

**Birth Beyond Borders: Childbirth Experiences of Migrant Women in Cape
Town, South Africa**

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Research Title Birth Beyond Borders: Childbirth experiences of migrant women living in Cape Town, South Africa.

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Abstract

Background Childbirth is significant for women and how it unfolds can influence the outcome of labour and have lasting impacts on them. It is important for women to receive good quality care during this time of intense vulnerability. However, evidence suggests that women are at risk of disrespect and abuse during this phase. South Africa is a top destination for migrants from Africa and migrant women may be more likely to experience discrimination during childbirth. This study therefore aims to explore the childbirth experiences of migrant women and will contribute to our understanding of how to address their health care needs during childbirth.

Methods The qualitative study was conducted in Cape Town, South Africa. Using an exploratory approach, participants were purposively sampled in collaboration with the Scalabrini Centre of Cape Town. The study included eight women from various African countries. Participants were interviewed using a semi-structured interview guide and thematic analysis was applied to the data. The reproductive justice framework was used to organise interview findings.

Results The study revealed that migrant women had positive experiences during childbirth but also reported negative events. Women were satisfied with health care services in South Africa, compared to their countries of origin. Particularly that they didn't have to pay for services, health care workers (HCW) provided them with information about health care procedures and HCW were available to assist them when they needed help. Some women however, reported being neglected, treated unfairly and discriminated against. Some, especially negative experience, might have not been exclusive to migrant women but might have been worsened because of their migration status.

Conclusion Women reported having positive childbirth experiences. However, the study also revealed that even though South African legislations protect migrant's right to health, migrant women still experience negative experiences during childbirth. Some negative experiences may have been heightened because of discrimination against migrants in public health care facilities. Therefore, it is essential that interventions are developed, such as the use of interpreters, to support migrant women during childbirth. Furthermore, healthcare workers must adhere to the already existing legislation, and migrant women must be provided with information on accessible channels to report any ill-treatment during childbirth.

Key words: Reproductive Justice, Birth Justice, Migrant, Bodily Autonomy, Quality Care, Childbirth

Background

Women's childbirth experiences may have long lasting impacts on them even after childbirth.¹ The World Health Organisation (WHO) reports that approximately 287 000 died during pregnancy, after pregnancy and during childbirth in 2020.² In South Africa, 88 maternal deaths per 100 000 live births were recorded in 2020.³ Risk of morbidity and mortality is increased with poor quality care and it is important for women to be provided with quality care during this time of intense vulnerability.²

Quality of care requires health care workers (HCW) to act in the best interest of the patient and provide respectful care to pregnant women.⁴ Interactions between HCW and patients is an essential aspect of health care because it affects the patients' experiences and their perception of quality of care.⁵ Effective communication, respect, confidentiality, and autonomy are important for respectful maternity care.⁵ Furthermore, positive interactions between HCW and patients lead to a trusting relationship between the two and contributes to a positive birth experience.⁵ Positive impacts of support during labour include better maternal outcomes as well as satisfaction with the childbirth experience and feeling in control.⁶

Ill-treatment of women during this time of vulnerability has been reported.⁶ Studies reveal that disrespect and abuse towards women is common during childbirth in South Africa.⁷ A negative childbirth experience affects a women's psychological and physical wellbeing.¹ Negative childbirth experiences additionally make women fearful of giving birth at a later stage.⁸ This indirectly leads to maternal mortality since women who have had negative birth experiences may be less likely to access health care services in future.¹

Migrant women are more likely to experience discrimination and negative childbirth experiences in their host countries. Studies show that discrimination against migrants, often as a result of widespread xenophobia, in the health care sector in South Africa is an ongoing issue.^{9,10} Research reveals that women asylum seekers and refugees face huge challenges related to their sexual and reproductive health and rights.¹¹ Migrant women additionally face several challenges when using services in their host countries such as insufficient support, language barriers and cultural differences.¹² Language barriers, communication problems and poor interactions between HCW and migrants contribute to the negative health outcomes of migrants.¹³ Migrant women have also been reported to be at a high risk of still births, caesarean section, mental health issues and congenital anomalies in their infants.¹² It is clear from existing literature that migrant women are more likely to experience negative health experiences and outcomes.¹³

This is concerning since South Africa has progressive legislation and policies concerning migrant's rights, including their right to access health care services. The South African Bill of Rights states that everyone in the country has the right to access health care services, this includes pregnant migrant women and children under the age of six.^{9,10} This right is applicable to every resident of South Africa.¹⁴ The Refugees Act 130 of 1998 states that refugees have the same right to access health care services as South African citizens.¹⁵ Furthermore,

all pregnant women and children under the age of six have the right to access free public health services, regardless of their nationality or documentation status.¹⁶ It is also important to note that the health care system in South Africa faces many challenges. South Africa uses a two-tiered system, the public health system is overburdened and under resources while the private sector is well resourced but serves less people.⁴ The public system provides care to approximately 83% of the population, which means that HCW in the public sector provide services to high numbers of people, with limited resources. Research highlights that the lack of resources has led to health care workers in the public sector working under pressure, resulting in compassion fatigue.⁴

Migrants are at risk of being discriminated against in the public health sector. South Africa hosts approximately 273 488 refugees and asylum seekers.¹⁷ Gauteng and the Western Cape were estimated to experience the largest inflow of migrants from 2016 to 2021.¹⁸ Given that South Africa continues to be the top destination for African migrants, it is concerning that they are at risk of being discriminated against when seeking medical assistance.¹⁷

It is essential to address inequalities that affect health outcomes related to sexual and reproductive health to ensure that all women regardless of their nationality have access to high quality maternity care.² Due to the vulnerability of migrant women, it is important to obtain insights into their childbirth experiences and conduct research on disrespect and abuse during childbirth in order to develop interventions which can reduce disrespect and abuse.⁷ Therefore, this study aims to explore the childbirth experiences of migrant women living in Cape Town. This study will provide us with new insights on the topic to address this gap in research. Moreover, this study will contribute towards addressing the health care needs of migrant women during childbirth and reduce maternal infant and child morbidity and mortality rates.

Conceptual framework

The reproductive justice framework was used to conceptualise the childbirth experiences of migrant women in Cape Town. The framework was developed in response to the limitations of reproductive movements which focused on legal access to abortion and contraception while overlooking structural issues which affect individuals reproductive experiences.¹⁹ The reproductive justice framework was developed in response to the ways marginalised women were not included in conversations about reproductive rights globally.¹⁹ The framework is based on three values: the right to have a child, the right to not have a child and the right to parent a child or children in a safe and healthy environment.¹⁹ The right to have a child refers to the right to decide to have a child and when to have a child without any coercion, violence or discrimination. This includes having access to sexual reproductive health services.¹⁹ The right to not have a child includes access contraception services and accurate reproductive health information as well safe and legal abortion. Finally, the right to parent in a healthy environment refers to raising children in environments which do not include any form of harm towards children.²⁰ An additional component of the reproductive justice is birth justice which focuses on how women are treated during all stages of pregnancy, birth and the post birth period. Birth justice this ensures that

women's needs are addressed at all times.²⁰ The reproductive justice framework additionally advocates for women's agency and their right to control their sexuality and reproductive rights.²¹ The reproductive justice framework has a dual focus on people's human right to bodily autonomy and making personal decisions as well as the obligation of the government and society to ensure that there are suitable conditions for people to make their own decisions.²² The theory further highlights that women's intersecting identities such as gender, class and race affect their reproductive health.¹⁹ The framework posits that marginalised groups face more barriers when trying to access healthcare and sexual and reproductive health services.²¹ Moreover, the framework aims to identify structural issues such as social, economic, gender, racial, environmental, financial, sexual, disability and carceral injustices which affect the reproductive rights of women. The reproductive justice framework aims to address these systemic barriers and argues that to achieve reproductive justice we need to identify all forms of oppression and recognise how they are interconnected.²² The framework allowed the researcher to understand how migrant women's identities affects their interactions with HCW and the quality of care they receive. By exploring the childbirth experiences of migrant women this can assist in addressing mortality rates among migrant women. Furthermore, the framework will allow us to promote access to sexual reproductive health services by addressing the needs of this group.

Methodology

Research design

This study used a qualitative exploratory design to explore the birth experiences of migrant of woman in Cape Town. The research design was suitable for the study because there is limited knowledge on this topic and the study design is used to describe and understand human experiences where limited research exists.²³ Furthermore, the research design ensured that migrant women were able to talk freely about their childbirth experiences,²³ and provide us with new insights to address this gap in research.²⁴

Study setting

The study was conducted in the city of Cape Town. In 2019, the population of Cape Town was approximately 4 392 562.²⁵ South Africa was additionally reported to be a popular destination for migrants from Africa,²⁶ and the majority of international migrants were reported to be in Gauteng (52%) followed by the Western Cape, with 12% of migrants living in the province.²⁵ Cape Town was suitable for the study since it hosts many migrants from Africa and other parts of the world, especially those from Southern Africa.²⁷

Sampling and Participants

The study population included migrant women who used the services at Scalabrini Centre of Cape Town. The Scalabrini Centre of Cape Town was identified by the researcher as one of the centres which provide services to migrants. The researcher contacted Scalabrini Centre and applied with their researchers to collect data at the centre. The Scalabrini Centre assists migrants to integrate into local communities through various services and

additionally ensures that the rights of migrants are realised in their host countries. The centre was suitable for the study because they provide services to migrants from various African countries living in Cape Town. The participants were recruited through purposive sampling to allow the researcher to sample participants who would provide in depth information about the study topic.²⁸ The sampling method was heterogenous and allowed the researcher to obtain a variety of insights from participants.²⁸

The following inclusion criteria was used to recruit participants: if they were a migrant woman from another African country, over the age of 18, must have given birth in the past two years and must have given birth at a labour ward in a maternal facility in Cape Town. The participants were first recruited by a staff member at the Scalabrini Centre who explained the purpose of the study to them. If interested they gave permission for the researcher to contact them and schedule interviews.

