by a number of interconnected elements, including behaviour, and care-seeking behaviour. Some behaviours, like hazardous sex to ensure food security, are born out of vulnerability, and some vulnerabilities are born because of discrimination. With the exception of wars and other factors, economic possibilities and the improvement of life prospects have been the motivating factors for women labour migrants in the textile industry. There was a relatively small percentage of people who moved, but they did so for security and to be nearer to their partners.

Social ties were a major driving force behind women's migration, notwithstanding the possibility of other variables pushing female labour migrants to travel abroad. According to social network theory, it is simpler for migrants to acquire support and information before setting out on their journey because of their interpersonal connections (Borgatti, et al, 2009; Jennisen, 2007). The majority of those surveyed claimed that friends and family helped them travel to South Africa by giving them accurate information about their destination.

Majority of migrants reported terrible events connected to their travels, such as detention, physical, and mental abuse, which calls for mental health care. Women labour migrants are more likely to steadfastly turn to self-medication or rely on unofficial medical procedures to treat their health issues if they do not have access to adequate services. Particularly, relative to their sexual and reproductive rights, the unique health needs of migrant women and girls frequently go fulfilled. Gynaecological consultations and services for reproductive health may not be offered to migrants receiving medical care while they are travelling.

The study's findings have also identified that women labour migrants are accommodated by close friends on arrival. In a case where the movement was facilitated by the employer, women labour migrants are then accommodated in the factory where they will be working. The living conditions inside the factory are inhuman, unhygienic, and squalor. According to reports, migrant women frequently encounter violence when they try to enter South Africa from nearby nations (Human Rights Watch, 2009b; MSF, 2009). The southern African region confirms the rising global patterns in female migration (Perbady and Dinat, 2005; Lefk o-Everett, 2007). The UN's participation through the UN Convention and its strategic partners in developing and campaign about female's access to sexual reproductive health services is necessary because

this can be regarded as a contravention of individual human rights. In comparison to other Southern African countries, the number of women traveling to South Africa has increased. Most women are increasingly crossing borders without their husbands or partners in quest of better and more sustainable livelihoods (Dzingirai et al., 2015). While some of these women have proper immigration documents, the majority are undocumented, making them more vulnerable to various forms of assault (Bloch, 2010; Rutherford, 2020), as presented in this study.

Because they are more vulnerable to gendered disparities and pervasive violations, their migratory paths and experiences differ from those of men. Migrant women are particularly vulnerable to a variety of forms of violence, including sexual and gender-based violence, exploitation, forced labour, and health risks (Rutherford, 2020). This has been proven as well in this study as participants shared their journey to Newcastle textile industry in search for work. Notwithstanding the fact that South Africa's constitution guarantees everyone the right to health care, migrants and refugees face numerous obstacles (Crush and Tawodzera, 2014). This report aims to add to existing debates about the difficulties that migrants and refugees face in obtaining health care in South Africa.

It focused on how difficult it is for foreign migrant women in South Africa to get public health care due to underlying social and institutional reasons of vulnerability. The research revealed that when migrant and refugee women seek public health care, they are prone to various forms of violence that can easily be misinterpreted as difficulties that solely impact migrants and refugees. Migrant women's unfavourable experiences in public hospitals and clinics are not entirely due to their status as outsiders. Instead, the 'crisis of care' that affects any patient (citizen or foreigner) accessing South Africa's public healthcare system can raise negative impact on migrant and refugee females. The study's findings revealed that migrant women encounter a number of interconnected barriers when it comes to accessing healthcare services. Linguistic and cultural difficulties were among them, as were the requirement for proper immigration documentation, xenophobia and prejudice, and language and cultural barriers.

7.2.1 Migrant women health-seeking behaviour and socio-cultural influence with regard to access to healthcare needs

The study's findings on the healthcare needs of the migrant's accessibility to FP programs, prevention of mother-to-child transmission, cervical cancer screening, emergency contraceptive, post-exposure prophylaxis and HIV/AIDS are discussed. The chapter also

dwells on the psychological aspects for women labour migrants. The chapter discusses the findings health-seeking behaviour for women labour migrants with focus on the influence of the social cultural norms, ethnicity, nationality, gender, education level, poverty, etc. Lastly, the findings on the knowledge of access to healthcare services for women labour migrants within the Newcastle area. More than fifty per cent of the interviewed women labour migrants knew where to access healthcare services within the Newcastle municipality. Although there was a choice on the facility they preferred, as most of the interviewed women preferred Pro-clinic that was in town, the argument was that the facility was accommodative than the closest facilities.

