Barriers to Gender-based Violence Care: A Qualitative Study of Migrant and Refugee Women

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Abstract

South Africa has long served as a destination for migrants from sub-Saharan African nations, with a growing proportion of this population being women in recent years. Female migrants experience an increased risk for gender-based violence (GBV) during the migratory journey and upon resettlement. Accessible and culturally sensitive health, psychosocial, and justice services are necessary to promote holistic recovery for survivors. However, numerous barriers, influenced by widespread xenophobia and increasingly restrictive immigration legislation, have limited this population's access to care. The study aims to explore the barriers encountered by female migrants when accessing care services following experiences of GBV. This qualitative, exploratory study was conducted in Cape Town, South Africa between June and December 2023. Participants were purposively sampled and recruited in partnership with a local migrant organization. Their countries of origin included Burundi, the Democratic Republic of Congo, and Zimbabwe. Data was collected through face-to-face, semi-structured in-depth interviews with 12 female migrants and four key informant (KI) service providers. Interviews explored women's experiences of accessing and utilizing post-violence care services. Inductive thematic analysis guided the study. Data analysis revealed that within a context of xenophobic discrimination and economic instability, female migrants face multiple obstacles in the accessibility and acceptability of post-violence care services. Notable themes in accessibility include a lack of access to information deriving from participants' severe levels of isolation and language barriers. This is compounded by social inaccessibility due to cultural norms against reporting GBV and bureaucratic inaccessibility from prolonged documentation processes. Acceptability of services found multiple reports of xenophobic treatment and victim-blaming behaviour from service providers which impacted women's willingness to seek care. However, many still expressed generally positive sentiments about the progressive nature of social services in South Africa in contrast to their home countries. A lack of information about available post-violence resources, language and cultural barriers, as well as bureaucratic challenges, are limiting the migrant woman's ability to seek help following instances of GBV in Cape Town. Findings demonstrate how non-governmental organizations and individual citizens are currently filling a gap in referrals and service provision raising concerns about sustainability. Advocacy and government intervention are necessary to ensure post-violence care services can adequately meet the needs of migrant women. This mini-dissertation is comprised of two components; Part A is the research protocol for how the study was conducted and Part B in a journal manuscript detailing the process and findings of the study.

List of Acronyms

AAAQ Framework	Availability, Accessibility, Acceptability, and Quality Framework
CEnR	Community Engaged Research
DRC	Democratic Republic of Congo
GBV	Gender-based Violence
HREC	Human Research and Ethics Committee
KI	Key Informant
MRASA	Muslim Refugee Association of South Africa
NGOs	Non-Governmental Organizations
NSP-GBVF	National Strategic Plan for Gender-based Violence and Femicide
SA	South Africa
SAPS	South African Police Service
TCCs	Thuthuzela Care Centres
UN CESCR	United Nations Committee on Economic, Social and Cultural Rights
UNICEF	United Nations Children's Fund
UCT	University of Cape Town

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Part A:

Research Protocol

Introduction

The following protocol is for a qualitative exploratory study to investigate the barriers encountered by migrant women when accessing care services following experiences of gender-based violence. The study is a collaboration between the Muslim Refugee Association of South Africa (MRASA) and the Division of Social and Behavioural Sciences in the Faculty of Health Sciences at the University of Cape Town (UCT). The research will serve as the minor dissertation for the realization of a master's in public health for Kathleen Bradley and is funded in part through a thesis support bursary by the Migrant, Gender, and Health Systems Response project.

Background

For decades, South Africa has experienced a continual inflow of migration with official estimates reporting 3.95 million foreign-born people currently living in SA, 6.6% of the overall population (1). An estimated 75% of these migrants come from sub-Saharan Africa and have various motivations for coming to South Africa including fleeing from experiences of war or discrimination and pursuing economic opportunity and relative political stability (2). The proposed study will focus on the experiences of female migrants.

Restrictive migration policy and rising xenophobic sentiments have made the migrant lived experience increasingly more difficult in SA. Even still, migrants enter the country in large numbers each year, with the female subset of this population quadrupling from 1990 to 2015 (3). Migrant women constituted 43.1% of all incoming migrants in 2020, and it continues to grow (3). Upon arrival, these women face a double jeopardy of discrimination due to the intersection of their gender and migratory status (4).

The vulnerabilities experienced by migrant women place them at increased risk for violence during their migratory journey and upon resettlement (5). Types of violence experienced by migrant women include extortion, xenophobic discrimination and attacks, and intimate partner and gender-based violence (6). This study will investigate the procurement of care following experiences of gender-based violence (GBV). GBV can be physical, psychological, and sexual violence, in addition to threats, coercion and intentional deprivation of rights (7).

Migrant women's risk of experiencing GBV is amplified due to their vulnerable status in a country with an already pervasive culture of violence against women. Globally, an estimated 27% of women report having experienced physical or sexual intimate partner violence in their lifetime, in South Africa this number rises to one in three women for sexual violence and one in two women for physical violence (8). South African Police Service (SAPS) 2021/2022 statistics reported a total of 52,694 sexual offences, including 41,739 rape cases, amid speculation of vast under-reporting of these crimes (9). In 2021, the

nationally reported rate of intimate femicide rate in South Africa was 5.6 per 100,000 women, five times the global average (10).

The impact of this violence can have devastating consequences for a woman's physical health and mental well-being (11). Physical and mental health effects can include injuries, unwanted pregnancies, sexually transmitted infections, depression, anxiety, and post-traumatic stress disorder (7). In the situation of migrant women, these effects can also negatively influence their ability to integrate into their new community leaving them to experience continual marginalisation and an ongoing elevated risk of exposure to violence (11).

In response to the issue of gender-based violence, the South African government released a 2020 National Strategic Plan for Gender-based Violence and Femicide (NSP-GBVF) which identified migrants as a specific target group (12). The plan recognizes that vulnerability is intensified due to "factors such as race,...migrant status,... and sex work which all intersects with experiences of violence extending vulnerability further" (12). The plan is intentional in recognizing migrant women as essential beneficiaries of all services developed as a result of this agenda. Therefore, any identified barriers that prevent them from doing so should be a priority area of concern for policy makers and stakeholders in public and migrant health.

Evidence shows that timely access to patient-centred post-violence care, such as health services, psychosocial care, and legal interventions, improves outcomes and resiliency rates for violence survivors (13). However, significant barriers exist to accessing this type of care. These can include both individual and systemic barriers. Individual barriers can include a lack of knowledge of available resources, internalized feelings of shame among survivors, or fears of secondary trauma or stigmatization (14). Systemic barriers can include physical or financial accessibility of services (15).

Overview of Post-Violence Care Services in Cape Town

In response to the high incidence rates of violence against women, the South African government has implemented various strategies for post-violence care services. One approach is Thuthuzela Care Centres (TCCs), a multidisciplinary, victim-centred service delivery model, which originated in 2008 (16). The goal of a TCC is to streamline the medical and legal services needed by victims of rape, sexual assault, and domestic violence to decrease secondary trauma and improve legal outcomes (17). They do so by providing patients with case managers, offering medical services such as post-exposure prophylaxis, support through legal investigation, and referrals to additional psychosocial services. Additional public post-violence care services include community health centres and SAPS. Community health centres can provide services such as physical examinations, treatments of physical injuries, counselling and more.

SAPS also has specific areas entitled the Victim-Friendly Rooms which are designed to support survivors of gender-based violence (18). This service was created to provide a safe space for women when applying for protection orders or laying criminal charges against an abuser. They also express a commitment to providing these services with sensitivity and referring victims to additional services when needed.

Supplemental to public services are private non-governmental organizations (NGOs), such as rape crisis centres and domestic violence shelters. These organizations provide services such as emergency hotlines, psychosocial care, and referrals to health clinics and police services. For migrant women, there are also migrant organizations, such as MRASA, which have social workers and referral networks equipped to respond to incidents of violence.

Literature Review

Previous research on migrant women living in South Africa has investigated patterns of migration and explored themes of gender, xenophobia, and their effects on social integration (3,5,19,20). Another area of study has focused on the relationship between migration and GBV. These studies have reviewed the prevalence rates and influencing factors of GBV within this population (21,22). They have looked at how migrants define GBV, their perceptions of the causes of violence, and the ways GBV intersects with the migratory journey (4,11,23).

A growing area of research has also explored the theme of medical xenophobia to understand how it manifests within the South African context and impacts access to healthcare. Medical xenophobia has been found to occur at all phases of the healthcare process from in-take procedures to interactions with healthcare providers (24–27). It decreases migrant's likelihood of accessing services and limits the treatment options they receive (28). While these topics have been explored separately, the number of studies which link South African migrant women's experiences of violence and access to services is limited. A gap therefore remains in understanding the barriers to post-violence care access experienced by migrant women, especially within the south-to-south migratory context. This theme is an understudied and relevant area of focus which can contribute to a larger understanding of the public health needs of this population.

Rationale

Although migrant women experience an increased risk for GBV, migrant organizations report significant barriers to post-violence care experienced by their beneficiaries. Due to their increased vulnerability, it is essential that these services are viewed as accessible and acceptable to female migrants. The current gap in the literature on this topic is especially concerning due to the increasing rates of incoming female migrants. It is in this context that this study aims to provide empirical data on the barriers to post-violence

care for migrant women. With hope that the findings can contribute to inform future efforts towards promoting equitable, inclusive services for all women living in South Africa.

Research Aim and Objectives

This study aims to explore the barriers experienced by migrant women linked to MRASA when accessing post-violence care services in Cape Town.

Barriers to access will be investigated through the following objectives:

1. Explore the barriers experienced by migrants when identifying post-violence care services.
2. Explore the barriers experienced by migrants when accessing and utilizing post-violence care services.
3. Explore the perceptions of post-violence care service providers regarding the barriers experienced by migrants when accessing their services.

Research Paradigm and Conceptual Framework

Research Paradigm

This study is located within the interpretivist paradigm. This paradigm is defined by the idea that reality is socially constructed and views the context in which the study takes place as critical to the interpretation of the data (29). The knowledge of this study will therefore be co-created through the collaborative efforts of both the researcher and participants (30).

Conceptual Framework

To conceptualize access to post-violence care services, this study will implement a human rights-based approach to healthcare. As regulated by the United Nations' Committee on Economic, Social and Cultural Rights (UN CESCR), the South African government has the duty to ensure the right to health and work towards the "progressive realization" of this right (31). To apply this approach, the underlying determinants of the right to health, as defined in the UN CESCR General Comment No. 14, will be used to guide the investigation. These four determinants are availability, accessibility, acceptability, and quality and create what is commonly referred to as the AAAQ framework (31). Previous research has divided these determinants by the categories of supply (availability and quality of care) and demand (accessibility and acceptability) (32). For the scope of this study, focus will be given to the demand-side factors of accessibility and acceptability. In this context, accessibility will refer to four overlapping criteria which are information accessibility, social accessibility, bureaucratic accessibility, and physical accessibility. Acceptability will be viewed as care that is "respectful of medical ethics and culturally appropriate" (31).

The AAAQ Framework has been operationalized to evaluate healthcare services in many sectors and contexts. This includes a 2019 tool developed by the United Nations Children's Fund (UNICEF) to identify barriers impacting women and girls when accessing aid in humanitarian settings (33). This tool will be used in the development of the interview guide and the data analysis process (Appendix A). Utilization of the AAAQ framework not only provides credibility to the study but also allows the implementing partner organisation a well-respected strategy to operationalise the findings. As a tool guided by legally binding international doctrine, this framework can subsequently inform how data can be used to hold duty bearers accountable when advocating for increased accessibility and acceptability.

Methodology

Study Design

This study will employ an exploratory qualitative research design. An exploratory design is defined as a systematic and purposive approach to maximize the discovery of descriptive or qualitative data about an area of social or psychological life (34). These characteristics align with the interpretivist paradigm and the aim of the study as it allows for the collection of rich data about the lived experiences of study participants (35). An exploratory study is also ideal as it is the preferred methodological approach in circumstances with limited previous understanding of the phenomenon under study (34).