The study consisted of eight participants between the ages of 24 and 40 (see Table 1). The study sampled women from different African countries, namely, Burundi, the Democratic Republic of Congo and Zimbabwe. Five of the women had only given birth in South Africa while three had given birth in South Africa and their country of origin. All participants gave birth between 2022 and 2024 in a hospital in Cape Town. All participants gave birth to healthy babies except two, one who lost their child after childbirth due to a genetic illness and the other who had a premature baby. The migration statuses of the women varied and included refugees, an asylum seeker, women who were undocumented and those that had work permits. In this study all these women are referred to as migrants.

Table 1: Demographic information of participants

Participant ID	Age	Country of Origin	Migrant status	Number of years in Cape Town	Number of children	Hospital of childbirth
1	27	Zimbabwe	Refugee	26	2	Somerset Hospital
2	24	Democratic Republic of Congo	Undocumented	2 and half	1	Mowbray Maternity Hospital
3	33	Democratic Republic of Congo	Work Permit	12	2	Somerset Hospital
4	27	Burundi	Asylum Seeker	4	2	Somerset Hospital
5	26	Zimbabwe	Undocumented	6	2	Tygerberg Hospital
6	39	Democratic Republic of Congo	Refugee	13	4	Mowbray Maternity Hospital

7	37	Zimbabwe	Work Permit	15	2	Karl Bremer Hospital
8	40	Zimbabwe	Undocumented	5	2	Tygerberg Hospital

Data Collection

The researcher conducted 10 interviews with participants, but two were not included in this study because the women gave birth before 2022 and did not meet the inclusion criteria. A semi-structured interview guide (Appendix C) was developed with reference to the Reproductive Justice Framework and was used to guide the interviews.

Interviews were conducted in a private room at the Scalabrini Centre. The interviews were conducted in English by the primary author of this paper, since the participants stated that they were comfortable communicating in English. Interviews ranged from 15 minutes to one hour and the interviews were audio recorded and transcribed by the researcher. Interviews were stopped after the 8th interview when the same information was coming up from participants, therefore data saturation was reached. The interviews were transcribed with the assistance of an AI transcription tool on Microsoft Word and then reviewed and edited for accuracy by the researcher.

Data analysis

Thematic analysis, particularly the Braun and Clarke²⁹ method, was used by the researcher to analyse the interview data. Thematic analysis was used to fully comprehend the interview data and additionally identify the common themes from the interviews. The researcher started by familiarising themselves with the interview data by repeatedly reading through the interview transcripts to obtain an in-depth understanding of what was said by the participants. The researcher also made notes of what appeared to be important or what was common among all the interviews while reading the interview transcripts. The researcher uploaded the transcripts on NVivo and inductively coded the transcripts. The codes were then grouped into themes before writing the results section.

Ethical Considerations

Ethical clearance for the study was obtained from the University of Cape Town's Faculty of Health Sciences Human Research Ethics Committee HREC REF: 879/2023 (Appendix E). The researcher additionally obtained ethical approval and permission to conduct the research from the Scalabrini Centre (Appendix F) before recruiting participants. Participants were given an opportunity to read and sign the informed consent forms (Appendix D) before the interviews. The interviews were conducted in a safe and private space where participants were comfortable and felt free to express themselves. The Scalabrini Centre requires researchers

to reimburse clients with money to cover their transport expenses. Participants were therefore, reimbursed with R100 after interviews

Rigour

Several methods of rigour were used to ensure that the research outcomes are accurate. Triangulation of data was done through the comparison of research findings with other studies.³⁰ To ensure rigour and ethical procedure, the co-supervisor of the study was sent the first interview transcript to check whether the interviews were conducted correctly. The researcher additionally kept a journal to record every step of the research process. Before data collection commenced, the interview guide was piloted with two participants who did not meet the study requirements. The researcher conducted member checking by having a brief discussion with research participants about their insights at the end of the interview.

Results

The study explored the childbirth experiences of migrant women living in Cape Town including how they perceive the quality of care they received as well as their interactions with HCW. Guided by the reproductive justice framework, the study found that identities of migrant women, specifically them being foreign nationals influenced how HCW treated them.

Migrant women shared both positive and negative experiences about their childbirth. The positive perceptions and experiences are presented first to provide some context and then the focus of the rest of the results is on exploring and understanding the migrant women's negative experiences and perceptions. The negative experiences of migrant women are organised according to the focus of the reproductive justice framework, firstly birth justice and women's right to give birth in a healthy environment as well as women's right to bodily autonomy. This includes themes which may have affected this right such because of HCW' negative attitudes, the availability of HCW and medical procedures being done incorrectly. Secondly the other themes in the study including informed consent, disregarding patients and language barriers were grouped under the right to bodily autonomy.

Illustration of themes:

Positive perceptions of quality of care	Birth justice and the right to give birth in a safe and healthy environment	Right to bodily autonomy
<ul style="list-style-type: none">• Satisfaction with the quality of care	<ul style="list-style-type: none">• Healthcare workers negative attitudes and discrimination• Preference for approachable healthcare workers• Neglect by health care workers• Medical procedures done correctly	<ul style="list-style-type: none">• Disregarding women's concerns• Informed consent• Language barriers

Positive perceptions about quality of care

The childbirth experiences of women included both positive and negative experiences. In discussing their experiences many women started off with positive reflections of their experiences. Many women mentioned that they were overall satisfied with the quality of care they received when asked about how HCW can improve their services

Improving, but for me, I don't see anything [they need to improve], they are fine, they're doing their job you see, we are many in the hospital, but they try to see each and every one according to the folder, they read and do everything... - Participant 6, Refugee from DRC.

Women acknowledged that HCW were not always able to assist due to systemic issues such as staff shortages. Many of these positive reflections were made in comparison to their prior experiences of birth or health care in their home country. This was noted by one woman when speaking about her experience in Zimbabwe:

What I can say, in Zimbabwe, my birth experience was okay but the problem was you had to bring your own things, your own gloves, your own razor, yeah, they will give you a list to say, bring a syringe, bring everything that's going to be used for you. We were buying for ourselves, so that when you come to give birth, you provide with your stuff, even the surgical gloves, you're supposed to have them - Participant 7, Migrant woman from Zimbabwe.

Women not having to bring their own medical supplies made their childbirth experience much easier than in their home country. Some women additionally mentioned that their childbirth experience was better in South Africa compared to their home country because they did not have to pay medical fees.

If you don't have money, they can't take you like to give you medicine. To make an operation, they can't, you need to give money first – Participant 2, Undocumented woman from DRC.

Paying no fees might have been a big priority for women especially because most of them mentioned that they were not employed. Furthermore, another participant was happy with the HCW following procedures and advanced technologies:

Here [in SA] it's the best, you know technology is, level of technology is higher [than at home]- Participant 3, Migrant woman from the DRC.

Women also mentioned that they were happy with HCW providing them with sufficient information before a medical procedure was conducted. One woman describes how she was provided with information before her emergency C-section:

Yeah, when I, when I, when I I go there [operation room] when I was there on the table before they start everything they tell me, we need to do this and this because when we was pushing we checked the baby it was in the bad position. So, we need to do this emergency [C-section] - Participant 2, Undocumented woman from DRC.

Explanations of medical procedures put women at ease about their health and their children's health and they were therefore comfortable to ask questions and gain more clarity about medical procedures.

She [doctor] was informing all the time what's happening, why they're keeping me and whenever she comes to listen to the heartbeat, even the nurses, like I told you, they would sit and then I'll ask them, "so the report, you're writing, what did you find out?", "No, there is progress don't think too much, do you feel any pain? Can we give you painkillers because whatever is happening to you might affect the baby, remember that, don't think too much" [nurse speaking] - Participant 7, Migrant woman from Zimbabwe.

HCW would additionally advise women on potential future pregnancies. One participant who lost her child due to a genetic condition a few days after giving birth stated that she was provided with advice on what to do in future should she fall pregnant again.

They were counselling, giving some advice. From your future pregnant you have to be more careful. You have to talk to the doctor and tell them about your previous experience. So, like the thing that that happened last year, must not happen in future – Participant 3, Migrant woman from the DRC.

The informational efforts by HCW allows women to be at ease about what is going on and they are comfortable to ask more questions. Some women were also satisfied with the availability of HCW and their ability to assist them when they needed help. A participant described how HCW would regularly check on them:

The way they [HCW] take care of us. They give us medication, food, everything. They always come and checkup, you know, if you're already doing your pills. - Participant 3, Migrant woman from the Democratic Republic of Congo

This demonstrates that women were always supported and were in a safe environment and could be assisted if there was an emergency. Women further mentioned that in instances where the doctors and nurses were not available, student HCW were available to assist them.

The thing is with Somerset, they always have these students. They're always showing up like after every 10 or 20 minutes they are there checking up on you. "You okay? Do you need help? Do you need this? Do you need assistance to sit up" or whatever the case may be and to check up on the baby so yeah, I I had, I had assistance - Participant 1, Refugee from Zimbabwe.

This ensured that women had someone to always assist them even when the HCW were not available. Despite many women noting that the experience was positive and in many cases comparing the experience in South Africa to better than it was or could have been at home, the women also reflected on their childbirth experiences as being complex with many examples of negative experiences.