Because they are more vulnerable to gendered disparities and pervasive violations, their migratory paths and experiences differ from those of men. A quarter of interviewed women labour migrants chose to return and seek medical assistance from their countries due to fear of being discriminated as they were undocumented migrants. Apart from the fact that South Africa's constitution guarantees everyone the right to health care, migrants and refugees face numerous obstacles (Crush and Tawodzera, 2014).

The chapter focused on how difficult it is for foreign migrant women in South Africa to get public health care due to underlying social and institutional reasons of vulnerability. The research suggested that when migrant and refugee women seek public health care, they are prone to various forms of violence that can easily be misinterpreted as difficulties that solely impact migrants and refugees. Migrant women's unfavourable experiences in public hospitals and clinics are not entirely due to their status as outsiders. Instead, the 'crisis of care' that affects any patient (citizen or foreigner) accessing South Africa's public healthcare system may result in negative impact for migrant and female refugee.

The study's findings revealed that migrant women undergo a series of interconnected barriers when it comes to accessing healthcare services. Linguistic and cultural difficulties were among them, as were the requirement for proper immigration documentation, xenophobia and prejudice, and language and cultural barriers.

The interviewees reported that at other healthcare centers they asked for valid immigration credentials for them to get healthcare services because they were foreigners. They stated that they were required to have valid passports and temporary or permanent resident permits when visiting a hospital. Identification documents were frequently requested by hospital officials in order to verify their legal status and treatment eligibility. One of the participants stated that

trying to seek treatment without presenting documentation such as passports and proof of address was difficult. It is impossible for undocumented migrants to create bank accounts or engage in any activities that require papers. That implies they would most likely not be forced to show proof of residency at public clinics and hospitals (Crush and Tawodzera, 2014).

The clinics' consistent need for documentation from migrant women limited their access to public health care, and also influenced some of the women to avoid going to the clinic. If they did not offer documents proving that they were lawfully residing in South Africa, some of the participants said it was difficult to seek care at public clinics and hospitals. As a result, several of the participants chose private healthcare services over legal immigration documentation because they were more concerned about the patient's ability to pay.

While the majority of the participants worked within the textile industry on different level of responsibilities and were unable to afford medical assistance or the expensive prices charged by private health institutions. Several of the interviewees said they took over-the-counter drugs to avoid paying expensive fees and being asked for legal documentation at public healthcare facilities. This, however, elevated their health risks because it involved self-diagnosis, even when some of the problems might have required medical treatment. These outcomes are in line with Crush and Tawodzera (2014), who argue that using over-the-counter medicine without seeking expert treatment at a hospital is potentially risky for everyone, but especially for undocumented migrants, because they may be exposed to unsuitable medicine.

7.2.2 Challenges encountered by women labour migrants in accessing healthcare services in the Newcastle area

Several participants stated that when they went to a clinic, some of the nurses spoke to them in IsiZulu, the local language. The women stated that they were expected to be able to communicate in the language. However, they could only understand the most basic components of the language, such as greetings. They were only able to communicate in English after that. However, talking in English and being unable to completely express themselves in a local vernacular was a visible and audible sign of difference that led to discrimination and xenophobic attitudes from some healthcare staff.

The women labour migrants said that not being able to speak in the local language made them more vulnerable since some healthcare personnel used it to chastise them and make them feel like they did not belong. When a patient and a healthcare practitioner are unable to communicate in a local language, the only option is for the patient and the healthcare provider

to communicate in English, which is the most often used language in business and commerce in South Africa. The use of English by the foreign migrant women, on the other hand, frequently engendered resentment and exacerbated the nurses' negative opinions toward them. When women visited public healthcare facilities, the language barrier resulted in poor communication and, in most cases, fear and worry.

Some women labour migrants did not feel cared for as people in need of medical attention, whilst amongst them were those who extensively benefitted from healthcare services within the area. Their argument was that their focus was on accessing services they did not pay much attention to the negativity. Although amongst the respondents were those who felt that their status as foreigners caused them to be treated badly and judged by several medical personnel. The participants viewed those activities as xenophobic since they had been discriminated against by some healthcare personnel who openly said that they did not like migrants and refugees accessing the same healthcare system as South Africans. Certain portion of the interviewees reported that some healthcare workers' dislike sprang from a strong prejudice and contempt for foreigners.

