"Foreign migrant women's perceptions of obstetric care in the Cape Town metro-pole."

A dissertation for the Master's of Medicine degree

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Declaration

I declare that this thesis is my own unaided work. It is submitted to the Faculty of Health Sciences at the University of Cape Town, for the Master's of Medicine in Obstetrics & Gynaecology degree. At no other University or Institution has it been submitted as a requirement for a degree or any other qualification.

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Abstract

This study explores the maternal healthcare experiences of nine foreign migrant women who received obstetric care in the Cape Town metropole. The Republic of South Africa's legislation enshrines the right to health for all who live within the country's borders, regardless of residency status. In practice however, foreign migrants can experience significant challenges and, in the Cape Town metropole how these women experience obstetric care has not been a focus of scholarly interrogation**.** With this study I hope to establish the factors that influence migrant women's experiences positively or negatively and to utilise the knowledge gained from their experiences to enhance pregnancy care of migrant women in the longer term.

A literature review was performed covering the areas of migration to South Africa, migrant women's health, migrant's health challenges and official South African healthcare policies. Data was collected by doing one on one, open-ended and semi-structured interviews with nine foreign migrant women from seven different countries and with two key stakeholders employed at two of Cape Town's largest refugee centres. The interviews were recorded, professionally transcribed and then data inductively coded using thematic analysis. Thematic analysis was used since it is a way to extract descriptive information concerning the experiences of migrant women in Cape Town and to construct meaning, in order to understand their perceptions about the obstetric care.

The findings indicate that the attitudes & behaviours of staff, language, prior traumatic experiences, degree of assimilation and healthcare systemic issues are some of the chief factors that influence perception of care. Xenophobia and dismissive behaviour were the main issue with staff but that was juxtaposed against some excellent and compassionate care received. Some of the women struggled to communicate the na-

ture of their problems and being understood but also found understanding local staff a significant barrier. Having had to endure staff attitudes and behaviours can reasonably be agreed to have delayed monitoring or intervention. Language barriers resulted in adherence issues with medications, potential missed appointments, issues around informed consent and missed opportunities at health promotion. The women had a poor understanding of the local healthcare system's design and had expectations in relation to their own experience of the system in origin countries. When these expectations were not met, it was perceived as poor. A key challenge was the failure of the facilities to recognise the asylum documentation and the rights afforded to those who had them. The reasons for fleeing their countries included warfare, genocide, political turmoil and economic deprivation. The journeys to Cape Town were fraught with further trauma and this made the women vulnerable to mental health issues which also impacted their perceptions of care. Further, a traumatic birth in Cape Town carried significant sway over how further births in Cape Town were viewed.

It is clear from this study that multiple, complex factors influence the way foreign migrant women perceive their care. These factors are personal and unique to each individual but there were commonalities. Trained interpreters, cultural sensitivity training, education surrounding documentation, allowing birth partners to be present during visits and births, extra safety checks on perinatal mental health for first time births in Cape Town and a more robust, confidential and accountable complaints system were recommendations by this cohort.

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Abbreviations

HREC	Human Research Ethics Committee
IOM	International Organisation for Migration
MMed	Master's of Medicine
MOU	Maternity Obstetric Unit
SADC	South African Development Community
UNHCR	United Nations High Commission for Refugees
UN	United Nations

Chapter 1: Background

1.1 Introduction

South Africa's political and social history has at many periods included unfair and unequal distribution of resources of all kinds, including access to health care[1]. This has often come at the expense of the well-being of the majority of the population that make up this country. With the new political dawn in 1994 and with the introduction of the new Constitution in 1996, broad sets of laws were established to try and overcome these previous barriers to healthcare and a health-for-everyone policy was adopted that enshrined basic healthcare to anyone within the borders of the country.

This 'anyone' includes non-nationals and over the last 2 decades many cross-border migrants have become part of the fabric of our society with recourse to public services. Little is known about their experiences of our healthcare system and even less is known about the experiences of migrant women during pregnancy and childbirth.

According to Statistics South Africa, Census 2011[2] showed there were just over 2.1 million documented international migrants in 2011, which translates to about 4.2% of the total population of the country. A documented migrant[3] is defined as one who satisfies all the legal requirements to enter, stay and, if applicable, hold employment in the country of destination. The Census makes no comment on the number of undocumented immigrants and as recently as mid-2021, officially has made no estimation of that number.

South Africa is an important destination for many people who seek better socio-economic opportunities according to the United Nations High Commission for Refugees[4]. This is due to the relatively stable democratic government, infrastructure and economic opportunities[5]. Cross-border migration from Lesotho, Mozambique, Swaziland,

Botswana, Zimbabwe and Malawi started in the mid-nineteenth century providing labour services to the nascent mining and sugar industries.[6] Political unrest, war and economic crisis in Somalia, Ethiopia, Rwanda, Burundi and Democratic Republic of Congo have also led to a rise in the number of displaced persons to South Africa from the mid-1990s. Globalisation[7], improvements in communication, transportation systems and infrastructures that are all features of the modern time we live in, have led to an increasing number of people becoming aware of better opportunities in countries other than their countries of birth. This has contributed to an increase in migration volume.

According to the Census, the majority of immigrants to South Africa come from Africa (75.3%) and of these, 68% from the Southern African Development Community (SADC) region. The SADC regional bloc includes Zimbabwe, Botswana, Mozambique, Zambia, Namibia, Tanzania, Lesotho, Angola, Democratic Republic of Congo, Malawi, Swaziland, Mauritius, Madagascar and Seychelles. Immigrants from other African countries outside the SADC constituted only 7.3% of the total number of international migrants in South Africa. Of those from SADC countries, 45.5% come from Zimbabwe, 26.6% from Mozambique, 10.9% from Lesotho and 5.9% from Malawi.

A closer examination of the Census statistics shows the highest percentage of immigrants in South Africa are between the age group 25–34 years (34. 3%) and 15–24 years (18.4%), followed by people in the age group 35–44 years (17.5%). Almost 40% of international migrants from SADC countries are females and almost 74% were in the age group 15–44 years, signifying an increase in female migration[8] especially women during their economically productive years and during their reproductive ages. Just less than half of international migrants (47%) entered South Africa recently between 2006 and 2011. The majority of them (52%) chose Gauteng as their destination with the Western Cape, at 12%, hosting the second largest group.

Some of the challenges of international migration include integration of the migrants in their new countries, health and psychological problems, isolation, separation from families and struggles to acclimatise to environmental, cultural and climatic changes. Other challenges faced by international migrants include language barriers, a shortage of employment opportunities, xenophobic violence and exploitation by some employers.[9 10]

One serious challenge, though also true for rural South African migrants, is the documented verbal abuse and denial of care of migrant patients who are perceived as being burdens on public services.[11] Patients perceived as migrants can also face threats to confidentiality of medical information or substandard care because of a lack of interpreters.[12]

Over the last decade, increasing numbers of foreign-born patients have been attending antenatal services across Groote Schuur, New Somerset and Mowbray Maternity Hospitals. According to Western Cape Government Department of Information Management, for the first full year (2008/2009) that data was collected on the province-wide patient administration tool called Clinicom, 169 patients of 10285 (1.6%) were foreign born. For the 2017/2018 data year, 1362 patients of 8498 (16%) were documented as being immigrants, demonstrating a considerable increase in numbers of this population.[13] No research could be found concerning the unique experiences that patients may experience when booking for antenatal care in the Western Cape provincial healthcare system.

Plenty of studies have researched access to health care services among migrants and increasing attention is now focusing specifically on migrants' access to maternal healthcare these studies have predominantly been conducted in developed countries.

Bulman et al[14] looked at Somali refugee women's experiences of maternity care in London and found unequal access to maternity services due to inadequate provisions of interpreting services, stereotyping and a lack of understanding from staff of cultural differences impacting on health-seeking behaviour. Mitu[15] looked at Bangladeshi women's childbirth experiences in the United States where she found women longed for the support from extended family that they would have received at home and that the experiences of the women differed based on their socio-economic status. Many of the women looked positively upon Western medicine and there was a trend towards medicalised birth in comparison to the poor access to women's health back home. Carolan et al[16] studied antenatal care perceptions of African women attending maternity services in Melbourne. She found that the women went through a journey of adjustment from first viewing pregnancy as not special and merely a natural process to coming to understand the value of routine pregnancy care.

More applicable to our context, Mafuwa[17] researched Zimbabwean experiences at selected public healthcare centres in Cape Town. Some of Mafuwa's findings included immigrants struggling to access healthcare because of their immigration status, receiving delayed care since South African citizens were given preferential status, being mocked with disparaging names and being accused of coming to South African to have their children. Makwanda[18] studied Zimbabwean women's experiences accessing healthcare services during childbirth in Johannesburg. He highlighted issues with cultural and linguistic discrimination; care facilities administrative hurdles; feelings of disempowerment; financial burdens and a lack of social support networks all affecting the participants' experiences of their pregnancies.

1.2 Research Question and Research Objectives

The main research question is as follows:

- How do foreign migrant women perceive obstetric care in the Cape Town metropole?

The responses to the main research question will address the following objectives:

- To establish the factors that influence migrant women's experiences positively/negatively in the obstetric care system
- To utilise the knowledge gained from their experiences to enhance care linked to treating migrant pregnant patients in the longer term

1.3 Rationale

The number of women who are in their reproductive years migrating to South Africa has steadily been increasing and there is a dearth of literature on the needs and experiences of these women when it comes to pregnancy and birth- arguably the most vulnerable time in a women's reproductive life. This research project seeks to focus attention on this vulnerable population group, often hidden from view in terms of scholarly interrogation and policy, who are nonetheless accessing care at South African public facilities. Given the potentially significant impact of obstetric care on pregnancy and birth outcomes, this study aims to uncover the lived experiences, both positive and negative, of migrant women who access public healthcare during pregnancy and childbirth in Cape Town. The study further seeks to delineate the challenges they may face and how any of these factors may be mitigated.

Chapter 2: Literature Review

2.1 Migration to South Africa

Camlin argues that women's mobility in sub-Saharan Africa has continued to receive little attention in migration studies in part due to a continued scarcity of national level data for the study of sex-specific migration patterns in the region.[19] The first analyses of migration research that specifically studied it from the vantage point of gender emerged about three decades ago. This brought attention to the male gender bias that had taken root in migration studies. From the seventeenth century through to the the early 1990s, South Africa's legislative policies sought to maximise on the cheap labour of Black Africans (local and migrant) in order to support the expanding mining and farming industries.[20] Male seasonal or transient work migration was a cornerstone of South Africa's segregated economy.

Independent female migration to and within South Africa has occurred at least since the late 19th century, when many moved to the Witwatersrand to pursue economic opportunities in the gold mining boom as well to form parts of the domestic labour and informal sectors.[21] The apartheid government's inmigration control laws specifically excluded women as labour immigrants to South Africa[22], but the internal migration of women in southern African nations of Zimbabwe, Lesotho, Swaziland, Mozambique and Botswana increased over the 1970s.