Birth justice and the right to give birth in safe and healthy environment

Health care workers negative attitudes and discrimination

Women felt that they faced discrimination and unfair treatment from HCW due to being migrants. One woman noted how statements from one nurse made her uncomfortable.

The other one said, "you foreigners, just come here for, every time, foreigners, [I am] sick and tired of attending [to] foreigners". That's one thing that made me to be uncomfortable - Participant 8, Undocumented woman from Zimbabwe.

Health care workers' attitudes and overt remarks were perceived by women as displays of discrimination towards them. In some instances where participants wanted clarity about medical procedures, they reported that HCW responded in a rude manner such as the one example provided below:

But this one, even the nurse that put me a balloon was very rude, she told me, "is it your first child" and I said no, it's not, but it's my first time here and it's my first time you putting this thing, she said "no, you're supposed to be strong, we must put you that thing and you must go back home" and I said no, you can't just put me this thing you must take it out. - Participant 5, Undocumented Migrant Woman from Zimbabwe.

While all women could have experienced this, the example above with HCW specifying migrant (foreign) women suggests that this may be heightened due to their status as migrants. Women stated that they were not always comfortable communicating with HCW because of their negative responses. The following participant noted this succinctly:

Like I said before, I was not comfortable because most of them [HCW], they were speaking up, like shouting, so I was not comfortable to continue to ask something because why they speak like this- Participant 8, Undocumented woman from Zimbabwe.

Women would therefore limit their communication with HCW to avoid being shouted at or treated unpleasantly. The HCW' reactions discouraged women from communicating their needs which may result in them not having any autonomy over their body. These experiences also reveal that all but specifically migrant women may not find themselves in a safe and supportive environment during labour.

Preference for approachable health care workers

To avoid HCW that were rude, women identified ones they preferred and were comfortable communicating with and whom they found approachable. This was noted by one woman:

There was other nurse that I was free to say something, because if I tell the other ones, they were just like, "no, you must just sit here sisi [sister], you don't tell us what to do". So, there was one person I was communicating to them, then I can see that this nurse is good, so it's better I must tell this nurse, because if I tell this [other] nurse, she's gonna reply in a rude way – Participant 5, Undocumented Migrant Woman from Zimbabwe.

This meant that women were not always comfortable and at times had to wait for a HCW that was approachable to voice their concerns to. This may have delayed care and raising of issues or complications. A woman mentioned that she was not comfortable with pushing when a rude midwife was around, and she had to wait for them to leave and ask for assistance from a nurse she was comfortable with.

That's when I called the coloured sister I said sisi [sister] please come I ask her 'what's happening?', she said 'your baby is, I think about 5 to 6 centimetres away and if you can't push, the she's, the way the baby's stuck, you might lose your baby, so we have to operate you quickly, so that we take the baby out' - Participant 7, Migrant woman from Zimbabwe

Participants further mentioned that they preferred communicating with doctors over the nurses.

So, you want to talk to them nicely, they're so, I don't know, but the doctors are fine and once the doctor is there, they [the nurses] are pretending to be good. It's so rare to find a good nurse. Yeah in 10%, you given, [you] get maybe two, but the rest, yoh - Participant 3, Migrant woman from the DRC.

The above highlights the power dynamics operating in healthcare systems, where patients deem doctors being more superior and better than nurses. These experiences may have been common among all women including

locals, however because of the normalised discrimination against migrants in public health services, it may be more likely for migrant women to identify and seek out HCW they were comfortable with. This means that women are not always free to communicate their concerns and needs because they must wait for the HCW, they are most comfortable with. This displays the power dynamics between HCW and women.

Neglect by health care workers

Women provided some examples of feeling that HCW were available to assist them (see results above), however there were examples of women who felt neglected. Neglect occurred when women were left unattended for extended periods and or not assisted when they required help. One woman mentioned that she was not attended to for approximately three hours after she was admitted into the hospital, and she felt that this could have been because of her status as a migrant.

I think maybe it's because I'm a foreigner here, so they don't care about a foreigner. Rather than in my country, my first pregnant, they were coming, keeping on checking, how are you feeling, what is happening, checking the centimetres... - Participant 8, Undocumented woman from Zimbabwe.

Women being neglected can result in serious medical complications and failure to assist if urgent medical attention is required. Another participant described how she was not attended to and was subjected to offensive and derogatory terms used by locals to discriminate against foreign nationals.

So that time they were just leaving me there, "haibo gweja, uyanxola" (this foreigner is making a noise), you know when they're talking their own language, you are making very noise [a lot of noise], but I was telling them, but I'm in pain - Participant 5, Undocumented Migrant Woman from Zimbabwe.

This demonstrates that women might have been neglected due to their status as migrants. Women additionally mentioned that HCW would also refuse to help them when they needed assistance from them. As noted by one participant who mentioned how she was in pain and wanted the HCW to assist her:

I tried to talk to her nice[ly], can you please sisi [sister] help me, I'm so painful, there's no way I can even put my feet down, just help me, just with one hand, can I put only my head down, [she said] "Sisi, hurry up, hurry up we need to change that bed and put the new sheet, so you have to go" [Nurse speaking] - Participant 3, Migrant woman from DRC.

Ignoring women's request for medical attention or assistance could result in medical complications for the women and their children. This also additionally not foster a healthy and safe environment for women to give birth in.

Medical procedures done incorrectly

Women reported that some medical procedures were not conducted correctly by HCW putting the woman and child at potential risk. One participant mentioned that she had a cervical balloon inserted to induce labour that was left in for a period longer than it should have been.

I told my husband I'm in pain now, they [HCW'] said no you can come back tomorrow when I go back tomorrow, remember I was having that balloon [cervical balloon] and I was in pain when I went back tomorrow to the Tygerberg Hospital, the doctor asked me "who put this balloon, because you're not supposed to sleep the whole night with it" then I said I don't remember the nurse and he said "no you are supposed to tell us which nurse gave you this balloon because it's only for three hours or four hours, it's for making the baby quick" and I was in pain, I was in pain, pain - Participant 5, Undocumented Migrant Woman from Zimbabwe.

Another woman described how she was not stitched correctly after giving birth:

They stitched me, but they stitched me wrong...then the new ones [HCW starting new shift] they came in. So, when they came in to check on me they found out that the [other nurses] stitched me wrong, so they had to retake, take off the the whole those stitches and stitched inside, because apparently there was like in inside meat or I don't know how to call it. They they had to stitch the inside because the ones that had left it just stitched on outside - Participant 1, Refugee from Zimbabwe.

It is not clear if this problem of poorly conducted medical procedures was specific to migrant women but regardless, it could compromise the health of the mothers and their babies. Furthermore, this also violates their right to access quality healthcare services and their right to give birth in a safe environment.

Right to bodily autonomy

Disregarding women's concerns

Women reported that some of the concerns they raised would be dismissed and that their expressions of discomfort, pain or concerns during labour were disregarded by HCW. Furthermore, they felt that HCW did not show empathy towards them. One participant described how a health care worker dismissed her when she was in labour:

I was like, okay, I need to give birth, so I started screaming, she was like, the lady that assisted me, she was like no, "you're not in labour yet" [HCW], I'm like, 'I'm in labour, the baby is here". So, when the other doctor she came out from wherever I don't know, and then she was like, no, the baby is here, she's like one centimetre away, the baby is here we need to take her to the [delivery room]... - Participant 1, Refugee from Zimbabwe.

Women could be at risk of complications or emergencies if their concerns are not heard, and this certainly impacts on women's autonomy during childbirth. One woman described how a doctor refused to listen to her request:

I just tell her [doctor] "no, I'm not trying to offend you or something, but if you can see [my arm] it's so painful", and she said, "I want that part that is swollen, ndi funa lena (I want that one)" [doctor speaking]. So she didn't know that I speak Xhosa.- Participant 7, Migrant woman from Zimbabwe

This demonstrates the power dynamics and imbalance between women and HCW with women being disregarded and ignored.

Informed consent

Despite some women noting the value of information shared with them, some women reported not being provided with sufficient explanation about the need for certain medical procedures, and therefore provided with limited opportunity to make decisions regarding childbirth. One participant felt that she was uninformed about medical procedures.

They told me to push the baby, but I just couldn't, I was shaking. She [doctor] just took a form, she said sign here, we are operating, you now, I just took the pen and signed - Participant 7, Migrant woman from Zimbabwe.

Furthermore, women would be asked to perform certain procedures without a clear explanation of the advantages and disadvantages of such procedures:

Like sometimes they [HCW's] was coming with that things to put inside of the anus so we can make poo poo, they was coming with that things and after that they give me, they they show me in a sign so you're gonna go to the toilet to put inside and then wait for a little bit minute, you're gonna make a poo – Participant 2, Undocumented woman from DRC.

In some instances, medical procedures were explained during the procedure and not before they were done as noted by one woman with regard to her stitches:

But like with the stitches that never really got like a notification that especially when they had to redo the stitches I was, I didn't know they, okay, they did the stitches and then I was like “oh what's happening now?” So only to find out later that no ‘We had to do stitches, redo stitches for you’, so I didn't know that that happened until like mid [procedure]...- Participant 1, Refugee from Zimbabwe.

In instances where medical procedures were explained, women felt that they were not given an in-depth explanation as described by a participant:

She [HCW] didn't explain what I understood because the way she explained to me she just saying “you are due to your date” and I was not even over my time, [due date] she said “you are due your time and you're saying you have pain, so now we need to put this balloon [cervical balloon] so that the baby will move fast”, that that was the reason, she told me - Participant 5, Undocumented Migrant Woman from Zimbabwe.