The presumption (often held more by migrant women themselves) is that when they received poor medical treatment from healthcare workers, it was due to the healthcare workers' xenophobic attitudes. This is one of the main challenges in assessing the reasons why the respondents faced difficulties when trying to access public health care. However, according to Shaeffer (2009), it is critical to recognize that not all instances of substandard care can be labelled as "medical xenophobia". Instead, many migrants and refugees sought care at the wrong facilities due to a language barrier and a lack of understanding of South Africa's healthcare system.

According to Mojaki et al. (2011), the South African healthcare system uses a hierarchical referral system in which lower-level healthcare providers seek assistance from higher-level providers with better resources and capacity. It is probable that when some of the participants were referred to other facilities, they mistook it for rejection and 'medical xenophobia', based on the latter story. To be considered 'medical xenophobia', according to the definition of xenophobia (Landau et al., 2005), medical treatment must be erroneously withheld to migrants and refugees on the basis of their nationality or legal status to live in South Africa.

Other factors, on the other hand, could lead to the wrongful denial of medical care. South Africa's healthcare system is seen to be in disarray and facing numerous challenges

(Maphumulo and Bhengu, 2019). The shortage of employees is one of the many obstacles, which means that public healthcare workers generally work long shifts and are likely to be weary. Exhaustion and fatigue may have a role in their bad attitudes and behaviour towards both local and foreign patients in some cases (Crush and Tawodzera, 2014).

Several factors, as evidenced by the accounts, exacerbate the health risks faced by migratory women. South Africa is a violent country by nature, and migrants are particularly vulnerable to violence, as they are frequently subjected to xenophobic violence (Crush et al., 2017; Munyaneza and Mhlongo, 2019). It is also a society where rape and sexual gender-based abuse are common, and migrating women are no exception. They live in a precarious situation, and their lives are always in danger, both on their voyage to this country and while they are in South Africa (Von Kitzing, 2017; Hlatshwayo, 2019).

Despite the fact that undocumented migrant and refugee women are entitled to their universal human health rights, inconsistencies in policies and legislation regarding migrant and refugee health care expose them to a variety of health risks and vulnerabilities, making public health care difficult to obtain. Alfaro-Velcamp (2019), states that legal authority has been put on hospital officials, who are not authorized to decide on people's legal immigration status, regardless of whether migrant women are documented or undocumented, discrimination and bad attitudes on the part of individual care providers are the most important impediments and obstacles to their health. "The health rights that are provided to migrants on paper are belied by the harassment and refusal they confront in clinics and hospitals" (Shaeffer, 2009).

The women were exposed to health risks due to a lack of documents or identification as foreigners. The narratives, more than anything, reveal the power relations that exist between healthcare practitioners and migrant women. Healthcare personnel have a significant position in the performance of their duties, as they are constitutionally required to treat every patient with dignity and respect, regardless of country of origin. In certain cases, this power was misused, making it difficult for migrant women to obtain adequate health care. The women reported that they were afraid of being chastised, shouted at, and having their concerns dismissed.

The language barrier between migrant women and some healthcare personnel promoted unfavourable and discriminatory attitudes; it is vital to mention. Migrant women found it difficult to receive quality healthcare facilities in South Africa due to their inability to

completely articulate themselves in English or the native language, as well as residents' negative sentiments toward outsiders.

Discriminatory and xenophobic views are deeply founded in the assumption that the presence of foreigners in South Africa implies that the country's population will rise. Individual healthcare providers' perceptions that if foreign women gave birth in South Africa, they would be straining the country's resources and worsening South Africa's structural, social, and economic problems are influenced by widespread negative beliefs and knowledge about migrants among local South Africans (Crush and Tawodzera, 2014).

Because of strong negative attitudes toward foreigners, migrant women's health rights are frequently disregarded and violated. According to Benatar (2004), most South Africans are dissatisfied with the quality of healthcare services provided by state institutions, as reported by Crush et al. (2013). Staff shortages and higher workloads are to blame. Some South Africans, including healthcare practitioners, believe that poor service delivery is caused by an inflow of immigrants, whom they believe are bringing contagious diseases and socio-economic difficulties to the country's healthcare system.