Women's migration to South Africa in recent times needs to be viewed through the lens of major socio-economic and political transformations occurring on the continent from the mid-1980s. Reasons for migrating include historic poor economic conditions exacerbated by International Monetary Fund sponsored Structural Adjustment Programs with ensuing liberalisation of the economy, devaluation of local currencies, a dramatic reduction of government spending that led middle class Africans families into poverty and ensured that those who were poor remained so or even worse off.[23] The

single biggest reason for cross-border migration by women was cited by Wentzel as being the search for employment and economic opportunity.[24]

During the same period multiple civil unrests and political crises occurred with wars breaking out in Somalia, Zaire (now the Democratic Republic of Congo), Rwanda and Burundi and this resulted in many families fleeing for their lives. In Wentzel's study, 20% of females said security was their main reason for coming to South Africa. Wentzel's cohorts' other chief reasons for migrating included improved educational opportunities, spouse or other family members already living in the Republic, environmental concerns and lifestyle/health related concerns.

Intersecting with all these reasons were the major socio-political changes in South Africa and the lifting of sanctions in 1990 that culminated in the release of African National Congress leader, Nelson Mandela. This was followed by the first democratic elections in 1994. The blend of the economic crises, political unrest in other regions of Africa, and the opening of South Africa's borders made it possible for women from other African locations to consider the country as a destination. The increasing feminisation of migration is a result of the shifting needs for various types of skills, such as in the hospitality industries, household service, nursing, educators, care work and other typically female dominated professions.[25]

In urban zones, Landau argues that there is a prominence of a nativist discourse directed towards migrants from neighbouring countries by both state officials and citizens of the Republic, claiming these cities to be for citizens only.[26] Poor African migrants, in particular, are 'othered' and are seen as economic burdens and as burdens on governmental services. According to Landau, an unhealthy mix of poor documentation, societal ignorance and outright discrimination can result in migrants' being de-

nied access to critical services such as healthcare that can have immediate and long-term consequences.

2.2. Migrant Women's Health

The systemic inequalities experienced by migrants have a significant impact on overall health and well-being and migration is increasingly recognised as a determinant of health as it has a direct impact on health outcomes.[27] Vearey states that despite the liberal and progressive laws enacted since 1994 that enshrine the right to health for all in South Africa, foreign migrants still struggle to access public healthcare services and are perceived as burdens on the health system.[28] The collaborative United Nations Population Fund/International Organisation for Migration report also concludes that female migrants are an important challenge for public health as increasing evidence points out that migration can adversely affect the health of migrant women as they are likely to be of reproductive age and have specific health needs.[29] Dias states that foreign migrant women face unique and new social, structural and cultural contexts that frequently exposes them to risk factors that adversely affect their health.[30] These include legal, labour and financial factors as well as health professionals' stereotyped, discriminatory and sometimes hostile attitudes to migrant women.

Migrants move not only across geographical borders but also across, between and among medical systems according to Sargent and Larchanche.[31] Significant changes in risk to health and treatment choices thus accompany migration but they vary in relation to the features of the migrant population such as gender, ethnicity, class and legal status. They also note the fact that migrants' reproductive health is a pressing issue from a public health perspective because many migrants are of reproductive age, thus the increase in female migrants has also increased the need for scholarly, policy and clinical attention to pregnancy, birth and postpartum period health. Sargent also comments that the health of migrants is directly correlated with their degree of

social integration and productivity and that illness debilitates migrant populations and exacerbates their marginalisation. This marginalisation places immigrants at further risk of ill health and inadequate access to care.[32]

Castaneda states that reproduction is linked with "both gender and national identities and migrants may find reproductive decisions deeply contested in narratives of the nation-state".[33] Castaneda examines the concept of "demographic theft" in Germany, where high fertility among "foreigners" has created anxiety concerning the future of the German citizenship model, based on "right of blood" rather than on territory of birth. Chavez observes that Latina women in the United States are perceived unfairly as a high fertility population, threatening the dominant society with cultural displacement and overburdening the health system.[34] Within South Africa urban contexts, Landau argues that South Africans increase nativist rhetoric and 'other' foreign migrants and insinuate that new arrivals have no place in the local system. This problematises pregnancy among migrant women, especially those who are undocumented.

Davies highlights that structural inequalities experienced by many migrants have a significant impact on their overall health and well-being and that migrant health goes beyond the traditional treatment of diseases among migratory populations but also involves access to maternal healthcare services. Davies states that even migrants with legal right to remain in South Africa and those more socio-economically stable in society may experience challenges and limits in accessing healthcare services, mainly due to language and cultural differences as well as institutional and structural obstacles within the host country.[27]

2.3 Migrants' Healthcare Challenges

Vearey emphasises the persistence of challenges faced by cross-border migrants despite the policy guidelines, frameworks and progressive changes made since the end

of the apartheid era that should help uphold the right to access healthcare for all in South Africa.[28] Some healthcare centres manufacture their own guidelines which run against the national legislation. One such example is the frontline level of bureaucratic 'policing' that takes the form of demanding migrant documentation as a form of access control to the healthcare system. Pursell, in her study of Somali women in Johannesburg, states this is partly due to confusion and ignorance about migrants' rights to healthcare access. Many South Africans wrongfully assume that all migrants are illegal here and that this confusion is perhaps caused by the unfamiliarity with refugee identity document.[35] Pursell states it may also be a broader unwillingness to consider that refugees and migrants are entitled to healthcare services regardless of their status.

Pursell also highlights how not being able to communicate in a South African language prevented migrants from being understood and being able to clearly communicate the nature of their health problem. This meant that many were turned away from hospitals and clinics because they could not communicate. Also, they were only treated for the superficial or most obvious problem because it was difficult for medical professionals to obtain any extra information in order to make a more comprehensive assessment of the health issue. Further issues highlighted were the lack of knowledge how the local health system functioned (where to start, referral pathways etc.), xenophobia & racism, user fees and expectations of health service levels.

2.4. The South African Healthcare Policy

According to the South African Constitution, the right to healthcare services is provided for in three sections of the Constitution. The Constitution[36] provides for access to healthcare services including reproductive health and emergency services, basic healthcare for children and medical services for detained persons and prisoners. Universal access is provided for in Section 27(1)(a) which states that "everyone has the

right to have access to healthcare services, including reproductive healthcare…". Section 27(1)(b) provides for the state to "take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right" and Section 27(3) states that no one can be denied emergency medical treatment which includes all forms of maternity care. The Constitution, under Section 27(2) also obliges the State to refrain from denying or limiting access to healthcare services to anyone and that these services should be available to all on a non-discriminatory basis. In a landmark case dealing with access to social grants, Khosa & Others vs Minister of Social Development & Others, the Constitutional Court of South Africa ruled that the "everyone" under section 27, that pertains to access to healthcare, food, water and social security, "cannot be construed as referring only to citizens".[37] Further South African legislation[38] grants refugees entitlement to basic health services under Section 27 and under Section 22(1) confers rights for those seeking asylum within the country.

The National Health Act of 2003 also states in Article 5 that "a healthcare provider. health worker or health establishment may not refuse a person emergency medical treatment" and the Act also establishes standards for handling complaints by health users and mandates provincial health departments to establish concrete complaint procedures and investigations through Article 18.[39] Moreover, the National Health Act's Section 4 gives in general terms the ways in which people are able to gain access to healthcare service and noted that pregnant and lactating women and children below the age of six are eligible for free treatment in public health care facilities.

Therefore, it is clear that foreign migrants are legally allowed access to healthcare in South Africa, especially women and children. However, this access to care for female migrants in particular remains challenging for many, which can have a significant im-

pact on health outcomes. Pregnant women's experiences in the health service need to be better understood in order to facilitate better care.

2.5 Mistreatment of Women in South African Labour Wards

The World Health Organisation identifies delivery in a health facility as an important strategy that can reduce mortality, especially when the delivery is attended by skilled healthcare professionals.[40] The literature also indicates that poor outcomes in labour are related to the abuse, disrespect and neglect of mothers.[41] Disrespect and abuse during labour and childbirth is more prevalent in low and middle income countries.Disrespect and abuse during childbirth is considered by experts to be a barrier to the effective utilisation of the skills of healthcare providers, an important indicator for Sustainable Development Goal.[42,43]

The Guideline for Maternity Care in South Africa indicates that healthcare workers have the responsibility to respect, care for and be empathetic to women regardless of the poor working environment or supposed unsafe behaviour of women during labour. 44 According to the Saving Mother's Report for 2014-2016, women's delay in seeking help form facilities arises from perception that they are mistreated during childbirth.[45] Malatji and Madiba identified verbal abuse in the form of shouting, rude language & judgemental comments in their study cohort. Further they highlighted issues of neglect and abandonment during labour, patients being ignored when requesting assistance or analgesia and refusal to provide services linked to obstetric care by midwives. The patients also felt that their care lacked support and was undignified and patients from foreign backgrounds felt they were discriminated against and influenced the care they received.[41] Makandwa and Vearey, in their cohort of Zimbabwean women who delivered in Johannesburg, found that the experience of abuse negatively impacted on the

women's willingness to continue seeking healthcare. The abuse led these women to make decisions to skip their antenatal visits or delayed seeking care, thus risking their and their babies' well-being, for fear of further abuse.[46]

2.6 South African Healthcare Legislation Policy-Practice Gaps

On the announcement of national health insurance reforms by the South African government, Michel et al identified a few reasons for the good healthcare legislative framework but poor translation on the ground. These included a lack of a direct critical component or audit for policy implementation and adherence to core standards, ineffective supervision, a lack of resources, a lack of efficient processes or systems (including budget/financial ones, supply chain and communication channels) and human factors such as motivation, knowledge of the legislation and the power to implement policy.[47]

Chapter 3: Methodology

3.1 Introduction

This study is a qualitative phenomenological study that used an interpretivist paradigm, which is "associated with an interpretive effort to gather a range of in-depth accounts with the aim of building a detailed picture of how a particular phenomenon is understood by those who have personal experience of it".[48] According to Cresswell, a phenomenological study describes the meaning for several individuals of their lived experiences of a concept or a phenomenon.[49]

This study utilised in-depth open-ended, semi-structured interviews to explore the narratives of the experience of cross-border migrant women during pregnancy and childbirth in Cape Town. The research question and the objectives of this study require qualitative research methods.

Joubish describes qualitative research as being concerned with developing explanations for social phenomena through the analysis of unstructured information. He also states that it is used to gain insight into "people's attitudes, behaviours, value systems, concerns, motivations, aspirations, culture or lifestyles".[50] In turn this research information can be used to inform policy formation and, in this instance, healthcare provision.

Joubish further states "qualitative research is an inquiry process of understanding a social or human problem based on building a complex holistic picture, formed with words, reporting detailed views of informants and conducted in a natural setting".[50] This qualitative approach is important in gaining insight into reality as understood and experienced by migrant women during pregnancy and delivery.

3.2 Study Design

The chosen research design is a case study. According to Hitchcock and Hughes[51], a case study:

• is concerned with a rich and vivid description of events relative to a case;

• provides the chance to blend a description of events with the analysis of them;

• focuses on individual actors or groups of actors and seeks to understand their perceptions of events;

Case studies strive to portray what it is like to be in a particular situation and to capture the thoughts, feelings and perceptions about said situation.