Women felt that they were not provided with enough information about medical procedures even in instances where they needed the information to make informed decisions about their bodies.

Language barriers

Another factor which could affect the ability of women to make decisions regarding their body that was specifically more complex for migrant women is the language barrier between them and HCW. While those who spoke English were able to use this to understand the HCW, others struggled during delivery because their English was not good. A woman from DRC described language challenges during delivery.

That time I was understanding small English, but you know to speak, like to answer them, it was very difficult. So, when they tell my mother-in-law this is this and then she translates for me, I understand already, but I don't know how to give them answer - Participant 2, Undocumented woman from DRC.

Women found alternative ways to communicate with HCW and HCW also suggested that women find informal translators if they could not communicate with them. This allowed women to communicate with HCW even if they were not fluent in the local languages but only where these options were found. This ensures that women understand what is happening, however, this also means that some things cannot be fully explained by the HCW. Women additionally mentioned that they would assist each other if they noticed that someone is struggling with understanding English:

But sometimes also when you are in a room in a big room, there's some mothers they can speak your language when you don't understand, when the doctor don't understand very well, she can translate to her – Participant 2, Undocumented woman from DRC.

Language barriers affect communication between HCW and patients, this affects migrant women more due to their inability to communicate in local languages and their limited knowledge of English. HCW therefore used alternative ways to ensure that they can communicate with the women. However, this also meant that neither the women nor the HCW could fluently communicate with each other, this could have also discouraged women from communicating or asking the HCW anything.

Discussion

The reproductive justice framework was used to analyse the childbirth experiences of migrant women living in Cape Town. The reproductive justice framework states that people's intersecting identities result in different reproductive experiences.²³ Therefore, the intersecting identities of migrant women affect the quality of the reproductive health services they receive and their reproductive decision making.²³

The findings of this study reveal that migrant women in Cape Town had positive experiences during their childbirth but that most also reflected on negative aspects of their experiences. Research has shown that the experiences and satisfaction of migrants are complex and nuanced.³¹ Women stated that they were overall largely satisfied with the health care services provided to them, and they stated that the experiences were positive in comparison to the health care services and their experiences in their countries of origin where services and the situation was worse. Most women in the study were unemployed and mentioned that not

having to pay fees to access health care services made the childbirth experience positive for them. Therefore, women were able to experience childbirth without any financial implications. Women additionally reflected on having positive experiences about things that they assumed would be negative. For, instance, women reported that HCW provided them with sufficient information before medical procedures were conducted. Women might have perceived this as positive because they had lower expectations of the treatment from HCW. Research has shown that migrants expressed a fear of being discriminated against in hospitals because of their migrant status.¹⁰The findings of the study further revealed that some HCW were available to assist patients. The availability and physical presence of HCW during labour promotes positive childbirth outcomes for women.³² In instances where HCW were not available to assist, women appreciated that students were present. The availability of students was also highlighted in a study by Chekero and Ross,¹⁰ however, the study stated that student nurses attending to patients could be risky because they lack experience.

This study revealed that some migrant women were treated unfairly and discriminated against due to their migrant status and many reported examples of HCW being rude to them. The existing evidence supports these findings. One of the biggest obstacles also noted in a study about refugees when accessing health care facilities were the negative attitudes and discrimination by HCW.⁹ Studies further show that women who spoke a foreign language are more likely to experience disrespectful care.³² Migrants face discrimination in the form insensitive comments, stereotyping and discrimination in health care settings.⁹ A study by Malatji and Madiba⁷ reported that midwives at a hospital in Pretoria would make judgemental remarks about the high parity of migrant women. While there were examples of how this was specific to or heightened for migrant women, the South African literature shows that in midwifery-led obstetric units, all women are frequently disrespected and abused during labour.⁷ This was also evident in a study by Mapumulo et al.³³ where women reported that nurses spoke to them harshly during labour.

Due to how migrant women were treated by HCW they were not comfortable with making requests or asking HCW questions because of how they anticipated them to react. Therefore, women would limit their interactions to avoid being treated unpleasantly. This was also reported in a study by Zihindula et al.⁹ where Congolese refugees giving birth in Durban would avoid nurses because they were unapproachable. According to the birth justice movement this reveals that vulnerable groups lack reproductive safety which means that they are deprived of their right to give birth in a safe environment, since they do not feel safe enough to voice concerns.²⁰ To overcome this challenge, women identified providers they were comfortable with, and they communicated with those providers when they needed assistance., In a study by Zihindula et al.⁹ migrants showed a preference for HCW of other races because they felt that their issues were better addressed by them. Therefore, migrant women were obedient in the presence of unapproachable HCW, and this suggests that there are power dynamics between the migrant women and HCW in these contexts. Studies have shown that there are hierarchical structures in medical systems where patients are often required to be passive and obedient while the HCW are the experts.³⁴ This has been reported in a study of women giving birth in South Africa where women believed that they had to be obedient to have a good relationship with HCW.⁸ HCW maintain

control and power over women's bodies by being unresponsive and providing disrespectful care to patients,¹ thus not creating a safe space for women to give birth.²⁰ The power dynamics in the study are also evident between doctors and nurses. Doctors are deemed to have more power than nurses. Moreover, nurses in the study were blamed for systemic issues like not always being available, possibly due to lack of resources and being understaffed, but doctors were not.

There are legislations which support migrants rights to access health care services in South Africa such as the Bill of Rights which states that everyone in the country has the right to access health care services¹⁴ and the Refugee Act 130 of 1998 states that refugees have the same right to access health services as South African citizens.¹⁵ It is therefore important that HCW follow these legislations and vulnerable groups, especially migrants should be provided with accessible and confidential channels to report any discrimination.

Some women additionally felt that they did not get sufficient attention or were neglected by HCW. Neglect such as unattended birth is regarded as a form of violence against women in labour.³⁴ Neglect was also evident in a study by Freedman et al.¹¹ with migrant women in Durban. Studies show that migrant women as well as teenage mothers are more likely to experience delays in being attended to when arriving at health care facilities.³⁵ Neglect of women during childbirth can have an adverse impact on the child and mother and it additionally violates their right to give birth in healthy and safe environments since the staff is not regularly available.

Medical negligence in the form of HCW performing medical procedures incorrectly was reported by migrant women, potentially putting the lives of women and their children at risk. Research shows that approximately 39% of all maternal deaths with avoidable factors were a result of a lack of skills in doctors, while 25% were due to a lack of knowledge in nurses.⁸ Moreover, about a third of the avoidable maternal deaths were a result of delays in referrals and failures to follow guidelines and procedures and the mismanagement of obstetric abnormalities.⁸ Birth justice aims to improve women's birthing experience and further states that people have the right to give birth in a healthy and safe environment.²⁰ As such, hospitals must be safe environments for childbirth and the correct protocols and procedures must be followed to make certain that women and children are not harmed in any way.

The findings of the study further revealed that HCW would refuse to assist patients when they needed help. Malatji and Madiba⁷ state that disregarding women's pleas for assistance was a common type of disrespect and abuse observed in their study in South Africa. This was also evident in a study about disrespectful care during labour in Durban where a nurses refused to assist women.³² These findings suggest that this, was not exclusive to migrant women, however, might be heightened for them. The reproductive justice framework states that the ability of any person to determine their own reproductive destiny is directly linked to the conditions in their community and these are not just a matter of individual choice and access.²² In this instance women may try to make decisions about their bodies but the attitudes of HCW prevent this from happening and the women's rights are not met.

Not only would HCW refuse to assist women, but they would also not provide them with sufficient explanation of medical procedures. This means that some patients were not well informed about medical procedures and therefore, could not give consent before medical procedures could be conducted. To be insufficiently informed means that patients are not given information or are provided with insufficient explanations about what the patients need, furthermore, patients are not provided with information about what is happening before actions are taken.¹ Findings of the study reveal that women would be asked to use enemas without the full explanation of advantages and disadvantages of using an enema. Research shows that the use of enemas during childbirth is usually the preference of HCW, and this procedure could cause discomfort in women and is unlikely to benefit the child or woman.³⁶ A study by Oosthuizen et al.³¹ revealed that it was common for physical examinations to be conducted on migrant women without any consent. This means that patients were denied their right to bodily autonomy by not being given the opportunity to make decisions about their childbirth.²²

Language barriers were noted as potential limitations to effective communication between migrant women and HCW, possibly impacting on important processes such as informed consent and information about choices. Studies reveal that midwives failed to explain to migrant women what they must do because of language barriers.⁷ Language barriers and communication failures affect the relationship between the patient and HCW. It can have negative effects on treatment management since some patients will not understand prescribed dosages of medication or what HCW recommend.⁹ The use of interpreters in the South African health systems has not been considered seriously and this has an impact on the quality of care provided to patients.³⁷ Reproductive justice is founded on the human right to make life decisions for oneself and the duty of society and the government to make sure that those decisions can be carried out.²² Therefore, the government must ensure that communication is possible by having interpreters and as such, individuals can achieve bodily autonomy by communicating their needs.