Although there is obvious evidence of an increase in the number of individuals moving into South Africa, the influence of migration on the healthcare system is controversial, according to Walls et al. (2016), with assumptions and opinions often driving reactions rather than statistics and evidence. Because they impact their ideas, responses, and behaviour toward migrant women, healthcare providers' beliefs and views can be called xenophobic.

Research undertaken by Jewkes et al. (1998), presents a counter-narrative to the latter approach. It was discovered that both local and migrant patients suffered as a result of the bad healthcare system, which is currently deteriorating on a daily basis. According to scholars such as Crush and Tawodzera (2014), South Africa's public healthcare system is severely overwhelmed, and most public facilities struggle to offer sustainable, high-quality care. As a result, migrant women may mistakenly identify any form of ill-treatment in hospitals with xenophobia, which is not always the case.

The social capital theory, which suggests that social capital is the foundation of the social and economic benefits of people or groups, has been used to analyze the coping and adaption mechanisms for women labour migrants in the Newcastle area. Looking at the mechanism women labour migrants used to ensure access to healthcare services, the SLF and CCF provided an indication of how the interrelationship of the vulnerability of the people, the presence or

absence of various livelihood capitals, and the impact of institutional structures make it possible for the migrant women to adopt certain livelihood strategies to gain certain livelihood outcomes. This helps migrant women's coping and adaption strategies in a host community. People or groups of people are not inert and have socio-economic capital that has been accumulated over centuries and refined. The coping and adaptation strategies used by migrant women are as a result of their access to human, social, economic, physical, cultural, and political capital. Individual lifestyle decisions and the need for healthcare services are greatly influenced by culture and societal factors.

Different capital variables are discovered and investigated, and the complementarity of the factors leads to the coping and adaptation of the migrant women in obtaining healthcare services. These elements are relevant, together with the socio-economic traits the women have during their arrival, settlement, and long-term adaption in the host nation, as well as the demographic considerations that were mentioned earlier. For female labour migrants, it can be challenging to acquire even the most basic amenities like housing and schooling. As stipulated in South African Schools Act 84 of 1996, it must be noted that public schools should enrol learners and fulfil their educational needs without engaging in any form of unfair discrimination. The charter states that everyone in South Africa has a right to access healthcare services regardless of citizen status. Furthermore, Refugees Act 130 of 1998 states that children of migrants have the same entitlement to a primary education as children in South Africa. Despite having these rights, obtaining services can be difficult because of xenophobic attitudes, sentiments, documents, etc.

7.3 Possible interventions in the area of women migrants' access to healthcare services: Recommendations

Both the indigenous and host nations have the responsibility to guarantee that adequate healthcare facilities and services are available and accessible to all Africans without discrimination or prejudice. Despite the establishment and approval of various laws and international accords recognizing health as a fundamental human right for all and promoting women's mobility safety (WHO, 2018), implementation for these measures in practice is still far from optimal (WHO, 2018).

Most African countries do not offer migrants and refugees with the same level of access to health care as the one offered to their own residents (WHO, 2018). Several governments exclude migrant women from "health promotion programs such as: immunization and

vaccination, family planning campaigns, prenatal and safe birth campaigns, as well as infant nutrition campaigns including breast feeding" for women and girls on the road (WHO, 2018).

Immigrant-sensitive health systems, as well as awareness and sensitivity training on cultural and gender sensitivities for the health workforce, are required to address misogyny, xenophobia, and racism (WHO, 2010). Health facilities and clinics, for example, would be more accessible to migrants if they provided direct and non-discriminatory translation services (Mohamud et al., 2006). Prevention initiatives, such as the one launched in October to prevent breast and cervical cancer (Global Health Strategies, 2020), must include migratory women and be tailored to their individual requirements. Best practices, such as an inclusion of documented and undocumented asylum seekers and refugees as specified recipients of state-provided healthcare in South Africa, should be reproduced, according to a 2007 Department of Health Directive (WHO, 2010).

A dearth of statistics and literature on patterns of access to health care for diverse types of female African migrants necessitates more detailed intersectional studies of migration (WHO, 2018). "Population mobility may impair effective outbreak control and raise the danger of disease spreading across international borders," the WHO warned us in 2018 (WHO, 2018). This issue is exemplified by the recent Covid-19 epidemic.