This study also follows the principles of Community Engaged Research (CEnR) design through in-depth collaboration with a community partner, the Muslim Refugee Association of South Africa (MRASA). This partnership has been facilitated by the UCT Knowledge Co-op and a memorandum of understanding signed by all relevant parties has been included as Appendix B. Guiding principles of CEnR, such as trust, respect, and cooperation, will inform all phases of the research process (36). As such, this research will work to identify practical and actionable findings which address the concerns and interests of the study population.

Study Population and Sampling

The study population will be the migrant women who are beneficiaries of MRASA's programming. These women represent a variety of countries of origin including the Democratic Republic of Congo, Burundi, and Uganda. They also currently reside in various communities across the Cape Town metropolitan area with a high density of migrant populations, such as Atlantis and Bellville.

A sample of 12 participants from this population will be purposively selected using the maximum variation approach. Purposive sampling has been chosen for its ability to deliver rich data by strategically selecting respondents who are most likely to provide valuable and appropriate information (37). The maximum variation approach will enable the research team to investigate the phenomenon from a variety

of perspectives within our sample, this diversity will be based on participants' country of origin, English-language levels, and type of post-violence care accessed (38). Given the study's aim and objectives, it is essential to ensure that the views and voices of migrant women who are survivors of violence are captured and amplified which is enabled through purposive sampling (39).

The following inclusion criteria will guide the sampling process, all participants will be:

a. migrant women,
b. over the age of 18
c. have lived in the Cape Town area for at least a year
d. beneficiaries of MRASA programming
e. have accessed or attempted to access post-violence care services

The researcher has chosen to include both access and attempt to access care in the inclusion criteria due to the study's nature of investigating barriers to care. A position of attempting to access services without receiving care is therefore still seen as having a valuable perspective on the barriers. The study sample will aim to represent the diversity of the migrant population found in Cape Town by representing various countries of origin and communities across the metropolitan region. Although this is negotiable and will be dependent on the availability and willingness of participants.

Relevant stakeholders, including MRASA staff and post-violence care service providers, will also be maximum variation purposively sampled as key informants. Four service providers will be interviewed, and their responses will be used to triangulate participant data and provide greater context to the service provision experience. The key informant sample has been limited to four services providers due to the time limitations of the study and will be purposively selected to represent different types of services - shelter services, psychosocial care, and migrant services - which have exposure to migrant woman who have experienced GBV.

Recruitment

Following the obtainment of ethical clearance, the researcher and members of the MRASA staff will collaborate to recruit study participants. The staff of MRASA, who have pre-existing relationships with program beneficiaries, will play a vital role in the identification and recruitment of study participants. Staff will distribute an informational flyer (Appendix C) and present the research overview to program beneficiaries through both formal and informal communication channels. The staff will intentionally focus on former beneficiaries of their programming rather than current to ensure that respondents do not feel obligated to participate in exchange for receiving services.

After it is confirmed that a potential study participant meets all inclusion criteria, they will complete an informed consent form (Appendix D) and be assigned an interview date. Recruitment will continue until 12 participants have been identified or until data saturation is reached, meaning no new themes or findings are evident in the data (40).

Key informants will be recruited through the support of MRASA's professional network. The four service providers will also receive an overview of the research topic and complete informed consent forms.

Research Site

Research will be conducted at the MRASA office located in Athlone, Cape Town. This location has been identified as the best option for ease of access and safety for both the researcher and participants. A private room within the office space will be made available to ensure privacy and confidentiality.

Data Collection

Data will be collected through semi-structured individual interviews with study participants. This data collection strategy has been chosen because it aligns with our exploratory design and will allow for open-ended, qualitative data on complex participant experiences, opinions, and perspectives (41). This approach was also selected for its flexible nature which is necessary due to the emotionally sensitive research topic (42).

The semi-structured interview guide was drafted based on the empirical literature, including the AAAQ framework and guiding questions developed by UNICEF (33). It was then enhanced through collaboration with MRASA staff. This co-creation process ensured that the questions aligned with what is known about the field and what the partner perceives to be relevant and critical to the research process. This rigorous development technique was used to contribute to the credibility and trustworthiness of the study (42).

All interviews were conducted "post-violence" meaning after a woman had experienced an incident of violence. This does inherently mean that they have left a violent situation meaning there may be on-going high risks of violence for some of the participants. This makes confidentiality and safety of utmost importance for data collection strategies.

Interviews will be conducted at the MRASA offices in Athlone. The researcher recognizes that conducting interviews in the partner office may negatively impact participants openness or willingness to share information. However, because the services of MRASA are not the focus of exploration the researcher reasons this would not heavily impact this study, In contrast, by the facilitation of interviews in a familiar space, the researcher aims to create a safe space for participants to feel comfortable sharing their

experiences (43). To maximize convenience for study participants, the interviews will be strategically planned around already occurring MRASA programming. This will ensure that the time and location of the interview are accessible for participants (41).

Interpreters will be provided by MRASA to facilitate the interviews when necessary. MRASA interpreters have pre-existing relationships with beneficiaries through previous programming which helps to promote a safe space in the interview process. Translations will allow interviews to be facilitated in the participants' preferred languages to ensure that they can express themselves fully. This will help to promote high-quality data collection, although it is important to recognize that nuanced understandings may also be lost during the translation process (43). It must also be acknowledged that these pre-existing relationships between the interpreters and participants may also negative effect a participant's comfortability in sharing their perspectives and experiences. This will be mitigated as best as possible by the researcher through discussions with the interpreter prior to the interviews.

Semi-structured individual interviews will also be conducted with key informants. These interviews will also be facilitated at the MRASA office or at a secondary location identified to be more convenient for the researcher or key informant.

Interview guides which will be used to facilitate both participant and key informant interviews have been included in Appendix E. All interviews will be audio-recorded with the participant's consent. Interviews will then be transcribed verbatim by the researcher and translated by MRASA staff when necessary. If a participant does not feel comfortable being recorded during the interview, detailed notes will be taken instead.

Data Management

Ensuring the safety of research participants throughout all phases of the study is an essential element of CEnR (36). To manage the data effectively and confidentially, a numeric identifier will be assigned to each participant during the informed consent process (44). These codes will ensure that no identifiable participant information will be contained in the research data. Codes will be used for interview scheduling, to manage data retrieval, and to code transcripts with participant demographic information. The master list will be stored on a Microsoft excel document which is only accessible to the researcher and her supervisor. This process will enable the research team to map interview data with relevant demographic information of participants such as their community, languages spoken, and length of time living in Cape Town.

Interview audio files and transcription documents will be coded with the numeric identifiers and stored in password-protected folders. Transcription documents will be printed and securely stored during thematic analysis.

Data Analysis

Inductive, descriptive thematic analysis will be used to identify patterns within the data following the six steps of the Braun & Clarke framework (45). The researcher will begin by familiarizing herself with the data through transcription and repeated readings following each in-depth interview (45). After familiarization, preliminary coding of each transcription will be conducted manually, and a codebook will be created using Microsoft excel. These initial codes will be done at a semantic level where themes are identified within the explicit meanings of the data (46). This phase of data analysis will be completed simultaneously with the data collection process to inform subsequent interview facilitation strategies (43).

Following preliminary coding, a first-round thematic identification will be completed to discern broad-level themes and find associations between the themes (45). The researcher's supervisor and MRASA staff will then serve as secondary analysts to review the identified themes. They will also support the next phase of developing and refining these themes into a cohesive thematic map (45). The final step will be developing a concise and coherent report for data dissemination.

Ethical Considerations

Ethical considerations for this research are numerous due to the sensitive nature of the research topic and the vulnerable status of participants. To ethically guide the overall study process, the researcher will strive to embody the following collaborative principles: mutual respect, authenticity, solidarity, and social justice (47). The researcher will begin by seeking research approval from the UCT Health Science Faculty's Human Research and Ethics Committee (HREC) and the UCT School of Public Health and Family Medicine.

There will be no material benefits to participants for their involvement in the study, beyond compensation for transport costs provided by MRASA. This will be explicitly communicated with the participants during informed consent and reiterated in the interview process. With this in mind, the research will be carried out in a way that maximises migrant women's safety and security through informed consent, same sex interviewers, and relationship-building with MRASA and other migrant organisations. The researcher is hopeful that findings may ultimately lead to improved access to post-violence care through the applied work of MRASA and care providers in the community. Therefore, the rights of female migrants to access

gender-sensitive health and justice services will ultimately be enhanced through their involvement in the research and the implementation of the findings.

Informed Consent and Confidentiality

All participation in the study will be on a voluntary basis with informed consent. Informed consent forms will be completed upon registration for the study and reiterated throughout the interview process. Participants will be able to withdraw from the study at any time, even without reason. Participants will be made aware that withdrawal from the study will not impact their ability to benefit from the services of the partner organisation.

For confidentiality, a numeric identifier will be used to code all interview transcripts. The master list will only be accessible to the researcher and her supervisors. The research partner, MRASA, has also agreed to a confidentiality binding agreement in the signing of a memorandum of understanding for the research process. All identities of participants will be hidden in the final research report and any future publications of the research. If names are required, pseudonyms will be used.

Participant Safety during Interview Process

The researcher's prior professional experience in the field of GBV prevention makes her specially prepared to conduct interviews in this format. She has completed training on how to sensitively handle disclosures of GBV and facilitate necessary referrals. To ensure ethical and safe interview experiences, the researcher will follow the World Health Organization's guidelines for conducting research about violence against women (7). These guidelines include conducting interviews in complete privacy, limiting interviews to only one woman per household, recognizing and minimizing participant distress during the interview, and providing referrals for support (7). Questions have also been intentionally designed to ensure that no language will be offensive for the participants and respectful, gentle probing will be used for any unclear responses.

Participant Debriefs and Referrals

Aligned with ethical standards, a social worker from MRASA will facilitate a debrief with each participant following the interview process. A referral network has been developed to ensure that any research participant in need of further support or services will be referred appropriately. The research team will also offer a pamphlet for relevant referral services to all participants following the interview. This will allow participants to follow up with services directly in case there is any later need for support. Participants may also refuse to take the pamphlet at their discretion if they fear it may present a risk to their personal safety.

Knowledge Dissemination of Findings

A key element in ethical research on violence against women is maximizing the benefits to the participants and their communities (7). One powerful way to do that is to use study results to promote social change. For this study, the goal is that the findings will be used by MRASA to advocate for systematic enhancements to service access for migrant populations and to improve their program delivery of supporting their beneficiaries.

Following the completion of the research project, a presentation of findings will be facilitated by the researcher for MRASA staff and relevant stakeholders. An interactive group debrief will also be led by the researcher and MRASA staff with all participants. This debrief will present the study's findings and give participants a voice on how MRASA should implement the results. The debrief will be presented in a group setting which includes study participants as well as other beneficiaries and no identifying information will be shared. This will be done to ensure anonymity of study participants and share the study findings with a larger audience who may also benefit from any programming subsequently implemented by MRASA. The researcher will also create a user-friendly report on the findings which MRASA can use for advocacy efforts. Unidentifiable raw data may also be shared with MRASA staff with participant consent. External knowledge dissemination efforts will include an op-ed and radio interviews with migrant-focused media outlets. These processes are detailed in the previously mentioned MOA attached as Appendix B.

Rigour

Rigour is a vital element of all qualitative research to ensure quality and validity (48). A thorough audit trail will be maintained. This will be used to capture any adaptations of the research protocol (48). Field notes which were collected throughout data collection will be used to create a thick description. This will contextualize the participants and setting to facilitate a deeper understanding for future utilization of the research (48). In data analysis, the researcher's supervisor and a MRASA staff member will be consulted throughout the theme identification process (46).

Research Positionality and Reflexivity

Another essential element of rigorous qualitative research is a declaration of the researcher's positionality and reflexivity. To begin, the researcher would like to acknowledge her positionality as a white, middle-class woman from the United States of America. The researcher will also be interacting with participants as a representative and extension of the UCT which applies a layer of academic privilege associated with a prestigious institution. Additionally, the researcher does not speak any of the languages spoken by participants in this study besides English. It is important to recognise this positionality will impact data

collection and interpretation as the lived experiences of the participants will be interpreted through the lens of the researcher. It is essential that research participants feel well-represented throughout the research process and in the findings.

