



**THE EXPERIENCES OF EXPATRIATE MOTHERS REGARDING
PREGNANCY, CHILDBIRTH AND MOTHERHOOD IN HOST CITY
CAPE TOWN, SOUTH AFRICA**

Student Name: Annaloice Penduka

Student Number: PNDANN002

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Department of Health and Rehabilitation Science

Supervisor: Associate Professor Sheila E. Clow

Co-supervisor: Dr Nicola A. Fouché

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ABSTRACT

The study explored the experiences of expatriate mothers' pregnancy, childbirth and motherhood in a host city. This included identifying how expatriate mothers access public healthcare, and adapt to motherhood in a host country in a subsequent pregnancy. These expatriate mothers had previously experienced childbirth in their country of origin.

A descriptive qualitative approach was utilised as it describes individuals' lived experiences. Purposive sampling was chosen and I had an in-depth conversation with nine expatriate mothers. Thematic analysis was used to identify themes and sub-themes.

Findings: The participants established that antenatal care was easily accessible. Mothers were confronted with a lack of respectful care in labour wards. They also had personal challenges. This all led to the development of the four themes. These are: expatriate mothers' need for support; organised antenatal healthcare; high cost of living; as well as labour and childbirth challenges in Cape Town (public healthcare). These revealed mothers need support to manage motherhood in a different setting. Further, the expatriate mothers rely on their husbands as their main support in the host city.

Recommendations: An emphasis on teaching of respectful maternity care in midwifery is needed, the availability of more and highly skilled and caring midwives and the need for support groups for expatriate mothers.

ACRONYMS, ABBREVIATIONS AND DEFINITIONS

- **BANC:** **B**asic **A**ntenatal **C**are program “is an approach that is used in the public health institutions of South Africa to provide health care services to pregnant women. The approach was introduced as a quality improvement strategy based on the belief that good quality Antenatal Care (ANC) could reduce maternal and perinatal mortalities and improve maternal health” (Ngxongo, Sibiya & Gwele, 2016).
- **Childbirth:** the process of giving birth to a child, which is one of the most significant life events for a woman and her family (Lowdermilk, Perry, Cashion, Alden & Olshansky, 2016).
- **Country of origin:** is used now thereafter it will be referred to as “original country” or “home country” throughout the study.
- **Episiotomy:** a surgical incision that is usually made with a sterile pair of scissors during the second stage of labour, when the head of the baby is crowning, and the tissue around the vagina opening begins to tear, or does not seem to be stretching enough, to allow the baby to be delivered (Medical Dictionary for the Health Professions and Nursing, 2012).
- **Expatriate:** a person [woman/mother in this study], who is temporarily living outside her country of origin, and plans to return to her country of origin eventually (Harzing & Christensen, 2004).
- **Immigrant and Expatriate:** for purposes of this study, these terms are used as reflected in the cited references. The participating mothers will be referred to as *expatriates*, living temporarily away from their country of origin.
- **Gravida:** indicates the number of times a woman has had confirmed pregnancies, regardless of outcomes (Lowdermilk *et al.*, 2016).

- **Home Affairs:** “The Department of Home Affairs is a custodian, protector and verifier of the identity and status of citizens and other persons resident in South Africa” (Republic of South Africa [RSA], Department of Home Affairs [DHA], 2018).
- **Human Resources:** the personnel of a business or organisation. In this study, human resources apply to healthcare professionals, who are available to provide support to expatriate mothers.
- **Mother’s experience of childbirth:** a maternal experience in which a woman adjusts to her parental role. This role development occurs during the perinatal and postnatal periods, in stages, or phases that are characterised by behaviour and actions, which tend to be dependent and interdependent on healthcare professionals, family, or the expatriate community (Lowdermilk *et al.*, 2016).
- **Migrant:** a person/s, who move across an international border, away from their habitual place of residence, whether the movement is voluntary or involuntary, regardless of the person’s legal status, the reason of move, or their length of stay. The composition and causes include migration as refugees, economic migrants, and other purposes, such as family reunification (International Organization for Migration, 2017).
- **Refugee:** “a person that has been granted asylum status and protection in terms of section 24 of the Refugee Act no 130 of 1998”. The refugee could be a person, who has left his/her home country, with a well-founded fear of persecution for reasons of race, religion, nationality, political opinion, or membership in a particular social group (Republic of South Africa [RSA], Department of Home Affairs [DHA], 2017).
- **Uber:** a transportation networking company, with a location-based app that makes hiring a private driver easy (www.uberestimates.com).

- **Xenophobia:** “At the international level, no universally accepted definition of xenophobia exists, though it can be described as attitudes, prejudices and behaviour that reject, exclude and often vilify persons, based on the perception that they are outsiders or foreigners to the community, society or national identity” (International Organization for Migration, 2017).

BANC: Basic **AN**tenatal **C**are programme.

CTG: **C**ardiotocograph. A graph that shows a tracing of the recorded foetal heartbeat and the uterine contractions during pregnancy and delivery (Heelan, 2013).

DRC: **D**emocratic **R**epublic of the **C**ongo.

HCW: **H**ealth**c**are **w**orker.

ID: **I**dentity **D**ocument/foreign passport.

IsiXhosa: A local South African language.

MOU: **M**idwife **O**bstetric **U**nit.

Pick n Pay: Supermarket chain with stores in all major cities and towns in South Africa, as well as Malawi and Australia.

SDGs: **S**ustainable **D**evelopment **G**oals.

UCT: **U**niversity of **C**ape **T**own.

UN: **U**nited **N**ations.

UNHCR: **U**nited **N**ations **H**igh **C**ommission for **R**efugees.

UNHRC: **U**nited **N**ations **H**uman **R**ights **C**ouncil.

USS: **U**ltrasound **s**can.

WHO: **W**orld **H**ealth **O**rganization.

ZSDP: Zimbabwe **S**pecial **D**ispensation **P**ermit. The ZSDP was implemented in 2009 for Zimbabweans who fled political and financial instability in Zimbabwe, as well as those who might have been living in South Africa illegally. This permit has been renewed thrice for Zimbabweans, but only for people who originally applied in 2009 (RSA, DSD, 2018).

DECLARATION OF RESEARCHER

I, Annaloice Penduka, hereby declare that the work on this dissertation/thesis is my original work (except where acknowledgements indicate otherwise), and that neither the whole work, nor any part of it has been, is being, or is to be submitted for another degree at this, or any other university.

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Signed by candidate

Signature: Annaloice Penduka _____

Date: 12 August 2020

DECLARATION OF LANGUAGE PRACTITIONER

I hereby declare that the thesis, *The experiences of expatriate mothers regarding pregnancy, childbirth and motherhood in host city Cape Town, South Africa* by Annaloice Penduka, for the partial fulfilment of the degree MSc in Nursing, has been language edited by me.

After a career as editor-in-chief at a leading publishing house, I now work as a freelance text editor.

Signed by candidate

Lambert Daniel Jacobs (BA Hons, MA, BD, MDiv)

30 June 2020

DEDICATION

I dedicate this minor thesis to my late father, Elisha Magege, who always believed that it does not matter how you start in life, but it matters how you change your destiny, and my husband, Moses Penduka, for walking down this road with me, turning my dream into a reality.

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CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 Introduction

Over 200 million immigrants are currently living in foreign countries worldwide, with many forcibly displaced individuals and families from the African continent (Pottie et al., 2011; Stern & Szalontai, 2006). In this chapter, I introduce the study by providing a background, which motivates the reason/s for this current study on expatriate mothers' pregnancy and childbirth experiences in Cape Town, South Africa. The concept of migration, reasons for migration to South Africa, expatriate mothers and various sections of the South African health services are discussed, and the problem statement and conclusion complete the chapter.

1.2 Background

As a midwife in the public health care system in Cape Town, I experienced that healthcare offered to expatriate mothers was not aligned with the legal obligation of the Constitution of South Africa (Republic of South Africa [RSA], 1996), which is, universal access to reproductive health care for all. In addition, the expatriate mothers, whom I met, expressed their challenges with access to reproductive healthcare – during pregnancy, during labour, and postnatal. According to literature, it seemed to be a concern among this population (Crush & Tawodzera, 2014; Makandwa & Vearey, 2017; Tebid, Du Plessis, Beukes, Van Niekerk, & Jooste 2011). The plight of this population motivated me to study the expatriate mothers' pregnancy, childbirth and motherhood experiences in Cape Town.

1.2.1 Setting for the study

The study was conducted in Cape Town, Western Cape Province of South Africa. The targeted population was expatriate mothers, who had previously experienced childbirth(s) in their home country, and were currently living in Cape Town, where they had given birth again in the public health sector. Cape Town has a population of 4 004 793, of which 70,3% utilise public healthcare

facilities (Republic of South Africa [RSA], Government Communications & Information System [GCIS], 2016). South African literature has cited public healthcare workers' burnout being contributed by under-staffing and heavily burdened facilities (Rouleau, Fournier, Philibert, Mbengue, & Dumont, 2012). A high volume of expatriates access the formal health delivery system, which is already overburdened (Human Rights Watch, 2011). As expatriates might not be reflected accurately in census data, it is impossible to know how many additional people would require health services, in general, and MCH services, in particular. This problem is similar when births are not registered, as the government cannot plan or budget for sufficient healthcare services or schools (Human Rights Watch, 2011). The lack of regular legal status, the lack of knowledge on how to access public healthcare, as well as a language barrier, have been cited as challenges for expatriates, trying to access public healthcare (Crush & Tawodzera, 2014).

1.2.2 Migration

A migrant is a person, who has moved across an international border, away from his/her habitual place of residence, whether the movement maybe voluntary or involuntary. The composition and causes include migration as refugees, economic migrants, and other purposes, such as family reunification (International Organization for Migration [IOM], 2017). The International Organization for Migration (IOM, 2015, p. 37) states, "... migrants are attracted to the fast-growing economies of new growth centres in East Asia, South Africa, Brazil and India". "Population movements among low and middle income countries, known as South-South migration, have gained importance with developing countries" (IOM, 2015, p. 37), and such populations are predicted to continue moving. A report by the United Nations High Commissioner for Refugees (UNHCR, 2017) on global refugee trends has identified South Africa as one of the most developed countries in Africa, with the highest number of migrants from Africa (1,7 million), who request to settle.

For African immigrant women, who originate from countries facing hyperinflation, war, and other human rights violations, such as Zimbabwe,

Malawi and the Democratic Republic of Congo, the decision to migrate is a matter of survival, for them and their families (Crush & Tawodzera, 2014; Moorhouse & Cunningham, 2012). By mid-2018, the global refugee population reached 25,7 million (UNHCR, 2017). Global figures indicate that 50 percent of migrants migrate to high-income countries, while the rest is distributed in low- and middle-income countries, like South Africa (Organization for Economic Co-operation and Development [OECD], International Labour Organization [ILO], International Organization for Migration [IOM], & United Nations High Commissioner of Refugees [UNHCR], 2019, p. 8).