3.3 Research Context

The research took place at the two biggest refugee centres in Cape Town.

The Scalabrini Centre of Cape Town is dedicated to alleviating poverty and promoting development throughout the Western Cape by assisting refugees and migrants integrate into their communities socially and economically. They have a Women's Platform that builds a multi-national network of women to share skills and resources for economic and social integration. Scalabrini saw 1970 refugees seeking assistance in 2016.[52]

Since its inception in 2007, the Adonis Musati Project has been involved in a number of initiatives and activities to assist the vulnerable asylum seeker and refugee population in Cape Town, including the provision of health and welfare, training, education, advocacy and psychosocial and mental health care. The Adonis Musati Project saw 445 beneficiaries of its services in 2016.[53]

The benefits of recruiting participants via these centres were that they were likely to be trusted by international migrants and refugees and the research supervisor had an established working relationship with the Scalabrini Centre in particular. The endorse-

ment from these centres possibly allowed potential participants to have trust in the research and researchers, thus aiding recruitment.

3.4 Study Population

There were two subsets of participants:

1. One key stakeholder from each refugee centre.

This person was intimately involved in individually assisting women attending the refugee centre for whatever reason. They had to have been employed at the centre for at least six months to ensure that they were conversant with the healthcare and other issues facing foreign migrant women.

2. Foreign women accessing the refugee centres for whatever reason.

Due to the potential difficulties in recruiting participants, convenience and snowball sampling was used. Women over the age of 18, who had ever had obstetric care in the Cape Town metropole were eligible for this study. Women had to be fluent in either French or English.

The number of languages used was limited due to the limited scope of an MMed project. Women who had miscarried, delivered stillborn babies or who had suffered a neonatal loss were also excluded from the study. The investigators were explicit in the counselling, information sheet and consent form that we were not asking about the participants' legal status in South Africa in order to avoid feeling of distrust in the participants and an ethical conundrum for the researcher in the case of undocumented migrants.

Mindful of recall bias, defined as a "systematic error caused by differences in the accuracy or completeness of the recollections retrieved ("recalled") by study participants

regarding events or experiences from the past"[54], the researchers debated what the cut-off time-frame since delivery should be in order to have the most accurate accounts of women's experiences. While the ideal would be to interview women as soon after delivery as possible, there was compelling evidence to show that women recall their birth experiences accurately as long as 20 years after delivery. Simkin showed that, "[15-20] years later, women's memories are generally accurate, and many are strikingly vivid, especially of onset of labour; rupture of the membranes; arrival at the hospital; actions of doctors, nurses, and partners: particular interventions; the birth; and first contact with the baby".[55] Takehara et al showed that women showed a remarkable consistency of memory of their birth experiences immediately post-delivery and 5 years later.[56] They also showed that women's feelings about their births tend to become more positive over time. However, we do acknowledge that women may remember negative or traumatic birth experiences more vividly, which may bias the participants to be those with more negative perceptions of their experiences. Due to the evidence of memory retention of birth experiences, we decided not to include a cut-off time since delivery as one of our exclusion criteria.

3.5 Recruitment

The refugee centres' contact staff members identified a key stakeholder, both of whom had contact with many women accessing the centre for whatever reason. This strategy served two purposes:

1. To hear from the key stakeholders about any accounts they have heard from women about their birthing experiences in Cape Town; and
2. To help us identify possible participants (whom we then asked to help identify further possible participants).

This study thus used a combination of convenience and snowball sampling.

With respect to recruiting women for the study, the following was made clear

through the key stakeholders and the researchers:

a. The role of the interviewer was only in the capacity as a researcher, not a health-care worker, and the interview was not to be a medical consultation.

b.There were no questions asked about legal status in South Africa.

At the end of the interview, the researcher asked participants whether they knew of anyone else who might be eligible for the study. We advertised on noticeboards at the centres, asking potential participants to contact either the key stakeholder or the investigators if they were interested.

All participants were given an information sheet and consent form to read in the language of their preference and were given an opportunity to ask questions. The researcher has a good working proficiency in French. Written consent was obtained from all participants.

3.6 Data Collection Methods

Data collection took place through in-depth one-on-one interviews. The investigator conducted in-depth interviews with a female observer at the respective recruitment sites in a private room. This observer was initially the principal investigator but later a female research nurse was used. She was chosen as she had research experience, is a part of our departmental research team, and understood the role of an observer. She was not identified as a nurse. The observer did not interview the participant but her role was to help put the participants at ease as well as to mitigate any risk to the interviewer and participants, given that the researcher is male.

If the participant wished to have a companion of her choosing with her during the interview, this was permitted. Participants were given time to read the study information leaflet, and if they agreed to participate, consent was discussed and signed. Con-

sent included the interview being recorded and transcribed but this was not compulsory.

Each participant was initially asked a few non-study related questions in either English or French to test the competency of the individual in understanding the language being used as well as to gauge whether they would be competent to participate.

Interviews were transcribed by an independent professional transcription service, Top Transcriptions.

3.7 Data Safety & Monitoring

Recordings were kept on the investigator's computer. Printed transcripts and interview notes were securely stored. Electronic transcripts were kept in password protected files on the investigator's computer. All recordings, transcripts and interview notes were anonymised using a numerical system known only to the researcher and principal investigator.

3.9 Data Analysis

By reading and re-reading interview transcripts, data was inductively coded and analysed using thematic analysis. NVivo software was used to code the data so that it could be easily coded and thematised. Thematic analysis is one of the most common forms of analysis in qualitative research. It is a method for identifying, analysing and reporting patterns within qualitative data.[57] The process involves the identification of themes through careful reading and re-reading of the data. Themes are patterns across data sets that are important to the description of a phenomenon and are associated with a specific research question. Themes also provide commonality among subjects.

Data coding and analysis were done concurrently with data collection (that is, coding and analysis after each interview) to inform subsequent interviews and to determine when data was saturated. Within NVivo, recurring themes were identified and categorised and after seven interviews already no more new themes were being revealed from the data. Two further interviews were carried out and once these two interviews revealed no new themes after being coded, it was determined that data saturation had been reached.

3.10 Ethical Considerations

Turton argues that research into vulnerable groups and their life circumstances can only be justified if the research is directed at improving their life circumstances.[58] The Belmont Report[59] explains the unifying ethical principles for using any human subjects for research:

A. Respect for persons and Autonomy

This study was voluntary. A prospective participant was explained the nature of the study ensuring they understood what the study was about. They were provided with an information sheet further explaining the study's design and purpose before informed consent was taken verbally and in the written form. Each participant who agreed to take part in the study was given the option to opt out of participation at any point. Each participant was given the choice to have the audio of their interview recorded or not and informed that interview notes would be taken but kept anonymous.

B. Beneficence

The study will have no immediate benefit for pregnancy care for the participants who have already delivered. It could, however, benefit them in empowering them by validating their narratives and be part of a process of catharsis for those who may have

not spoken about their experiences before. This research is an evaluation of the experiences of foreign migrant women who have delivered in the Cape Town metropole with the aim of informing our current care and hopefully to act as a useful tool in aligning policy with national guidelines and standards. This will hopefully benefit future foreign migrant users of the pregnancy care services in the city.

C. Non-maleficence

The study was anonymous. The study had no direct harm to the respondents. No questions were asked of the cohorts' legal status in the country so there was no risk of immigration status being revealed and thus endangering them from that legal aspect.

C. Justice

The Constitution enshrines that anyone who lives in South Africa is entitled to healthcare equally and with respect. This study is being pursued to evaluate if foreign migrant women are receiving fair, just and equal treatment as prescribed by the laws of this country.

One of the ethical issues which were identified at the start of the research was the possibility that the study may reveal concerns surrounding irregular migration status. This concern did not materialise as it was not part of the research questions and never came up with any of the women interviewed. The other ethical concern we had was that opening up discussions about historical birth experiences may result in psychological trauma. We made provision for any of the participants who wished to have a counselling session afterwards, to meet with a psychologist if they wanted to. None of the women requested counselling when offered it.

3.11 Reimbursement of Participants

Transport costs and the provision of a supermarket voucher to the value of R150 was reimbursed to each study participant.

3.12 Trustworthiness of Data

The researcher, having worked with obstetric patients for many years, has witnessed poor treatment of migrant women accessing obstetric care, and thus carries certain expectations and biases. The inclusion of open-ended, neutral questions, as well as explicit questions about positive experiences in the healthcare service, aids in mitigating these biases.

Transcripts were verified with participants where possible, and data coding was checked by the supervisor. With respect to recall bias, it is acknowledged that women may remember negative or traumatic birth experiences more vividly, which may bias the participants to be those with more negative perceptions of their experiences, however, women were specifically asked about any positive experiences, and in fact several participants had only positive experiences. This variety in narratives together with the achievement of data saturation lends credibility to the findings. Furthermore, triangulation of data was aided by the two different recruitment sites, synthesising data from two different sources as well as the fact that the birthing experiences occurred at multiple sites across the Cape Metropole.

3.13 Limitations

A potential limitation was the fact that the researcher was male. However, the accompanying female observer seemed to allow the participants to feel more comfortable, which aimed to mitigate this limitation.

A second potential limitation was the possibility of participants not feeling free to speak had they known the researcher and observer were medical staff. The research team were deliberately not identified as such to mitigate this potential limitation. One interview was completed but had to be excluded because a participant recognised the researcher as having been part of her obstetric care.

The sample size was small but this is typical in qualitative research. However, data saturation was reached as described in Chapter 3.9.

None of the participants refused audio recording.

Chapter 4: Findings

4.1 Introduction

This chapter will start with a brief, anonymised biographical overview of the 9 migrant participants who were included in this study as well as the two stakeholders at each centre. This will be followed by an outline of the main themes that came up during the interview processes and these will be elaborated on. This study combines the deeply personal experiences and views of migrant African women, from 7 different countries, who were pregnant, attended antenatal care and delivered in Cape Town metropole public health care facilities. The findings and discussions were done thematically, as five main themes were identified.

4.2 Biographical Overview

The following table illustrates basic demographics, countries of origin and sites of obstetric care.

Table 1. Overview of respondent demographics, countries of origin and sites of care

Respondent	Age	Length of time in SA	Children Delivered in Cape Town	Care Institutions	Country
A	37	20 years	3 (2006,2011,2016)	Retreat MOU Groote Schuur	Democratic Republic of Congo
B	38	10 years	2 (2012, 2019)	New Somerset	Zimbabwe
C	44	21	3 (1999, 2001, 2008)	St Monica's MOU New Somerset	Somalia

D	32	9	1 (2015)	New Somerset	Zimbabwe
E	36	14	2 (2007, 2011)	New Somerset	Rwanda
F	36	19	1 (2004)	Retreat MOU Groote Schuur	Rwanda
G	32	7	2 (2014, 2019)	Retreat MOU Mowbray	Burundi
H	38	10	2 (2011,2015)	Retreat MOU Mowbray	Democratic Republic of Congo
I	31	9	2 (2010, 2016)	Hout Bay Mowbray	Malawi

Stakeholder 1 hailed from Zimbabwe and was the Scalabrini Centre's Women's Platform manager. She had a background in psychology and counselling and had been in her current role for six months. In this role she oversaw a platform that has a personal development aspect that covers language learning, understanding integration, job seeking assistance, finance stability education and health education via workshops as well as peer counsellor training.