The content of the study also has direct relevance to the researcher as both a woman and a violence prevention practitioner. The researcher's proximity to the subject matter will undoubtedly shape all phases of the research process from development to data collection and analysis. A consistent process of thorough and critical self-reflection is crucial to maintaining rigour.

These reflections will be captured through bracketing exercises done by the researcher to document her experiences and expectations about the research topic and process (49). This will be completed at the beginning of the research journey and reiterations will be done as needed (50). The researcher will also maintain a reflexivity journal throughout the study and conduct debriefs with a supervisor. These techniques will be important to document how the research context affects the researcher's internal world and influences data analysis and interpretation (51).

The researcher is also cognizant of the potential emotional burden of investigating sensitive topic matters. In response to this concern, she will implement self-care practices into her research journey and utilize university-supported psychosocial services when needed.

Study Timeline

Activity	Expected Timeline
Protocol Submission	June 2023
Data Collection	August – October 2023
Data Transcription	September – October 2023
Data Analysis	November 2023 – January 2024
Final Write-Up	February 2024

Conflicting Interests, if any

The researcher has no conflicting interests to be reported at this stage.

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Part B:

Journal Manuscript

Research Article

Barriers to Gender-based Violence Care: A Qualitative Study of Migrant Women in Cape Town

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Abstract

Background: South Africa has long served as a destination for migrants from sub-Saharan African nations. Female migrants experience an increased risk for gender-based violence (GBV) during the migratory journey and upon resettlement. Accessible and culturally sensitive health, psychosocial, and justice services are necessary to promote holistic recovery for survivors. However, numerous barriers, influenced by widespread xenophobia and increasingly restrictive immigration legislation, have limited this population's access to care. The study aims to explore the barriers encountered by female migrants when accessing care services following experiences of GBV.

Methods: This is a qualitative, exploratory study conducted in Cape Town, South Africa between June and December 2023. Participants were purposively sampled and recruited in partnership with a local migrant organization. Their countries of origin included Burundi, the Democratic Republic of Congo, and Zimbabwe. Data was collected through face-to-face, semi-structured in-depth interviews with 12 female migrants and four key informant (KI) service providers. Interviews explored women's experiences of accessing and utilizing post-violence care services. Inductive thematic analysis guided the study.

Results: Data analysis revealed that within a context of ever-present violence, xenophobic discrimination, and economic instability, female migrants face multiple obstacles in the accessibility and acceptability of post-violence care services. Notable themes in accessibility include a lack of access to information deriving from participants' severe levels of isolation and language barriers. This is compounded by social inaccessibility due to cultural norms against reporting GBV and bureaucratic inaccessibility from prolonged documentation processes. Acceptability of services found multiple reports of xenophobic treatment and victim-blaming behaviour from service providers which impacted women's willingness to seek care. However, many still expressed generally positive sentiments about the progressive nature of social services in South Africa in contrast to their home countries.

Conclusion: A lack of information about available post-violence resources, language and cultural barriers, as well as bureaucratic challenges, are limiting the migrant woman's ability to seek help following instances of GBV in Cape Town. Findings demonstrate how non-governmental organizations and individual citizens are currently filling a gap in referrals and service provision, raising concerns about sustainability. Advocacy and government intervention are necessary to ensure post-violence care services are adequately prepared to meet the needs of migrant women.

Keywords Migration, Gender-based violence, Accessibility, Acceptability, Qualitative Research

[1] The MPH candidate is the only author of the final paper provided here in accordance with degree requirements. The final manuscript will include multiple co-authors (detailed in the author contributions declaration) when it is submitted for publication to the journal, BMC Women's Health.

Background

South Africa is currently home to approximately 3.5 million foreign-born people (1). An estimated 75% of these individuals have relocated from other countries within Africa, making South Africa one of the largest south-to-south migration destinations worldwide (2). They have come in diverse forms including economic migrants, asylum seekers, refugees, and undocumented migrants, among others. Migration has been driven by a variety of push factors, including violent conflict, poverty, and environmental hazards, as well as the pull factors of South Africa's relative political and economic stability (2).

Although migrants represent less than seven percent of the national population, they are often used as political scapegoats, receiving blame for the utilization of scarce national resources and for bringing drugs and violence into South African communities (3). Though these claims are unfounded, they drive polarization, frequently resulting in incidents of xenophobic discrimination and violence (3). It is important to contrast these claims by recognizing the essential role of migrants in South Africa's social, political, and economic life. Research has shown that south-to-south migration plays a vital role in economic development by bridging gaps between knowledge and skilled labour; ultimately contributing to improved quality of life for the entire population (2).

Recent legislation has led to an intersection of migration and healthcare reform which creates a unique opportunity to reflect on how to best develop a more migrant-aware health system in South Africa. The 2023 White Paper on Citizenship, Immigration and Refugee Protection and the National Health Insurance Bill cultivate a space for researchers to critically analyse the current functioning of both systems and advocate for evidence-based transformation (4,5). Recent policy analysis on this intersection has found that there is a general absence of migrant representation in health-related policy and a lack of prioritization for an inclusive political response (6). Additionally, calls to action to create a migrant-aware South African health system acknowledge there is a general dearth of necessary data to understand the health needs of this population (7). To ensure that the needs of this special population are accurately addressed, it is important to first understand the defining characteristics of the group. Recent demographic trends have varied dramatically from previous decades with the number of female migrants quadrupling from 1990 to 2015 (8). With women constituting 43.1% of all incoming migrants in 2020, it is important to contemplate how these shifting demographics impact the public health needs of this population (9).

One important area of consideration is the relationship between migration and experiences of gender-based violence (GBV). Due to the insecurity of their circumstances, female migrants face an increased risk for GBV during their migratory journey and upon resettlement (10). In the South African context, this

risk is amplified due to their vulnerable status in a country with a pervasive culture of violence against women. Globally, an estimated 27% of women report having experienced physical or sexual intimate partner violence in their lifetime; in South Africa this number rises to one in three women for sexual violence and one in two women for physical violence (11). South African Police Service (SAPS) 2021/2022 statistics reported a total of 52,694 sexual offences, including 41,739 rape cases, amid speculation of vast under-reporting of these crimes (12). Violence against migrant women contributes to these statistics. A fact recognized by the South African government through the inclusion of "migratory status" as an influencing factor for marginalisation and exploitation in the Gender-based Violence and Femicide-National Strategic Plan (GBVF-NSP) (13).

The impact of GBV can have devastating consequences for a woman's physical health and mental well-being. Physical and mental health effects can include injuries, unwanted pregnancies, sexually transmitted infections, depression, anxiety, and post-traumatic stress disorder (14). Additionally, surviving GBV can impact one's ability to connect with oneself and others which can lead survivors to struggle with building and maintaining new relationships (15). These effects can be particularly damaging in the context of migrant women as it negatively impacts their resettlement and social integration (16). Ultimately, this leaves them vulnerable to experiencing continual marginalisation and an ongoing elevated risk of exposure to violence (17).

Previous GBV-related research on migrant women living in South Africa has focused on determining prevalence rates and identifying risk factors (18,19). Studies have also looked at how migrants define GBV, their perceptions of the causes of violence, and the ways GBV intersects with the migratory journey (17,20, 21). Outside of GBV, a growing area of research on this population focuses on healthcare access, including topics such as medical xenophobia and how it manifests in the South African context (22–24). These studies have contributed important points to our understanding of how migrant women experience and understand violence as well as the challenges they encounter when attempting to access healthcare services. Despite this, there is limited evidence for the link between South African migrant women's experience of GBV and related service accessibility. A gap therefore remains in understanding the barriers to post-violence care access experienced by migrant women, especially within the south-to-south migratory context.

Although recovery from GBV can be seen as a lifelong process, evidence shows that timely access to trauma-informed, patient-centred post-violence care can improve outcomes and resiliency rates for violence survivors (15). For the purposes of this study, post-violence care was defined as legal, health, and psychosocial services. This included police reporting, subsequent criminal proceedings, and accessing essential health and psychosocial care. GBV must be viewed as a violation of both the survivor's body

and rights which jeopardizes their physical health and well-being (25). Recovery requires the coalescence of these services to holistically address this violation and empower a survivor on their healing journey. Recent research calls for increasing intersectoral collaboration in violence response to ensure there is an integrated approach in both health and justice services (26). This study therefore explores migrant women's barriers to access with this comprehensive definition of post-violence care.

Due to their increased vulnerability to violence, it is essential that post-violence care services are viewed as accessible and acceptable to female migrants. Currently, migrant organizations working in Cape Town report significant barriers to care experienced by their beneficiaries. This study aims to provide empirical data on the barriers of the identification and utilization of these services through in-depth interviews with both female migrants and service providers. As a result, this article aims to inform future programming and policy efforts to promote equitable, inclusive post-violence care for all women living in South Africa.

Conceptual Framework

To conceptualize access to post-violence services, this study has implemented a human rights-based approach to healthcare. The underlying determinants of the right to health, as defined in the United Nations Committee on Economic, Social and Cultural Rights General Comment No. 14, have been used to guide the investigation (27). These four determinants are availability, accessibility, acceptability, and quality and create what is commonly referred to as the AAAQ framework (27). The AAAQ framework has been widely operationalized to evaluate healthcare services in various sectors and contexts. This includes a 2019 tool developed by the United Nations Children's Fund (UNICEF) to identify barriers impacting women and girls when accessing aid in humanitarian settings (28). The researcher applied this tool in the data collection and analysis phase of the research process (Appendix A). Utilization of the AAAQ framework not only increases the rigour of the study, it also provides a strategy for the implementation of the study findings. As a tool guided by legally binding international doctrine, this framework can inform how the findings can be used to hold duty-bearers accountable when advocating for increased service accessibility.

Previous research has divided these determinants by the categories of supply (availability and quality of care) and demand (accessibility and acceptability) (29). For the scope of this study, focus has been given to the demand-side factors of accessibility and acceptability. By applying these criteria, the author is able to use the framework to represent the voice of the service user, namely migrant women. This amplifies their perspective and deepens the understanding of what influences their utilization of services. In this study, accessibility refers to the ease with which the service user can identify and successfully access services following an incident of GBV. To explore this determinant, characteristics such as information

accessibility, social accessibility, bureaucratic accessibility and physical accessibility have been explored. Acceptability focuses on the level of comfort a service user has in utilizing the services. This has been viewed as care that is "respectful of medical ethics and culturally appropriate" (27).

Methods

Research Design

This article is based on a qualitative exploratory study conducted with female migrants in Cape Town, South Africa from June to December 2023. This study design was adopted to investigate the participants' perceptions of the barriers to accessing care services following experiences of gender-based violence. A qualitative exploratory design is useful to study an under-researched topic and deeply contextualise within the study setting (30). This design was deemed suitable due to the limited pre-existing literature on the topic and because it provides the opportunity for study participants to contribute to the creation of new knowledge (31).

Sampling and Participants

The study population included migrant women living in Cape Town who are beneficiaries of a local migrant organisation. Purposive sampling with a maximum variation approach was used to select participants. This strategy was adopted for its ability to deliver rich data by intentionally including respondents who are most likely to provide valuable and appropriate information (32). The maximum variation approach allowed the researchers to investigate the phenomenon from a variety of perspectives within our sample (33). Diversity was based on participants' country of origin, English-language levels, and type of post-violence care accessed. The sample included twelve female migrants. Their migratory status included refugee (6), asylum seekers (2), and undocumented asylum seeker (4). Those who are classified as undocumented have either yet to receive asylum seeker documentation or have expired asylum seeker documentation. Collectively, they will be referred to as migrants throughout this article to encapsulate all three types of migratory status. Their age ranged from 35 to 65 years old and their countries of origin included the Democratic Republic of Congo (DRC), Burundi, Uganda and Zimbabwe. The demographic information of participants is summarized in the following table.