1.2.3 Migration to South Africa

Many refugees and immigrants come to South Africa because of its close geographical location to their countries of origin, as well as the prospects of a stronger economy and human rights culture than their own countries (Smit & Rugunanan, 2015). These include refugees, asylum seekers, and expatriates, seeking better opportunities (StatsSA, 2017).

Since 2008, Cape Town has become home to the second highest number of migrants, after Johannesburg (StatsSA, 2017), because of the perception of many job opportunities and resources. It is in an agricultural region, and known for its wine production, which accounts for 60% of its regional exports. Cape Town is also well known for fishing, and 75% of fishing in South Africa occurs off the Western Cape coast, providing opportunities for casual and seasonal work (RSA, GCIS, 2016). In 2015, some 300 000 people were employed directly and indirectly in the Western Cape wine industry (RSA, GCIS, 2016).

The Constitution of South Africa (RSA, 1996) was founded on the following principles, *inter alia*:

- i. Human dignity, the achievement of equality, and the advancement of human rights and freedoms;
- ii. Non-racism and non-sexism;
- iii. Supremacy of the constitution and the rule of law.

These constitutional principles promise to protect vulnerable and marginalised populations, including expatriate mothers, which attract many immigrants to the country (Smit, 2015). The increasing population entering Cape Town includes high volumes of women, in contrast to the traditionally high volumes of male migrants. According to the 2011 Census, the number of immigrants in Cape Town is twenty-eight (28) percent and these are immigrants in search of better prospects (Statistics South Africa [StatsSA], 2012).

1.2.4 Expatriate mothers

The motherhood role commences with pregnancy, and continues for life (Lowdermilk et al., 2016). During pregnancy and childbirth, as the mother learns to commit to her newborn child, family support is important to her emotional and physical wellbeing (Razurel, Bruchon-Schweitzer, Dupanloup, Irion, & Epiney, 2011). With the advent of childbirth, when a woman transitions into the parental role, three phases (role attainment, need of social support and body changes) can be observed. These phases are characterised by dependent, independent and interdependent roles. The parental activities include the ability to breastfeed and adjust to the role of being a mother (Lowdermilk et al., 2016, p. 260; Razurel et al., 2011).

In addition to these behaviours is the reality that mothers must endure the stress-induced changes that occur in families over time. The widely cited model of Duvall (1957) defined these stress-induced changes as family development changes. Duvall (1971) developed a family theory that comprised eight developmental stages. The first stage is married couples without children. The second stage is childbearing families with the oldest child between birth and 30 months. The third stage is families with preschool children, and the fourth, families with school-age children. The fifth stage is families with adolescent children, and the sixth, launching families (first to last child leaving home). The seventh stage is middle-age families (empty nest to retirement), and the final stage is aging families (retirement to death of both spouses). As the second to the fifth stages are occurring for the mothers in this current study, they have to initiate this process again, with an additional family member in a foreign country. In most traditions, for mothers to cope with postpartum stress

dimensions, as well as live through the family developmental stages, the extended family and the community surrounding the mother, could provide a positive influence (Lowdermilk et al., 2016).

Expatriate mothers, who are experiencing pregnancy and childbirth, have additional challenges, while living in a foreign country (Balaam et al., 2013; Hynes, Sakani, Spiegel, & Cornier, 2012). These challenges include access to healthcare services, language barriers and finding work, as many of them would become part of the low-income inhabitants. Another challenge could be the negative attitudes of healthcare professionals towards expatriate mothers during pregnancy and childbirth (Crush & Tawodzera, 2014; Hunter-Adams & Rother, 2017; Makandwa & Vearey, 2017). Some expatriate mothers may experience fragmented and unethical care from midwives, resulting in psychological distress, which leads to poor reproductive healthcare service attendance, during and after pregnancy (Balaam et al., 2013).

Smit and Rugunanan (2015) assert that the expatriate pregnant women, especially those with a low socio-economic status, using public health facilities, did not always receive equitable access to healthcare services. Given that migrant women account for over one-fifth of the annual births in South Africa justifies the relevance of researching their experiences, so that the barriers to healthcare can be identified, with the aim of reducing maternal mortality and morbidity among immigrant mothers (Balaam et al., 2013; Tebid et al., 2011).

Hynes et al. (2012) investigated the maternal mortality in ten countries. The findings of their study revealed that over 273 000 global maternal deaths occurred in 2011, and nearly all of these were in developing countries. The 2014-2016 South African institutional maternal mortality rate was 132.19/100 000 live births (National Committee on Confidential Enquiries into Maternal Deaths, 2018). Avoidable maternal death factors were summarised in the South African Saving Mothers Report 2011-2013, with expatriate mothers being identified as a marginalised and vulnerable population (Pattinson, 2014).

Other factors that may influence high mortality and morbidity among immigrants may be social and political xenophobia, hostility towards foreigners from the community and political authorities, including government ministers and the police force (Palmary, 2002). Xenophobia has been documented as one of the contributing factors to fragmented reproductive public healthcare services for all women. In addition, it has propelled them into becoming passive participants in their healthcare, leading to poor maternal health outcomes, including higher mortality and morbidity rates (Makandwa & Vearey, 2017; Tebid et al., 2011).

1.2.5 South African healthcare service

“South Africa is a party to the *1951 Refugee Convention relating to the Status of Refugees*, its *1967 Protocol* and the *1969 OAU Convention regarding Specific Aspects of Refugee Problems in Africa*” (UNHCR 2011). This implies that the country recognises the need to protect people who are regarded as refugees and asylum seekers (Manby, 1997). These healthcare obligations have been supported by South Africa in the reproductive public sector, when the Sustainable Development Goals (SDGs) 2030 were developed, to assist in reducing mortality and morbidity (United Nations Development Programme [UNDP] & Republic of South Africa [RSA], 2017).

The Sustainable Development Goals for 2030 – Goal 3 (UNDP & RSA, 2017), for South Africa include the following sub-goals:

“3.1: to reduce maternal mortality to less than 70 per 100 000 live births;

3.2: to end preventable deaths of newborns and children under 5 years of age, with South Africa aiming to reduce neonatal mortality to at least as low as 12 per 1 000 live births and under-5 mortality to at least as low as 25 per 1 000 live births by 2030 (South Africa, 2017);

3.7: to ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes;

3.8: to achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all” (UNDP & RSA, 2017).

The National Health Policy of South Africa outlines that all pregnant women, lactating mothers and children under six years of age, should have access to free healthcare (Human Rights Watch, 2009; Susuman, 2015). This implies that healthcare is free, irrespective of race and nationality (Republic of South Africa [RSA], Western Cape Government: Department of Health [WCGH], 2018). Access to public healthcare is expanded in section 1.2.5.1.

Midwifery care involves women accessing maternal healthcare services, namely pregnancy, labour and postpartum care (Renfrew et al., 2014). The midwife is the first line of care for most mothers who access the primary public reproductive healthcare services. “A midwife is a person who is qualified and competent to independently practise midwifery in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice” (Republic of South Africa [RSA], Nursing Act, Act No. 33 of 2005, s30(2), p. 25). Midwifery includes “... optimising normal biological, psychological, social, as well as cultural processes of reproduction and early life” (Renfrew et al., 2014, p. 3). The midwife is a person who provides “... timely prevention and management of complications, consultation and views and working in partnership with women to strengthen women’s own capabilities to care for themselves and their families” (Renfrew et al., 2014, p. 3). It is estimated that midwives, when educated and regulated to international standards, have the competencies to deliver 87% of the services needed, in developing countries, that could reduce maternal and newborn mortality and stillbirths by 27% & 82%, respectively (UNFPA, WHO & ICM, 2014).

1.2.5.1 Public sector organisation of healthcare in South Africa

In South Africa, every woman has the right to reproductive healthcare services, and no one can be denied reproductive healthcare, as well as emergency medical treatment, according to the Constitution of South

Africa (Republic of South Africa [RSA], 1996). Unfair discrimination among groups of people is not allowed, and provision is made for non-citizens [expatriates] (Makandwa & Vearey, 2017).

Access to the public reproductive healthcare system is organised into three levels of care for everyone, and all users access the primary level of care. The first level is primary healthcare, which is a comprehensive approach to all health care. Its main principles are accessibility, equity, health promotion, disease prevention, community participation, appropriate health technology, and a multi-sectoral approach. Primary level care is an essential part of healthcare provision in South Africa, and is comprehensive, promotive and preventive (World Health Organization [WHO], 2003). The primary level of care also includes Midwifery Obstetric Units (MOU) and Basic Antenatal Clinics (BANC). The MOUs are birthing units in primary level facilities and are managed by ¹midwives in the community (RSA, WCGH, 2018). Expectant mothers are advised to book their first visit to the clinic before 20 weeks. Subsequently, they are advised to visit every six weeks up to 28 weeks, then at 34 weeks, and thereafter as indicated by the clinic/MOU (RSA, WCGH, 2018). Mothers can deliver at designated Midwife Obstetric Units (MOUs), provided they have a healthy pregnancy. If complications arise during birth, they would be transferred to a secondary level hospital (RSA, WCGH, 2018).

Pregnant mothers are screened at a primary level for possible risks to their health and the health of the foetus. Pregnant teenage girls, as well as pregnant women aged over 35 years, are regarded as higher risk therefore, they are cared for at secondary level where pregnancy

¹ In South Africa MOUs are staffed with registered midwives with a basic or/and post graduate midwifery diploma while the clinic is staffed with registered nurses that are not specific to midwifery but to general nursing practice. The definition of a midwife and a nurse is not necessarily of the same qualification: "A professional nurse is a person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice" (Republic of South Africa [RSA], Nursing Act, Act No. 33 of 2005, s30 (2), p. 25). The participants used the terms "nurse" and "midwives" interchangeably in their narratives.

complications are managed by an obstetrician or other medical specialist (RSA, WCGH, 2018).

At tertiary level, all serious and/or complex health conditions in pregnancy, such as severe hypertension, a family history of genetic disorders, multiple pregnancy, and previous history of uterine surgery are referred and managed. These institutions are also teaching hospitals in South Africa that help improve reproductive healthcare services (RSA, WCGH, 2018).

1.3 Problem statement

Expatriate mothers account for one-fifth of all births in South Africa, and their healthcare experiences of pregnancy, childbirth and motherhood in a foreign country are important to explore (Balaam et al., 2013). As an expatriate mother and midwife in the public health care system in Cape Town, I experienced that the healthcare offered to expatriate mothers is not aligned with the legal obligations of the Constitution of South Africa (RSA, 1996). In addition, while working in the public hospitals in Cape Town, the expatriate mothers I met expressed their challenges with accessing reproductive healthcare, during pregnancy, during labour, and postnatal and this was a perception that needed to be investigated. Looking at the literature this seemed to be a concern about this population (Crush & Tawodzera, 2014; Makandwa & Vearey, 2017; Tebid et al., 2011).

The concerns of expatriate mothers regarding access to public reproductive healthcare services, as well as supportive care from family and the community, postnatally, is an issue that needs to be approached as a comprehensive issue for investigation.