Stakeholder 2 was a South African and also had a background in psychology. He had completed his psychology internship at the Adonis Musati Project and at the time of

the interview ran individual and group counselling services at the Adonis Musati Project. He had been with the institution for 3 years.

Having analysed the transcribed in-depth, semi-structured interviews from the experiences of the 11 participants, six broad themes were identified that impacted on their perceptions of care:

(1) Attitudes & behaviours of staff

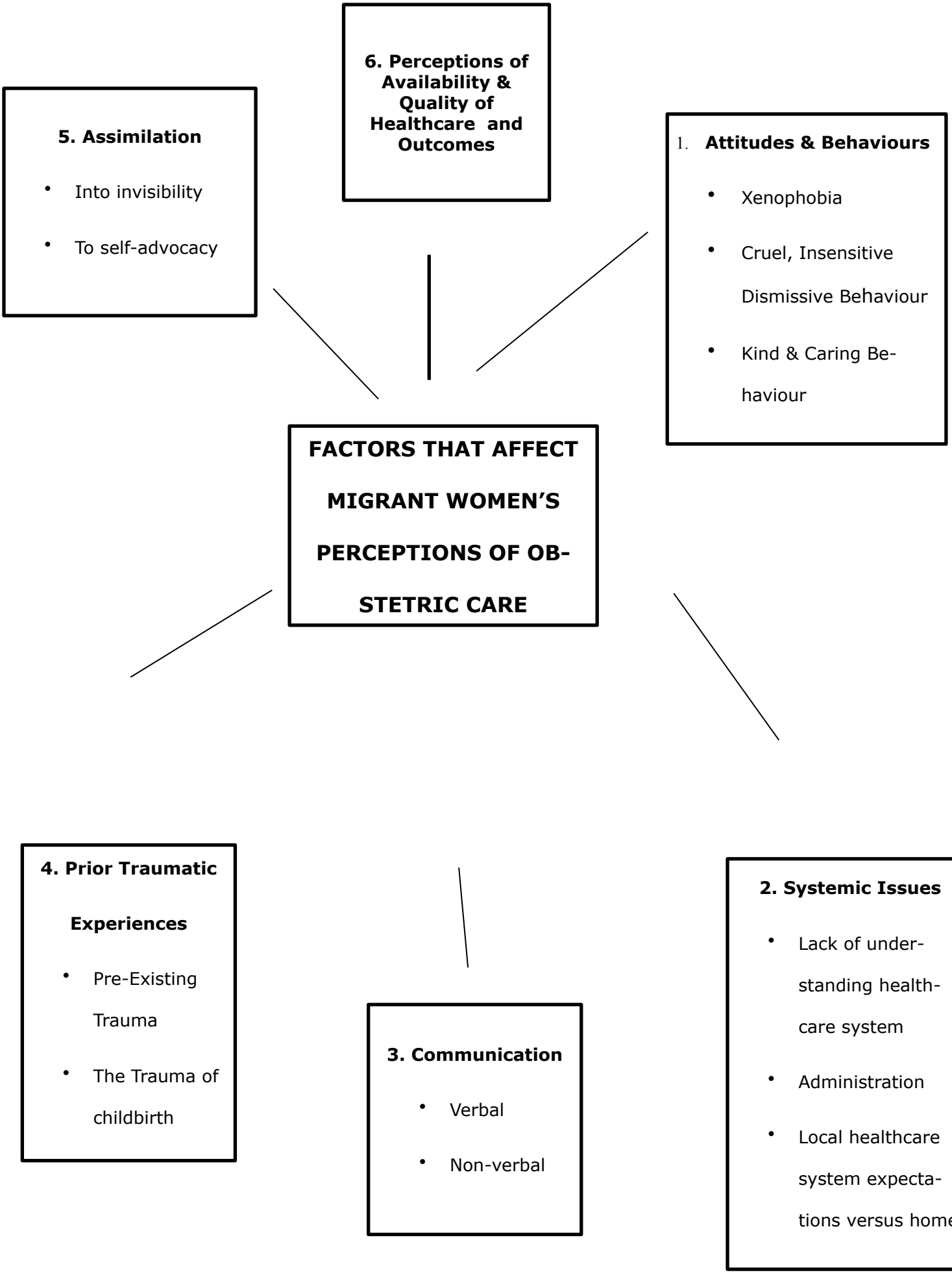
(2) Systemic issues

(3) Communication

(4) Prior traumatic experiences

(5) Degrees of assimilation

(6) Perceptions of Availability & Quality of Healthcare and Outcomes


6. Perceptions of Availability & Quality of Healthcare and Outcomes
5. Assimilation
• Into invisibility
• To self-advocacy
1. Attitudes & Behaviours
• Xenophobia
• Cruel, Insensitive Dismissive Behaviour
• Kind & Caring Behaviour
FACTORS THAT AFFECT MIGRANT WOMEN'S PERCEPTIONS OF OBSTETRIC CARE
4. Prior Traumatic Experiences
• Pre-Existing Trauma
• The Trauma of childbirth
3. Communication
• Verbal
• Non-verbal
2. Systemic Issues
• Lack of understanding healthcare system
• Administration
• Local healthcare system expectations versus home

4.3 Attitudes and Behaviours of Staff

From the interviews it became apparent that the attitudes and behaviours across all types of staff members (administrative, nursing and medical) were a problem for most of the migrant women. These attitudes and behaviours caused trauma for some and made the migrant women sometimes hesitant to approach healthcare facilities for help, afraid to ask for help, limited how open they felt they could be with their care-givers and broke down trust.

4.3.1 Xenophobia

Some respondents spoke of experiences of frank xenophobia.

"She says what are you doing here? So I thought here on my table, here in the hospital. I tell her to have a baby, and she says no, no what you (sic) doing in my country? And at that moment when I am waiting for my baby to come out, I think the only thing in the world I need is kindness.' - Respondent C

'We have to do all this work because you guys keep having babies like animal or whatever." - Respondent C (overhearing comment from midwife about Somali women having large families)

"...She (nurse) said that we are the ones that make the country too full"- Respondent G

"...another thing that I was quite shocked by was there were 'foreigner' sticker that was put on their page and the sticker basically stated that they were non- South Africans" - Stakeholder 2

Even in the absence of frank xenophobia, some respondents' care was compromised due to their internalised 'otherness'.

"I didn't feel confident enough to ask, and I think maybe partly it's because I'm not a South African citizen, so I've noticed that like even if like someone who is also from here, ask the question or whatever she can answer back you know she knows her rights… even though I know some of my rights but I don't have that confidence to actually - I don't want to end up being ostracised. You also don't want to be… targeted because I'll need to use this services again and maybe sometimes… if people know your name like something was done (for example reporting the experience) like someone would discipline them then it moves around and then people say at the hospital 'Oh there's that lady who (reported)… [or]maybe it's being paranoid." - Respondent D

"Some of the foreigner women, they take it have- like they deserve it. I don't know it's like we, we've managed to take these things like it's… we deserve to be treated that way I think. They're going to do [this to you] you're going to just have to take it. Powerless…indeed you have nothing to do after, like nothing…" - Respondent E

4.3.2 Cruel, Insensitive or Dismissive Behaviour

Some respondents revealed that when it came to access to healthcare, they felt powerless and vulnerable to ill-treatment and felt disempowered to approach healthcare facilities and to ask questions or make comments. Even if they were able to ask questions, they felt ignored and undervalued. There was also a sense from the women that when they were being spoken to, they were being spoken down to, rather than as pa-

tients who were fully engaged in their own well-being, or quite well-informed. Some respondents complained of feeling unheard and of not being taken as seriously as South African patients. The women found that when trying to explain something from their medical histories it was either dismissed as inconsequential, they felt rushed or they were made to feel as if they didn't know what they were talking about or unable to understand what was happening. This kind of treatment at the hands of clinicians was not without dire consequences.

"I will never forget this. I could actually see her standing. You know when somebody, says [in local African language] you know, 'she (the patient) is irritating, She is being a nuisance"… She's speaking to the other nursing staff about me … And at that point I'm vulnerable, you know." - Respondent B

"…she tried to tell them that she had high blood pressure and she thought there was something (wrong) happening with the baby and all this, and then she goes to the clinic, the clinicians and all and the nurses are like 'no'." (in the end the mother had stillbirth and she herself had a seizure linked to her pregnancy hypertension)**- Stakeholder 1**

"And she (the nurse) was pulling me up, I was crying, and she called the others, 'Look at this one, she is crying!'.. And she didn't have to do it that way."- Respondent G

"Doctors would come, also talking to us, they were okay but obviously an experience, I just think you know that sometimes they speak about a person and they don't realise, or they don't care that the person can hear you...so if they have that they should have at least moved out of earshot and say what-

ever they want to say, but sometimes talk and about somebody and they think you don't understand."- Respondent D

4.3.3 Kind & Caring Behaviour

While evidence of xenophobia was apparent, and, in particular at the the primary care level, most of the women were happy with care of the doctors and nurses who looked after them and their babies in the hospital setting. There were several accounts of extremely caring staff members, demonstrating that experiences of poor care were not universal.

"Yes, and that one, she was an old lady, so I think also she felt like a mother, but she was there and every time she would come and say, you must not take the baby like that. Come! She'd pick up the baby and say, this is what you must do. Is it your first baby? I said, yes. This is what you must do. The baby is going to have wind and you must keep rubbing the baby." - Respondent E

" [the staff] they check everything. They were like helping, they were like smiling..these people they know what they're doing. They will take care of you. They were doing whatever they can do." - Respondent A

"There was a nurse, they were very nice. They checked me; they checked me...They will ask you that, they can tell you what they want on that day then they'll say any question? Do you want to ask something? Yes, you can ask you what you want and what you don't know you can ask." - Respondent G

"Yes. I mean from the doctors... like this time around, the second time around the doctor that I had, he would come in and check on me all the time... " - Respondent B

4.4 Communication

Of the nine women interviewed, only two had had any schooling in English and none of them had had any schooling in either Afrikaans or Xhosa, the official languages

used in Western Cape government facilities. Some of the women who had more than one child in Cape Town, by their own admission, didn't even understand any of the local languages at all during their first pregnancy and some others had a very basic comprehension of either English or Xhosa that had been gleaned from television or living amongst native speakers in Cape Town.

"So I told her (the nurse) and she says 'you don't know what you're talking about', by then everything you say I can understand but I cannot reply with the speed that I need to (due to language difficulties)."- Respondent C

"For me it's basically on the language. Immediately when somebody notices, you're not from South Africa, 'I'm not going to treat you fine'. Immediately you can tell that, no, this person is being unpleasant, you know. It's the unsaid, not what they say. It's how they are around you." - Respondent B

"And this was the historic moment (realising that not being able to communicate in a local language) for me that I associated with not being able to speak, not been able to speak, to me is pain. And not being able to take (the care that) is rightfully yours." - Respondent C

"They're ignoring me because I can't speak very well English. Because maybe they see that I'm not from this country. I'm like maybe they're sick and tired of us I don't know." - Respondent E

"Their first experiences when they were still not as confident in their English, when they were still very new, that's when some of these things (poor care) happened." - Stakeholder 1

One participant acknowledged that the language barrier may lead to incorrect perceptions of poor care.