Table 1: Demographic Table

Participant ID	Country of Origin	Age	Migrant Status	Accessed post-violence care services?
1	Zimbabwe	42	Refugee	Yes
2	Burundi	45	Asylum Seeker	No
3	Burundi	47	Undocumented Asylum Seeker	No

4	Burundi	37	Refugee	Yes
5	DRC	65	Refugee	No
6	DRC	45	Undocumented Asylum Seeker	No
7	DRC	46	Refugee	Yes
8	Uganda	48	Undocumented Aylum Seeker	Yes
9	DRC	41	Asylum Seeker	No
10	DRC	35	Refugee	Yes
11	DRC	45	Refugee	No
12	DRC	47	Undocumented Asylum Seeker	No

The following inclusion criteria guided recruitment efforts; participants needed to be migrant women who were over the age of 18 and had lived in the Cape Town area for at least a year. All participants were also beneficiaries of the partner organisation, a measure included due to the sensitive nature of the research to ensure follow-up support would be possible if necessary. Initially, we aimed to only target participants who had accessed or attempted to access post-violence care services. However, the highly specific nature of this selection criteria impacted the sample size. Ultimately, there were participants interviewed who did not have experiences of accessing post-violence care. It was decided their data would be included in analysis as they still provided valuable insights into barriers to care access and to the general context in which these migrant women at risk of GBV live. Participants' type of service engagement has been stated in the findings when relevant.

To triangulate participant data, four KIs were sampled for interview. They were also selected through purposive maximum variation sampling and with the inclusion criteria that they were service providers with experience with migrants in the post-violence care space. Employers included shelter services, psychosocial services, and migrant support organisations.

For recruitment, potential participants were approached by the staff of the partner organization and given an informational overview of the study. Interested beneficiaries then completed an informed consent form and were assigned an interview date. Key informants were recruited through the partner organisation's professional network. The four service providers also received an overview of the research topic and completed informed consent forms.

Data Collection and Procedures

The researcher conducted in-depth interviews (n=12) with the female migrants and KI interviews (n = 4) with service providers. Semi-structured interview guides were created to gain insights on migrant women's experiences of accessing care following incidents of gender-based violence and the perspectives

of KIs on this. Guides were informed by the AAAQ conceptual framework and adapted as necessary in the interview process (Appendix E).

Interviews were conducted in English and Swahili with the support of a translator as required. Interviews ranged in length from 20 minutes to one hour. All participant interviews were conducted in the partner organization's office to enable the women to feel physically and emotionally safe. Referrals for debriefing were provided to any participants who were distressed by the interview process. The relatively small sample size allowed the researcher to complete more comprehensive interviews and more thorough data analysis.

Key informant interviews explored KI's perceptions regarding the barriers to care experienced by the target population. This data was used to ensure rigour through triangulating the findings and contributed to understanding the larger context these services are operating within.

All interviews were recorded and then transcribed verbatim by the researcher. Initial transcriptions were facilitated with the assistance of AI transcription software through Microsoft Word and then verified and edited as necessary by the researcher. To ensure clarity of quotes in the findings section, some have been converted from third person to first-person tense. Minimal grammatical changes have been made for clarity while maintaining the intended meaning.

Data Analysis

Transcripts were coded and themes and sub-themes emerged as part of a process of inductive analysis following the Braun & Clarke framework (34). Familiarization with the data was completed by thorough reading and re-reading of the transcripts. Analysis was completed manually, and a codebook was developed using Microsoft Excel. To ensure rigour, the co-authors served as secondary analysts in the process of identifying the themes presented in the subsequent section.

Ethical Considerations

Due to the highly sensitive nature of the study, ethical considerations were of primary importance. First, ethical clearance for the research was obtained from the University of Cape Town's Faculty of Health Sciences Human Research Ethics Committee (Appendix F). In promotion of collaborative principles such as mutual respect and solidarity, the researcher began the research process by relationship building with the partner organisation to create a sense of familiarity and comfort with potential research participants. To ensure interviews were conducted with an emotional safe approach, trauma-informed techniques were applied including private and familiar interview locations, same sex interviewers, and participant-directed interview processes, such as allowing the participant to not respond to a question or end the interview at

any time. Debriefing sessions and informational pamphlets on referral services were offered upon the completion of interviews. Supplemental service referrals were completed as necessary. No additional risk was reported by participants as a result of their participation in the interview process. Research permission was received from all participating organisations and informed consent was obtained from all individual participants.

Results

Our study found that female migrants encounter numerous types of barriers in both the accessibility and acceptability of post-violence care. Guided by the definitions of accessibility and acceptability from the AAAQ framework, thematic analysis investigated how these challenges occurred at individual, interpersonal, and systemic levels. The barriers not only delayed participant access to care but also limited the efficacy of the care which subsequently negatively affected their healing journey. To better understand these specific barriers to access and acceptability, it is important to first consider the context of vulnerability experienced by this population in their everyday lives.

Context of Migrant Experience in Cape Town

Numerous environmental factors associated with migrant life contributed to a sense of heightened vulnerability for study participants. These conditions were reflective of the migrant women's intersectional identities and impacted how they navigated their social environment. Starting on arrival in South Africa, participants' resettlement was often hindered by systemic delays in administrative procedures. These delays and their impact are intensified for asylum seekers as they require documentation immediately upon arrival whereas other migrants may first enter on a visitor's visa for three months. Participants describe delays as occurring routinely with no explanation or clear solution and as a staple of the Home Affairs experience. They limit these migrant women's economic opportunities and integration into South African society.

> *I'm here for five years. Never get the paper from home affairs. They always promise me, "you come to get tomorrow." Til now I don't have the papers. I can't work without the papers. - Participant 12, Undocumented asylum seeker from DRC*

These bureaucratic delays were compounded by the ever-present threat of xenophobia. This overarching theme impacted all elements of migrant life. Participants shared how it led to feelings of isolation and can result in exploitation and discrimination in access to employment and housing.

> *This is what the major challenge is that when we're in a foreign country that you don't have a say. You don't have a right. The protection… Even in workplaces, if they want to do whatever they*

want to do, you can't report it to anyone because they know people and you don't. - Participant 1, Refugee from Zimbabwe

Xenophobia contributed to another contextual factor, economic insecurity. Multiple study participants shared how they were highly motivated to seek employment and provide for their families. However, the barriers created through inaccessible documentation and xenophobic discrimination proved almost insurmountable barriers to securing steady, viable employment.

For me, I think that the biggest change, strongest change, that can happen is if there is accessibility to job opportunities. Because I believe that what makes my situation worse is lacking for job, and the feeling that someone welcoming you, need to feed you, buy you soap, everything... at least if I could have a piece job where I can also contribute something, life could move on. - Participant 4, Refugee from Burundi

Participants shared examples of how these migrant-specific factors are occurring within a larger Cape Town context which is rife with inequality and community violence. One participant noted how their unique identity within this setting multiplies their level of insecurity.

That boy is 18 years old, when he killed my cousin. We were traumatized. How are we gonna say? We can't even. They can come to attack you in the night if you talk. Because in the first place, we are foreigners. They can kill your brother like this, but you just keep quiet. You can't say nothing. - Participant 11, Refugee from DRC

Beyond these fears, there is an acceptance of the levels of violence perpetrated in high-risk areas that can result in an inaccessibility of legal protections. One participant shared how she was refused services following an incident of community violence perpetrated against her husband which ultimately left him physically incapable of work.

The experience that I received at the police was very, very bad. Because once I arrived at the police, I tried to explain the case. I could not receive any help. They automatically reject me and say that everyone knows that is a dangerous area, so they cannot do anything. - Participant 7, Refugee from DRC

This context helps to provide a rich description of the setting where participants are attempting to access post-violence care services. Recognizing the larger social and economic structures participants are operating within allowed for a more thorough application of the conceptual framework to deeply analyse the findings, as detailed in the following section.

Barriers to Post-Violence Care Services

1. Accessibility

Within the theme of accessibility, results demonstrate how participants identified and accessed post-violence care services. The following subcategories from the AAAQ framework were applied to comprehensively explore the barriers experienced: information accessibility, social accessibility, bureaucratic accessibility, and physical accessibility.

1.1 Information Accessibility

When describing the process of identifying post-violence care services, participants shared how their severe levels of isolation limited their access to information. Many of the participants moved to Cape Town with few or no pre-existing social connections, they did not speak English or any other South African national languages, they were unable to seek employment due to their documentation status, and their physical movements were restricted by their partners.

> *I'm not working. I'm not allowed to go anywhere... So, I just left. I didn't say where I was going. So, now, if he comes and finds out I'm not there, there's going to be big problem.*
> *- Participant 3, Undocumented Asylum Seeker from Burundi*

This combination of circumstances left women experiencing violence isolated with limited options for emotional support or referral to care. While there was some awareness about the general availability of services, specific providers or the quality of care they deliver was unknown by many. Women shared they would need to do additional research to be able to access services.

> *So this kind of gender-based [violence care services], I don't really know what is happening. But I know there are people that are there. Institutions and organizations are helping people... Maybe I'll go into Google and search to see which services are doing that. - Participant 6, Undocumented Asylum Seeker from DRC*

One of the few resources which seems to be effective in facilitating access to services is word-of-mouth referrals from neighbours or community members. One GBV survivor shared how after a severe incident of violence the people living around her intervened to ensure she accessed necessary health services.

> *The neighbours, they were like "No, No, No." They had to raise an alarm that that woman would be killed there. So they made me go to hospital. – Participant 8, Undocumented Asylum Seeker from Uganda*

At times these referrals were done discreetly, as the neighbours feared retaliation from the perpetrator.

Because my neighbour just told the people, 'This mama here, she has a pregnancy, but the way they are treating her inside is bad.' They show me the police station. She said 'You must call the police. They are going to help you because this is not your life. But then don't tell your husband if I'm the one who gave you the number.' - Participant 10, Refugee from DRC

Limited knowledge of the types of services available poses as a first layer of barriers for the study participants. This can result in a significant escalation of the abuse before services are identified.

1.2 Social Accessibility

Stigma around reporting was seen as another significant barrier in these migrant communities. While in some instances neighbours served as referral systems for participants (as described above), others expressed how cultural expectations led to not reporting. This was especially common in instances of violence perpetrated by an intimate partner.

If you go to the police to report, my husband do this, my husband do this. I'm telling you the police will take him and lock him, but when he comes out you will be sorry. Because no one's going to help you, not friend, not family. "Aye! This woman take her husband [to] the police, they bring the white people culture and now they left our culture." That's the problem, we're living with here. - Participant 3, Undocumented Asylum Seeker from Burundi

The effect of this stigma is magnified by how closed and close-knit the migrant community is.

Another barrier is a shame someone feels to admit that they are a survivor or victim of GBV, especially in refugee communities, because it's communities that believe that whatever happens in the house must stay in the house…So even friends, someone can't even go and disclose to a friend... It also gives people fear that if I report, I'll be shunned from this community. – Key Informant 3, Social worker for a migrant support organization

Even in instances where women initially overcame this stigma and accessed legal services, the subsequent social pressures sometimes led them to reverse their decision. A GBV survivor from Burundi shared how this resulted in her ultimately bearing the cost from a lack of legal accountability for her partner.

It is really a taboo to lock your husband. So when they heard that I opened the case, they called, many family friends, they come and say please don't make him locked down in the prison... Then we didn't go to court. And after that, we break up, but the guy didn't fulfil his promises [to pay maintenance support for their child]. - Participant 4, Refugee from Burundi

Another dominating challenge was a migrant woman's sense of dependency on an abusive partner. Even after intervention from her neighbours resulted in access to health services, the previously mentioned GBV survivor from DRC shared how this dependency delayed her pursuit of legal aid and prolonged her experiences of violence.

> *Even the nurses, they kept asking me 'No, with the black eye... You can't tell me its nothing.' They said 'speak up.'...But I couldn't speak up because I didn't have anywhere to go. If I speak up and he puts me out, I didn't know if I could even find anywhere to sleep or what. So I didn't speak up... And then he said that he wouldn't take me back to the hospital because they would keep asking me questions and I would be tempted to tell them. - Participant 8, Undocumented Asylum Seeker from Uganda*

A final dimension of social accessibility from the AAAQ framework explores how competing responsibilities, such as childcare, may affect access to services. Women shared that as single mothers they struggled with minimal financial and parenting support.