The infection spread in communities is strongly linked to poor living and working conditions. As discussed in the previous blog entry in this series, migratory women are disproportionately affected by the Covid-19 restrictions, with many losing all sources of income and facing additional obstacles in meeting their own and their families' fundamental requirements, such as nutrition and health care (SIHMA, 2020).

Women can benefit from migration because it provides them with more autonomy, self-confidence, self-esteem, greater human capital, economic opportunities, skills and expertise, and it allows them to escape oppressive gender and cultural norms and traditions, all of which can benefit their origin and host communities (O'Niel, Fleury, and Foresti, 2016). Women may eventually resettle in their final destination, where they can work productively, continue their education, participate actively in the community as responsible citizens, and rebuild their lives in general, all while creating momentum for good change in their home areas (WHO, 2018).

Indeed, migrant women contribute a bigger percentage of their earnings in remittances than men, and women left behind are more likely to receive remittances than other members of the community (UN Women, 2013). Furthermore, as demonstrated by a South African program by

the non-governmental organization Africa Health Placements (AHP), host countries might benefit from migrant women working in health care to produce a "brain gain" (African Institute for Health and Leadership Development, 2017). It is critical to look after the health of migrant women in order for them to thrive in their communities and for Africa to become more gender equitable and inclusive (The Daily Vox, 2020).

As part of mandate from the 55th World Health Organization member states have been called upon to uphold resolution WHA55.18 (2002) on quality of care: patient safety, which urged Member States to “pay the closest possible attention to the problem of patient safety; and to establish and strengthen science-based systems, necessary for improving patients’ safety and the quality of health care”; recognizing that patient safety is a critical element of, and the foundation for, delivering quality health care; and welcoming the inclusion of the need for patient safety in the Thirteenth General Programme of Work, 2019–2023. This will ensure that the health care of women labour migrants taken into consideration.

7.4 Key contributions of the study

The clothing factories have been affected by the magnitude of imports clothing from countries like China, Indonesia, Brazil, etc. It is of essence to note that the South African textile local factories still manufacture clothing although at a smaller scale as compared to the imports. Textile factories like the one based in the Newcastle municipality are still operating although there might be violation of legislation during the process. The operation of these factories is at minimal level because of the product demand, as most clothing is imported into South Africa.

The unproductivity of these industries has led in the employment of undocumented women labour migrants as companies try to manipulate labour employment policies and payment of a minimum wage salary. Textile industries attract mostly women labourers as historically the industry has been dominated by women. The Newcastle textile industry is located in the National Health Insurance (NHI) previously pilot district that has now begun the rolling of the universal access to healthcare system in all public healthcare facilities, tertiary institution like Amajuba hospital and contracted general health practitioners’ facilities. The availability of this health facilities did not result in creating demand for access by women labour migrants. As the intersectional feminism theory argues that women labour migrants are geographically, economically deprived and vulnerable thus resulting in uneasy utilisation of these facilities given their migrant status as they fear being deported and abused. Background on women labour migration in the Newcastle area, context of Newcastle municipality, migrants working

conditions in the Newcastle textile industries and labour migrants in the Newcastle area have been identified.

Migration is not by choice as presented in this findings, women labour migrants migrate for survival and access to health care is a universal right in line with the United Nation Convention charter as the individual given exact to survival. Therefore, local authorities must derive means in supporting this vulnerable groups of women labour migrants through provision of necessary health care required. It will be impossible for the country to meet its Sustainable Development Goals around provision of healthcare services if a segment of a population is deprived from its rights, this may as well result in poor management of public health as the neglected population later interacts with the serviced and result in a regress. The Primary healthcare re-engineering team especially the Ward Based Outreach and Mobile can service this population with comfort so as to create the demand and improve access to healthcare services within their areas of work, as this has proven to be a bit uneasy for them visiting the local healthcare facilities.

Socio-cultural factors have an influence with regard to accessing healthcare services by women labour migrants as well as cultural health-seeking behaviour. It can be argued that socialization has an influence regarding one's choices whether good or bad. Though in this study women labour migrants had an influence from their friends or recruiter on deciding to utilise health care within the Newcastle area, one can as well argue that it could have as well been determined by the experience of the associate whether visiting the healthcare center was good or bad. It is worth noting that most women labour migrants who responded to have visited healthcare services were referred by friends and the influence around them as well as the family orientation background around healthcare needs.