1.4 Conclusion

The childbirth experience of mothers living in a host city is not a new issue. However, as migration is occurring at a larger scale worldwide, the implications for the health of expatriate mothers and their babies need to be understood. Where other studies focused on mothering away from home and accessing health care this study is

focussing on mothers' comprehensive experience in a host city. In this chapter, I set the context for this study of the experiences of the expatriate mothers, in relation to the public healthcare system in South Africa.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Recently there is an increased interest in the experiences of pregnancy and childbirth among expatriate mothers. Numerous studies focus on mothers, who are mothering away from home, immigrants' nutrition in pregnancy, the utilisation of healthcare, experiences of midwifery care and their vulnerability to HIV (Hunter-Adams & Rother, 2016; Makandwa & Vearey, 2017; Tebid et al., 2011). This current study focuses on pregnancy, childbirth and motherhood.

In this chapter, the literature search strategy is set out on expatriate women, expatriate mothers, the expatriate pregnant mothers and the midwife. The research explored expatriate mothers' pregnancies, childbirths and motherhood experiences in Cape Town. The narrative literature review was done in two phases. Phase one was for the research proposal and Phase two was an in-depth interaction with the literature which is presented in chapter five. The purpose was to identify the challenges while accessing public healthcare and adapting to motherhood away from home. The keywords used in conducting the in-depth literature review for the discussion chapter, were related to the themes and sub-themes that emerged.

2.2 Literature search strategy

2.2.1 Databases

Platforms like EBSCOhost with access to numerous databases, such as Africa-Wide, ERIC, CINAHL, MEDLINE, PsychINFO, Academic Search Premier, SocINDEX, and Health Source: Nursing/Academic Edition were searched. In addition, databases like Cochrane Library PubMed, Clinical Key, Web of Science, Scopus and Google Scholar were also used. These databases were utilised because of their association to Nursing, Midwifery and Health.

2.2.2 Key words

The key words were used in various combinations for the initial and in-depth literature reviews. I also used MESH terms to identify appropriate keywords. During the initial search strategy, the following keywords were used: migration AND women; expatriates OR immigrants; health AND migration; childbirth OR pregnancy OR delivery; family AND migration; as well as a set of key words (maternal child relation OR maternal care OR mother OR postnatal) AND maternity services. The initial literature search yielded 1 500 articles of which most were excluded based on the exclusion criteria. Out of those articles, 65 articles, books and documents were observed to be relevant and utilised for the research proposal.

The second literature search was expanded taking into consideration the themes that emerged from the conversations. These were: Motherhood AND postnatal care; migrant/foreigner, maternal AND health; healthcare; childbirth OR birth preparation OR childbirth experience; community support AND [help-seeking OR well-being]; cultural isolation; loneliness; transactional relationships; lack of social infrastructure; cost of living, migrant employment, family support, South Africa. Most of the literature had already been sourced during the initial search strategy and the second yielded 57 articles; therefore, for the full review and discussion, 122 articles were used. They comprised of 58 empirical peer reviewed literature, 16 books and 48 gray literature.

2.2.3 Exclusion criteria

This was guided by the inclusion and exclusion criteria of this study (Section 3.3.3), which included stillbirths, caesarean section births and articles that were written in foreign language. Table 2.1 displays the search strategy of the literature that I used.

2.2.4 Time period

The period of focus for the literature search was 2000 to 2019. However, where there was relevant content, namely, literature that had to be traced to the origin of earlier studies or references, these were included.

Table 2.1: Literature search strategy

Data base/ search engine	Keywords and phrases	No. of papers & books sourced initially	No. of papers & books sourced subsequently
EBSCOHost: Africa-Wide ERIC CINAHL MEDLINE PsychINFO Academic Search Premier SocINDEX and Health Source: Nursing / Academic Edition Cochrane Library PubMed Clinical Key Web of Science Scopus News sites and Google Google Scholar	Migration AND women; expatriates OR immigrants OR Foreigner OR alien; health AND migration; childbirth OR pregnancy OR delivery; family AND migration; set of key words (maternal child relation OR maternal care OR mother OR postnatal) AND maternity services; South Africa AND immigrant mothers; motherhood AND postnatal care; community support AND motherhood; maternal health childbirth birth preparation OR childbirth experience; help-seeking OR well-being AND South Africa	1 500, and relevant 65 1 435 were not included.	57
Total		65	122

2.2.5 Geographical location

The literature search was focused mainly on Southern African countries. Therefore, the search explored expatriate mothers' experiences of pregnancy and childbirth in South Africa. A few other countries with literature that focused on African migrants' maternal health, such as Australia, United Kingdom and Canada were included, as well as the information reported by the World Health Organization [WHO].

2.3 Literature review

Some African countries like Zimbabwe, Democratic Republic of the Congo and Malawi have suffered economic crises. Generally, these circumstances lead to low social-economic status, which usually ends in human rights violations (UNHCR, 2017). Therefore, people may seek economic refuge and prospects of better living conditions in South Africa (UNHCR, 2017).

Isis² and Al Shabaab³ also instigated major unrest in over 29 countries, with at least 143 attacks (some in Syria, Libya, Nigeria and Kenya), resulting in the displacement of over 65,6 million people (Higginbottom, Safipour, Mumtaz, Chiu, Paton & Pillay, 2013; Smit & Rugunanan, 2015; United Nations, 2019). There is minimal literature and a lack of written evidence or special accommodation for expatriate mothers in the public healthcare system in Cape Town, South Africa. This literature review addresses the broad concept of expatriate mothers and childbirth experiences followed by certain aspects surrounding their motherhood that overlap with my research. This literature review presents the following topics:

- Expatriate women
- Expatriate mothers
- The expatriate pregnant mother and the midwife.

2.3.1 Expatriate women

The decision of women to consider migration is motivated by economic necessity, viable labour decisions, professional qualifications and physical survival of their families, especially in countries with hyperinflation, like Zimbabwe (Moorhouse & Cunningham, 2012). These are referred to as 'pull factors' that motivate women to migrate. Historically and culturally, women from developing African countries have been chained by a triple yoke (sex, colour and class) of oppression (Moyo & Kawewe, 2002). This has assigned them the status of minors in the eyes of the law, and there has been no "respite" for women, post-independence, as they have remained at a lower socio-economic level, despite "carry[ing] the burdens of life" (Moyo & Kawewe, 2002, cited in Moorhouse & Cunningham, 2012, p. 496).

Makandwa and Vearey (2017) state that a significant number of women are migrating, which has become an economic norm in South Africa and worldwide, for women seeking economic empowerment. Their study also concluded that

² Isis: Islamic State in Iraq and Syria – this is an extremist militant group that rules by Wahhabi/Salafi (Harmanşah, 2015).

³ Al-Shabaab: a Somalian based militant Islamist group aligned with Al-Queda (Hansen, 2013).

there are “higher migration streams of women than men from countries like Mozambique, Malawi and Angola (52%, 51% and 53% respectively) emphasising the feminisation of migration in Southern Africa” (Makandwa & Vearey, 2017, p. 76). Thus, economic crises, lack of security and lack of food security are some of the reasons that compelled many people to flee their countries of origin (Higginbottom et al., 2013). The International Organization for Migration (IOM, 2015) emphasises higher levels of migrating women from their home countries to South Africa, thereby creating an imbalance on the gender demographic of their mother countries. Women of childbearing age are the highest documented immigrants in South Africa (South Africa Institute of International Affairs [SAIIA], 2017).

“While migration has economic, social, and cultural implications for the sending and host societies, remittances the migrants send home are perhaps the most tangible and least controversial link between migration and development” (Ratha, Mohapatra, & Scheja, 2011, p. 2). In addition, the World Bank estimates reveal that migrants sent over \$529 billion to their countries of origin in 2018; three times the size of official development assistance (The World Bank, 2019; Ratha et al., 2011). There is a positive socioeconomic significance for the host and mother country when women migrate (IOM, 2015). This implies that they are assisting to combat poverty in their countries of origin. The IOM (2015) supports the presence of migrants in the host country, reflecting that in South Africa, they have provided positive financial support, adding to the social significance by creating formal and informal employment. The World Migration Report (IOM, 2015) states that migrating women are presented with better economic and social opportunities, as well as fewer economic and cultural constraints. Immigrant women “occupy two-thirds of informal street trading, accounting for about 10 to 20 per cent of total employment in cities in Ghana, Zimbabwe and South Africa, providing an important source of livelihood with low barriers to entry” (IOM, 2015, p. 128).

Despite some women being the main breadwinners in their households (Landau & Jacobsen, 2004; Moyo & Kawewe, 2002), migrating women are perceived as passive and vulnerable, as they accompany their spouses who

are also seeking employment in the host country (Smit & Rugunanan, 2015). These migrating women are not perceived in their professional capacity [lawyers, nurses, academics], and have to resort to low-paid and informal work, as well as rely on their husbands, partners and families (Suto, 2009). Therefore, women are considered vulnerable by virtue of diminished autonomy and agency (history and culture) (Richter, Groft, & Prinsloo, 2007). For some, this is also because of the lack of documentation which leads to difficulties with securing employment in the formal sector (Human Rights Watch, 2009).

The plight of migrants in South Africa highlights many problems. These include; legal issues, survival strategies, xenophobia and daily life struggles, language barriers, access to services, social acceptance and the availability of basic needs (Moyo & Kawewe, 2002; Nkosi, 2014; Smit & Rugunanan, 2015). These affect the expatriate women, as this influences their access to resources and the way they relate to the community around them. The language barriers affect their access to social services and basic needs, including access to healthcare.

These refugees, asylum holders and those with no legal status, or border jumpers, often reside in unsafe communities with high crime rates because of their low socio-economic status. Various studies illustrate that xenophobia occurs mostly in these low socio-economic communities (Crush & Tawodzera, 2014; Hunter-Adams & Rother, 2017). Consequently, expatriate women develop a lack of trust in their surrounding community members (Moorhouse & Cunningham, 2012; Smit & Rugunanan, 2015).

2.3.2 Expatriate mothers

The childbirth experience of an expatriate mother, trying to adjust to a new environment, generates its own challenges. These mothers still have to traverse childbirth, and bring their own cultural beliefs and practices to this foreign healthcare facility (Benza & Liamputtong, 2014).

Tebid et al. (2011) state that a fifth of the live births in South Africa are to expatriate women. Mothers need social support and interaction, security, family, as well as a direct link to healthcare services, especially maternal

healthcare services, while navigating pregnancy, childbirth and motherhood (Lübke, 2015; Makandwa & Vearey, 2017). Like any woman experiencing motherhood, expatriate mothers require family, as well as guidance throughout pregnancy.

Expatriate mothers are most vulnerable during pregnancy, childbirth and the early postpartum period, as they are away from their usual social context (Benza & Liamputtong, 2014). Factors such as language barriers, exclusion from care, xenophobia and the lack of knowledge on how to access healthcare facilities, lead to limited access and delivery of maternal healthcare services to expatriate women in Gauteng (Makandwa & Vearey, 2017; Tebid et al., 2011). Smit (2015) observed that expatriate mothers residing in South Africa live in constant fear for their lives, their wellbeing, and their children's welfare, due to the xenophobic attacks, which occurred in 2008.