Limitations

A limitation of the study is that it did not sample South African women, therefore the experiences of migrant women could not be compared to local women directly to see if migrant women's experiences were only exclusive to them. Even though South African women were not sampled in the study, their experiences were highlighted in the literature review and discussion section in comparison to migrant women's experiences. The study additionally did not provide a comparison between migrant's experiences in South Africa and those in an international context. An additional limitation of the study is that it only sampled a small number of women from one centre where the participants were attending development classes and most of them were able to speak English at the time of birth except for one woman which may have somewhat limited the representivity of the study. This can therefore introduce selection bias in the study because the results only represent a certain group of migrant women. This was due to time and budget constraints linked to this being a small student research project. The available data could not fully explore intersectionality due to having a small sample size, it would have been beneficial to explore this for the study. However, the literature supports these findings and

suggest that despite a small and potentially somewhat limited sample the findings are valid. Furthermore, the findings of the study provided us with valuable insight about the childbirth experiences of this specific group.

Conclusion

The study provided more insight on migrant women's childbirth experiences, which is a topic that has not been extensively studied in South Africa. The study revealed that migrant women reported having positive childbirth experiences and they also reported negative experiences and disrespect and abuse by HCW during childbirth. Migrant women reported that they were satisfied with services provided in MOU's and that they didn't have to pay for services. They also reported that services in South Africa are better than in their home country. The study additionally revealed that women were happy with the availability of HCW and their efforts to always provide them with information. Women may have found these experiences positive because they had assumed they would have negative childbirth experience because they are foreigners or because of the services they received in their countries of origin. The findings of the study reveal that some women were discriminated against by HCW, were neglected and disregarded, were not provided with enough information and faced language barriers when they had to communicate with HCW. Research has shown that disrespect and abuse has been reported in South African MOU's and this study shows that migrant women are at a higher risk of ill-treatment from HCW due to their status as migrants. This study highlights that even though legislation in South Africa states that migrants have the right to access health care services, interventions still need to be developed to ensure that HCW follow legislations so that women are not discriminated against and are able to practice their reproductive rights. Furthermore, migrant women should be provided with accessible channels to report discrimination. This will ensure that all women regardless of their nationality have access to high quality maternity care.

Recommendations

The findings of the study provide us with significant insights to promote the healthcare needs of migrant women during. More research is needed on the childbirth experiences of migrant women, especially those who do not have access to centres such as Scalabrini Centre. This will ensure that the needs of all migrant women are explored. This topic could also be explored using other research methodologies such as the participatory action research design. This research design will ensure that migrant women are actively involved in the research process and the development of interventions that are suitable for them. Participatory action research could also include HCWs which will give them an opportunity to contribute to policy development. South Africa has legislation which promotes migrants right to access health care services in the country. Therefore, migrants should be educated about their rights to health and anonymous channels must be created for migrant women to report any discrimination. Women in the study faced language barriers and struggled to communicate with HCW's and this is because there are no translators in the health care system. Translators in the health care system could play an important role in facilitating communication between HCW and migrants.

List of abbreviations

DRC	Democratic Republic of Congo
HCW	Health Care Worker/s
MOU	Midwife Obstetric Unit
StatsSA	Statistics South Africa
WHO	World Health Organisation
UCT	University of Cape Town

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from the University of Cape Town's Faculty of Health Sciences Human Research Ethics Committee (Appendix E). The researcher additionally obtained ethical approval and permission to conduct the research from the Scalabrini Centre before recruiting participants.

Consent for publication

Not applicable

Availability of data and materials

The datasets used and analysed during the current study are not publicly available due to participants privacy but are available from the author on reasonable request.

Competing interests

The author declares that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Authors' contributions

Mmapitsi Semanya, first author of the study, had the responsibility of developing the protocol, collecting data, analysing the results and writing the manuscript.

Associate Professor Lucia Knight and Jessica Dutton, the second and third authors of the study, provided methodological suggestions, reviewed and provided feedback on manuscript and protocol.

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Appendices

Appendix A: Research Protocol

Background

Pregnancy and childbirth are significant life events that women remember for most of their lives.¹ The manner in which childbirth unfolds can influence the outcome of labour,² and have a long-lived impact on women.³ Ill-treatment of women during this time of intense vulnerability has been widely reported.³

It is essential that women are provided with quality care during childbirth. Quality of care, as defined in the Guidelines for Maternity Care in South Africa, refers to health care workers acting in the best interest of the patient while providing respectful care to pregnant women.⁴ Interactions between health care workers and patients is an important aspect of health care as it affects the patient's experience and perception of quality of care.⁵ Research has shown that interaction that includes respect, effective communication, confidentiality, and autonomy is important in respectful maternity care.⁵ Positive interactions and communication between a health care provider and women create a trusting relationship which contributes to a positive birth experience.⁵

A negative health experience during childbirth can affect a woman's overall wellbeing, including their psychological and physical wellbeing.¹ Disrespect and abuse during childbirth indirectly leads to maternal mortality since women who have had negative birth experiences may be less likely to access health care services because of their fear of abuse. Furthermore, the negative birth experiences may decrease their trust in health care workers and the health care system.¹ Due to this, maternal mortality remains a global public health issue which can be addressed if women have access to quality care during pregnancy, childbirth and after childbirth.⁶ The World Health Organisation (WHO) reports that approximately 287 000 women died during pregnancy, after pregnancy and during childbirth in 2020.⁶ In South Africa, 88 maternal deaths per 100 000 live births were recorded in 2020.⁷

Studies reveal that migrant women are more likely to experience negative health outcomes.⁸ Factors which could lead to migrant women's negative experiences in the health care services are poor user-provider interaction, language and communication barriers, poor standard of care,⁸ obstetric violence and discrimination.⁹

Discrimination and hostility towards migrants in the health care sector in South Africa has been a persistent issue, even though South Africa has progressive health legislation and policies concerning migrants' rights, including their right to access health care services.^{9,10} The South African Bill of Rights states that everyone has the right to access healthcare services, and no one may be refused emergency medical treatment, regardless of their nationality.¹¹ The Refugees Act 130 of 1998 highlights the rights of asylum seekers and refugees in South Africa, the act states that refugees have the same right to access health care services as South African citizens.¹² Furthermore, the Gauteng High Court recently ruled that all pregnant women and children under the age of

six have the right to access free public health services, regardless of their nationality or documentation status.¹³ However, pregnant migrant women often face discrimination in the health care sector.¹⁴

Even with the abovementioned legislation protecting the rights of migrants, migrant women are still at risk of facing negative health experiences during childbirth. This can result in negative psychological outcomes for the mother and baby,¹⁵ which includes persistent negative memory of pain, fear of childbirth and postpartum depression.¹ Furthermore, migrant women are at an increased risk of mental health issues, pre-term birth, congenital anomalies, still birth and admission to neonatal care units.¹⁶

This is concerning since South Africa remains the leading destination for many African refugees and migrants. South Africa hosts approximately 273,488 refugees and asylum seekers.¹⁷ The exact number of refugee women in South Africa is unknown, however, Freedman et al¹⁸ estimates that 35% of asylum claims were made by women in 2015.

Literature review

The childbirth experiences of women have been studied globally. Literature has found poor labour outcomes are due to poor quality of care during labour.² Studies further reveal that migrant woman are at risk of experiencing negative experiences in the health care sector due to poor interactions with health care workers and discrimination.^{9,10,14}

The following literature review will delve deeper into women's experiences of childbirth. Literature on migrant women's childbirth experiences in South Africa is limited; therefore, the review will also include the childbirth experiences of South African women across different settings in the country. The literature review will specifically focus on women's interactions with health care workers and their perceptions of the quality of care they receive. The literature review will explore the abusive treatment and non-dignified care women face in labor. Furthermore, literature on neglect, non-consented care, a lack of information as well as language barriers. The literature review will lastly focus on discrimination which is common among migrants accessing health care services in the public health care sector in South Africa.⁹

2.1. Physical abuse

Abusive treatment towards pregnant women or women giving birth has been normalized in many countries including South Africa.¹⁹ Studies posit that abuse during childbirth is used as a form of discipline and a way to control the behaviour of women.¹⁹ South African women from a low-income community in a study by Kruger and Schoombee²⁰ that aimed to explore the psychological experience of motherhood, reported that they were handled roughly and were assaulted if they did not cooperate with nurses. Not only were women subjected to abuse, but they also witnessed the abuse of other women. An additional form of abuse women faced was deliberately being refused anaesthetics and analgesics when in pain.²⁰

2.2. Non-dignified care

Women who had given birth in the public sector in South Africa felt that interactions with healthcare providers were aggressive and rude.³ Women in a study conducted in South Africa which explored disrespect and abuse experienced by women in childbirth in the Tshwane district reported that midwives spoke to them in a harsh manner when they did not understand what was expected from them.²¹ Women feared asking for information because they were threatened if they did.¹⁹ Furthermore, participants mentioned that they would be reprimanded if they were being too loud during labour or asked for water or pain relief.¹⁹ Some women reported being scolded about personal issues that were not related to labour.² Midwives were additionally judgmental towards women, these judgments included remarks about their high parity, and this was a common issue for migrant women.²¹ A study conducted in Durban, South Africa additionally revealed that there was a lack of privacy among healthcare workers, and they would discuss patient's private information in the presence of other patients.²²

A study that explored the experiences of migrants from Democratic Republic of Congo (DRC) with hospital services in Durban reported that migrants are often verbally abused and mistreated in healthcare facilities.¹⁰ Migrants were referred to by derogatory terms by hospital staff,¹⁸ some pregnant migrant women further stated that they were verbally abused and questioned about their eligibility to give birth in South Africa.¹⁴