Their upbringing experiences influence their choices, experience and knowledge regarding access and utilization of healthcare services. Beliefs system determine their choices regarding their trust on western medication in comparison with traditional medicines practices. Their cultural practices had an influence with regard to health-seeking behaviour and most studies do not specifically focus on women labour migrants given their vulnerability circumstances.

South Africa is a signatory to the UN convention and has declared access to health care as a universal right with further policies like the *Batho Pele* and patient charter. As argued by other scholars and the findings of this study, the health environment is not conducive for migrants accessing healthcare services based on staff attitudes, language barrier, culture shock and distance to facilities. Although studies have identified the challenges regarding the mentioned

issues, these challenges were not for the textile industry women labour migrants population as different setup might present different findings, thus is the case of women labour migrants in the Newcastle area. For instance, in the findings of this study, women labour migrants who were able to communicate in English were able to take better care of their health as well as women who could speak at least one Nguni language. It is important to note that respondents who consistently visited healthcare facilities overcame their fears around deportation. Perhaps this anxiety could have been a result of being an undocumented migrant labourer. Beliefs system had influenced choices to health-seeking behaviour although. The study established that women labour migrants who were able to interact with each other were influential around health-seeking behaviour, choices and lifestyle.

The study established that challenges encountered by women labour migrants in accessing healthcare services were identified at facility level. These challenges related to the initial registration as the facility required identification document, given the migration status of women labour migrants, thereafter, felt threatened and vulnerable to being deported. The approach by the administrator had an influence regarding the accessibility to healthcare services by the respondents. Therefore, some ended up utilising one passport so as to avoid explaining that they did not have any form of an identification document. Other impediments relating to language barrier and the position of vulnerability by women labour migrants and the staff attitude influenced the health-seeking behavioural pattern by women labour migrants. Communication was an observable sign of difference that led to discrimination and xenophobic attitudes from some health staff for some of the participants.

External factors and the livelihood capitals of coping and adaptation of women labour migrants in the environment and working conditions has as well been established by the study. Economic factors influenced access to healthcare services for women labour migrants as some respondents opted to utilise healthcare facilities in town like Pro clinic that was perceived to offer good standard healthcare services for patients. Therefore, that meant for women labour migrants who could not afford money for local transport ended up utilising healthcare centers that they were not conversant with or opted not to visit the health facility at all. Politics influence how women labour migrants were treated by staff in healthcare centers. The attitude of significant leaders as well influence the attitude of staff in health facilities. For instance, the MEC of health in Limpopo province has been seen on social media negatively raising her views regarding provision of health care for women migrants, the sentiment was contrary to the universal health charter and South Africa stance on provision of healthcare services.

Social networks had an influence on women labour migrants' coping and access to healthcare services as they relied on recommendation from each other on where to better access healthcare services within the Newcastle area. The study has also determined that women labour migrants who had experience and skills in working in the textile industry were better positioned in securing employment and better coped within the Newcastle area and easily accessed basic healthcare needs in comparison to those who lacked skills and knowledge of working within the textile industry. According to the findings this had also influenced their remittance and living conditions, although most of them preferred staying in pairs whilst some opted to stay within the factories in dilapidated living conditions in fear of being deported. The study identified the level of education as a factor contributing to ability to socialize and securing a better responsibility on the textile industry, as some women labour migrants who could speak English were given responsibilities of being team leaders/supervisors in certain departments.

7.5 Suggestion for future research

It can benefit the knowledge about access to healthcare services by women labour migrants if future research can focus more on developing industries that are prone in hiring general labour and the developed industries. This can give a broader understanding on the difficulties encountered by women labour migrants regarding the provision of healthcare services. It is necessary for the researcher to note that access to healthcare services is a human rights issue. There is a need for similar research to focus on the experiences of men labour migrants in accessing healthcare services in South Africa. This is because research has shown that fewer males visit healthcare centers compared to their counterparts.

In chapter four of this study, the researcher explored the living conditions and health risks in the region while talking about the causes that lead women labour migrants to go to the Newcastle textile sector. A similar study with focus on other part of the textile sector and similarly emphasising on the same factors can increase the knowledge hub on women labour migrants whilst expanding to other areas that might present a unique view and experience.