When expatriate mothers encounter negative birth experiences, it may contribute to mental health problems, such as postpartum depression, psychosis, and anxiety resulting in women feeling more vulnerable (Donnelly, Hwang, Este, Ewashen, Adair & Clinton, 2011; Tebid et al., 2011). This goes against the agenda of the Sustainable Development Goals 2030 (UNDP & RSA, 2017) which advocates for provision of wide, health area coverage, and includes the protection of marginalised and vulnerable migrant women. The goal also promotes access to reproductive healthcare, including social protection of migrant women (sub-goal 3.7) (Hagen-Zanker, Postel, & Vidal, 2017). South Africa has been working towards integrating reproductive health into national strategies and programmes (UNDP & RSA, 2017).

Supportive structures could be introduced to assist mothers who are adjusting to a new environment, seeking maternity healthcare services and may reduce mothers' risk to morbidity and mortality. The Three Delays model – delay in deciding to seek care; the delay in accessing care and the delay in getting the correct/appropriate care/treatment has been used to inform HCW on why mothers delay to access healthcare (Thaddeus & Maine, 1994). The delay to seek healthcare is caused by the migrant mothers' fear about possible illegal

status, and the perception of a healthcare professional's negative attitude (Thaddeus & Maine, 1994; Smit & Rugunanan, 2015). Addressing language and cultural barriers appears to promote antenatal clinic attendance, thereby preventing pregnancy and childbirth complications, and enhancing positive motherhood adaptation and experiences (Benza & Liamputtong, 2014; Lowdermilk et al., 2016).

2.3.3 The expatriate pregnant mother and the midwife

The experiences of expatriate mothers were captured by the Human Rights Watch in Johannesburg, stating, "The health rights afforded to migrants on paper are belied by the harassment and denial they face in hospitals and clinics, while their ability to survive and remain in good health is undermined by violence, displacement, and threat of deportation. It is not only the lives and livelihoods of migrants who suffer the consequences of these abuses" but also their families (Human Rights Watch, 2009, p. 8). The expatriate mothers have reported incidents of experiencing poor treatment in public health facilities, such as, being denied access to care because of their nationality, and being referred to in derogatory terms like *makwerekwere* (Tebid et al., 2011). If midwives improve the experience of the mothers receiving care, especially those with low English proficiency, and low socio-economic status, it may improve the healthcare experiences for immigrant mothers, when accessing public healthcare (Barimani & Vikström, 2015; Cacciani et al., 2011).

The midwife's role is to be the health care professional who provides the mother with a sense of security during the perinatal period, by establishing trust as well as a good rapport during pregnancy, childbirth and motherhood (Persson, Fridlund, Kvist, & Dykes, 2011; Renfrew et al., 2014). The midwives' responsibility is to accommodate all types of beliefs and cultural practices, within their scope of practice, for the safety of the mother and child (Lowdermilk et al., 2016).

The mother's sense of security during her early postnatal period is related to the maternal health and social support (Lowdermilk et al., 2016). Her sense of control, as well as her attitude, depends on how the midwives facilitate her

behaviour, autonomy and basic control of skills, such as breastfeeding (Persson et al., 2011). A good relationship between the mother and midwife would influence the mother's general wellbeing, and reduce her chances of postnatal depression, with its associated lack of maternal role attainment (Persson et al., 2011; Razurel et al., 2011).

Renfrew et al. (2014) assert that midwifery is associated with the efficient use of resources, as well as positive outcomes, when administered by educated, trained, licensed and regulated midwives. Midwifery is "skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum and early weeks of life" (Renfrew et al., 2014, p. 3). Furthermore, midwives provide mothers with emotional, spiritual, social and cultural support, which is holistic care during childbirth. Midwives are both "the connector and the driving force behind the continuum of care, ensuring that the mothers maintain a balance between preventative and supportive care, as they integrate into the community" (Renfrew et al., 2014, p. 7). Worldwide midwives have been assigned the duty of providing care and extending their practice to expatriate mothers from diverse cultures which requires particular insight and sensitivity (Tebid et al., 2011).

Potential problems mainly occur due to the lack of rapport and communication barriers, which lead to an impaired relationship between midwives and immigrant mothers (Balaam et al., 2013; Tebid et al., 2011). Midwives need to create an environment that is safe and sensitive to the diverse needs of mothers, according to their ethical code of conduct, which is to provide respect for patients' human dignity and uniqueness (Tebid et al., 2011). The ethical code while conducting midwifery includes core values such as trustworthiness, respect, responsibility, fairness and non-maleficence (South African Nursing Council [SANC], 2013). These values will not be effective without the distribution, training, as well as support of the regulatory body such as SANC in South Africa, in making these values a part of the midwifery profession and form the foundation thereof.

However, there are specific needs that were highlighted by various authors internationally, such as the need for more skilled midwives, to care for pregnant mothers; midwives who are sensitive, communicate easily, and accept the mothers' foreign status (Balaam et al., 2013; Benza & Liamputtong, 2014). Therefore, this indicates that there is a care gap between what is expected from the midwives and what expatriate mothers experience. The ICM highlights four areas that midwives should focus on in future, namely: a) advocacy; b) dissemination of ERA global standards – education, regulation and association; c) research and practice; and d) communication (ICM, 2014). This would help improve the overall experience of all mothers, including expatriates.

The focus of experience is not only about midwifery care, but also the overburdened healthcare system that is contributing to burnout of nurses, who perceive that expatriate mothers are to blame for the overcrowding of hospitals (Makandwa & Vearey, 2017). Consequently, the midwives have no patience with expatriate mothers, who enter into their already burdened public healthcare system (Makandwa & Vearey, 2017). The expatriate mothers' increased numbers have caused public healthcare workers to respond negatively, or display negative attitudes towards expatriate women (Tebid et al., 2011). The former authors say that this has resulted in the migrant mothers' apprehensiveness, as well as poor attendance and utilisation of reproductive health services. These challenges have earned midwives in public health facilities a negative reputation, and have been documented as contributing factors to the decline in public maternal healthcare attendance by immigrant mothers (Filby, McConville, & Portela, 2016; Harries, Gerdt, Momberg, & Greene Foster, 2015; Nkosi, 2014).

2.4 Gaps and limitations in literature

The literature review highlighted several concerns. Expatriate mothers account for one-fifth of the births in South Africa (Ketzinger, 2008, cited in Tebid et al., 2011). There is minimal literature on the expatriate maternal and neonatal mortality rate. This could imply that more avoidable deaths may be occurring in this population;

however, no specific study has investigated this population from this viewpoint, which is a gap in literature that this current study will not be addressing.

There is a dearth of literature on how expatriate mothers experience their pregnancies and childbirths, while residing in Cape Town, as the studies on expatriate mothers in South Africa are mostly derived from Gauteng⁴, and the challenges may, or may not, be the same for Cape Town.

2.5 Research question

What is the experience of expatriate mothers regarding pregnancy, childbirth and motherhood in Cape Town, South Africa?

2.6 Purpose of the study

The purpose of this current study is to explore and describe the experiences of expatriate mothers, regarding pregnancy and childbirth in Cape Town, South Africa.

2.7 The objectives of the study

The objectives are to:

- Explore and describe the experiences of expatriate mothers, regarding pregnancy and childbirth in Cape Town, South Africa.
- Identify the challenges that constrain expatriate mothers from receiving good quality reproductive health care.

2.8 Conclusion

Expatriate women's pregnancy, childbirth and motherhood experiences are influenced by societal and cultural values, which vary depending on the adjustment process in their host country, and the availability of healthcare services (Benza & Liamputtong, 2014).

⁴ "Gauteng is one of South Africa's major provinces and contains the country's largest city, Johannesburg. It is also geographically one of the smallest provinces in South Africa, but is highly urbanised and is the most densely inhabited province in South Africa" (Gauteng Information Directory, 2019).

The review of the literature revealed that limited studies have been conducted in Cape Town on this subject. Knowing the expatriate mothers' experiences may highlight issues for midwifery care and may inform initiatives relating to healthcare provision for them.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

In this chapter, I describe the chosen design and the methods that were used to obtain information. It is structured by introducing the research design (3.2), followed by the population and sampling (3.3). Information gathering and management are described in 3.4 and 3.5. The chapter concludes with an explanation of research rigour (3.6) and ethical considerations (3.7).

3.2 Research design

A qualitative descriptive research approach was chosen as it was the most appropriate to describe the lived experiences of the subjects. The descriptive research design selected for this study provides a framework through which I was able to collect and analyse the information (Creswell, 2013). The information collected through having conversations with the participants was a way to explore and understand the meaning that individuals ascribe to a social or human problem. It enabled me to gather information at the participants' residence. The research design comprises the plans and the procedures for research, which include all the steps, from broad assumptions, to detailed methods of information gathering, analysis, and interpretation (Creswell, 2013).

The aim of a qualitative approach is to focus on the qualitative aspects of "meaning, experience and understanding, that this method is used to study human experience from the viewpoint of the research participant in the context of which the action takes place" (Brink, Van der Walt & Van Rensburg, 2017, p. 121).

3.3 Population and sampling

The target population is defined as the total number of individuals, or information, from which the results of a study are expected to emerge, and from whom those individuals are selected to participate in the study (Kothari & Garg, 2014). The

population comprised of expatriate mothers, who had previously experienced childbirth(s) in their home country, and were currently living in Cape Town, where they had given birth again.

3.3.1 Sampling method

A purposive sampling method was chosen for this study. The ultimate goal of a purposive sample was to invite participants deemed information-rich (Holloway & Wheeler, 2010). I had six initial conversations, and realised that information saturation had not been reached. A further three participants were recruited and conversed with. The final number of participants was nine and the conversations were conducted until no new information emerged.

3.3.2 Sample size

I aimed for a sample size of between six and 12 participants, consisting of mothers from diverse circumstances and backgrounds (age, socio-economic status, country of origin, and number of years in Cape Town), to gain rich and meaningful descriptions. The heterogeneous population included mothers who belonged to the same subculture, which in this instance was a group of expatriate mothers experiencing pregnancy and childbirth in the host city. In order to establish when no new information emerged, information analysis was done concurrently with information gathering.

3.3.3 Inclusion criteria

Individuals who met the following criteria were selected.

Expatriate mothers:

- who had given birth in their own cultural context, and had given birth to another child in Cape Town.
- whose Cape Town born child (up to one year of age) should be living with the mother at the time of the study. There was only a limited number of mothers who met this criterion; therefore, this was expanded to include children up to three years of age.
- who were aged from 18 to 35 years.

- who had a normal pregnancy, without complications or hospitalisation [this did not exclude mothers who suffered from antenatal and postnatal depression during this pregnancy], and who had given birth between 37 and 40 weeks' gestation.
- who had given birth in a state or public sector health facility.
- who were either married or in a long-term partnership with the same partner and living together in the same city at the time of study. I wanted to identify whether any formal support system was available to the subject.
- who were fluent in English or Shona, as I am fluent in English and Shona and was able to provide authentic interpretation of the participants' narratives, but all the participants opted to converse in English.