2.3. Neglect

Healthcare workers would often neglect women and leave them unattended for long periods.²³ Neglect also involved an attitude of disinterest from healthcare workers as well as a lack of empathy and not paying attention to a woman's needs.¹⁹ Women who were neglected during labour or watched other women experience neglect would experience stress and anxiety.²¹ South African women in a study by Malatji and Madiba²¹ in the Tshwane district in Pretoria reported that midwives would leave them in the labour room unattended for long periods. Similarly, a study conducted by Zitha and Mokgatle² that explored the interactions of women and midwives in a semi-rural area of South Africa during childbirth found that nurses would sleep while on duty. Women were not monitored regularly and were not provided with information.¹⁹ Healthcare workers would sometimes use neglect as a form of punishment; however, research also shows that a shortage of staff sometimes makes it difficult for healthcare workers to attend to every patient efficiently²⁰. Malatji and Madiba²¹, state that women reported they would have loved for their family and spouses to be with them in the labour ward, but they were not allowed to enter the ward. As a result, the lack of a birth companion increased the women's feelings of loneliness and abandonment during labour.²¹

A migrant woman in a study by Zihindula et al.¹⁰ mentioned that she was left unattended by a nurse who questioned her about being in South Africa as a foreigner. In addition, migrant women giving birth in Limpopo stated how they were ignored when they stated their symptoms.⁹ Furthermore, a study conducted in Limpopo revealed that migrant women were only assisted by training health care professionals.⁹ Women being left unattended meant that some would deliver their babies without any assistance.²¹ A Congolese woman giving

birth in a South African public hospital in Durban mentioned how she was left by herself for approximately 10 hours after childbirth to give birth to the placenta.¹⁸

2.4. Non-consented care and lack of information

Not only were women neglected but they were also not provided with information about procedures or asked for consent before medical procedures. Women were not provided with enough information and instructions on what and what not to do during the labour process.³ Furthermore, patients in a study at a district hospital in Pretoria were only provided with information after examinations.² Women felt their preferences were ignored even though they voiced them.³ Moreover, they were not asked for consent before medical procedures, vaginal examinations conducted in settings that did not respect the women's right to privacy and student nurses were invited to observe without the women's consent.²¹ However, women who were provided with information reported having good interactions with healthcare workers. Women who had good interactions with healthcare workers were more likely to freely communicate with healthcare providers and have a positive childbirth experience.²

Migrant women reported being forced to undergo medical procedures they were not comfortable with. A majority of migrant women in a study by Chekero and Ross⁹ stated that most doctors insisted that they had a C-section even though they were not thoroughly examined. Furthermore, migrant women reported that positive interactions with student nurses were more common than positive interactions with senior nurses.²³

2.5. Language barriers

Research shows that the health system in South Africa has not prioritised the use of interpreters in health care facilities.²⁴ Therefore, migrant women could find it hard to communicate to healthcare professionals due to differences in language.¹⁰ A language barrier means that migrant women are not able to express their concerns to healthcare practitioners. Furthermore, migrant women found it hard to question a doctor's decisions or actions because they may lack the vocabulary to communicate effectively.²⁵ This language barrier could result in multiple negative health outcomes which includes patients overdosing on prescribed medicine due to them not understanding health care workers.¹⁰

2.6. Discrimination

Language has also been used as a tool to screen patients' identities and discriminate against foreign nationals. Migrant women attending antenatal classes at South African public healthcare facilities were expected to speak isiZulu or Sesotho and were denied treatment if they were not fluent in the local languages.²³ Makwanda and Vearey²³ additionally found that the quality of healthcare migrant women received decreased when they revealed their nationality. Moreover, migrant women reported being segregated by healthcare workers when they went to healthcare facilities for labour.²³

A majority of studies have focused on women in their home countries and not women in foreign countries. For instance, a study conducted in Kenya reported that women in labour are often victims of physical abuse, non-

consensual care and detainment due to non-payment of fees.²⁶ Women in Rwanda were threatened by healthcare providers, and they were also left by themselves during childbirth.¹ Furthermore, women were not provided with full information about medical procedures.¹ However, reports on the childbirth experiences of migrant women are limited even though research has shown a link between obstetric violence and being a migrant.²⁷

Rationale

Research has been conducted on women's experiences of quality of care during childbirth, however, there is relatively little known about the childbirth experiences and maternal health care experiences of migrant women.²³ Furthermore, there is specifically limited research aimed at exploring the childbirth experiences of migrant women in Cape Town, South Africa. Despite disrespectful care being recognised as an issue in South Africa, not much research is focused on the quality of care provided during childbirth.³ A majority of studies conducted in South Africa do not specifically focus on the childbirth experiences of migrant women who may be subject to additional discrimination and communication barriers.¹⁴

A majority of the local research is concerned with migrants' access to public health care services, medical xenophobia and discrimination.¹⁴ Studies have additionally examined the experiences of refugees within the health care system in cities such as Durban.¹⁰ Moreover, some researchers studied migrant's experiences of sexual reproductive health care services and their needs.¹⁸

Studies on migrant women have explored their health seeking behaviours,²³ as well as their access to health care facilities.⁹ Research has additionally focused on the discrimination migrant women face in public health care facilities and their strategies to avoid this discrimination.⁹ A majority of these studies solely focused on Zimbabwean nationals and not on migrant women from various African countries.

There is a gap in research which focuses on migrant women in Cape Town and this is concerning considering that the Western Cape and Gauteng were estimated to experience the largest inflow of migrants from 2016 to 2021.²⁸ It is essential to address inequalities that affect health outcomes related to sexual and reproductive health to ensure that all women regardless of their nationality have access to high quality maternity care.⁶

Gaining insight into how migrant women experience childbirth in maternity care centres in Cape Town, will contribute towards implementing interventions to support this vulnerable group. Furthermore, research on the wellbeing of migrants is essential for their own health as well as population health.⁶ The study will contribute towards addressing the health needs of migrant women during childbirth and reduce maternal, infant and child morbidity and mortality rates.

Aim and objectives

The aim of the study is to **explore migrant women's childbirth experiences in Cape Town, South Africa.**

In order to reach the abovementioned aim, the following objectives will be explored:

- **To explore how migrant women perceive the quality of care they receive during childbirth.**
- **To explore how migrant women experience interactions with health care workers during childbirth.**

Theoretical background

Given that the study aims to explore how migrant women experience childbirth in Cape Town, the reproductive justice framework will be used to guide the study. The reproductive justice framework was developed in the USA in response to the ways in which marginalised groups had been excluded from the international conversation on reproductive rights.²⁹ The three core values of reproductive justice are the right to have a child, the right to not have a child and the right to parent a child or children in safe and healthy environments.³⁰ The framework focuses on a women's agency and women's right to control their sexuality, gender, work, and reproductive rights.³⁰ The reproductive justice framework focuses on people's human right to bodily autonomy as well as the obligation of the government and society to ensure that there are suitable conditions for people to make their own decisions.³⁰

The framework posits that marginalised groups face more barriers when trying to access healthcare and sexual and reproductive health services.³⁰ Moreover, the framework aims to identify structural issues such as social, economic, gender, racial, environmental, financial, sexual, disability and carceral injustices which affect the reproductive rights of women.³¹ Therefore, this framework will allow the researcher to understand how migrant women's identities affects their interactions with health care workers and the quality of care they receive. This will be done during the data analysis process by identifying patterns and recurring themes about migrant women's childbirth experiences and if it is affected by their social identities.

Proposed Research Methodology

6.1 Research study design

This study will follow a qualitative research methodology as it aims to explore and understand how migrant women experience childbirth in maternal obstetric units in Cape Town. The study will use qualitative exploratory research study design. This study design is used to describe and understand human experiences or phenomenon that limited research has been conducted on.³² An exploratory research design is suitable for this research study since little is known about the childbirth experiences of migrant women in Cape Town. A qualitative exploratory design allows the researcher to obtain in depth information about human experiences under study.³² Moreover, this study design will allow the participants to express how they experienced childbirth in the South African context. A qualitative exploratory research design is advantageous for identifying future research priorities.³²

6.2. Study Setting

The study will be conducted in the city of Cape Town. The population of Cape Town in 2019 was approximately 4 392 562.³³ The City of Cape Town is the second largest populous and economic city in South

Africa after Johannesburg.³³ South Africa has shown to be a popular receiver of migrants from Africa,³⁴ with a majority of international migrants residing in Gauteng (52%), followed by the Western Cape with 12% of international migrants living in the province.³³ Cape Town hosts numerous migrants from different parts of the world and Africa, particularly migrants from Southern Africa.³⁵ This study setting was chosen due to the number of migrants and refugees residing in the city. Furthermore, the researcher is a student at the University of Cape Town, therefore, it will be easy for the researcher to access the site.

6.3. Study population and Sampling approach

The study population will be migrant women who use the services at the Scalabrini Centre of Cape Town. The Scalabrini Centre assists migrants and refugees with integrating into local communities. The centre works with migrants from various African countries including Zimbabwe, Angola, Rwanda, Somalia, and the Democratic Republic of Congo. Research participants will be recruited through purposive sampling. Purposive sampling will allow the researcher to obtain in depth information from the study participants.³⁶ The study sample will be heterogenous as it will include women from various African countries, women who currently reside in different communities in Cape Town and women who have given birth in their countries of origin. Furthermore, the study will sample women with different migrant statuses including expatriates, refugees, asylum seekers and immigrants. According to the Constitution of the Republic of South Africa, the National Health Act 61 of 2003 and the Refugees Act 130 of 1998 migrants have right to access health care services in South Africa,^{11,37,12}, therefore, the researcher will obtain the perspectives of women with different migrant statuses from different backgrounds.

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

- a) they are a migrant woman,
- b) over the age of 18,
- c) must have given birth in the past 2 years,
- d) must have given birth at a labour ward in a maternal health facility in Cape Town,
- e) must be from another African country.