> *Because for me, I don't have relatives around here. So everything lies on me. You see, like if you got your sister or someone to make a plan. But since I'm alone, it's very difficult because you don't have anyone to rely on. - Participant 1, Refugee from Zimbabwe*

This burden of care leads participants to prioritize providing for their families over accessing services for themselves.

1.3 Bureaucratic Accessibility

The denial of care due to expired documentation is one of the prominent themes of bureaucratic accessibility. One participant shared the following story about her experience attempting to access police services following a physical attack.

> *When I arrived, they requested the ID. Then when I removed the ID, they tell me that "the paper is expired and how can we help someone when their paper is expired?" - Participant 7, Undocumented Asylum Seeker from Burundi*

Even just the fear associated with being undocumented posed as a barrier in determining to seek care. One KI who is a social worker for a migrant support organization shared about how this fear manifests in her clients.

> *They fear to approach the police. First of all, because the documents are not up to date, or they've been expired. And they do not have the means of explaining, because of language barrier, to*

explain that "look I applied for this document and I'm still in the waiting period." So, in that case they sort of cover up for the perpetrators who have abused them because they fear to approach the police because of lack of documentation. - Key Informant 4, Social worker for a migrant services organisation

Bureaucratic barriers were also seen in connection to the previously mentioned theme of dependency on perpetrators. KIs noted that, beyond financial reliance, perpetrators were often relied on for documentation purposes as well. This can be used as a way for perpetrators to control their partners and further restrict their access to care.

1.4 Physical Accessibility

In the study, physical accessibility was primarily reported as a challenge in the procurement of police services. Participants shared examples of how SAPS officers required them to report to the station closest to the location of the crime to receive assistance. This was mandated even if the service was not physically accessible or properly equipped to respond. A participant shared how after a sexual assault this created barriers to her initial reporting and follow-up investigation of the crime.

They took me to the police station. And I stood there. I didn't have shoes. I didn't have a proper jersey on. I stood there for a long time. I pitched there around from 3 o'clock til, like, 4, 5 o'clock. ... They said, "No, we're not going to help you with anything. You must go to Athlone where the crime happened." - Participant 1, Refugee from Zimbabwe

This same participant contrasted her experience of inaccessible public services with the flexibility of accessing private psychosocial care. She appreciated how this NGO used a variety of service options to effectively ensure accessibility.

They are very flexible. They have got also 24-hour counselling sessions. Which is great. You can call them when you need help. They have got a lot of positive vibe to it. You can do it online as well. - Participant 1. Refugee from Zimbabwe

While these services are filling an important void left by government entities, they are also overburdened and under-resourced. This can have a ripple effect on physical accessibility due to limited resources.

Apart from GBV, we have a huge need for shelter just in Cape Town. So I think even shelters that are specific for GBV are filled with homelessness... Currently, we only have that one shelter that we really rely on and if it's full, then it's difficult for us to assist the client. - Key Informant 3, Social worker for a migrant services organisation

These four categories of accessibility have demonstrated how participants' choice of and access to services can be limited through numerous factors.

2. Acceptability

The perceived acceptability of services is another determining factor that affects a woman's decision to utilize post-violence care. To understand acceptability, the study investigated participants' perspectives regarding the quality and content of service delivery, including the cultural and gender sensitivity of care.

2.1 Unethical and Xenophobic Behaviour from Service Providers

As an introduction to acceptability, it is important to recognize that it has been normalized for these migrants to expect a baseline level of xenophobic discrimination in almost all instances of care. It was presented as common knowledge that while they should be able to access public services, they will inevitably be delivered with discriminatory behaviour from service providers.

> *It's the societal norms and judgments and stereotypical attitudes that might affect them when they go to access the services, but not necessarily that they won't receive the services. But they will still experience discrimination, stigma, and labelling and anything else that has to do with just not being a citizen in this country. - Key Informant 2, Social worker for SGBV response service*

Instead of an appropriate trauma-informed violence response, participants described how xenophobic attitudes were a first reaction of service providers when reporting to an incidence of GBV.

> *I was staying in the house, renting a room in a house because everyone woke up and they came out because he comes up and was breaking the windows... They had to call the police. The police had to come out because he was like, "I must kill you."... Then the police came they said, "After all you are all foreigners. Where is your documents? I need your documents. I'm sorry, people, but how are you here?" - Participant 8, Undocumented Asylum Seeker from Uganda*

Xenophobic treatment also occurs through the weaponization of the language barrier. The same participant shared how her accent or lack of ability to speak a South African language has been used to identify her migrant status in order to refuse services or offer lower-quality care. This was exemplified in an instance she shared about attempting to organize an ambulance for a fellow migrant who had just experienced a severe case of domestic abuse.

> *It's hard to get transport when it's an emergency... The ambulance we called it was nothing, nothing, nothing and she couldn't walk. So another person eventually called in Afrikaans, that's*

when they respond. They know it, they say "Ah you can't call because they hear the accent, they know the accent." - Participant 8, Undocumented Asylum Seeker from Uganda

Participants also reported no knowledge of services they could refer to for protection against this type of discrimination. One participant shared her experience of being sexually assaulted while she was working as a security guard. Instead of receiving a referral to care from her employers, she was met with resistance and discrimination which left her feeling helpless.

It was like something good for them, when I was trying to talk, they start to laugh...They know I can't speak Xhosa, but they start to speak in Xhosa. I can't hear what they're saying... But I don't have any choice. - Participant 9, Asylum Seeker from DRC

Victim-blaming behaviour was reported as another common occurrence and emphasized the need for gender diversity in service providers.

I wish the cases of rape can be handled by women police.. Because he was actually blaming me... So he was actually saying it's your fault that it happened to you. I was like, what? - Participant 1, Refugee from Zimbabwe

Participant's stories also showed how service providers used these victim-blaming attitudes to rationalize their unethical care. One extreme case included a forced procedure of family planning treatment at a health facility after a participant was accused of having a miscarriage because she was "too old" to be getting pregnant. In actuality, the miscarriage had resulted from an incidence of GBV.

Then after some serious beating, I got a miscarriage and I went to hospital…So they had to remove the baby. So then I was sleeping and in the morning, I felt the implant. And they were saying "oh you're old, you're old why did you get pregnant?" And at that time I was 38. So I had the implant... So I had to stay with it even though everyday it was bleeding. It did not go well with me. - Participant 8, Undocumented Asylum Seeker from Uganda

Ultimately this type of mistreatment led to a breakdown of trust in public services.

Don't go to the police. Never go to the police. Just stay at home. Just stay at home. It's too traumatic. - Participant 1, Refugee from Zimbabwe

The frequent occurrence of both xenophobic and gender discrimination during experiences of care results in low levels of acceptance and leads to the devaluation of care.

2.2 Economic Benefits of Services Influence Acceptability

Participants shared views of finding services more acceptable if they offered opportunities for financial security. As previously discussed, migrant women live in a financially vulnerable context and often have a sense of economic dependency on their abuser. A woman is therefore more inclined to pursue a post-violence care service if it provides an opportunity to ensure a sense of financial stability, for example, through maintenance claims.

> *I must get maintenance from this guy. Because he can't abuse me like this and he's working... [In] South Africa, they cannot allow that. He must support the kids. - Participant 10, Refugee from DRC*

However, where there seems to be a lack of possible positive outcomes, participants expressed not seeing value in reporting the abuse or accessing services.

> *They say ok even if I go to the police, he doesn't have income. They say this money you are going to support your five children? That's also why I didn't go to the police. - Participant 3, Undocumented Asylum Seeker from Burundi*

The sustainability of the outcomes resulting from the services also influences the acceptability. Because these services are being accessed in severely financially insecure environments, participants reported it was difficult to find a long-term solution.

> *I've experienced a lot of challenges and I've realized there is not real help. In the services, there's not really help that can make you sustainable on a level like financially… I'm not able to return back home so I'm even willing, if I can, to go somewhere else because I do not really see sustainable help [in South Africa]. - Participant 5, Refugee from DRC*

Though participants are encouraged by the potential economic benefits of accessing services, the ineffective delivery and lack of sustainable outcomes lead to low acceptability levels and a sense of disappointment in the system.

2.3 Positive Perspectives of Social Services

Although there were significant issues raised around service delivery and performance, many participants still shared an overall positive perspective towards social services in South Africa, especially in contrast to their home countries.

At least here, people are educated. They know it, they know where to run to in a certain situation. If something happens, we've got services in places, but back home, we do not have that. So, you have to do it by yourself. - Participant 6, Undocumented Asylum Seeker from DRC

Additionally, the larger cultural attitudes in South Africa against GBV positively influence migrant women to be accepting of services. These cultural trends have helped mainstream services, such as psychosocial care, which may have been stigmatized in a migrant's home country.

Because they're in this society, the South African society, where most of the women, the South African women, stand up and speak about gender-based violence, speak openly. So that's sort of also an encouragement for other women who are foreigners in this country to come out and speak. - Key Informant 4, Social worker for a migrant support organization

Service providers also shared how they perceived migrant clients of accepting more basic forms of psychosocial services in comparison to national clientele.

The environment of being in a foreign country when an incident happens actually increases their vulnerabilty. So, they always come with less expectations than our people [South Africans] who would demand services... To them, they appreciate the fact that they even have access to services. such as counselling, that is free. - Key Informant 2, Social worker for SGBV response service

Overall private organizations, such as migrant or psychosocial support NGOs, were seen in an especially positive light. Many of the participants shared that if they knew another migrant woman experiencing gender-based violence they would first refer her to a migrant organization before other options.

It's one organization that I saw that doesn't treat us as victims. We're not treated as victims at all. Like you don't feel like you're low... You feel like a human being which is something that you don't experience a lot after all this. - Participant 1, Refugee from Zimbabwe

Investigation into the acceptability of services shows a mixed reception to the potential benefits and difficulties associated with care. By layering these varying levels of acceptability onto the barriers of accessibility, a fuller picture of the complexities of post-violence care can be examined.

Discussion

By applying the AAAQ framework to these narratives from migrant women, the barriers impacting their recovery from GBV and limiting their access to health, justice, and psychosocial services are revealed. To work towards achieving an end to violence against all women, as included in Sustainable Development Goal 5, these barriers must be addressed (35). While global leaders, such as the World Health

Organization and UNICEF, have developed guidelines for increasing service accessibility for this vulnerable population, it is clear from these findings that much remains to be done to fulfil the rights of migrant women to access post-violence care in this urban South African context (28,36). By using qualitative analysis to understand the details of the lives of this underserved group, programming and policy initiatives can be better informed to respond effectively (37).

Identification and Utilization of Services

The findings have shown how limited access to information resulting from language barriers and weak social networks impact a migrant woman's knowledge of available post-violence care services. These barriers are then compounded by the social stigma around reporting violence. In these circumstances where GBV disclosure is seen as violating cultural norms, awareness of support options may be even further restricted. This situation is then further impacted by the financial and legal dependency a survivor often has on the perpetrator. This dependency, resulting in part from the gender inequality institutionalized within migration systems, creates subsequent delays in post-violence care access (38). In this way, the stories from this study paint a picture of the complexity influencing a migrant women's decision-making when seeking help and identifying support options.

In the examination of bureaucratic accessibility, this study's findings contribute to a vast collection of literature detailing the impact of the bureaucratisation of migration in South Africa. As seen in Chekero and Ross[20] the rights migrants have "on paper", or in legal frameworks such as the Constitution and Refugee Act, have substantially less influence than the impact of "having papers" [legal documentation]. Not having documentation stands out as a significant barrier to service access among study participants. Firstly, it is important to continue to collect and tell these stories of bureaucratic inaccessibility as a way of demanding accountability from the migrant regulation systems within SA. Furthermore, the participant's stories extend this argument by detailing how even after migrants have experienced violations of their rights, through acts of GBV, they can still be met with further systemic violence in the denial of services due to documentation. This series of actions re-victimizes survivors by limiting both their legal recourse and access to support for healing. The high level of dysfunction within the South African migration system is widely documented and acknowledged by the government (5). Yet it remains that the ultimate costs, paid primarily in the form of loss in well-being, fall on the victims of this dysfunction. Future research, programming, and policy action must acknowledge this impact and question how increasingly restrictive migration discourse and legislation will continue to perpetuate this.