"So that time we can say maybe the nurse is rude or something but she is not because we can't even communicate to each other. She'll be telling you the right way that you must do but when you don't listen and understand or when you don't hear what she's saying, you can't, we can't cope, then you were saying 'this nurse, she's rude!" or "I didn't deliver very nice." - Respondent I

4.5 Systemic Issues

It became clear during some of the interviews that accessing the health system was a problem during their pregnancies. For others, it was a lack of understanding how the Cape Town healthcare system was structured and how the referral system worked that influenced how they saw their care. Another aspect highlighted was administrative confusion surrounding documentation proving their identity and proof of address. The migrant women's own comparisons of the system here versus the system in their home countries also influenced the perceptions of their care.

4.5.1 Lack of Understanding the Healthcare System

Each country uniquely sets up its healthcare system to service the needs of its populations. Migrant women, familiar with the system in their home countries, then encounter the three-tiered system of care in Cape Town which is new and even confusing to them. This potential misunderstanding and confusion can then influence their perceptions of their care.

"'[Referring to accounts from other women who have received care at particular hospitals] Listen, when I went to Karl Bremer they didn't treat me right.'

So now let's say if they're given Karl Bremer on their lists they don't want to go there, so that becomes also a mini factor where they are like 'I've heard about this place the other lady said it wasn't good.' But they said let's say maybe Somerset and the other place and the other places is good, let's try there. So, they might also have that pre-knowledge that they don't want to be going that side of town, because this is what they heard, and they listen to the horror stories even if some of them aren't true." – Stakeholder 1

"I mean I've heard people go to the hospital and then get kicked away…and then they feel like they've been kicked away because they're foreigners and that's not the case and we have to as social workers or counsellors explain to them, you know that's not your first point of entry."- Stakeholder 2

4.5.2 Administration

To enter Cape Town's antenatal care system, a migrant woman has to a present with a confirmed pregnancy test to her local clinic as dictated by her residential address. On attempting to book for her pregnancy, a requisite form of identification and proof of home address has to be presented. The former can take the form of her passport or valid documents from the Department of Home Affairs and the latter is either a utilities bill or an affidavit from a police station confirming her residency at the given address. Some respondents reported inappropriate 'gate-keeping' on the part of front-line administrators.

"I had the experience like you give them that A4 paper (asylum document). They won't, they will take, a notice 'Is not ID!, I'm asking for ID.' 'I don't have my, this is my ID." So, like they must know (what the documents are), not just say this is not ID or, oh but this is only expiring in one month, you know." - Respondent F

"I think with documents, with refugees and asylum seekers, often documentation on a mass scale is a problem and now when they move into institutions where that is a required of the asylum seeker…and then again we have to always say language barrier on top of that. Because that message isn't being clearly explained to them. So now I feel that sometimes there is inappropriate attitudes but sometimes it's obviously a communication [problem] between two parties." - Stakeholder 2

4.5.3 Local Health System Expectations versus Home Country

Some of the respondents had delivered a baby in their home country prior to arriving in South Africa. For those that hadn't, they at least knew of a close relative or friend who had experienced a birth within the home healthcare system. These experiences, either firsthand or otherwise, contributed to expectations of how the respondents expected their pregnancy care and births to be in South Africa, both from a biomedical point of view but also from a cultural vantage point.

Respondents reflected on the unexpected difficulty of not being allowed a birthing partner during their labour, in particular at the MOUs where the limited space in delivery rooms and concerns about staff safety precluded this from happening. This lead to feelings of profound loneliness in some of the respondents.

"From there on I was on my own which wasn't very nice. The other mothers who are there, I didn't know. In my culture, when you have a child you are spoiled, mommy is there, mother in law is there, the sister is there, there isn't anything for you to do. Because of that I did not know the process of the hospital in South Africa." - Respondent C

"The ambulance came, they told us that we can't carry your husband, we want only you. But I spent, it was difficult for me, I spent the whole night there and I was alone. Like some other times when you went to the Hout Bay clinic or went to Retreat, some they come with the interpreters. But when you are there for the labour, you'll be alone."- Respondent I

Some respondents acknowledged that there were benefits to medical care in South Africa as compared to their home countries but that staff behaviours and emotional support would be better at home.

"The development are not the same (meaning South African services are superior). Poor is way not the same. But emotionally [it would] maybe [be better]in my country. They wouldn't like telling me some stuff that they shouldn't. You see. Maybe it's going to...cost more. Because I have to pay for that kind of money for C-section and stuff like that [in my home country]. In that way. But emotionally I would, it will be better [in my country]." - Respondent E

4.6 Assimilation

Two of the women interviewed had only had one child in Cape Town. Despite the difficulties encountered by six of the remaining seven women, the other respondents all had second births in the Cape Town metropole. The inter-pregnancy intervals ranged from 4 years to 10 years between births of the first Cape Town born child and the next children. In general, second-time experiences of pregnancy and childbirth were much improved. This seemed to be due to knowing what to expect, but also due to assimilation into local cultures, systems and languages. Assimilation could take different forms.

4.6.1 Assimilation into invisibility

Some of the respondents spoke of ways in which they diminished themselves as people or their behaviours to render themselves invisible and thus not attract the attention or ire of medical facility staff as a way of navigating the system with fewer problems. This may have been beneficial in the short term, but the lack of self-advocacy could contribute to poorer health outcomes in the long run.

"..You take a step back, even when you know that you should be asking questions, you should be upfront, you kind of take a step back because you are worried what is the reaction that you will get from this person...You just carry your tummy and move on quickly and you avoid" - Respondent B

"And to be honest I was trying to just stay within myself, by myself not to create problems. My husband was outside and I just kept quiet hoping that if I don't show her (the nurse) that I find that wrong, the rest may go as smoothly." - Respondent C

"You also don't want to be targeted, because I'll need to use this service again...maybe it's being paranoid but you don't know but also it's part of, I think, I don't know if anything would really have been done if you made a complaint. So you avoid [speaking out]."- Respondent D

4.6.2 Assimilation towards resilience & self-advocacy

On having a second child within the Cape Town metropole hospital system and after having lived in Cape Town for a longer period of time, some of the respondents said they felt more empowered to advocate on behalf of themselves with their following pregnancy due to their previous knowledge from the first experience, improved language skills and also from also understanding the system and how society works better. This improved ability to advocate for the self and others appears to be a form of

assimilation that could contribute to better outcomes than assimilation by invisibility.

"The second one was… it was fine. I don't know maybe from experience or giving a birth when you're having the second one. You feel okay…you have some experiences…It wasn't that bad. You know when sometime you expect something, that's when you get very disappointed. And then you don't get it. So for my second one it was like… I don't expect anything from…you because I know how you operate." - Respondent E

"It was better this time around and I do feel that a lot of it had to do with the person that I became to be… I feel like now I've processed, I've prepared myself. I now know what is it that I need to do, what kind of person. My resilience now. I'm more resilient so, now my experience is different in this case because I get there, I know exactly what the process is, I don't have to ask anybody anything, I know it's from this stage to this stage. I'm just following. I'm just doing my things. Second time around I was more prepared, I was ready." - Respondent B

"Even when I was having the boy I was, I was fluent speaking English. In a way I felt like I could take what was mine, but at the same time respect the other people." - Respondent C

4.7 Prior Traumatic Experiences

4.7.1 Pre-existing Traumas

The full range of reasons why people migrate from one nation to another are endless and deeply personal. Some of the reasons women seek asylum or refuge in a new country include war with associated violence with losses, famine, economic deprivation, ethnic discrimination and genocide. The psychological impacts of any one of these, never mind combinations of them, are likely to be carried by these women

throughout their lives. Their psychological well-being is often neglected in the adopted country and the lasting effects of prior traumas can alter how they perceive and experience the world and its external stimuli.

"And I would say maybe the level of trauma they have getting here would also have a huge impact. That's something that the more I learnt in my practices as a counsellor, I'm learning that the trauma that the people come with is very much affecting their functioning in South Africa. I don't want to say it incapacitates because there's many amazing refugees and asylum seekers that do they come in, they go out and they've gone through incredibly difficult situations but I think it's just always that layer that has to be looked at.' – Stakeholder 2

4.7.2 The Trauma of Childbirth

Against the multitudes of trauma experienced by migrant women as described above, came for some, extremely traumatic experiences of giving birth.

"Yes, there was no time for me to process so, as I'm thinking now, I'm actually feeling emotional because I never went back, you know, to that day and…I mainly focused on, you know what, I don't remember the birth of my child because it was just chaos all around me and I did not have a chance to process anything at all." - Respondent B

"Ja, I was scared of getting pregnant again. Be in the hospital and what because I said to myself no. No ways. Can, you can even be traumatised with that… Yes, very much. Because now I'm done." (meaning that she had decided not to have any further children because of her birthing experience) **- Respondent E**

4.8 Perception of Availability & Quality of Healthcare Outcomes

While not part of the original question list, after the first two respondents made reference to a hypothetical choice of country for delivery and their respective hypothetical answers given their Cape Town experiences, I then posed the question to the other respondents about whether they would prefer to birth in their home countries or again in Cape Town. Some of the women still preferred to have their next baby in Cape Town even if some aspects of the experiences were negative.

"I would deliver them here…because I was the one who suffered, not my babies. Back home my child…suffer. I would have loved it better if my child was checked by paediatric as she was born [like here in Cape Town]" - Respondent B

"The quality of the medical care [at home] they're not as good as here [in South Africa]. And you're going to pay only seventy five rand." - Respondent H

Chapter 5: Discussion

5.1 Analysis of Results

Gilmore states that "when non-nationals are deprived of opportunity to be healthy, this not only endangers their own health, but also promotes denial and discrimination. It jeopardises public health efforts, in particular prevention efforts, thereby, threatening the public's health.'[60] Thus, the poor treatment of migrant women has a much broader knock-on effect.

This project sought to establish the factors that influence migrant women's experiences in the public obstetric care system in Cape Town, be those experiences positive or negative.

Experiences of xenophobia were clearly evident in interviews with some respondents. **Xenophobia** was particularly rife when care was at a primary care level midwife obstetric unit (MOU) and in all cases within this cohort of participants, the xenophobia emanated from nursing staff. All nine women could not recall a xenophobic incident involving a doctor and all felt that the care provided by medical doctors was good. Some xenophobic acts were clear verbal acts directed at the individuals while other examples were subtle displays such as seeing all South African patients first (even if they came late) for antenatal visits, and then only seeing foreign migrants.

The xenophobia experienced by these women sadly reflects the commonly held attitudes and perceptions in the more general South African society that foreign migrants take up local jobs, are the cause of crime escalation and that they are an economic and social drain on already constrained resources.[61]

Foreign migrants are often othered and designated distant secondary status, even when a migrant has legal leave to remain within the Republic. Landau argued that there is a prominence of a nativist discourse directed towards migrants from neigh-

bouring countries by both state officials and citizens of the Republic, claiming these cities to be for citizens only.[26] According to Landau, an unhealthy mix of poor migrant documentation, societal ignorance and outright discrimination can result in migrants' being denied access to healthcare exposing them to adverse pregnancy outcomes. Our study finds similarly to this and provides further accounts to demonstrate the potential for poor pregnancy outcomes for the simple reason that these patients are migrants.