3.3.4 Exclusion criteria

Expatriate mothers:

- Who had only given birth to a child in Cape Town.
- Whose Cape Town born child had died.
- Who had one child in their home country, and that child had died; and
- With chronic mental illnesses. This may cause difficulties in accessing healthcare, because of the underlying illness.

3.3.5 Recruitment

Recruitment of the participants commenced after ethics approval was received (July 2018) from the University of Cape Town, Faculty of Health Sciences Research Ethics Committee (HREC 359-2018 – Appendix I). The participants were invited to participate in this study, through strategically placed posters and flyers (Appendix II) in environments where expatriate mothers seek postnatal support, such as places of worship, social expatriate meeting groups, and neighbourhoods where expatriates live. Other public spaces, such as municipal libraries and local shopping centre bulletin boards were also utilised to recruit

participants. The mothers contacted me via cell phone calls or text messages, to express their interest in participating in the study. Some participants that agreed to participate refused to continue after having consulted their husbands about the interview and they refused for them to participate due to the power dynamics in their relationship.

Although I gave the option of using a private room in the University of Cape Town (UCT), Department of Health and Rehabilitation Sciences, all the participants chose to have the conversations at their homes. A pre-conversation site visit was conducted for a general enquiry to ascertain if the location was safe (see Appendix IX), as well as to have an information session with the participant. The study aim was explained to the participants, and consent forms were signed by those who agreed to participate. In each conversation, I provided refreshments (fruit juice and biscuits), during the information sharing session regarding the participant's experience of the conversation.

3.4 Information gathering⁵

A descriptive study is focused on who, what, and where experiences of the participants, and provides an overall picture of a population, or phenomenon, by relating situations or events (Sandelowski, 2000; Vaismoradi, Turunen, & Bondas, 2013). A conversation guide was utilised to keep the participants focused on the research question (Appendix IV).

3.4.1 Conversation guide

A semi-structured conversation was used, in which the questions were designed to achieve a balance of direction and flexibility (Gerrish & Lacey, 2010). A semi-structured conversation guide (Appendix III), containing mostly open-ended questions, was developed to aid the conversation process, and to

⁵ According to van Manen (1990), the word 'data' is misleading as it has overtones of quantitative research approaches. It is more appropriate in phenomenology to speak of 'gathering' or 'collecting' lived experience material, even if it is in different forms. The choice of data vs information is in keeping with a descriptive and at times an interpretive stance.

allow the participants to answer in their own words. An audio record was used with consent from the participants.

To conduct a productive conversation that captures the information required, the participants and I came to a mutual agreement for each session, e.g. the amount of small talk before, or during the conversation; cell phones to be muted; and no interruptions or uninvolved individuals entering the room while the conversation was in progress. This was not always possible, as some of the venues chosen by the participants for the conversation were susceptible to environmental noise. I approached the conversation process cognisant of all ethical considerations (presented in section 3.8) (Creswell, 2013), and used vocabulary that was easily understandable.

A conversation approach allows a more flexible way of information gathering, while allowing the participant to experience some sense of control. The research questions were used to guide the conversation and designed to gather information related to the expatriate mothers' experiences. However, the sequencing of questions was not the same in the conversations, as it was dependent on the participants' responses (Holloway & Wheeler, 2010). The semi-structured conversation accommodated for probing, and enabled answering the research question.

3.4.2 Pilot conversations

I conducted two pilot conversations in July 2018, to test the information guide and the process. The information collected in these conversations has not been used in this current study. The pilot conversations were used to assess whether the main study would yield appropriate information, as well as to ascertain if the estimated time was sufficient to collect the required information (Creswell, 2013). Being a novice researcher, testing the information gathering tool was important. Certain areas were identified as needing attention, for example how to probe to get the experiences that related to the study. In addition, I identified the importance of pre-visits and telephone calls, to ensure that the participant met the stipulated inclusion criteria.

3.4.3 Other strategies

The use of field notes written soon after each conversation, allowed me to capture the feelings and gestures, or any contradictory action observed in the participants' demeanour, during the conversations. These were recorded while the information was still fresh, which obviated the need to concentrate on making detailed notes during the conversations, which could have interfered with the flow of the conversation.

I maintained a reflective journal, in which personal reflections were recorded on each completed conversation. Minimal note taking occurred during the conversations. These notes were used to highlight pertinent observations that occurred during the conversations. Using the written notes obtained during the conversation conjured some insights, which was useful for information analysis. It was important to document not only the conversation, but also every aspect of the research such as the environment in which the participant resided. This was done for quality assurance and trustworthiness of information gathered, and later analysis.

Journal Entry 8 July 2018

I have completed my second pilot conversation. I did not realise the living conditions of some of these participants. The woman called Precious lives in a one-roomed shack with her two children and husband. She is lonely and heartbroken and being unable to communicate in English makes it difficult for her to integrate into her community. The conversation with her was heart breaking; I felt her struggles and emotions (isolated and lonely).

After this conversation, I felt more motivated to have further conversations and get this study out there for professionals and the world to know what goes on in the lives of these expatriate mothers.

3.5 Information management

In qualitative research, content analysis is a dynamic form of verbal and visual information analysis that will make sense of the information obtained (Sandelowski, 2000; Creswell, 2013). Data analysis involves the reduction of exhaustive descriptions of information into categories and formulating themes (Creswell, 2013).

3.5.1 Transcription

I used nine conversations from the participants (of which eight were audio-recorded), field notes were recorded, and reflections written up after each conversation. The ninth conversation was transcribed on the participants' premises and deleted from the audio recorder, as she did not want to be audio-recorded. I listened to the recordings, and read and re-read the field notes and reflections, before beginning the process of transcribing. I transcribed the nine conversations verbatim with all the pauses, emphases and laughter, voiced by both the participant and by me. The information from the audio-recordings, reflections and field notes were titled and dated. Subsequently, the notes of the environment, as well as noteworthy observations that occurred throughout the conversation process were incorporated into the relevant transcripts. This proved to be a very long and time-consuming process; however, it allowed me to become more familiar with the information and was valuable during information unravelling. Finally, I summarised the conversations, extracting the common clusters of words, commencing with the information analysis and the supervisor listened to all audio-recorded conversations and compared these with the transcripts to ensure accuracy of the original record. Information was transcribed and then analysed using Colaizzi's seven step approach.

3.5.2 Information unravelling

Colaizzi's (1978, cited in Valle & King, 1978) strategy of descriptive data analysis was considered appropriate. This approach has been used extensively in nursing research and has been observed to be adequate as a data analysis method for this type of work (Creswell, 2013). Colaizzi (1978, cited in Valle & King, 1978) proposed the following seven steps in the information unravelling process to analyse qualitative data:

1. I read each transcript several times to become more familiar with the contents. Subsequently, I started to colour code the material by selecting a phrase close to the meaning of the information. All the transcripts were colour-coded, to facilitate the tracking of the emerging codes.
2. The significant statements in each transcript that connected to the phenomenon under study were extracted and recorded on a separate sheet with a transcript reference. I returned to the transcripts and extracted the sentences that were directly related to the research question.
3. Identifying the meanings or the formulation of meaning from the significant statements followed. At this stage, I attempted to understand and hear what was not said, but portrayed, by the participants.
4. The meanings were sorted into categories, theme clusters, sub-themes and, finally, the main themes. Once I was able to formulate themes from the sub-themes and theme clusters, a meeting was arranged with the study supervisors to discuss these, as well as verify whether these themes were emerging from the information.

After this exercise, I returned to the transcripts to check if any significant statements were missed. After the initial six conversations, I realised that information saturation had not been reached. A further three participants were recruited and conversed with. The same process of information management was followed. Thus, analysis was done on information collected from nine conversations.

5. The study findings were integrated into a description of the question under study. The results were organised into a table with the four main themes and their corresponding sub-themes that emerged from the information analysis.
6. Subsequently, I formulated the fundamental structure of the expatriate mothers' experiences, by describing it in the form of a statement. In this step, I formulated the description of the themes and sub-themes that emerged, which were refined and named appropriately, with the guidance of the study supervisors.

7. The final step was to check and validate the information. The strategy of member checking was used to validate the credibility of qualitative data, by going back to the study participants for discussions on the themes that were emerging (O'Brien, Harris, Beckman, Reed, & Cook, 2014), as well as validation and confirmation that the sub-themes and themes found were true reflections of their narratives. The descriptions of the expatriate mothers' experiences were discussed and confirmed with each participant via telephone after the themes were approved by the supervisors. Figure 3.1 illustrates the steps of the information analysis process.