The study will sample 20 migrant women; however, sampling will stop if data saturation is reached earlier. This suggests that the researcher will continue sampling participants until no additional information is found.³⁸ Recruiting women who have given birth in the past 2 years ensures that women can still clearly recall their childbirth experiences. The sample size will only include up to 20 participants since the study aims to understand women's experiences and this will allow the researcher to obtain finer details regarding the women's experiences.³⁹

6.4. Recruitment

The researcher and a staff member at Scalabrini Centre will recruit research participants. The staff member has worked with migrant women at the centre, and she will be essential in identifying suitable participants for the

study. A recruitment brochure (see Appendix B) detailing information about the study including the aim of the study and prerequisites to take part in the study will be distributed to women at the centre. Interested candidates will be required to contact the staff member or the researcher. Should the interested candidates meet the inclusion criteria as listed in the recruitment brochure, they will then be asked to complete a consent form, and they will be provided with an interview date.

6.5. Data collection

Data will be collected through in-depth semi-structured interviews. The interviews will be conducted by the master's student researcher, and they will be held in person with each participant. The interviews will range between 45 minutes and an hour in length and will be held at the Scalabrini Centre in Cape Town CBD. A private room will be used to allow the women to be comfortable to express themselves and share their experiences. The semi-structured interviews will enable the participants to have an interactive discussion with the researcher.³⁹ Furthermore, a semi-structured interview allows the researcher to do some probing to get more information from the participants.⁴⁰ A semi-structured interview guide (see Appendix C) will be used to guide the interviews.

The reproductive justice framework was used to develop the interview guide. Elements of the reproductive justice framework were integrated in the interview guide to obtain a comprehensive understanding of migrant women's childbirth experiences. The interview guide explores questions related to respecting migrant women's agency and decision-making capacity during childbirth. Furthermore, the Respectful Maternity Care Charter by the White Ribbon Alliance as well as the World Health Organisations standards for improving quality of maternal and newborn care were used to enhance the questions and ensure they will provide insight about whether the rights of women were upheld during childbirth.^{41,42}

The interviews will be recorded with the permission of the participant. If participants are not comfortable with being recorded, detailed notes will be taken during the interview. Since the research participants are migrant women, not all of them may be comfortable with speaking English, as a result an interpreter from Scalabrini Centre will be used if participants are not comfortable with expressing themselves in English. An interpreter from the centre will be suitable for this study since they have a pre-existing relationship with the migrant women, and this will be essential; in creating a safe space for the women to share information about their childbirth experiences. However, should participants require an independent interpreter, the student researcher will make the means to source one. An interpreter will be invited to the interview and will translate all information that is shared during the interview.

Field notes will also be taken during the data collection process. The field notes will record every detail during data collection and will be used to understand the phenomena under study or will add more information or make sense of the data collected.

Research participants will be offered light refreshments during the interview as a form of reimbursement.

6.6. Data management

It is essential that participants information is securely stored at all times.⁴³ The personal information of participants as well as the data collected from them will be stored in password protected folders on Dropbox, which is a secured online storage. This includes signed consent forms as well as interview recordings and transcripts. The participants identities will be replaced with numeric identifiers in order to maintain confidentiality and ensure that participants cannot be identified by anyone.⁴³ The information will only be accessed by the researcher, supervisor and co-supervisor. The information will be stored for no more than 5 years. The interview transcripts will additionally be uploaded on NVivo for the data analysis process.

6.7 Data analysis

The data will be analysed through thematic data analysis, specifically the Braun and Clarke method.⁴⁴ Thematic analysis is suitable for the study because it allows the researcher to comprehend the data collected from participants and identify the common themes from the data.⁴⁴

Interview recordings will be transcribed and analysed by the researcher. The first step of thematic data analysis is familiarisation, this means that the researcher will read over the transcripts to fully understand what the data entails before the actual analysis. The researcher will additionally make notes and memos of what appears to be important from the data. Secondly, the researcher will develop initial codes from the data and then they will code the transcripts on NVivo. The codes will be reorganised and grouped into broader themes which will present the experiences of the research participants.⁴⁶ The supervisor will be consulted throughout the data analysis process to ensure that the codes are not biased or subjective.

6.8. Ethical considerations

Before commencing with the study, ethical clearance will be obtained from the Human Research Ethics Committee (HREC) of the Faculty of Health Sciences at the University of Cape Town (UCT). Ethical considerations in the study are essential to ensure that research participants are not subjected to emotional or physical harm.⁴⁵

The participants who voluntarily agree to be part of the study will be asked to read and sign a written informed consent letter (see Appendix D). Participants will be given the opportunity to seek clarification from the researcher regarding any parts of the consent which they do not understand. They will additionally be provided with time to carefully read through the consent form in their own time. The consent form will provide the research participants with all the details about the study, this includes the purpose of the study and what their information will be used for. The consent form and information sheet will also highlight that participation in the study is voluntary and participants can withdraw from the study anytime they wish to do so.⁴⁵

The personal information of participants will be protected, as discussed in the data management section. The participants personal information will be replaced with numerical identifiers and the information will be stored

in a secure cloud-based storage service for no longer than 5 years. The information and interviews of participants who wish to withdraw from the study will be destroyed and not included in the analysis.

The questions posed to the research participants may result in emotional distress, therefore, participants who may need further support will be referred to a mental health practitioner within the Scalabrini Centre since they are familiar with the services at the centre.

6.9. Rigour

Rigour in qualitative research is important to ensure that the research process and outcomes are thorough and accurate.⁴⁸ An important way to ensure rigour is by recognising and stating one's positionality, by doing this the researcher acknowledges that their identity and beliefs could influence how they conduct their research. Furthermore, a researcher's positionality may influence the researchers' interpretations and understanding of the topic under study.⁴⁶

The researcher is a black South African woman who has minimal experience working with women who have given birth or migrant women and as a result, their position could influence how the research is conducted. To ensure rigour, the researcher will keep a reflexive journal and take note of every part of the research process, including any personal biases or preconceived ideas. This will ensure that the researchers' preconceived notions do not influence the research.³⁹

The researcher has received training in qualitative research methods. Furthermore, they have worked as a data collector in qualitative research and therefore have experience in qualitative research interviewing. The researcher will pilot the interview guide to learn where they can change and adjust the interview guide and how to conduct the interview with the vulnerable participants. Furthermore, an audit trail will be used to take note of the entire data collection process and the write up.⁴⁶ Thick description will also be used to describe every process of the research including the data collection process. Thick description entails the rich description of the setting, the sample and their individual characteristics, and how the analysis and data collection was performed.⁴⁶ Member checking is an additional strategy which will be used to ensure rigour. Member checking will be done at the end of the interview by discussing the key points from the interview with the participants to ensure that all information is recorded and that the participants responses were accurately recorded and understood.

6.10. Dissemination of findings

The dissemination of findings will be achieved by presenting the key findings of the study to participants and stakeholders at the Scalabrini Centre. This research can be used by the centre to advocate for quality health care services for vulnerable groups such as migrant women. Furthermore, the research findings can be used to implement interventions that address the health needs of migrant women during childbirth. The research study may additionally be submitted for publication in peer reviewed journals.

6.11. Study timeline

Activity	Timeline
Protocol submission	November 2023
Data collection	March - April 2024
Data Transcription	May 2024
Data analysis	June 2024
Write up	July - August 2024

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Appendix B: Recruitment Brochure

Invite to Participate in a Research Study!

My name is Mmapitsi Semanya, a Masters student in Public Health at the University of Cape Town. As part of my studies, I am required to undertake a mini dissertation. The research will explore the childbirth experiences of migrant women living in Cape Town.

Who can participate?

- migrant woman,
- over the age of 18,
- must have given birth in the past 2 years,
- must have given birth at a midwife obstetric unit in Cape Town,
- must be from another African country.

As part of the research, the participants will be invited to participate in a 45 – 60 minute in-person interview conducted by the Master's student and a follow up discussion

Should you have any other questions or concerns regarding the research, please feel free to contact the researcher at smnmma005@myuct.ac.za/0791619088.

Appendix C: Interview guide

Introduction

Thank you for meeting with me today,

I am Mmapitsi Semenya, a Masters student in Public Health at the University of Cape Town. Today I will be interviewing you for my Masters thesis about the childbirth experiences of migrant women in Cape Town. This research hopes to contribute to the implementation of interventions to support migrant women and address the health needs of migrant women during childbirth. You can let me know if you want to take a break or stop the interview. Remember participation in the study is voluntary you can withdraw from the study at any point you wish.

Please be assured that all information you share with me will be confidential and will only be accessed by myself and my supervisors. When writing up the research your name will be replaced with a numeric identifier.

With your permission, I would like to audio record the interviews to ensure that I capture all the information you will share with me today. Please note that the audio recordings will be stored in a secure folder only accessible to myself and my supervisors.

Do you have any questions before we begin with the interview?

Icebreaker

- What don't you like about Cape Town?

Background questions

- Please tell me more about yourself.
What is your name? How old are you? What is your home country? How long have you been in South Africa? How long have you been residing in Cape Town?
- How many children do you have?
When and where were your children born?

Quality of care received during childbirth.

- Can you provide a detailed description of your overall childbirth experience, including any significant moments or feelings?
- How would you describe and compare your birth experience in your home country and Cape Town?
- How would you describe the treatment you received from the healthcare workers during childbirth?
Prompt: Can you describe a few things that made your experience pleasant? Can you please describe a few things during childbirth that you were not happy about?
- How would you describe the level of attention you received from the healthcare workers?
Prompt: Were healthcare workers always there when you needed them?