When women labour migrants access the public healthcare system in South Africa, this research elicits a knowledge of their perspectives and experiences with access to healthcare services within Newcastle textile enterprises in KwaZulu-Natal province. Although there are isolated examples that show migrant women being treated unfairly when seeking public health care, it is crucial to note that some of the incidents could be misinterpreted as being exclusive to migrant women. The outcomes of this study show that the challenges surrounding migrant

women's access to public health care are based on their own preconceptions and opinions. A similar study can assist in expanding the knowledge on the subject by concentrating on women labour migrants on specialised field so as to determine if education has an influence in health lifestyle choices. Despite extremely high unemployment rates, the majority of irregular migrants are able to find employment in places like textile industries. On the other hand, the Immigration Act 13 of 2002 the is an allowance for individual unskilled and semi-skilled labourers to receive work visas.

It is critical to note that new research should consider the existence of other invisible structures of violence, such as language barriers and the women's lack of understanding of the state of the South African public healthcare system, as reasons for some of the poor treatment they receive. It cannot be denied that there is a fine line between 'medical xenophobia' and a deteriorating South African public healthcare system, which invariably leads to vulnerability when it comes to obtaining excellent care and services for both local and migrant women.

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9. APPENDICES

Appendix 1: Interview Guide

1. Why do you see a need to visit healthcare Centre/ Clinic?
2. What do you mostly visit the healthcare Centre/ Clinic for?
3. What are health conditions that you are aware off?
4. What activities do you engage in to improve your health?
5. How does your sociocultural background influence your healthcare choices?
6. What impact does your culture have in accessing healthcare services?
7. How does your sociocultural aspect does determines usage of healthcare services?
8. What health care services are you aware of in the Newcastle area?
9. What services do you receive in this healthcare centers?
10. What challenges do you encounter in health services?
11. What provisions have been made at your workplace to ensure that you access health services?
12. What do you think should be done to improve your access to health care services by the health Centre?
13. What do you think should be done to improve your access to health care services by your employer?

Appendix 2: Informed Consent Form

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL

For research with human participants

INFORMED CONSENT RESOURCE TEMPLATE

Note to researchers: Notwithstanding the need for scientific and legal accuracy, every effort should be made to produce a consent document that is as linguistically clear and simple as possible, without omitting important details as outlined below. Certified translated versions will be required once the original version is approved.

There are specific circumstances where witnessed verbal consent might be acceptable, and circumstances where individual informed consent may be waived by HSSREC.

Information Sheet and Consent to Participate in Research

Date:

Greeting: Dear Participant

My name is Mlungisi Lungisile Ntshangase from University of KwaZulu Natal Pietermaritzburg Campus under the faculty of Human Social Science in Gender Studies Cluster. Institution contact details are: **HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION**

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

You are being invited to consider participating in a study that involves research titled, An Examination of the experiences of women migrants labourers in accessing health care services in Newcastle Municipality. The aim and purpose of this research is to exam your experiences in accessing health care services within the Newcastle municipality. The study is expected to enroll 35 women labour migrants working in the clothing textile industry residing within Newcastle municipality. It will involve the following procedures interviews which will not last more than 2 hours. The duration of your participation if you choose to enroll and remain in the study is **expected to be (provide).**

The study may involve the following risks and/or discomforts (describe). We hope that the study will create the following benefits (describe if relevant; otherwise state that the study will provide no direct benefits to participants. Describe the scientific/other benefits hoped for from the study). The researcher must disclose in full any appropriate alternative procedures and treatment etc. that may serve as possible alternate options to study participation.

If the research could potentially involve risk, explain in full if compensation exists for this risk, what medical and/or psychosocial interventions are available as treatment, and where additional information can be obtained.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions you may contact the researcher at (provide contact details) or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Your participation in this study is completely voluntary. You may withdraw at any time if you may feel uncomfortable to continue. In the event of refusal/withdrawal you will not incur penalty or loss of treatment. The researcher will not use your name or share the information provided to your disadvantage. However, your withdrawal from participating may delay the completion of the study. To withdraw from participating you must let me know as soon as possible. I may also decide not to consider you as a participant when you are unavailable for arranged interviews and you are out of reach in your mobile networks.

There will be no any financial incentives neither cost incurred by you or researcher during the study.