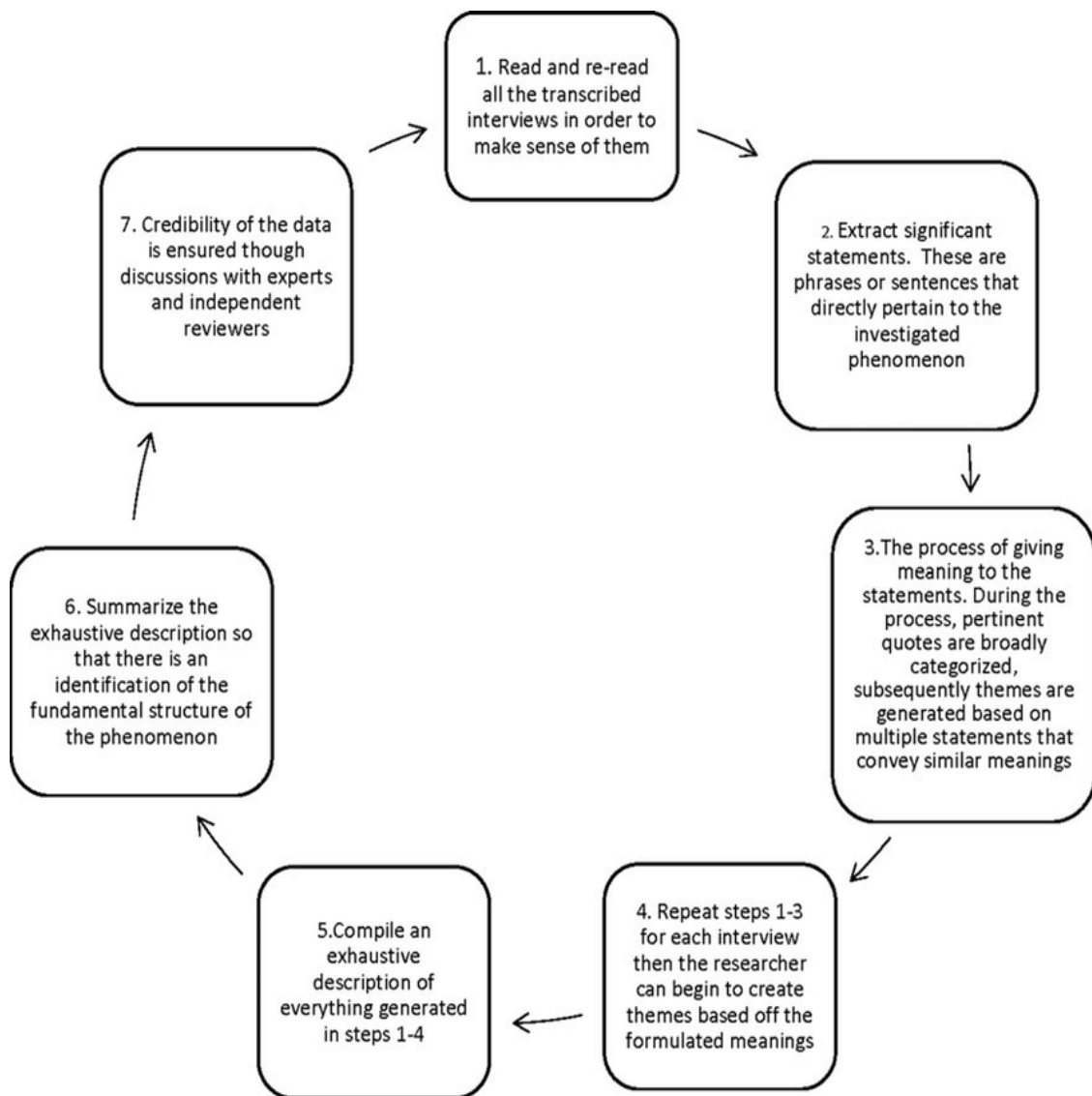


Figure 3.1: Seven steps of data analysis (Colaizzi, 1978, cited in Valle & King, 1978).

3.6 Ensuring scientific rigour

In qualitative research, the researcher should demonstrate the true value of his/her study, by showing that it is credible and applicable to professional practice (Holloway & Wheeler, 2010). I earnestly followed a set of research qualities, as explained in sections 3.6.1 to 3.6.4, which ensured the trustworthiness of the study. Credibility, transferability, dependability and confirmability (Marshall & Rossman, 2011) are presented below.

3.6.1 Credibility

Credibility refers to “the idea of internal consistency to ensure rigour” (Holloway & Wheeler, 2010, pp. 298-300). It can be achieved by prolonged engagement with the participants and the information. Negative case analysis, participant checks, validation of my reflections occurred regularly, in consultation with the supervisors, to ensure that the information provided remained consistent and honest, and that rigour was presented in the information (Brink et al., 2017).

In summary, to establish credibility, I:

- (i) Kept a reflective journal during the research process and went back to the participants to confirm the feelings, or notes that had been jotted down, to confirm the transcribed material;
- (ii) Discussed each conversation with the participants for validation, and they confirmed their experiences through the identified themes and meanings from their verbal account; and
- (iii) Consulted with the study supervisors, who examined each step of the analysis process, to confirm and assist in shaping the emerging themes.

3.6.2 Transferability

In a qualitative descriptive study, transferability refers to the probability that the findings in one context could find similar meaning in a similar context or situation (Holloway & Wheeler, 2010). A small expatriate population was sampled, and semi-structured conversations were used to develop a thick description of mothers’ experiences of pregnancy, childbirth and motherhood, in

the contexts of their countries of origin, and in the host city. I provided detailed descriptions of previous experiences and current circumstances, which would allow other researchers to determine if my study findings might be transferable to their settings.

3.6.3 Dependability

Creswell (2013, pp. 189-195), states that, “dependability deals with the way in which a study is conducted”. Dependability should be consistent across the research study, and the analysis process should be presented openly. Dependability requires conceptualisation of the research topic, collection of the information, interpreting the findings, and reporting results (Creswell, 2013). There was a need to demonstrate consistency in the information gathered, as well as transparency, by providing details of the research process and instruments (Appendix III, IV, VI) for the results to be more dependable (Creswell, 2013).

3.6.4 Confirmability

Confirmability refers to “objectivity, the quality of the results produced by an inquiry in terms of how well the results are supported by informants involved in the study” (Holloway & Wheeler, 2010, p. 303). References to the published literature, when testing findings, may indicate consistency with the current understanding in this field, or might highlight some aspects that are different (Holloway & Wheeler, 2010). I kept a record of field notes and journal entries, in which an account of all the concerns that arose during the entire research process was documented. This included what was seen, heard and experienced, as well as my thoughts, feelings and reflections on the experiences of the expatriate mothers.

Additionally, telephonic conversations were utilised with all the participants, who could not attend a second session with me, due to their commitments. The participants also offered to use WhatsApp messages for any follow up questions that I may have had, records of which were kept throughout the research process.

3.7 Ethical considerations

In all research involving humans, consideration for the ethical conduct of the research should be undertaken to ensure, protect and safeguard the interests of the participants (Holloway & Wheeler, 2010, p. 54). This is guided by professional and international instruments, e.g. the Helsinki Declaration (World Medical Association, 2013). I upheld the principles outlined in the Declaration of Helsinki, with special recognition of clauses 12 (researcher competence), 16 (risk and burdens), and 18 (risk and benefits analysis), which emphasise the importance of safe ethical research with minimal risk to research subjects (World Medical Association, 2013).

The research proposal was submitted for approval to the Human Research Ethics Committee of the Faculty of Health Sciences at the University of Cape Town to conduct the study, which was obtained (Appendix I). There was a need for expansion of the eligibility criterion for the age of the Cape Town born child, which was approved by the Human Research Ethics Committee (Appendix V); the ethical principles of autonomy, beneficence, non-maleficence, and justice, which overlap with the clauses 16 and 18 of the Helsinki Declaration, were upheld. To ensure that the research was conducted in an ethical manner, I provided a detailed account of the study intentions at each stage of the research process, to ensure that these ethical principles were observed.

3.7.1 Researcher competence

The Helsinki Declaration (Clause 15) requires that researchers possess the skills and display the capability to conduct a research conversation (World Medical Association, 2013). My experience as a midwife with specialist midwifery training, and as an expatriate mother (from Zimbabwe), who had previously completed a counselling skills course, ideally positioned me to conduct this research, and affirmed my competence to conduct qualitative conversations. The study was conducted under the supervision of two experienced researchers, who were able to guide me in the processing and information unravelling.

The research conversations were conducted in English, with an option of Shona, as the participants were all multilingual. I am fluent in both languages, which was crucial to capture the contexts embedded in these languages. All of the participants opted to communicate in English.

3.7.2 Autonomy and informed consent

Autonomy refers to the obligation to respect the decision-making capacities of a person. It requires the use of informed decision-making and associated consent, where the participant is fully aware of the purpose of the research and research procedures such as conversations and follow-ups (Bowling & Ebrahim, 2005; Brink et al., 2017). The participants were provided with an information sheet (Appendix VI) which contained details about the nature and purpose of the study, the information gathering process, as well as any risks or benefits involved in their participation, which was voluntary.

Informed consent (Helsinki Clause 25) is embedded in the principle of respect for autonomy, which carries the obligation for the researcher to obtain voluntary participation from research participants (Brink et al., 2017). In order to provide informed consent, the participants were made aware of the risks and potential benefits, which they may encounter during the study. All the participants consented and signed the form (Appendix VII).

3.7.3 Confidentiality

Strict confidentiality (Helsinki clause 24) was maintained throughout the research process. Qualitative research is exploratory and often includes sensitive information. The participants chose pseudonyms to replace their real names. The transcripts and audio recordings of the conversations were shared only with the study supervisors for quality control and information unravelling purposes.

The information linking participant names to their pseudonyms has been put into a discreet file, on a password protected computer, and external flash drive to which only I have access, and will be destroyed after five years (Holloway & Wheeler, 2010).

3.7.3.1 Information protection and storage

The information provided by the participants has been kept confidential. First, the audio recorder was stored in a locked cupboard, to which only I had access, and the conversations were downloaded onto my personal exclusive-use computer and the audio recorded was destroyed once the audio file was downloaded. Secondly, pseudonyms chosen by the participants were used throughout the study, which maintained confidentiality. This was necessary for the collection of primary information, so that details could not be traced back to the participants. Conversations can only be linked to the participants' identities by me, for confidentiality purposes. When a report or article about this research project is published or presented, participant identity will be protected, as only pseudonyms will be used.

3.7.4 Beneficence

Beneficence is derived from the Latin word *bene*, and means it provides kindness, and is underlined in the biomedical ethical principle code (Brink et al., 2017). The study provided no immediate benefits. No incentive was offered to the participants to ensure that neutral, un-coerced information emerged from the conversations. The participants were informed of their right to access the research findings, should they so wish. The participants verbalised experiencing an enhancement of self-esteem because of my personal engagement, which facilitated in-depth sharing of experiences by the participants. My engagement with the mothers allowed them to express their fears, as well as their positive encounters.

3.7.5 Non-maleficence

Non-maleficence, or to do no harm, refers to the exclusion of hazardous experiments and procedures that could cause discomfort, anxiety, harassment and the invasion of privacy (Brink et al., 2017). Minimal risks were anticipated for the participants in this current study, such as emotional risk, loss of time, loss of privacy, and fatigue from talking. The participants were informed that at any point during the conversation and feedback sessions, if they felt emotional or fearful, I would stop and give them the option of continuing with the

information gathering at another time. The participants were also aware of the public sector counsellors, to whom I could refer them, should they feel the need of emotional assistance.

3.7.6 Benefits and risks/ Protection of vulnerable participants

The participants were informed that they would experience no direct benefits from this current study, which was clearly stated on the information sheet (Appendix VI). However, there could be societal benefits, such as potential increased knowledge of expatriate mothers' experiences of the public-sector healthcare delivery system in Cape Town. Since the study was about expatriate mothers, some of whom were illegal immigrants, as research participants, regardless of their migration status, individuals had the right to decline or withdraw their participation at any stage, if they felt uncomfortable about continuing. In such cases, the participants would be excluded from the study, and not experience any penalty, but this did not occur.

3.7.7 Justice

Justice ensures that all the participants are treated with fairness and impartiality during all stages of the research (Creswell, 2013; Terre Blanche, Durrheim & Kelly, 2006). Distributive justice refers to the perceived fairness of selection to participate in the research (Holloway & Wheeler, 2010). This principle was adhered to by including the first mothers who met the study inclusion criteria. There was no consideration of ethnicity, or economic status, as I was in search of diversity, and ensured that the participants were afforded an equal chance of being selected. Some of the participants were from informal settlements, while others were from the suburbs. It was important to me that no one group be excluded from participating. I approached the participants as a novice researcher, to display a balanced power relationship that was favourable to the participants.

3.7.8 Conflict of interest

There were no perceived conflicts of interest. No persons or companies with a proprietary interest in the study were involved.

3.8 Dissemination of findings

The dissemination of the results will be achieved by meeting and presenting the findings to the participants and stakeholders. Subsequently, this research may be submitted for publication in peer-reviewed journals, as well as for presentation at relevant local and international conferences. The intention is to present the findings to policy makers, midwives and expatriate groups, who may be able to contribute, and provide more insight into any recommended implementations, after the study. Further, the aim is to provide insight to healthcare workers, as well as all public service providers, regarding the childbirth experiences of expatriate mothers. This would ensure that service provision is informed by women's voices.