- Can you describe the healthcare workers' willingness to assist you?
Prompt: How did healthcare workers react when you needed assistance from them?
- Could you share your thoughts and feelings regarding respect for your privacy during the childbirth process?
- Can you elaborate on your experiences with healthcare workers seeking your consent before carrying out any medical procedures during childbirth?
Prompt: Were medical procedures explained to you?

Interactions with health care workers

- Can you share your experiences regarding how healthcare workers communicated with you during your childbirth journey?
Prompt: Did they communicate in a language you understood? Did you understand what was required from you from the nurses? Were you provided with an opportunity to communicate your needs?
- How would you describe the level of respect you felt you received from healthcare workers throughout your childbirth experience?
- Can you describe a few things that made you happy with the way the health workers were communicating to you?
- Can you describe aspects that did not make you happy with the way the healthcare workers were communicating to you?

Additional questions: (I am now going to ask you a few questions about the services you received after giving birth)

- Did you return to the facility where you gave birth?

For what services?

Did you go to another facility for postpartum care?

- Did you receive contraceptives after delivery?

Did you agree to this?

Was there a conversation about you getting contraceptives?

- Were you given any information about how to register your child and get a birth certificate?

Conclusion

- How do you think the healthcare workers can improve the care of migrant women during childbirth?
- Is there anything else you would like to add?

Thank you for your time and sharing your experiences with me.

Appendix D: Consent form

Title of research: *Exploring migrant women's childbirth experiences in Cape Town, South Africa.*

Researcher: Mmapitsi Semanya

Email: smnmma005@myuct.ac.za / Phone: 0791619088

Supervisor: Lucia Knight

Email: lucia.knight@uct.ac.za / Phone: 0216505313

Co-supervisor: Jessica Dutton

Email: jessi.dutton@gmail.com / Phone: 0626530018

Contact information: Human Research Ethics Committee (HREC), Faculty of Health Sciences UCT

Email: marc.blockman@uct.ac.za / Phone: 0214066338

Please contact the above persons should you have any questions or concerns regarding the research.

Introduction:

My name is Mmapitsi Semanya, a Masters student in Public Health at the University of Cape Town. As part of my studies, I am required to undertake a mini dissertation. The research will explore the childbirth experiences of migrant women living in Cape Town.

Before you decide to take part in the study, it is important that you understand why we are doing it. Please read through the information below about the study before signing. If you have any questions, feel free to ask.

Please note that taking part in the study is voluntary and you do not have to take part if you do not want to. You can leave the study at any time you wish. Your decision to join or leave the study will be respected throughout the research process. We want to make sure that everyone who participates in the study feels safe, in control and that their choice is respected.

Study goal:

The study wants to learn more about the childbirth experiences of migrant women in Cape Town, South Africa. We want to understand how women feel about the care they receive during childbirth and how they feel about their communication with healthcare workers.

Why this study is important:

As a migrant woman you may have a different experience when using health care services. It is important that we understand how you experience childbirth in maternity care centres in Cape Town. We would like you to provide us with your experience on the services you received and your communication with healthcare providers. This research will help in implementing interventions to support women and ensure they have positive childbirth experiences.

Data collection:

If you wish to take part in the study, you will be invited for an interview between March and April 2024. The interview will take 45 minutes to one hour of your time. The interview will be done in a language you are comfortable with. The interview will be held in a private room at the Scalabrini Centre. Please let us know if you are comfortable being audio-recorded.

Possible issues:

Talking about your personal experiences may feel uncomfortable; however, we will refer you to a social worker at the centre if you experience any negative feelings.

Confidentiality and privacy:

The interview will be done in a private room at the Scalabrini Centre. Your identity will be hidden and your information will be kept safely on an online storage platform. The final study will not include your name or any personal information that will make you identifiable. Your information will be stored for no more than 5 years. Only the primary researcher and her supervisors will have access to the information you provide.

Thank you for your time and agreeing to take part in the study.

I (Name and Surname) _____ have read the procedures described above and I voluntarily agree to participate in the research study.

Participant Signature

Date:

Appendix E: Ethics Approval Letter



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



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

10 April 2024

HREC REF: 879/2023

A/Prof L Knight

Division of Social and Behavioural Sciences, FHS
Email: lucia.knight@uct.ac.za
Student: smnmma005@myuct.ac.za

Dear A/Prof Knight

PROJECT TITLE: EXPLORING THE CHILDBIRTH EXPERIENCES OF MIGRANT WOMEN LIVING IN CAPE TOWN, SOUTH AFRICA (MASTERS IN PUBLIC HEALTH CANDIDATE MISS MP SEMENYA)

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review and approval. Thank you for your response letter dated 01st March 2024, addressing the issues raised by the HREC.

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

Kindly note Point 7.2 with regards to reimbursement: The HREC reiterates that if women need to return to the Scalabrini Centre for the sole purpose of participating in the research then they should be reimbursed for the costs, specifically travel. Refreshments do not pay for transport and the women should not be financially embarrassed.

Approval is granted for one year until the 30 April 2025

Please submit a progress form, using the standardised Annual Report Form (FHS016) or FHS017 if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

The HREC acknowledge that the Masters in Public Health Candidate, Miss Mmapitsi Phuti Semanya will also be involved in this study.

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

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

Please quote HREC REF 879/2023 in all your correspondence.

Yours sincerely

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

HREC/REF 879/2023 formal approval letter

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

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use: Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH 2020), based on the Association of the British Pharmaceutical Industry Guidelines (ABPI), and Declaration of Helsinki (2013) guidelines. The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

HREC/REF 879/2023 formal approval letter

Appendix F: Ethics Approval Scalabrini Centre



25 April 2024

**SCALABRINI INSTITUTE
FOR HUMAN MOBILITY IN AFRICA**
47 Commercial Street, 8001 Cape Town
Tel +27 21 4614741
Email admin@sihma.org.za
Website www.sihma.org.za

To whom it may concern,

Concerning: Consent from Scalabrini Centre of Cape Town and the Scalabrini Institute for Human Mobility in Africa for data collection

We hereby agree permit Mmapitsi Semanya to conduct interviews with the Scalabrini Centre of Cape Town's clients provided that the research adheres to all the ethical principles for research with human participants. Any misconduct or any breach of the ethical principles will be not be tolerated.

Furthermore, as part of this process, we would request the researcher to write a summary of the **research work, its importance, and the data collection process feedback** (max 2 pages), which should be submitted within **a month after data collection**. This will be shared with the staff members, clients and posted on our website as a blog post. Within 6 months of the study completion, the researcher is expected to share the findings of the study/the full research report with us and if interested, we can support with organising feedback sessions to the participants.

Contact with the research participants will be made through Rachel, our Head of Research. Its important that the researcher remains in contact with her throughout the whole process.

Best regards,

Rachel Chinyakata
Head of Research
Scalabrini Institute for Human Mobility in Africa

Appendix G: Instructions for authors for the target journal



Submission Guidelines ▾

[Aims and scope](#)

[Fees and funding](#)

[Language editing services](#)

[Copyright](#)

▾ [Preparing your manuscript](#)

[Comment](#)

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[Review](#)

[Study protocol](#)

[Correspondence](#)

[Case Report](#)

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[Promoting your publication](#)

Research

Criteria

Research articles report the methods and results of an original study.

Reproductive Health requires that all datasets on which the conclusions of the paper rely should be available to readers. We encourage authors to ensure that their datasets are either deposited in publicly available repositories (where available and appropriate) or presented in the main manuscript or additional supporting files whenever possible. Please see Springer Nature's [information on recommended repositories](#).

Please carefully review our [Editorial Policies](#) and our [Standards of Reporting](#) section before submitting.

Plain English summary

We strongly recommend all articles in *Reproductive Health* contain a Plain English summary of no more than 250 words, in addition to the Abstract. This should be a summary of the article written in language suitable for patients and the wider public to easily understand. It should not contain technical terminology or complicated statistics. Please include this within the main body of your manuscript file. Please do not include the plain English summary as part of the official scientific abstract that is requested separately by the journal submission system. The plain English summary should be inserted immediately after the official scientific abstract within the manuscript file under the heading "Plain English summary".

By adding a plain English summary, we hope to broaden the reach of the article and bring it to the attention of a more general audience. Researchers are trained to be highly focused, specific, and conservative with extrapolation and speculation. These attributes are useful for scientific publications, but not for wider public understanding. Many non-scientists have difficulty understanding technical terms and jargon, and the public requires more context-setting by way of introduction and more help drawing a conclusion.

The following resources provide further information: INVOLVE [Plain English summaries](#) resource; The Plain English Campaign [guide on medical writing](#); [Cochrane Library](#).

Additional non-English language abstract

An additional non-English language abstract can be included within the article. The additional abstract should be placed after the official English language abstract in the submitted manuscript file and should not exceed 350 words. Please ensure you indicate the language of your abstract. In addition to English, we can support German, Spanish, French, Norwegian and Portuguese abstracts.

Title page

The title page should:

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

Abstract

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

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

Keywords

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

Background

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

Methods

The methods section should include:

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

Results

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

Discussion

This section should discuss the implications of the findings in context of existing research and highlight limitations of the study.

Conclusions

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

List of abbreviations

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

Declarations

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

- Ethics approval and consent to participate
- Consent for publication
- Availability of data and materials

- Competing interests
- Funding
- Authors' contributions
- Acknowledgements
- Authors' information (optional)

References

Examples of the Vancouver reference style are shown below.