This research will not be conducted for personal or unacceptable political gains; it will be conducted for academic reasons where in the findings will be handled properly to people concern. Your name will be kept secret. Abbreviation only known by researcher will be used

for coding. You will be informed about the details of the. You will not be deceived about any information related to the study. The recorded interviews will be formatted to a laptop and two computers afterwards. The recorded interviews will be marked from one to 35, as well as the transcripts. This will be done to ensure that none of the interviews will be misplaced or linked back to you by anybody except the researcher. The researcher will do all the transcripts by himself to “get immersed in the data.

CONSENT (Edit as required)

I (Name) have been informed about the study entitled (provide details) by (provide name of researcher/fieldworker).

I understand the purpose and procedures of the study (add these again if appropriate).

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at (provide details).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001
Durban
4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to:

Audio-record my interview / focus group discussion	YES / NO
Video-record my interview / focus group discussion	YES / NO
Use of my photographs for research purposes	YES / NO

Signature of Participant

Date

Signature of Witness
(Where applicable)

Date

Signature of Translator
(Where applicable)

Date

Appendix 3: Gatekeeper's Letter



**NEWCASTLE MUNICIPALITY
CLLR. SKHUMBUZO E. SHABANGU
WARD 24: NEWCASTLE LOCAL COUNCIL**

P.O. Box 6625
Newcastle
2940

Tel: 034 339 7088
Mobile: 078 1008 770/0727015287
Fax: 034 312 1915

Date: 30/1/2017

LETTER OF CONFIRMATION

I, Cllr. Skhumbuzo E. Shabangu in my capacity as a Ward Councillor of Newcastle Municipality Council hereby confirm that Mlungisi Lungisile Ntshangase ID: No: 8709066388081 a student of the University of KwaZulu Natal Pietermaritzburg Campus (student no: 216077015) under the cluster of Gender Studies registered for Doctor of Philosophy (Gender Studies) is granted permission to conduct the study on the "Experiences of women migrant labourers from Southern Africa in accessing health care services in Newcastle Municipality, KwaZulu Natal province". The study will assist the ward in identifying ways that could assist municipality in improving the health care of women labour migrants working in our textile industries.

I hereby grant permission for this person's document to be processed.

Yours faithfully

Cllr. S.E. Shabangu

CLLR. S.E. SHABANGU
WARD 24
CELL: 078 100 8773

Appendix 4: Ethical Clearance



01 August 2018

Mr Mlungisi L. Ntshangase 216077015
School of Social Sciences
Pietermaritzburg Campus

Dear Mr Ntshangase

Reference number: HSS/0135/018D

Project title: The experiences of women migrant labourers from Southern Africa: A conundrum of accessing health care services in Newcastle Municipality, KwaZulu-Natal Province.

Full Approval – Full Committee Reviewed Application

With regards to your response received on 29 July 2018 to our letter of 28 March 2018, the Humanities and Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully


Prof S Singh (Chair)
/ps

cc Supervisor: Dr Janet Muthuki
cc Academic Leader Research: Prof Maheshvari Naidu
cc School Administrator: Ms Nancy Mudau

Humanities & Social Sciences Research Ethics Committee
Professor Shemika Singh (Chair)
Westville Campus, Góvan Mbeki Building
Postal Address: Private Bag X04001, Durban 4000



01 August 2018

Mr Mlungisi L. Ntshangase 216077015
School of Social Sciences
Pietermaritzburg Campus

Dear Mr Ntshangase

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Yours faithfully


Prof S Singh (Chair)
/ps

cc Supervisor: Dr Janet Muthuki
cc Academic Leader Research: Prof Maheshvari Naidu
cc School Administrator: Ms Nancy Mudau

Humanities & Social Sciences Research Ethics Committee
Professor Shemika Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X04001, Durban 4000



EDITOR'S LETTER

28 July 2023

RGK (Proofreading and Editing Services)
831 Acanthus Avenue
Weltevredenpark
Roodepoort - 1709, GAUTENG
South Africa

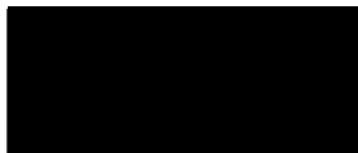
Dear Sir/Madam

Editing of PhD Thesis: Mlungisi Lungisile Ntshangase - 216077015

Title: Health Care Access and Challenges: A Case Study of Women Migrant Labourers in Newcastle, KwaZulu-Natal

This letter serves as a confirmation that the aforementioned thesis has been language edited.

Kind regards



Dr Refiloe Gladys Khoase (PhD)

Email: gladyskhoase@gmail.com