This study also adds to the existing South African research in the area of medical xenophobia. Prior studies, such as Hunter-Adams and Rother[39] have examined how language barriers affected the

experiences of antenatal care for migrants in Cape Town. The findings of this study support such claims by showing how service providers use language as a strategy to label and subsequently discriminate against migrant women. Often used as a gatekeeping mechanism, service providers may use a migrant's accent or inability to speak a local dialect to refuse services or provide poorer quality of care (23). This xenophobic behaviour contributes to distrust in services. As Zihindula et al[24] found in their study of DRC refugees in Durban, this can result in outcomes such as decreased service utilization and intervention misuse.This evidence provides support for the need for interpreters to be provided within public services. It should also be used to advocate for a functioning system of accountability where migrants can report unethical xenophobic behaviour from public servants.

Application of the AAAQ framework allows for a deeper exploration of the overlaps, contrasts, and connections within the categories. For example, an interesting dichotomy around social stigma arose when comparing social accessibility and acceptability. Participants shared how their migrant communities often carry rigid gender roles from their home culture which leads to risking stigmatization and exclusion if they report incidents of GBV, especially when perpetrated by an intimate partner. Contrastingly in the larger South African context, there has been growing acceptance of the need to disclose and actively speak out against violence (40). Resulting in part from the work of feminist movements in response to SA's alarming rates of GBV and femicide, this social shift has the potential to create a more enabling environment for help-seeking behaviours (41). Migrant women are left navigating a contradictory space. While South African culture may potentially provide empowering conditions, the effects of xenophobia still restrict their integration and sense of security in this environment. Therefore, the possible benefits of this shifting of social stigma are limited. Research agendas on south-to-south migration call for greater inquiry into social nexuses such as these (42). Engaging with this complexity specifically around perceptions of violence disclosure could provide rich and valuable information. This evidence could then be used to inform advocacy for post-violence care and deepen understanding of norm shifting in migrant communities.

Findings about the acceptability of services also revealed concerning points about migrant perceptions of standards of care. KIs raised an important reflection around the perceived difference in acceptability of care between migrant and resident clients. They argued that migrants have relatively lower standards of care, as seen in the normalization of xenophobic discrimination and mistreatment. While these standards may result from a recognition by migrant clients that there are no alternatives and a need to accept what is realistically available, this leads to basic, even discriminatory, levels of care to be viewed as acceptable. This acceptability can result in people experiencing significant hardship, such as job loss and homelessness, before receiving any substantial form of support. The impact of these delays in assistance

means ultimately more aid, with the associated financial costs, is required. This results in an increased burden on an already under-resourced system. It also epitomizes the mismatch between the strong human rights orientation of South African migrant legislation and the lack of capacity in the South African health and legal systems. Through the application of the internationally recognized legal obligations underscoring the AAAQ framework, advocacy efforts must be made to address this disconnect and support migrants in realizing their rights to accessible and high-quality care, free from discrimination.

This study has shown a pattern of non-governmental entities, including NGOs and individuals, filling a void in referral support and service provision. First, in the identification of services, community members were reported as being essential points of intervention and referral following instances of violence. Neighbours, even when there were limited pre-existing relationships with the survivor, have aided with referrals to medical or legal services. Participants also shared that services from private organizations, such as NGOs for psychosocial care and migration support, were seen as more acceptable and their preferred first line of care. While these grassroots interventions provide an essential level of support which may not exist otherwise, they raise significant concerns about sustainability. NGOs and individual citizens cannot replace government safety nets. These findings contribute to a larger narrative of how private fulfilment of service gaps legitimizes the state's retreat from social responsibility (43). This enabling of government failure to fulfil the right to health is particularly significant for migrant-related care during global trends of rising nationalism.

However, it's also important to recognize that the voice and choice of migrant women needs to be respected. There lies a potential opportunity to capitalize on these organically occurring referral systems. Examples such as a migrant peer educator program in Morocco apply this concept to support migrants in navigating the health system, overcoming communication barriers, and sensitizing migrants on relevant health topics (44). Migrant organizations in Cape Town could model this by equipping beneficiaries, who are deeply embedded in their communities, with the skills needed to identify high-risk situations, ethically handle disclosures, and properly refer to migrant-friendly services. This could be a powerful tool in addressing low information accessibility and supporting the most isolated of those experiencing GBV. Finally, it is important to stress the resilience and active engagement of the study participants in their pursuit of justice, healing, and a life free from violence. They are not passive victims. They are courageous women who have developed vital coping strategies to navigate their complex environments. Their choices to access services, or not, were reasoned and informed by their unique understandings of their circumstances. While the existing barriers influenced the feasibility of their choices, these women ultimately made the decisions they believed were best for the safety of themselves and their families. They are cognizant of the specific type of support they want and need. Not only do they have this

understanding, but they are also proactive in seeking out avenues they believe may fulfil these needs. Interventions which empower these pursuits will result in the most sustainable, effective care to enable them on the path to recovery.

Limitations

As a qualitative exploratory study, this research sought an in-depth understanding over generalizability. Transferability to similar context is possible and useful, especially considering the increasing trends of south-to-south migration and the feminisation of migration. This means an increasing number of women will be travelling between low-resource settings where they have increased vulnerability to violence in all phases of the migratory journey and will be resettling in environments with under-resourced and overburdened post-violence care services. Understanding the needs and challenges encountered by these women will be a growing priority.

A limitation remains in the size and characteristics of the study sample. The study was under firm time constraints which limited the recruitment process and resulted in participants with mixed levels of experience regarding access to post-violence care. While all participants shared barriers to accessing health or legal services, this point of access did not always occur following instances of GBV leaving the experiences outside of the scope of this study. Additionally, the limited number of participants could have restricted the variety of perspectives leaving some barriers unidentified.

Due to the highly sensitive nature of the study, it was also important to ensure that participants had access to follow-up support mechanisms which meant all participants were linked in some way to the partner organization. This means the perspective of other migrants who are even less integrated into services and may be experiencing even greater barriers to care were unable to be represented in this study. This connection to the partner organisation may have also influenced the comfortability of participants during interviews as they were held in the partner's offices and the interpreters were previously known to participants through the partner's programming. Efforts were made by the researcher to mitigate this through dialogue with the participants and partner staff. Finally, language limitations could have affected the participants' ability to express themselves fully. Although interpretation services were made available when required, in interviewing with an English-speaking researcher participants may have felt restricted in their expression and some sentiments may have been lost in translation.

Conclusion

The stories shared in this study were challenging, evocative, and, unfortunately, all too common. They are representatives of countless examples of systemic xenophobic discrimination and the rippling effects of

this inequality. The rights of migrant women are repeatedly violated first through the acts of violence themselves and then by the inability to secure accessible and acceptable care services. These findings should be used to guide future research to deepen our understanding of the complex intersections between GBV and migration. More critically, they should be used to inform response efforts to address the urgent needs of this population. To adequately respond to this need, post-violence care services require resources and a coordinated, collaborative approach. The human rights argument is indisputable. It is political will that is now required for action. International institutions must apply necessary pressure to protect these global citizens. The South African government must uphold the values of Pan-Africanism by recognizing the humanity of these women and fulfilling their duty to promote a society where all persons can live free from violence.

List of abbreviations

AAAQ Framework: Availability, Accessibility, Acceptability, and Quality Framework; DRC: Democratic Republic of Congo; GBV: Gender-based Violence; HREC: Human Research and Ethics Committee; KI: Key Informant; NGOs: Non-Governmental Organizations; NSP-GBVF: National Strategic Plan for Gender-based Violence and Femicide; SA: South Africa; SAPS: South African Police Service; UN CESCR: United Nations Committee on Economic, Social and Cultural Rights; UNICEF: United Nations Children's Fund; UCT: University of Cape Town

Declarations

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Authors' contributions

Author order for manuscript submission:

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The first author (KB) took a leading role and assumed primary responsibility for developing the protocol, conducting the interviews, analyzing the results, and writing the manuscript. The second and third authors (LK and JD) offered methodological suggestions, contributed to the analysis, and contributed to editing

subsequent versions of the protocol and manuscript. The fourth author (SB) supported the conception of the study and development of the protocol and interview guides.

Ethics approval and consent to participate

Participants were given both written and oral information about the study. Prior to interviews, all participants had to sign an informed consent form. Approval was received from the Faculty of Health Sciences Human Research Ethics Committee at the University of Cape Town (No. 408/2023).

Consent for publication

Not applicable.

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available due the highly sensitive nature of the study but are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Appendix A: UNICEF AAAQ Conceptual Framework

Availability, Accessibility, Acceptability and Quality framework:

unicef

A tool to identify potential barriers to accessing services in humanitarian settings

The **"Availability, Accessibility, Acceptability, Quality"** (AAAQ) framework was originally developed for the healthcare sector,[1] but it can also serve as a useful tool for assessing other types of services.[2] Barriers that impede access to services – including those that may not be immediately apparent -- can increase the risk of multiple forms of gender-based violence (GBV), particularly in humanitarian emergencies. As such, this adapted AAAQ framework, which helps to identify barriers women and girls may face accessing humanitarian aid and services, forms part of UNICEF's set of tools for GBV risk mitigation.

Availability refers to the existence of services. Are services sufficient in terms of quantity and type?

Accessibility includes many components, such as:

Physical accessibility: Are facilities located within a reasonable distance? Is the route to and from the facility safe to travel? Are there other forms of physical barriers, such as armed guards outside the facility?

Financial accessibility: How is the service funded? If so, is the fee reasonable/manageable given the economic circumstances/means of those who need to access this service? If so, is the fee reasonable/manageable given the economic circumstances/means of those who need this type of care? What other indirect costs are associated with the service (such as transport)?

Bureaucratic/administrative accessibility: Are there procedural steps that must be completed before accessing certain services? For example, is a particular kind of registration required? Does accessing relevant information require a bank account, internet access, mobile phone, etc.? What level of literacy and/or numeracy is needed? Are the facilities open at times that are convenient given the daily/weekly responsibilities and preferences of women and girls in the community?

Social accessibility: Do service providers respect non-discrimination in the provision of services? Are certain groups excluded from services because of language barriers? Are there female frontline workers (including translators/interpreters, if necessary)? Are there any risks of stigma related to a person being seeing in/around a certain facility? Are other responsibilities, such as childcare or household chores, affecting certain individuals' ability to access services?

Information accessibility: How is information about services communicated to the community? Is dissemination and content of the information accessible to those who need it, for example in various languages, formats and modalities (i.e. radio, drama, outreach, print etc.)? Are there alternatives to printed information in order to reach members of the community with limited literacy? Is personal information treated confidentially?

[1] World Health Organization Availability, accessibility, acceptability and quality infographic can be accessed here: https://www.who.int/gender-equity-rights/knowledge/aaaq-infographic/en/.