Some respondents revealed that when it came to access to healthcare, they felt powerless and vulnerable to ill-treatment and felt disempowered to approach healthcare facilities and to ask questions or make comments. Some respondents complained of feeling unheard and of not being taken as seriously as South African patients. The women found that when trying to explain something from their medical histories it was either dismissed as inconsequential, they felt rushed or they were made to feel as if they didn't know what they were talking about or unable to understand what was happening.

In the ward setting, some respondents felt like they were ignored, at times humiliated and shown little compassion. At other times, especially post delivery, they struggled to get assistance mobilising and their pain relief requirements were ignored. Many of the respondents felt alienated and some even felt at fault for what seemed to be antagonising the staff. Another aspect was clearly that it was certain individuals who repeatedly did not demonstrate professional conduct and that when doctors or senior nursing staff were around the behaviours altered to a better level of professionalism. Complaints about doctors were less frequent in this cohort and were largely linked to lack of communication.

However, there were also accounts from the women of **kind and compassionate care**. These came from largely healthcare workers in the hospital setting. Having questions answered patiently and being kept informed, attentive assistance for new mothers in the wards, moments of teaching, attempts at findings an interpreter but also simple acts of shared humanity resonated with some of the women. These more positive behaviours made the women feel welcomed, cared for, respected and part of South African society.

Health disparities such as unequal treatment related to **language barriers** are associated with unequal access to healthcare and unequal health outcomes.[62] Congruent with the literature, this project demonstrated the significance language in the respondents' experiences of healthcare. Migrant women who are unable to speak the languages of their new country are socially isolated and have limitations on how they can interact with their new communities socially but also when seeking public services. These women struggle to describe the nature and extent of their health problems when approaching public health centres. Pursell states that a healthcare providers will only treat migrants for 'the superficial or most obvious problem because it is difficult for healthcare staff to obtain any extra information in order to make a more comprehensive assessment of the health issue".[35] Time constraints in busy facilities also make for rushed consultations in which problems can be missed or overlooked when there is a language barrier. The way the healthcare staff spoke to them also either facilitated or inhibited the respondents from being equal participants in the consultation.

Further, being unable to communicate can result in delays of diagnosis and delayed starts to therapeutic modalities. Adherence to prescribed medication is compromised by the inability to inquire and understand why it is necessary and follow-up appointments can be missed when a migrant doesn't understand the instructions.

Seven of the nine women in this study had more than one child in Cape Town. All were emphatic in stating that their first pregnancy was fraught with more difficulties simply because all of them were new in South Africa then and had not yet mastered one of the local languages. Additionally, one of the women interviewed was of the view that some of the perception of poor care and bad service by migrant women was in fact as a result of misunderstanding the local languages and not understanding healthcare workers or their advice.

Several of the women during their first pregnancies were reliant on their spouse, other relative or a member of their own diaspora to act as interpreters during contacts for pregnancy care. However, at MOU level of care, birth partners were not allowed inside and so birthing without fully understanding what was happening was characterised by all who experienced it as difficult. Given the intimate nature of examinations that are part of the labouring experience, some of the examinations were perceived as traumatic as the respondents did not know that a vaginal examination was about to take place.

During the interviews, informed consent for medical procedures did not come up and this is a shortcoming. However, an inability to communicate with the healthcare staff and vice versa would not have met the threshold for informed consent without interpreters, which are often not available or not contacted by staff. Hunter-Adams highlighted some of the issues that Congolese and Somali migrants described such as medical procedures, including tubal ligation, which were performed without consent.[63] She also noted the pitfalls of having partners who tried to play the role of interpreter, which resulted in non-professional medical interpretation and also loss of income if they had to accompany their relative. Hulley, in her metasynthesis about intimate partner violence amongst minority ethnic and immigrant women, highlighted the significant barrier to intimate partner violence disclosure when the partner is used as in-

terpreter. She states the male perpetrators' local language skills and knowledge of the system were often more developed and this unequal power dynamic gave the male additional control over the patient and her interactions with public services, which could significantly impact on reproductive health outcomes and decision-making.[64]

The most significant factor that influenced the perception of the quality of care received by this cohort and that was mentioned by every respondent, was that of communication barriers. This was not unique to any level of staff member or level of maternity care facility and was often the first and most immediately felt hurdle to good care. **Verbal communication** in medical consultations, according to Silverman et al, is "well recognised as being important to the delivery of medical care and is usually easy to interpret and analyse. It is discrete with clear endpoints, it is mostly under voluntary control and communicates our cognitive thoughts more than our emotions".[65] Contrastingly, **non-verbal communication** is significantly harder to gauge and understand. Silverman states "it is continuous even in silence, operates at a less conscious level, leaks spontaneous cues and is the channel most responsible for communicating attitudes, emotions, and affect."[65] Unsurprisingly, non-verbal communication plays a significant role throughout a medical interview and is an important variable in doctor-patient interactions. Non-verbal communication helps to build the relationship, provides cues to underlying unspoken concerns and emotions and helps to reinforce or contradict verbal comments.[66]

A health worker-patient interaction is often an immediately trusting relationship by its nature and in pregnancy care can evolve rapidly to intimate clinical examinations. Hall postulates that in short-term or intermittent relationships, which characterises those between clinicians and patients, overall rapport and liking is strongly influenced by non-verbal cues.[66] Any incongruence or contradiction between what is said and the

healthcare worker's body language can breakdown that rapport and diminish patient satisfaction because non-verbal messages tend to override verbal messages.[66]

Health promotion, in the form of education via direct instruction from healthcare workers, audio-visual material or literature also was a stumbling block for the migrant women. For new mothers, away from their normal support structures, learning how to breastfeed and care for their newborns was experienced as difficult as they found they could not understand the instructions or were not approached because of the linguistic barrier.

For many new arrivals, the Cape Town metropole's multi-tiered primary, secondary and tertiary **system of healthcare** are an unknown entity. This system is based on residential address and it dictates which healthcare facilities one may access. Many migrants choose to reside in clusters of their own nationals within certain areas of Cape Town and one of their main sources of finding out how the system works is via other members of their diaspora. However, within these communities there is rumour and perceptions of some institutions being less migrant friendly than others.

As a result, some migrant women try to bypass the normal entry point of booking for antenatal care at their local clinic to go directly to a facility that, in the community's eyes, is perceived to have better care. Thus being redirected to the correct channels is perceived as anti-migrant and poor care when in fact it is lack of understanding of how the system is designed.

The main **administrative issue** that four of the women experienced was a frontline level of 'bureaucratic policing' and 'enforcement of the law' as a form of access control to the system from administrative clerks who did not know the legal rights migrant women have to access antenatal care irrespective of their status and a failure to

recognise legitimate documentation as valid and acceptable. The lack of awareness among facility staff (and healthcare professionals) about rights guaranteed in the Constitution of the Republic and the Refugees Act (130 of 1998) has contributed to the confusion and hurdles faced by migrant women in simply accessing or delaying access to care. The rights enshrined in theory are not always rights delivered in practice. Pursell's study postulated a broader unwillingness from society to consider that refugees and migrants are entitled to health care services regardless of their status which may influence how hospital administration interacts with foreign women seeking pregnancy care.[35] Pursell states the lack of knowledge among healthcare staff as to the different categories of migrants and their rights and entitlements, partly explains these attitudes towards migrants. Ninety percent of respondents in her interviews with health personnel were unclear about the different kinds of migrants. The lack of clarity about the different migrant categories and the rights of migrants to healthcare contributes to the perception that many so-called irregular immigrants are using the system illegally. This impression is often generalised to those migrants who are legitimately entitled to access healthcare services. Crush and Tawondera posit that those employed in the state health services play an active role in enforcing immigration policy and in the absence of official guidelines to discourage this (but sometimes even when such directives exist) they have the power to withhold care and influence the quality of the services experienced by migrants.[67] Our study also demonstrated the complexity and stigma around migrant documentation and finds similarly to the Human Rights Watch Report, "No Healing Here", that one of the main barriers to health for foreign migrants is discrimination by individual health care providers simply because they lacked South African identity documents or simply for being foreign.[68]

The two stakeholders interviewed both felt that initially migrant women don't know their own rights, some don't even know how to access the documents and how important the documents are for achieving the rights safeguarded by the laws of the coun-

try. With the passage of time and certainly with their next pregnancies migrant women are more knowledgeable about what they need to achieve their rights but this still does not guarantee against encountering difficulty at the administrative level.

A further administrative hurdle was the local hospital restrictions on only having one birth partner at hospitals and no partners at MOUs due to spatial limitations and security concerns. This was experienced as different and lonely by labouring mothers. Three of the women explained the loneliness of the South African birthing experience. In their home countries, they are surrounded by relatives and celebrated and looked after by members of their extended family at the hospital. This is especially true for first time mothers where certain cultural traditional practices, such as the Rwandan naming ceremony called Kwita Inzina[69], take place at birth and are not able to be done within the Cape Town care setting. The lack of individualised attention and care is experienced as being insufficient and impersonal compared to the home country context. Akhtar et al looked at the experiences of Pakistani migrant mothers taking their children to healthcare services in New Zealand after living there for three years. The mothers experienced disappointment at the care as they had direct access to specialist care in Pakistan versus a GP referral being required for paediatric referrals in their host country. The mothers, due to their past experiences of the Pakistan healthcare system, also expected a prescription at each encounter with a doctor as was the practice in Pakistan and when none came at certain consultations in New Zealand they felt that the doctor was not understanding them.[70] Priebe et al studied the views and experiences of care professionals looking after the health of migrants in sixteen European countries and also highlighted that a lack of familiarity with the healthcare system led migrants to have different expectations of the roles of doctors and patients and that this different understanding of the patient-clinical relationship may result in uncertainty or mistrust.[71] However, when all the women were asked hypothetically whether they would deliver another baby here in Cape Town or back home, five of

them were emphatic in stating that despite the myriad of difficulties faced, the safety of themselves and their babies during pregnancy was still more assured here than back home.

For those who went on to have **subsequent pregnancies**, the majority had found employment and by extension had improved on their ability to communicate in one of the languages spoken in the Western Cape. They were engaged in daily life and with this came renewed confidence and also a degree of assertiveness. With the lengthened period of residence in Cape Town and a familiarity of the system, second births were experienced as easier although still not without problems. Those who had second births managed their expectations of the healthcare system as they now had first-hand experience and entered the pregnancy care system with caution.