3.9 Reimbursement

There was no reimbursement offered in this current study. To minimise any incurred expenses by the participants, I provided light refreshments (fruit juice and biscuits) during the conversation sessions. Some of the participants had family responsibilities and were only able to have conversations at their homes, and in the evenings. I had offered to use the Uber taxi to transport the participants, should conditions not be favourable (civil unrest, gang fighting, personal harm) for the conversations and member checking sessions. All of the participants preferred to be in their homes.

3.10 Conclusion

In this chapter, I presented the research design and the research process. In addition, I illustrated how research rigour was established, and explained how the ethical considerations were addressed, to conduct a study of this nature, among expatriate mothers, living in Cape Town.

CHAPTER FOUR

FINDINGS

4.1 Introduction

In this chapter, a description of the participants and the contexts in which previous pregnancies were experienced in their home country is presented. I present the findings that emerged from the information collected during the face-to-face conversations, and the development of the theme clusters, main themes and sub-themes.

4.2 Profile of the participants

During the recruitment process, 18 expatriate mothers responded to the invitation. Twelve could not be included, as they did not meet the initial inclusion criteria. Of these excluded participants, three had children above the age of one year, four were first time mothers, with South African born children, two were over the age of 40, and three had required a caesarean delivery. While undertaking the information unravelling, it became clear that information saturation had not been reached; therefore, the participant pool had to be expanded. The inclusion criteria were amended to include mothers with children up to three years of age (Appendix V), thus three of the original excluded participants could be included. Ultimately conversations were held with nine participants. The selection meeting, as well as the follow-up conversations were conducted at the participants' residences.

The nine conversations were conducted in English. The age range was between 26 and 35 years. Five participants completed secondary education; one did not complete secondary schooling as she was denied entry to her final year after falling pregnant with her first child; while three were professionals, with tertiary education. The profile of the participants is described in table 4.1.

Table 4.1 Profile of the participants

Pseudonym	Age	No. of children	Current occupation	Current setting and type of housing	Country of origin	Setting of previous birth and pregnancy	Marital status
Gertrude	26	2	Cashier	Brick Suburban	Zimbabwe	Peri-urban Zimbabwe	Married, living with husband
Tsitsi	35	2	Cleaner	Brick Suburban (shared by 2 families)	Zimbabwe	Rural Zimbabwe	Married, living with husband
Martha	29	3	Domestic worker	Brick (2 rooms informal structure) Township	Malawi	Rural Malawi	Married, living with husband
Grace	35	4	Tuck shop owner/ Domestic worker	Brick Township (shared by 4 families)	Malawi	Urban Malawi	Married, living with husband
Chrissy	28	3	Housewife	Zinc Township.	Malawi	Rural Malawi	Married, living with husband
Prudence	35	4	Domestic worker/ tailor	Wood Township.	Zimbabwe	Small town Zimbabwe	Married, living with husband
Portia	35	2	Domestic worker/ Qualified pre-school Teacher	Brick One bedroomed flat	Zimbabwe	Urban Zimbabwe	Married, living with husband
Chipso	35	2	Housewife/ Qualified Chef	Brick Own four-bedroomed free-standing house	Zimbabwe	Urban Zimbabwe	Married, living with husband
Charity	34	3	Registered nurse	Brick Flat	Zimbabwe	Urban Zimbabwe	Married, living with husband

4.3 Description of the participants

In this section, I provide a brief description of each participant and her circumstances, to enable the reader to relate to the information, as the findings are presented.

4.3.1 Gertrude

Gertrude is a 26-year-old Zimbabwean mother, who is married with two children – a seven-year-old, and a four-month-old. She lives in a rented brick house,

with access to clean water and sanitation in a low-density suburb in Cape Town. Gertrude works as a cashier at Pick n Pay Stores. Her husband earns his income as an Uber driver, using his own car. They hold Zimbabwe Special Dispensation Permits (ZSDP), which are in the process of being renewed.

Gertrude gave birth to her first child at a public clinic in Zimbabwe, where she received health education and support throughout her pregnancy. She found access to healthcare in Cape Town easy, as the Basic Antenatal Care Clinic (BANC) was close by. The birth of her second child in Cape Town occurred at a secondary level public hospital. She alternates her work shifts with those of her husband's, so that both can cover work obligations, as well as childcare. She has no other family members in Cape Town, apart from her husband's sister, who is a homemaker, and she receives her main support from her husband. Gertrude migrated to Cape Town six years ago, with her husband, and states that the economic situation in Zimbabwe was "bad", with no suitable place to live, as they had no jobs and therefore no income or food.

4.3.2 Tsitsi

Tsitsi is a 30-year-old mother from Zimbabwe, who is married with two children, a 10-year-old⁶, and a one-year-old. The family lives in a two-bedroomed flat, which is shared with another family, in a high-density suburb in Cape Town. Each family has one bedroom, while the living room and kitchen are shared by both families. They have access to clean water and sanitation. The flat is a highly secure complex structure, with a mixed population of South Africans and foreign nationals.

Tsitsi was studying marketing in Cape Town, which she had to discontinue, as she needed to send funds to her family in Zimbabwe. Consequently, she found employment as a cleaner at a local company. Her husband is employed as a manager at a local supermarket. They both hold ZSDP permits to reside in South Africa.

⁶ Tsitsi in her interview mentioned that when she was pregnant with her first child she went back to Zimbabwe to be with her family until five months after giving birth.

Tsitsi gave birth to her first child at a rural clinic in Zimbabwe, which had no basic resources, such as delivery packs or medication. She found access to healthcare in Cape Town very easy, simply across the road from where they live. She accessed antenatal care at the BANC and gave birth at a local hospital.

Tsitsi's support system in Cape Town includes her husband and ten-year-old daughter. She pays a migrant mother from the Democratic Republic of Congo to care for her son when she is at work. Tsitsi asserts that the push factor for her to move from Zimbabwe was the political and economic situation, as no jobs were available for them. They have been living in Cape Town for 13 years.

4.3.3 Martha

Martha is a 29-year-old, Malawian mother of three children – a seven- and five-year-old, and a four-month-old. She has been married for seven years, and lives with her husband and children in a densely populated township⁷ in Cape Town. Their residence is a brick-walled house with two rooms – one upstairs and the other downstairs. They have access to clean running water and sanitation. She is employed as a domestic worker, and her husband is a gardener at one of the private schools in Cape Town. She uses local taxis for transportation, and warns that the neighbourhood is not very safe to live in.

Martha receives remuneration daily for the days that she is at work. She did not complete secondary education, as she was denied entry back into school after falling pregnant. She gave birth to her two older children in Malawi, in a public hospital. It was challenging to give birth in the public health facility, with limited resources and negative staff attitudes. During that time, the presence of her family made it easier to cope.

⁷ Township in South Africa is a suburb that is predominantly occupied by black persons. These townships were formally designated for black occupants by the Apartheid regime. Retrieved from: <https://en.oxforddictionaries.com/definition/township> 10/10/19. The township has extensions of informal settlements.

She found it easy to access public healthcare in Cape Town, and expressed that she received immediate care, health education, as well as a referral to a secondary-level hospital when the need arose, and received medication, unlike her experience in Malawi. She gave birth at a Midwife Obstetric Unit (MOU).

Martha's support system in Cape Town includes her brother and his wife, who live in another township, about 11 kilometres away. However, they are not always available when she needs their support, as they are in full-time employment. Martha has been living in Cape Town for three years. She migrated to follow her husband, as well as the prospect of a better life in South Africa. She has asylum seeker documentation that allows her to be resident in South Africa until her status is investigated and determined.

4.3.4 Grace

Grace is a 35-year-old Malawian mother, who is married with four children – a 14-, 12- and six-year-old, and a six-month-old. They live in a densely populated township in Cape Town. They rent two rooms in a brick house, as well as a front room, from which she operates a small shop, with fast foods and small groceries. Three other families (also tenants) occupy the house, with a separate entrance. They have access to clean running water and sanitation. Grace's two older children were born in Malawi at a government clinic, where basic resources were scarce. She had easy access to healthcare services in Cape Town and gave birth to her two younger children at an MOU.

Previously, Grace was employed as a domestic worker, and two months prior to the conversation, had started her small business. She makes use of public transport (minibus and trains). Grace had studied business administration at one stage but did not manage to complete her studies. Her husband is a supervisor at a private company, as well as a pastor at a church in the community.

They have no immediate family in Cape Town; however, they have managed to integrate their family into the community in which they live. They have been living in Cape Town for seven years. She has asylum seeker documentation

that she obtained when she migrated to Cape Town, in anticipation of a better life.

4.3.5 Chrissy

Chrissy is a 28-year-old Malawian mother, who is married with three children – a nine- and six-year- old, and a ten-month-old. They live in a shack⁸, one of five in a small compound, in a high-density township of Cape Town. Their shack is quite big, divided into two rooms by a curtain. There is one water tap outside on the smallholding, which everyone shares, as well as one water-flushing toilet. They have an electricity line plugged on to the main energy pole that provides them with power.

Chrissy is a homemaker and says that she has been unable to find employment. Her husband earns his income as an Uber driver, using his own car. This is their only source of income, as well as their transportation. Her husband's sister lives and works in a suburb of Cape Town, approximately 40 kilometres away. She is married and is their only immediate family support.

Chrissy's first two children were born in Malawi at a government clinic, where service delivery was impeded by the lack of basic resources (delivery packs, electricity). However, the healthcare providers were supportive. She gave birth to her youngest child at a local MOU. Chrissy discloses that healthcare services were readily available to them, with no discrimination, and access to more than basic resources (Ultra sound scan machine (USS), blood tests). They left Malawi six years ago, migrating to Cape Town in search of a better life, and hold refugee status in South Africa.

4.3.6 Prudence

Prudence is a 35-year-old Zimbabwean mother, who is married with four children – 15-year-old twins, a five-year-old, and a seven-month-old. The family lives in a wooden, two-bedroomed house, in a high-density township of Cape

⁸ "This is a very simple and small building made from pieces of wood, metal, or other materials" (Cambridge Dictionary, 2019).

Town. The house includes a small kitchen, as well as a corner office that Prudence uses for her tailoring work. They have access to clean water and sanitation. Her home is always tidy and clean. She reminisces about their life in Zimbabwe, before moving to Cape Town. They own a seven-bedroomed house in Zimbabwe, and have to transfer funds back home on a regular basis, to maintain it.

Prudence is employed as a domestic worker by day, and does tailoring at night, as well as on her days off. Her husband is employed as a professional at a private company. She refused to elaborate on what exactly his job entails, for fear of revealing his identity. They own a motor vehicle that is used for transportation.