[2] For example, the Danish Institute for Human Rights has developed a document called The AAAQ Framework and the Right to Water – international indicators that can be accessed here: https://www.humanrights.dk/publications/aaaq-framework-right-water-international-indicators

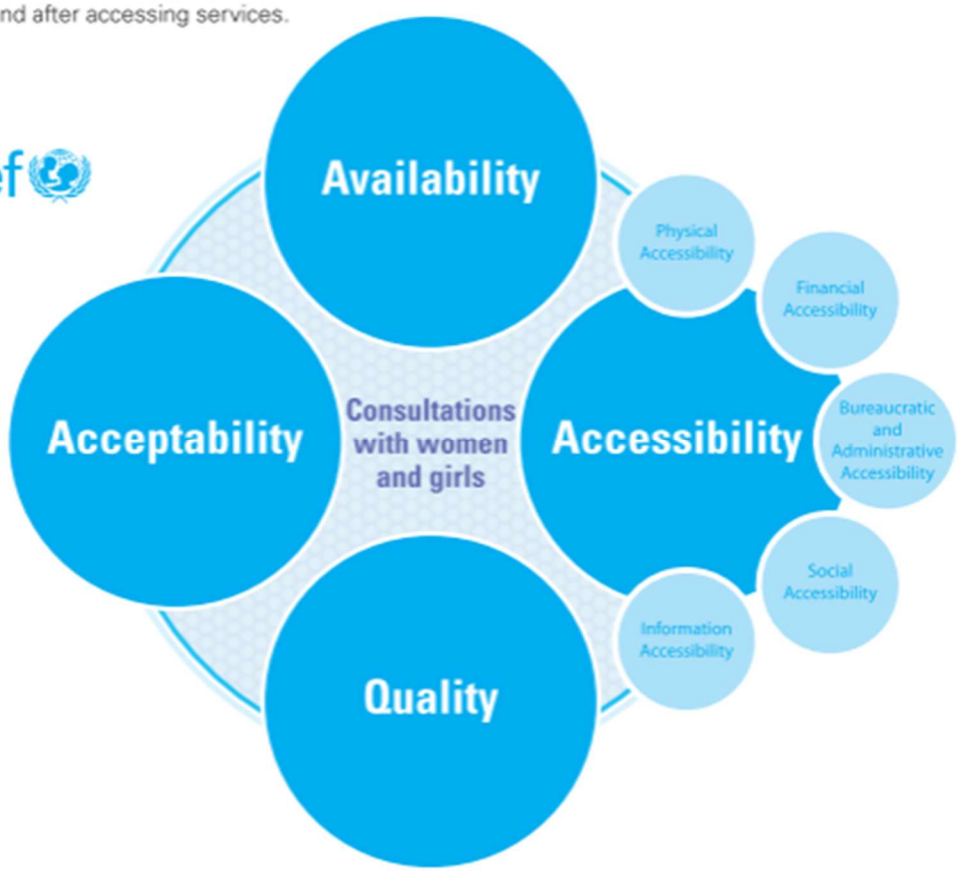
Acceptability: Are the services respectful of the culture of individuals, minorities, peoples and communities? Are services designed to respect relevant ethical and professional standards? Do service providers respect confidentiality and informed consent? Are services gender- and age-sensitive? Are there certain characteristics of the service providers (i.e. gender, international versus local staff etc.) that make the community more or less comfortable accessing services? Does the setup of distribution sites and or modality of distributions take into account cultural considerations?

Quality: Do service providers possess the necessary skills and training? Are there adequate supplies (i.e. drugs that are not expired and stored properly) that meet relevant standards? Is the environment appropriate, non-discriminatory, private and confidential as needed? Are the facilities safe and sanitary? Are services provided at an acceptable standard of care in alignment with relevant standards as appropriate? Quality also extends to the way people are treated before, during and after accessing services.

Consultations with women and girls

Consultations with affected communities in crisis, especially women and girls, is a critical component of effective humanitarian response. Consultations with women and girls, in addition to observation, secondary data review and other methods, can be utilized to better understand the specific barriers that women and girls face. Consultations can be conducted in the form of focus group discussions, participatory approaches and other methods.

unicef



For more information, contact Christine Heckman (checkman@unicef.org) or Sonia Rastogi (srastogi@unicef.org).

Appendix B: Memorandum of Agreement – Knowledge Co-op and MRASA

MEMORANDUM OF AGREEMENT (#644)

Made and entered into by and between

Muslim Refugee Association of South Africa (MRSA)
A registered non-profit organisation, having NPO number 068-857
Herein represented by Mr Nurudean Ssempa in his capacity as Deputy Director: Education and Mentoring, and he being duly authorized thereto

(hereinafter referred to as "the Organisation")

And

THE UNIVERSITY OF CAPE TOWN THROUGH THE UCT KNOWLEDGE CO-OP
A university established in terms of the Higher Education Act, 1997, and the statute of the University of Cape Town, as published and gazetted on 24 January 2020 in Government Gazette No 41, 42967 and amended under Government Gazette No 45954 and Government Notice No 1793 of 25 February 2022, herein represented by Jessica Senekal, in her capacity as Legal Advisor and she being duly authorized thereto, having its principal place of business at Bremner Building, Lower Campus, Lovers' Walk, Rondebosch, 7700, South Africa

(herein after referred to as "**UCT**")

(Hereinafter collectively referred to as the "Parties" and individually as the "Party")

PREAMBLE

Whereas UCT Knowledge Co-op is a unit within UCT which works in partnership with communities to address development challenges. The unit aims to make it easier for community partners to access UCT's skills, resources and professional expertise and works by matching community groups with academic partners in a collaboration that meets the needs for research or practical support identified by the community group;

And Whereas the Organisation is a non-profit organisation dedicated to uplift the plight of refugees; religiously, socially, morally, and academically and has identified the challenge of barriers to access Domestic Violence (DV) services amongst refugees.

And Whereas the Parties wish to establish an arrangement to govern the relationship between them on the basis of the terms and conditions contained hereinbelow.

1. **Definitions**

In this Agreement, unless clearly inconsistent with or otherwise indicated by the context, the definitions set out hereinbelow shall apply:

1.1. "Agreement" means this memorandum of agreement between the Parties captured in this document, together with any annexures, which are incorporated herein by reference.

1.2. "Commencement Date" means 3 February 2023, notwithstanding the date of last signature hereto, provided that ethics approval has been obtained where required;

1.3. "Intellectual Property" means intellectual capital relating to the Project in the form of any and all technical or commercial information, including, but not limited to the following: specifications and formulae; data, systems and processes; production methods; trade secrets; undisclosed inventions, financial and marketing information; as well as registered or unregistered intellectual property in the form of patents, trade marks, designs, know-how and copyright in any works, including literary works or computer software programs;

1.4. "Project" means the research to be undertaken towards the case study entitled: "A Qualitative Exploration of Barriers Experienced by Migrant Women when Accessing Gender-based Violence Support Services in Cape Town, South Africa" as set out in more detail in the brief description attached hereto as Annexure "A";

1.5. "Knowledge Co-op Representative" means Roshan Sonday;

1.6. "UCT Academic Supervisor(s)" means Associate Professor Lucia Knight, School of Public Health, in the Division of Social and Behavioural Sciences at UCT.

2. Purpose

With the support of the Organisation, Kathleen (Katie) Bradley, who is enrolled in the degree of Masters of Public Health (MPH) (hereinafter, "the Student"), shall conduct research towards the Project under the academic supervision of the UCT Academic Supervisor. The Student is undertaking the Project primarily as a learning experience and is not able to offer advice as an expert on the matter to be researched.

3. Duration

3.1. The Project will commence on the Commencement Date (see clause 1.2 above) and shall endure until 29 Feb 2024.

3.2. The Parties may extend this Agreement if required by mutual agreement in writing.

4. Nature of the Partnership

4.1. The use of the term "partner" in this Agreement is not intended in a way that implies the creation of a legal partnership, joint venture or any other kind of legal entity between UCT and the Organisation in order to implement the proposed Project. It is rather used to express a partnership in which both Parties have equal status.

4.2. The Parties are entering into this Agreement on the basis that they are equal partners who bring different and yet complementary strengths to the tasks of the Project.

4.3. The Parties commit themselves to the common goal of achieving the objectives of the Project to the standard acceptable in the academic field. Their relationship in implementing this Project will be underpinned by principles of transparency and trust.

5. Roles and Responsibilities of the Parties for the Project

5.1. Student tasks:

- Share the research proposal with the Organisation for comment.
- Conduct field work and write a thesis.
- Intermediate reporting on progress on a quarterly basis.
- Share findings with the Organisation via a copy of the thesis, an executive summary of relevant findings and a presentation to stakeholders.

5.2. The Organisation tasks:

- Introduce the Student to stakeholders.
- Advise on the selection of participants for the Project.
- Provide access to secondary data including publications and reports.
- Provide feedback and comment at times during the research process.

5.3. Knowledge Co-op tasks:

- The Knowledge Co-op Representative will introduce the UCT Academic Supervisor(s), the Student and the Organisation to each other and mediate the process towards completion of the Project.
- Disseminate outputs from the Project.

6. Finances

Unless expressly otherwise agreed upon in writing, there shall be no consideration payable by either Party for the performance of work by the other Party under the Project and each Party shall be responsible for procuring its own funding and paying its own costs incurred in respect of the Project.

7. Confidentiality and disclosure of information

7.1. Neither Party nor their respective employees, consultants or agents shall disclose, use or make public, any information or material acquired or produced in connection with or by the performance of this Agreement, other than in the performance of their respective obligations under this Agreement, or as required by law, without the prior written approval of the other Party, which may not be unreasonably withheld.

7.2. The Parties intend that the provisions of this clause shall be binding on them and shall survive the termination or expiration of this Agreement.

7.3. The Parties agree that any person interviewed during the course of the Project will be advised of the nature and consequences of the Project and will thereafter complete and sign an informed consent form before any interviews commence.

8. Intellectual Property and Publication

8.1. Each Party shall retain all rights to existing Intellectual Property owned by it at the commencement of the Project arising under this Agreement. The rights to any Intellectual Property created by the Student during the course of the Project period shall be vested in UCT.

8.2. The Parties agree that the products of this process stipulated above (Clause 5.1) will be made available to the public on the UCT Knowledge Co-op website under a Creative Commons licence.

THUS DONE AND SIGNED AT CAPE TOWN ON THIS 19th DAY OF APRIL 2023,

for and on behalf of **the UNIVERSITY OF CAPE TOWN**

Name: Jessica Senekal Signature: _____

READ AND ACKNOWLEDGED:

Student **Kathleen (Katie) Bradley**	April 25, 2023	_____
Academic supervisor **A/Prof Lucia Knight**	04 May 2023 Date	_____ Signature

THUS DONE AND SIGNED AT Athlone ON THIS ___ DAY OF 11th May 2023,

for and on behalf of Muslim Refugee Association of South Africa (MRSA).

Name: **Mr Nurudean Ssempa** Signature: _____

Appendix C: Recruitment Informational Flyer

Study Overview and Invitation

Research Participation Opportunity: The Muslim Refugee Association of South Africa and the University of Cape Town are collaborating to investigate the barriers experienced by migrant women when accessing or attempting to access gender-based violence care services.
If you are a woman, over the age of 18, with experience accessing GBV care then you may be eligible to participate in this important study.

The Purpose of this study: is to investigate the barriers experienced by migrant women when accessing gender-based violence care services. This important study is a collaboration between the University of Cape Town and the Muslim Refugee Association of South Africa with the goal of gain an understanding the structural, social, and cultural barriers which limit access to care. We are inviting you to participate in this research study to provide your perspective on these barriers and to share your own experiences of accessing services. You will be asked questions on what you know, think, and feel about this topic.

Appendix D: Informed Consent Form

Title: *Barriers to Gender-based Violence Care: A Qualitative Study of Migrant Women*

Lead Researcher: Lucia Knight
Email: lucia.knight@uct.ac.za Phone: 0216505313
Co-lead Researcher: Jessi Dutton
Email: jessi.dutton@gmail.com Phone: 0626530018
Student Researcher: Kathleen Bradley
Email: brdkat010@myuct.ac.za Phone: 0635376644
Contact Information: Human Research Ethics Committee (HREC), Faculty of Health Science UCT
Email: marc.blockman@uct.ac.za Phone: 0214066338

❖ Before you decide to be a study participant, it is important that you understand why this study is being done. Please review the following important information about the study before signing. If you have any questions, please feel free to ask.

The Purpose of this study: is to investigate the barriers experienced by migrant women when accessing gender-based violence care services. This important study is a collaboration between the University of Cape Town and the Muslim Refugee Association of South Africa with the goal of gain an understanding the structural, social, and cultural barriers which limit access to care. We are inviting you to participate in this research study to provide your perspective on these barriers and to share your own experiences of accessing services. You will be asked questions on what you know, think, and feel about this topic.

Why have I been invited: As a migrant woman living in Cape Town, you have a unique experience when it comes to accessing health care services, including gender-based violence care. As researchers, we would like to understand your experiences when accessing these services and any challenges you faced. We value your thoughts and experiences in understanding this topic which helps us understand the issue more as researchers.

Consent: Informed consent is an on-going process throughout research. Discussing services related to gender-based violence can be an emotional or difficult conversation, so you are free to request to stop without any explanation. You are also allowed to refuse to answer questions which makes you uncomfortable or you do not wish to answer. If you have questions or concerns, feel free to stop the interview and ask for more clarification. Following the interview, you are also allowed to withdraw an

answer at any given time. If you feel upset or stressed during the session or after the interview, let one of the researchers know so that we may refer you to a counsellor.