With the passage of time since the first Cape birth, the women had also had time to process their first pregnancy, motherhood and life in a new country. The **resilience** developed, emotionally and psychologically, changed them in fundamental ways, making them stronger than they believed themselves to ever be. Ungar defined resilience as "In the context of exposure to significant adversity, whether psychological, environmental, or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual's family, community and culture to provide these health resources and experiences in culturally meaningful ways".[72] Mawani showed that over time refugees found support within their own group for reasons of language, connection and trust, often via religious groups, and this was associated with positive health outcomes.[73] This is in keeping with this study's respondents whose lives straddle their old worlds and their new ones. All found deep connections, emotional support and local knowledge from their compatriots but equally with other for-

eign migrants who had to navigate the same hurdles and acclimatise to their new host country. Çetrez found that foreign migrant women showed greater resilience, adaptability and acculturation than men after living in their new host countries for a few years. His study attributed this finding to re-negotiated gender roles and the women, through their working lives, becoming independent and resilient.[74]

Resilience made the women in this study more confident but also empowered them to be advocates for themselves, their unborn babies and others. Certainly some of the women's personalities were more introverted and shy but even those who weren't, some felt they had to diminish who they were as people to navigate the first pregnancy and thus avoid difficulties. However, with further pregnancies, all of them were truer versions of themselves and this is directly linked to being more confident and comfortable in the Cape Town milieu. Both NGO stakeholders also held the view that second births in Cape Town were, in their interactions with migrant women, generally spoken about as being more positive and they attributed this to the knowledge gained from their own experiences integrating as well as those shared by compatriots living as migrants here as well.

Although there is evidence of increased resilience in migrants, people from refugee and asylum seeker backgrounds who resettle in middle and high income countries are more likely to suffer from a mental illness than the general community due to a range of pre- and post-settlement traumas including experiences of war, torture, political unrest, family separation, economic deprivation, forced migration and resettlement in unfamiliar environments.[75] Çetrez's study showed that despite women showing greater resilience and acculturation, these same women reported much lower mental health even after many years as a result of the stress of acculturation.[74] This is contrasted with Stillman's findings that foreign migrants from Tonga to New Zealand ex-

perience a gain in mental health, with the gains larger for women and for those with lower levels of mental health in their country of origin.[76]

The difficulties faced by many asylum seekers on their way to safety may even surpass the **traumatic experiences** back home. Social disconnection, economic worries associated with a lack of job prospects and the anti-immigrant sentiment can aggravate pre-existing mental-health disorders on arrival in a new country.[77] The most common mental health disorders include post-traumatic stress disorder, depression and anxiety disorders.[66] Sexual violence, defined as a sexual act or attempt to obtain a sexual act without the voluntary consent of the victim or with someone unable to consent or refuse[78], is considered a present threat during forced displacement and the search for asylum.[79] The consequences can be extremely serious and in women it can lead to mental disorders, obstetric complications, sexual dysfunctions, unwanted pregnancies, unsafe abortions and sexually transmitted infections.[80] Any one or combination of these factors can influence the health-seeking behaviours of foreign migrant women in a new place and can also colour the perception of her pregnancy care and labour.

Some women experienced their first pregnancy as very traumatic, leaving a long-lasting impact on their lives and even talking about their past experiences was a raw experience for them. These traumas included obstetric related complications but also the psychological traumas of the care they received. On top of the psychological impacts of leaving their home countries, those who perceived their care as traumatic have had to quickly adapt to life as a new mother in a new country with little time to look after their mental health. One of the women was even entirely put off having any further children by her experiences even though she desired a bigger family.

A recurring theme that came up in the interviews was **fear.** Much of this fear was

linked to being singled out or marginalised for being different, an almost imposed visibility because of the way they looked, dressed, spoke or acted.

Some respondents opted instead to adopt 'strategic invisibility'- a conscious decision. This is a decision that settled refugees may undertake to escape labelling by institutions or others.[81] Polzer defines it as avoiding visibility to escape the negative impact of 'imposed visibility'.[82] Lollar proposed two forms of invisibility.[83] The first is in relation to the lack of a detailed and inclusive view of those in dominant or powerful positions that includes the absence of viewing the group in question beyond their label. The second form of invisibility is one that is strategic: a deliberate response to the dominant group or to the imposed label. Strategic invisibility is a tool that can help refugees blend in and enable choice in what and how to present oneself and protect the individual. She calls it a form of resistance.[83] However, in rendering themselves invisible to avoid unnecessary difficulties, migrant women will at times not complain about poor quality care thus compromising their health and pregnancy outcomes.

Anticipating that many respondents might report negative experiences, the research team was mindful to explore **positive experiences** as well. These were specifically asked about but also came up spontaneously. Despite the clear difficulties experienced, there was care that was experienced by some of the women as expert, warm, compassionate, respectful and kind especially once care was transferred to secondary or tertiary settings. Many of them remarked on how safe they felt from a biomedical viewpoint with high levels of trust in the sound healthcare provided to them and their babies. Some of the women even stated that they would have another baby in the metropole given their previous experiences. No women mentioned any xenophobia from fellow South African patients and friendships made during this time with local fellow patients was warmly received. One of the respondents even linked her feelings of belonging to South Africa after having had a wonderful childbirth experience in

Cape Town and it inspired her to become part of South Africa.

This research project was interested in understanding what influenced the perceptions of maternity care for foreign migrant women. With the exception of frank xenophobia, a lot of what is experienced by the foreign women is also experienced by South African women accessing care. South African women often encounter language barriers, those without the requisite identity documents or proof of address struggle to make booking visits for pregnancy and women accessing public facilities also encounter abuse and judgment.

5.2 Limitations

At the outset, the investigator's sex (male) was considered a potential limitation principally because of the concern around female respondents speaking about intimate birthing details. All of the respondents came from very conservative cultural and religious backgrounds and even with the female research assistant as aide, some of the women may still have felt less inclined to speak more openly. However, respondents were very grateful for the nature of the research and we feel that most of them spoke candidly, given the detailed accounts and lengthy interviews.

The investigator was also aware that there may be a bias to remembering more negative perceptions of their experiences. The investigator himself is a clinician and is a daily witness to the care foreign migrant women receive so his bias may also have subconsciously influenced the flow of narratives as they were being told. To mitigate this as much as possible, women were all asked direct questions about positive experiences. The number of positive experiences reported and the fact that the majority of the women would choose birth in South Africa over their home country seems to balance the potential bias towards negativity.

Given the limited scope of an MMed, this study was limited to respondents who spoke English or French. The rich narratives from migrant women who couldn't communicate in either of these two languages were not interrogated and this is a major limitation. South Africa has foreign migrant women not just from the African continent and the experiences of African women alone may not reflect the issues faced by women from other regions. Also given that language was pointed out as a barrier, the researcher did not interrogate at all about informed consent to medical interventions and if there were any particular difficulties linked to this aspect of language.

Though only nine women and two stakeholders were interviewed, data saturation was reached. Furthermore, utilising only one data source, in depth interviews, and managing to recruit only from Cape Town Metro-West facilities makes the findings' applicability to Cape Town as a whole hard.

5.3 Recommendations & Implications for Clinical Practice

The first recommendation from the women in this study was to provide in-person or telephonic **interpreters**. Language was the one factor that all nine women brought up as a dilemma. The use of trained, volunteer-driven interpreters from the respective communities who can be trusted and maintain confidentiality is recommended.

Secondly, the women recommended introductory **cultural sensitivity classes** for all levels of staff in the public health sector to have a basic understanding of the experiences of foreign migrants' lives. Further to this was the recommendation specifically to train administrative staff about valid **documentation** and for all staff to be made aware of the **legal rights** afforded to migrant women accessing pregnancy care. Vanyoro's study counters the narrative around foreign migrant patients' bureaucratic

hardships by stating that in some healthcare facilities in South Africa, local inhabitance trumps legal rights to be resident in the Republic and demonstrated examples where instead of using the the 13-digit South African identity number, a migrant's date of birth was used to open up medical records by administrative staff and thus smoothing the process for migrants to access health services.[84]

Foreign migrant women understood that the request to allow birth partners at the MOU is complicated by space and safety concerns. However, this denial of having a supportive **birth partner** during labour, for migrants and local women, cannot be justified.

Another recommendation from the women was to have a foreign migrant do their perinatal **mental health assessment**. They must trust that person more and the individual responsible for this may pick up on cues that may indicate vulnerability to psychological harm that would be otherwise missed by a South African. The women also suggested a follow-up visit for women who have had their first baby in Cape Town to check that they are coping with their new role.

The final recommendation from the respondents was to have a more **confidential complaints process** in which they were taken seriously and that there was better accountability for those who are found to be guilty of xenophobia.

5.4 Recommendations for Future Research

Given the limited scope of this MMed, the investigators were unable to interrogate why certain nursing and administrative staff, the two groups that the foreign migrant women had most issue with, behaved in the manner they did towards these women. A The treatment of migrants by these two levels of staff, in particular at primary care MOUs, was highlighted by most of the women as much worse than in the hospital setting. A study involving these two groups of staff with particular emphasis on the primary healthcare level, would perhaps illuminate why foreign women are subjected to

the service they experience. The impact of an inability to give informed consent both physically and psychologically is a critical area to explore in obstetrics, given the intimate nature of the discipline. The impact of more readily available interpreters or involvement of the migrant community in care of pregnant patients would be another important direction of study, as language seemed to have the single biggest impact on women's experiences. It would also be recommended to repeat a similar study in other provinces as well as with more interpreters so that women who don't just speak English or French can have their own experiences documented.

5.5 Conclusions

This study offers insights into the healthcare experiences of pregnant foreign migrant women in the Cape Town public sector. This research project sought to focus attention on this vulnerable population group, often hidden from view in terms of scholarly interrogation and policy, who are nonetheless accessing care at Cape Town obstetric facilities and to allow better understanding of their experiences.

It is clear from this study that multiple, complex factors influence the way foreign migrant women perceive their care. These factors are personal and unique to each individual, yet there were common themes that nearly all mentioned.

Language was the theme that *all* the women stated had impacted their care. Language greatly affected their entry into the healthcare system, prevented clinical staff from understanding their medical histories or issues and delayed diagnoses or treatments. Further, consent to medical interventions was not always understood and opportunities at health promotion was lost due to a lack of understanding. A poor or no command of English was an immediate identifier of the woman as being foreign-born and at times healthcare workers utilised this to offer rushed or less comprehensive care. The inability to communicate in English and staff not being able to communicate with them in their native tongues, was also possibly the reason why the women per-

ceived their care as sub-standard even when the care was good. All women suggested that improved interpreter services would go a long way to improving care received during pregnancy and labour, reduce anxiety and build trust in the healthcare system.

The xenophobia experienced by the four women who recounted their experiences sadly reflect the commonly held attitudes and perceptions in the general South African society that foreign migrants, especially those from African countries, are a social and economic drain on limited resources in this country. This othering, including from healthcare workers, exposes foreign migrant women to adverse pregnancy outcomes especially since it leads to hesitation in wanting to access healthcare services, which can have debilitating, if not fatal outcomes.

The failure of proper accountability for staff guilty of xenophobia does not go unnoticed. This is a systemic failure in particular when so few migrant women feel they have the agency and courage to make formal complaints. The system is thus not trusted.

Even with the plethora of challenges these women faced, a narrow majority of them would still choose to have children in South Africa. Some of the women even had positive experiences such as genuine acts of compassionate, kind care that have remained with them in their memories. The belief in the safety of the biomedical practices in Cape Town and the gratis nature of care are juxtaposed with the findings of this study.