Confidentiality and disclosure of information: Numeric identifiers will be assigned to ensure that all data collected during the interview and research process will be kept confidential. Interviews will take place in a private room within the MRASA office to ensure privacy. With participant permission, interviews will be recorded and transcribed to allow for better understanding and analysis. If you feel uncomfortable at any time, you are allowed to stop the recording. All written and audio recordings will be stored in a password-protected folder. All information obtained in this study will only be shared with participant permission and approval. In our final report, we may use direct quotes or summaries from interviews, but they will be anonymous, and participants will not be identified by name. If there is need to refer to your words, we may use a fake name (pseudonyms). Your name may be used if you voluntarily request for it to be used.

Thank you for your time and agreeing to be part of this discussion!

Name of person seeking consent: Kathleen Bradley

I hereby consent to the above:

Signature of Participant: _____

Name of Participant: _____

Date: _____

Appendix E: Interview Guides

Mini-Dissertation Interview Guide

Introduction:

Thank you for taking the time to meet with me today.

My name is Kathleen Bradley, and I am a master's student studying public health at UCT. I am here today to conduct interviews to inform my thesis study on the barriers that migrant women experience when accessing gender-based violence care service. This research is being facilitated in partnership with the Muslim Refugee Association of South Africa who hope to use the findings of this study to improve the accessibility of these services.

First, I want to make sure you are comfortable with using this space for the interview?

I would like to begin by assuring you that we want this to feel like a safe space. This interview is a collaborative learning endeavor, and you are in control of where it goes from here. Please know that you are free to share as much or as little as you want, to take a break if you need to, or to stop the interview at any time.

The goal of this interview is to reflect on your experiences accessing gender-based violence care services. Examples of these types of services include: Thuthuzela Care Centres, public clinics, and police services. You may have accessed these services for yourself or on behalf of someone else. This interview is not focused on the experiences of gender-based violence that occurred leading up to the utilization of these services, we are solely focused on the experience of accessing services. You should not feel pressured or compelled to share any details about the violence. If you do want to talk to someone about this, please let us know and we can connect you to a qualified social worker. Do you have any questions about that?

I also want to remind you that everything said during this interview will be confidential. With your permission I would like to audio record the interview to ensure that I capture all of the valuable information you will share with me. Following this interview, all audio recordings will be saved in a password protected folder which only myself and my supervisor will have access to. We will use direct quotes from the interviews in the final report of this study, but all of the data will be anonymized to protect confidentiality. Do you have any questions or concerns about our confidentiality measures?

Do you have any questions about the interview process or the research in general?

Participant Interview Guide

(Version A: For participants who have accessed post-violence care services)

Ice Breaker

1. Please tell me about yourself and your experience with MRASA.

Experiences of Services

Now I would like to ask you to tell me about a time when you accessed or attempted to access gender-based violence care services. Examples of these services include: Thuthuzela Care Centres, public health clinics, and police services. As I shared in the introduction, please do not feel like you must share about the experiences of violence that led you to those services. Our interest is in the process of how you decided to look for services, how you found them, and how accessing them went for you.

2. Can you please tell me about your process of identifying the services you accessed.

Prompts: How did you look for available services? Where did you find this information? What were things you considered when you were trying to decide on what services to use?

3. Can you please tell me about your process of traveling to or communicating with the services that you used?

Prompts: Was there a phone number or messaging service you could use? What was the distance traveling from where you stay to the services? Are the facilities open at times that are convenient or accessible to you? Were there other options closer that you chose not to use? Why?

4. Please share about what happened upon arrival at these services.

Prompts: Were you asked to register upon arrival? Was it accessible to you (language used, written vs. oral)? Was there proof of identification or visas required? Were there any costs associated with accessing the services that limited your ability to receive care?

5. Please share about the experience of care you received.

Prompts: Did you feel comfortable communicating with the staff of the service organization? How did the services you received align with your own cultural values and traditions? Did you experience any discrimination or stigmatization when accessing the services? From who?

6. Please share about any experiences of follow up you may have had after your initial visit.

Prompts: Did you feel adequately supported and cared for? Did you experience any fear or increased risk following the access of these services?

7. Overall, how would you describe your experience accessing these services?

8. Were there any other challenges you experienced that you still haven't shared?
9. Based on the barriers you have described throughout this interview, which would you identify as the most challenging?

Moving forward:

10. If you knew someone experiencing gender-based violence, would you refer them to the services you used?
11. If you could improve these services to better suit the needs of migrant women, what would you do?
12. What role do you believe MRASA has in supporting its beneficiaries in the access of these services? How would you like to be supported?

Alternative Participant Interview Guide

(Version B: For participants who have not accessed any post-violence care services)

Ice Breaker

1. Please tell me about yourself and your experience with MRASA.

Knowledge of Services

Now I would like to ask you about your understanding of services you can access if you experience a situation of gender-based violence or domestic abuse. As I shared in the introduction, please do not feel like you must share about the experiences of violence that led you to looking for these services, I am only curious to hear what you know and think about these services.

2. Do you know of any services someone could go to for help if they have experienced gender-based violence? Can you please share a few examples?
3. Can you please tell me which of these services you would feel most comfortable going to if you needed assistance and why?
4. Can you please share about why you would choose to not access any of these services?
5. Please share what you believe to be the biggest barrier to accessing or choosing to access these types of services.

Moving forward:

6. If you knew someone experiencing gender-based violence, which services would you refer them to?
7. If you could improve these services to better suit the needs of migrant women, what would you do?
8. What role do you believe MRASA has in supporting its beneficiaries in the access of these services? How would you like to be supported?

Key Informant Interview Guide

Demographics:

1. Name?
2. Occupation?
3. Organization you work for?
4. Location of your organization?
5. Type of services your organization provides?

Content:

1. How frequently do you work with migrant populations?
2. How would you describe the migrant population that you work with?
3. Can you describe the GBV care services available to migrants in this area?
4. Describe the experiences of your migrant clients in accessing care.
5. What structural barriers do they experience?
6. What social and cultural barriers do they experience?
7. If you could improve these services to better suit the needs of migrant women, what would you do?
8. How do you think community-based organizations, such as MRASA, can support their beneficiaries in accessing migrant-friendly GBV care services?

Appendix F: Human Research Ethics Committee Approval Letter

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room 45 E-52-E-Floor- Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: hrec-submissions@uct.ac.za
Website: www.health.uct.ac.za/home/human-research-ethics

15 August 2023

HREC REF: 408/2023

A/Prof L Knight
Division of Social and Behavioural Sciences
FHS
Email: lucia.knight@uct.ac.za
Student: brdkat010@myuct.ac.za

Dear A/Prof Knight

PROJECT TITLE: BARRIERS TO GENDER-BASED VIOLENCE CARE: A QUALITATIVE STUDY OF MIGRANT WOMEN-
(MASTERS' CANDIDATE-MS KATHLEEN ELIZABETH BRADLEY)

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee (HREC) for review.

This is a thorough and comprehensive protocol that all involved should be commended for.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 August 2024.

Please submit a progress form, using the standardised Annual Report Form (FHS016) if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

The HREC acknowledge that the student: Ms Kathleen Bradley will also be involved in this study.

Please quote HREC REF 408/2023 in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FACULTY OF HEALTH SCIENCES HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637. Institutional Review Board (IRB) number: IRB00001938 NHREC-registration number: REC-210208-007

HREC/ref 408.2023

Appendix G: BMC Women's Health Research Article Manuscript Guidelines

Research article

Criteria

Research articles should report on original primary research, or present a new experimental or computational method, test or procedure. Manuscripts reporting results of a clinical trial must conform to CONSORT 2010 guidelines. Authors of randomized controlled trials should submit a completed CONSORT checklist alongside their manuscript, available at www.consort-statement.org. Research articles may also report on systematic reviews of published research provided they adhere to the appropriate reporting guidelines which are detailed in our editorial policies. Please note that non-commissioned pooled analyses of selected published research and bibliometric analyses will not be considered. Studies reporting descriptive results from a single institution or region will only be considered if analogous data have not been previously published in a peer reviewed journal and the conclusions provide distinct insights that are of relevance to a regional or international audience.

BMC Women's Health strongly supports open research, including transparency and openness in reporting. Further details of our Data availability policy can be found on the journal's About page.

BMC Women's Health strongly encourages that all datasets on which the conclusions of the paper rely should be available to readers. We encourage authors to ensure that their datasets are either deposited in publicly available repositories (where available and appropriate) or presented in the main manuscript or additional supporting files whenever possible. Please see Springer Nature's data repository guidance. Where a widely established research community expectation for data archiving in public repositories exists, submission to a community-endorsed, public repository is mandatory. A list of data where deposition is required, with the appropriate repositories, can be found on the Editorial Policies Page.

Professionally produced Visual Abstracts

BMC Women's Health will consider visual abstracts. As an author submitting to the journal, you may wish to make use of services provided at Springer Nature for high quality and affordable visual abstracts where you are entitled to a 20% discount. Click here to find out more about the service, and your discount will be automatically be applied when using this link.

Preparing your manuscript

The information below details the section headings that you should include in your manuscript and what information should be within each section.

Please note that your manuscript must include a 'Declarations' section including all of the subheadings (please see below for more information).

Title page

The title page should:

- present a title that includes, if appropriate, the study design e.g.:
  - "A versus B in the treatment of C: a randomized controlled trial", "X is a risk factor for Y: a case control study", "What is the impact of factor X on subject Y: A systematic review"
  - or for non-clinical or non-research studies a description of what the article reports
- list the full names and institutional addresses for all authors
  - if a collaboration group should be listed as an author, please list the Group name as an author. If you would like the names of the individual members of the Group to be searchable through their individual PubMed records, please include this information in the "Acknowledgements" section in accordance with the instructions below
  - Large Language Models (LLMs), such as ChatGPT, do not currently satisfy our authorship criteria. Notably an attribution of authorship carries with it accountability for the work, which cannot be effectively applied to LLMs. Use of an LLM should be properly documented in the Methods section (and if a Methods section is not available, in a suitable alternative part) of the manuscript.
- indicate the corresponding author

Abstract

The Abstract should not exceed 350 words. Please minimize the use of abbreviations and do not cite references in the abstract. Reports of randomized controlled trials should follow the CONSORT extension for abstracts. The abstract must include the following separate sections:

- **Background:** the context and purpose of the study

- **Methods:** how the study was performed and statistical tests used
- **Results:** the main findings
- **Conclusions:** brief summary and potential implications
- **Trial registration:** If your article reports the results of a health care intervention on human participants, it must be registered in an appropriate registry and the registration number and date of registration should be stated in this section. If it was not registered prospectively (before enrollment of the first participant), you should include the words 'retrospectively registered'. See our editorial policies for more information on trial registration

Keywords

Three to ten keywords representing the main content of the article.

Background

The Background section should explain the background to the study, its aims, a summary of the existing literature and why this study was necessary or its contribution to the field.

Methods

The methods section should include:

- the aim, design and setting of the study
- the characteristics of participants or description of materials
- a clear description of all processes, interventions and comparisons. Generic drug names should generally be used. When proprietary brands are used in research, include the brand names in parentheses
- the type of statistical analysis used, including a power calculation if appropriate

Results

This should include the findings of the study including, if appropriate, results of statistical analysis which must be included either in the text or as tables and figures.

Discussion

This section should discuss the implications of the findings in context of existing research and

highlight limitations of the study.

Conclusions

This should state clearly the main conclusions and provide an explanation of the importance and relevance of the study reported.

List of abbreviations

If abbreviations are used in the text they should be defined in the text at first use, and a list of abbreviations should be provided.

Declarations

All manuscripts must contain the following sections under the heading 'Declarations':

- Ethics approval and consent to participate
- Consent for publication
- Availability of data and materials
- Competing interests
- Funding
- Authors' contributions
- Acknowledgements
- Authors' information (optional)

Please see below for details on the information to be included in these sections.

If any of the sections are not relevant to your manuscript, please include the heading and write 'Not applicable' for that section.