It is hoped that some fairly easily accomplished changes in the system can come from this study, in order to improve migrant women’s care and their pregnancy outcomes.

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APPENDIX A

PARTICIPANT INFORMATION SHEET AND CONSENT FORM: FOREIGN MIGRANT WOMEN

Study Title: How do foreign migrant women perceive obstetric care in the Cape Town metropole?

Reference Number: HREF 430/2018

Principal Investigator: Dr C. Gordon

Address: Department of Obstetrics & Gynaecology

Old Main Building

Groote Schuur Hospital

Main Road, Observatory, 7925

Contact: 084 320 8212 (Dr F. Hendricks, investigator)

021 404 1981 (Dr C. Gordon, Supervisor)

021 404 6020 (Dr M. Patel, Co-supervisor)

Invitation to take part: Hello! My name is Fahad Hendricks. I am a doctor training to be a gynaecologist at the University of Cape Town. I am doing a study looking at foreign patients and what they think of the experience of coming to pregnancy clinic in the CapeTown metropole and giving birth at hospitals in this city. I am interested in understanding how you experienced your care during your pregnancy and how we may be able to improve on the areas in which you think we may not be doing as well as we can. This study hopes to use your testimony so that we can understand how you feel about the care you received to help us to inform the policy makers about how we can do better for your community.

What's involved in taking part?

* You will be interviewed by myself, Dr F. Hendricks or my supervisor, Dr Chivaugn Gordon.

You can have a partner, relative or friend with you.

* We will not be asking you about your legal status in South Africa.

* There will be an observer with us. She will be there to help put you at ease and offer some support if you need it. You can also decline her presence if you desire so.

* Participation is entirely voluntary and anonymous and you can withdraw from taking part at any stage with no judgement.

* You do not need to share anything with us that you do not feel comfortable speaking about.

* Only with your permission, I would like to record our conversation. This will only be your and my voice and no filming. If you do not wish to be record, I will not record you, but I will take notes, which may increase the duration of the interview.

* The interview will take approximately an hour.

* You will receive a copy of the information sheet and consent form for your own records.

Are there any risks to you by participating?

* The study has minimal risks.

* Sometimes speaking about bad experiences you have gone through can cause upset and other negative emotions.

* I will refer you to one of our counsellors after the interview if you feel you need help to try and cope with these feelings.

* Only I and the observer will know your identity and your anonymity will be protected and guaranteed.

* I will store the records of our interview in a safe, locked location that only I will have access to.

What are the benefits of being part of the study?

* There are no immediate, direct benefits linked to your participation.

*However, it is possible that talking about your experiences could benefit your overall well-being

* I hope that by you sharing your experiences with us, either positive or negative, we can inform the local authorities and help them to try and improve the kind of care we provide to all future foreign patients who come to antenatal care and deliver in Cape Town?

Will this cost you anything?

* There is no cost to taking part. We will pay for the transport costs today and your meal during the interview and provide you with a supermarket voucher.

What will happen to study information once the study is done?

* The information will purely be used for academic and research purposes in the hope that we can improve health care for foreign pregnant women in Cape Town. The findings will be presented to the Department of Obstetrics & Gynaecology, as well as potentially at conferences and in a written article in an academic journal. All the recordings and transcripts will be destroyed after the study is completed.

Is there anything else you should know?

* If you need further information, Dr F. Hendricks can be contacted on 084 320 8212.
* You can also contact the University of Cape Town's Faculty of Health Sciences Human Research Ethics Committee if you have any queries, concerns or complaints that have not be adequately answered for by the main investigator. For general enquiries, please contact:

Postal address: Groote Schuur Hospital, Private Bag, Observatory, 7937

Physical address: Room: E52.23, Old Main Building, Groote Schuur Hospital

Tel: 021 406 6338

Fax: 021 406 6411

DECLARATION BY PARTICIPANT

By signing below, I ....., agree to take part in a researchstudy entitled: How do foreign migrant women perceive obstetric care in the CapeTown metropole?

I declare that:

• I have read this information and consent form and it is written in a language with which I am fluent and comfortable.

• I have had a chance to ask questions and all my questions have been adequately answered.

• I understand that taking part in this study is voluntary and I have not been pressured to take part.

• I agree to the presence of a third party during my interview.

• I agree that my testimony may be used as part of research for a postgraduate degree and for academic journal publication.

• I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

Signed at (place) ……on ……2019

....

Signature of participant Signature of witness

DECLARATION BY INVESTIGATOR

I (name) .....declare that:

· I have explained the information in this document

to.....

· I encouraged her to ask questions and took adequate time to answer them.

• I am satisfied that she adequately understands all aspects of the research, as discussed above

Signed at (place) ..... on

(date)..... 2019.

.....	.....
Signature of investigator	Signature of witness

APPENDIX B

PARTICIPANT INFORMATION SHEET AND CONSENT FORM: KEY STAKE-HOLDERS

Study Title: How do foreign migrant women perceive obstetric care in the Cape Town metropole?

Reference Number: HREF 430/2018

Principal Investigator: Dr C. Gordon

Address: Department of Obstetrics & Gynaecology

Old Main Building

Groote Schuur Hospital

Main Road, Observatory, 7925

Contact: 084 320 8212 (Dr F. Hendricks, investigator)

021 404 1981 (Dr C. Gordon, Supervisor)

021 404 6020 (Dr M. Patel, Co-supervisor)

Invitation to take part: Hello! My name is Fahad Hendricks. I am a doctor training to be a gynaecologist at the University of Cape Town. I am doing a study looking at foreign patients and what they think of the experience of coming to pregnancy clinic in the Cape Town metropole and giving birth at hospitals in this city. I am interested in understanding how women experienced their care during pregnancy and delivery. This study hopes to use women's testimonies to understand how they feel about the care they received to help us to inform the policy makers about how we can do better for this community. You have been invited totake part because you are a key stakeholder involved with assisting many foreign migrants and you have heard accounts from women about their childbirth experiences in Cape Town.

What's involved in taking part?

*You will be interviewed by myself, Dr F. Hendricks or my supervisor, Dr Chivaugn Gordon.

*Participation is entirely voluntary and anonymous and you can withdraw from taking part at any stage with no judgement.

*You do not need to share anything with us that you do not feel comfortable speaking about.

*Only with your permission, I would like to record our conversation. This will only be your and my voice and no filming. If you do not wish to be recorded, I will not record you, but I will take notes, which may increase the duration of the interview.

*The interview will take approximately an hour.

*At the end of the interview we will ask you to help us get in touch with potential participants.

*You will receive a copy of the information sheet and consent form for your own records.

Are there any risks to you by participating?

*The study has minimal risks to you as a key stakeholder.

*Only I and the observer will know your identity and your anonymity will be protected and guaranteed.

*I will store the records of our interview in a safe, locked location that only I will have access to.

What are the benefits of being part of the study?

*There are no immediate, direct benefits linked to your participation.

*I hope that by you sharing any accounts of women's experiences, we can begin

to try and improve the kind of care we provide to all future foreign patients who come to antenatal care and deliver in Cape Town.

Will this cost you anything?

*There is no cost to taking part. Key stakeholders will not be remunerated.

What will happen to study information once the study is done?

*The information will purely be used for academic and research purposes in the hope that we can improve health care for foreign pregnant women in Cape Town. The findings will be presented to the Department of Obstetrics & Gynaecology, as well as potentially at conferences and in a written article in an academic journal. All the recordings and transcripts will be destroyed after the study is completed.

*We will provide a report and verbal feedback to the refugee centres, where we will invite anyone who is interested to attend and hear the results.

Is there anything else you should know?

*If you need further information, Dr F. Hendricks can be contacted on 084 320 8212.

*You can also contact the University of Cape Town's Faculty of Health Sciences Human Research Ethics Committee if you have any queries, concerns or complaints that have not be adequately answered for by the main investigator. For general enquiries, please contact:

Postal address: Groote Schuur Hospital, Private Bag, Observatory, 7937

Physical address: Room: E52.23, Old Main Building, Groote Schuur Hospital

Tel: 021 406 6338

Fax: 021 406 6411

DECLARATION BY PARTICIPANT

By signing below, I....., agree to take part in a research study entitled: How do foreign migrant women perceive obstetric care in the Cape Town metropole?

I declare that:

• I have read this information and consent form and it is written in a language with which I am fluent and comfortable.

• I have had a chance to ask questions and all my questions have been adequately answered.

• I understand that taking part in this study is voluntary and I have not been pressured to take part.

• I agree that my testimony may be used as part of research for a postgraduate degree and for academic journal publication.

• I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

Signed at (place) ……on ……2019

....

Signature of participant Signature of witness

DECLARATION BY INVESTIGATOR

I (name) .....declare that:

• I have explain the information in this document

to.....

• I encouraged them to ask questions and took adequate time to answer

them.

• I am satisfied that they adequately understand all aspects of the research,

as discussed above

Signed at (place) ..... on (date) ..... 2019.

.....	.....
Signature of investigator	Signature of witness

APPENDIX C

INTERVIEW SCHEDULE FOR FOREIGN MIGRANT PARTICIPANTS

1.Tell me about your experience of attending antenatal clinic, delivering your baby and your hospital stay in Cape Town in Cape Town.

Probes:

(a) How did the care you received during your pregnancy, labour and hospital stay make you?

(b) Did you have any positive experiences during your care? If so, what about the experience was good?

(c) Did you have any negative experiences during your care? If so, what about the experience was negative or difficult? In those difficult moments, how did you respond?

2.How much of the care you experienced do you think was influenced by your being born outside of South Africa?

3.How do you think we can improve the care we provide for people born outside of South Africa?

APPENDIX D

INTERVIEW SCHEDULE FOR KEY STAKEHOLDERS

1.Could you tell me what your role at your centre is?

2.In your capacity in this role, tell me of the experiences you have been told about from your clients of how they have perceived their obstetric care in Cape Town

Probes:

(a) Have there been any experiences that have particularly stood out as positive? If so, did the client expand on what about the obstetric care was good?

(b) Have there been any experiences that have particularly stood out as negative? If so, did the client expand on what about the obstetric care was lacking?

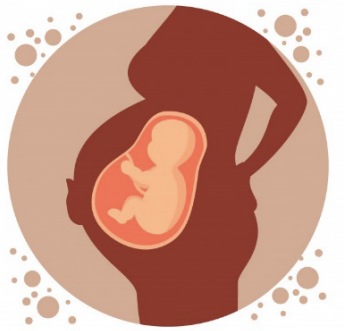
(c) Has any of your clients required psychological support after experiencing obstetric care in Cape Town?

APPENDIX E

RECRUITMENT POSTER

Have you given birth to a healthy baby in Cape Town?

We are looking for women born outside of South-Africa who gave birth at a hospital or clinic anywhere in Cape Town.



We want to interview you (English or French) for:

"A study about how foreign women perceive pregnancy care in Cape Town"

- The interview will take approximately ONE HOUR of your time. All information will be kept anonymous and private.
- We will cover your transport costs.
- The research is being done under the auspices of the University of Cape Town.

For more information contact:
Fahad Hendricks: 084 320 8212
You can phone him or send an SMS or WhatsApp message.