Prudence gave birth to the twins at a public hospital in Zimbabwe. When she gave birth, the healthcare providers were on strike. Consequently, she was forced to use a minibus taxi as an emergency vehicle, instead of an ambulance. At the time, resources were scarce because of the economic crisis in Zimbabwe, making the experience an unpleasant one. However, access to healthcare in South Africa was easy, as she had approached the antenatal clinic (ANC) at a local clinic, and was referred to a secondary institution for delivery, because of her previous history. She gave birth to her younger children at a local hospital in Cape Town.

Her immediate support is her younger sister, who followed her from Zimbabwe, and stays with the family. She assists Prudence with childcare, for which she receives an allowance. Prudence migrated to Cape Town, following her husband, in anticipation of a better life. They have lived in Cape Town legally for five years, with Zimbabwe Special Dispensation Permits.

4.3.7 Portia

Portia is a 35-year-old Zimbabwean mother, who is married with two children – a six-year-old, and a two-year-old. The family lives in a one bedroomed flat with a kitchen, bathroom, open plan dining and sitting room, in a high-density suburb of Cape Town.

Portia is a qualified pre-school teacher, and was previously employed at a school, where she was being underpaid, because of her illegal status at the time. The school management refused to provide her with the necessary paperwork to assist her with procuring legal documentation. Therefore, she resigned and found employment as a domestic worker in a wealthy suburb of Cape Town. Her husband is a qualified plumber, who was also being underpaid by his employers, for the same reason, resulting in his resigning to drive with the Uber Company, using his own car.

Portia gave birth to her six-year-old son at a local clinic in Zimbabwe. At the time, there were no basic resources, such as water, or delivery packs. The healthcare workers displayed a negative attitude towards her when she arrived at the clinic to give birth. Healthcare access in Cape Town was readily available, as she attended the local MOU for ANC, and gave birth to her two-year-old son at a local hospital in Cape Town.

Portia has no immediate family, but has childhood friends from Zimbabwe, who are her support system in Cape Town. Portia moved to Cape Town five years ago, following her husband, because of the high inflation rate and appalling living conditions back in Zimbabwe. She has not returned to Zimbabwe since her arrival in Cape Town, because of her illegal status and insufficient finances for travel.

4.3.8 Chipo

Chipo is a 35-year-old Zimbabwean mother, who is married with two children – a 15-year-old, and a three-year-old. They own a freestanding house, with four bedrooms, two bathrooms, two sitting rooms, entertainment room, and a pool, in a low-density suburb of Cape Town. They have access to clean running water and sanitation. They own three cars that they use for transportation.

Chipo, a qualified chef, stopped working when she became pregnant, because of the stress at work. Her husband is an accountant, who qualified as a chartered accountant when he arrived in Cape Town and has permanent

residency. In her previous pregnancy, she gave birth at a public hospital in Zimbabwe. The healthcare services at the hospital were excellent and accessible, with the necessary equipment available, while the doctors and health care workers (HCW) were considerate. Access to healthcare and navigation in Cape Town was not easy at the time she became pregnant with their second child, as her husband was still studying. Antenatal care was received at a local clinic, and she gave birth at a public hospital.

Their support system includes Chipo's brother-in-law and his wife, who are busy professionals, living in a low-density suburb of Cape Town 32 kilometres away. They have no other immediate family and hire help when the need arises. They migrated to Cape Town 11 years ago for better economic opportunities, as she disclosed that it was difficult to afford anything in Zimbabwe at the time.

4.3.9 Charity

Charity is a 34-year-old Zimbabwean mother, who is married with three children, a 16- and a nine-year-old, and a five-month-old. They live in a two-bedroomed flat, in a medium density suburb of Cape Town. They have access to clean running water and sanitation. The complex they live in is secure, with a small multinational population.

Charity completed matric⁹ in Cape Town, at the age of 29, and went on to study nursing. She recently completed her studies and is now working as a professional nurse. Charity's husband, an accountant, was granted permanent residence. They each own a car for transportation.

Charity gave birth to two children in Zimbabwe at a local public clinic. The clinic had courteous supportive healthcare workers, but inadequate basic resources. In Cape Town, she gained access to antenatal healthcare at BANC, which she considered a positive experience. Her child was born at a local hospital in Cape Town. However, the hospital was experiencing a shortage of hospital beds.

⁹ Final year of high school or secondary school certificate examination in South Africa (SAQA, 2014).

She travels home on a regular basis, and her family members from Zimbabwe visit her in Cape Town, at will, for support. She has a cousin from Zimbabwe, who came to live with her, whom she pays to mind her children. She has integrated well into her community, as she is also an informal trader, buying and selling various products, such as clothes and handbags.

She migrated to South Africa nine years ago, following her husband in anticipation of better economic opportunities. According to Charity, Zimbabwe was in an economic crisis, with no available job opportunities. Although her husband was granted permanent residence, she holds a study permit that has expired, and is currently causing problems for her, in terms of childbirth registration and continued employment.

4.4 Context of pregnancy, childbirth and motherhood of expatriate mothers in their countries of origin

During the conversations, the expatriate mothers spoke about their pregnancies, childbirths and motherhood experiences in their original countries. Although the original country narrative was not the aim of the study, I considered it important to record the contexts of these experiences, to aid an understanding of some of the findings and later discussion. The following common topics emanated from the mothers' narratives:

- Lack of basic resources in public health environment.
- Availability of older women support at home during motherhood.
- Emotional support by extended family members.
- Physical support by the extended family members.

4.4.1 Lack of basic resources in public health environment

Basic resources in a public healthcare facility are necessities for the full functionality of these facilities. These basic resources may include a constant supply of water and energy, sanitation, as well as waste disposal systems that are functional, reliable and safe (World Health Organization, 2017). In addition, healthcare facilities need to have stocks of medicine, supplies and equipment,

as well as emergency transportation (WHO, 2017). The following extracts were expressed by the participants:

Chrissy: *“At home [country] when you give birth there is no disposable diapers in the hospital; it’s only the rich people who get money. You need to go with your nappies, clothes and take your own linen savers to put on the bed so that you don’t mess the linen. You must buy your own linen saver, own razor blade to cut the umbilical cord, you must take new matches and a candle as sometimes there is no electricity and you may need to light your own candle and a baby blanket.”*

Portia: *“Okay. It was a little bit tough, because when you go to the maternity hospital, they didn’t have anything, they ask us to bring everything. We must take water there, we must take the things that we use in labour; the needles, the cotton and everything and they don’t have the material to use.”*

Another participant added the following regarding the lack of resources and training for diagnoses:

Grace: *“They don’t do any scans in our country, that doesn’t happen. They just use the normal foetoscope thing that’s used to hear the heartbeat of the child ... when I was going to the clinic they could not tell me with my first child whether my child was breech all of a sudden when I was in labour, when I was about to deliver that is when they realise that my child is breech.”*

Gertrude: *“The other thing is in Zimbabwe you have to pay if you are going to the clinic. If you are pregnant you must register first and then I think at that time it was 50 dollars [US] to register. That time, there was a water crisis as well, so if it’s your due date you have to go with water as there was a water problem.”*

The participants in this study reported on the lack of water, electricity, incomplete delivery packs, and availability of medication, at most public

healthcare facilities in their countries of origin. There was a lack of clinically skilled personnel, as well as a lack of ultrasound machines to aid diagnosis.

4.4.2 Availability of older woman support at home during motherhood

All of the participants mentioned that the support of older women in their original countries made a difference during their pregnancy, childbirth and transition to motherhood. Traditionally older women, usually non-working, could be present in their original countries, and had a tremendous influence on the pregnancy, childbirth and motherhood of the participants. Chrissy and Tsitsi clearly illustrated this in the following extracts:

Chrissy: *“She [mother-in-law] would teach me how to look after the child especially at night. She gave me advice like; that I sleep when the child is sleeping, how to change the nappies and how to wash them, and how to clean and care for the umbilical cord. She also taught me how to breastfeed my child, so that she doesn’t get choked when sucking milk and how to wash the hair so that the water doesn’t come to the nose.”*

Tsitsi: *“I actually stayed with my mother for five months. So that my parents and aunties could help me look after the child as this was my first child.”*

4.4.3 Emotional support by family members

Traditionally, after giving birth in their original countries, most of the expatriate mothers would go to their maternal homes for emotional and physical support. One of the participants stayed at her maternal home for five months to receive guidance and teaching on how to take care of a newborn child. This family support was viewed as important to the participants, as it removed the daily responsibilities from the new mother, allowing her body to rest mentally and physically while she adjusted into her new role. In addition, they mentioned that simply having their parents living in the same country/area as they were facilitated a better pregnancy experience, because of the emotional support. The following extract refers:

Martha: *“I can say my pregnancy was very good when I was in Malawi. I had my parents with me. The parents know everything. For instance, when I vomit, they take me and say, “Eat this and don’t refuse to eat.” [Her family provided support and natural remedies for pregnancy ailments].*

4.4.4 Physical support by extended family members

All the mothers considered that the physical presence of family in their original countries was of great value. The physical presence of the extended family in their original countries allowed them to follow a traditional practice of being with their families for one month postpartum. This enabled them to rest while the family cared for them and the newborn child. Gertrude and Prudence best describe physical support in the following extracts:

Gertrude: *“if you give birth in Zimbabwe your parents will take you, your family will take you for about ten days. They will be teaching you how you can take care of the baby, how to bath the baby, and how to breastfeed the baby.”*

Prudence: *“My mother, and later my mother-in-law came to help me with the children. My mother decided it was best she went back to her home and send to me one of my sisters to help me since I have many sisters. So, I stayed with my mother-in-law and one of my sisters. Mother-in-law took complete care of one of the twins, so in a way each child had a mother.”*

4.5 Experience of pregnancy, childbirth and motherhood of expatriate mothers in Cape Town

During the conversations, the expatriate mothers discussed their pregnancies, childbirths and motherhood experiences in Cape Town. The following main themes and sub-themes (Table 4.2) emerged from the mothers’ narratives:

Table 4.2: Summary of the main themes and sub-themes of expatriate mothers' pregnancy, childbirth and motherhood in Cape Town

Main themes	Sub-themes
1. Being an expatriate mother in the host city	<p>Participants voiced how they experienced a subsequent pregnancy, labour and mothering in a host city, and what support they required. This was expressed through the following sub-themes:</p> <p>1.1 <i>Feeling alone in the host city</i></p> <p>1.2 <i>Husband support</i></p> <p>1.3 <i>Family and community support</i></p>
2. Organised antenatal healthcare	<p>Participants reflected that their experiences of organised Antenatal healthcare (ANC) and availability of necessary resources were positive:</p> <p>2.1 <i>Access to antenatal healthcare</i></p> <p>2.2 <i>Efficient healthcare services</i></p> <p>2.3 <i>Healthcare workers experienced as respectful and connecting</i></p>
3. High cost of living	<p>Participants experienced life in Cape Town as expensive:</p> <p>3.1 <i>Need to access adequately remunerated and reliable work</i></p> <p>3.1.1 <i>The lack of access to maternity benefits</i></p> <p>3.1.2 <i>The pressure of repatriating funds</i></p> <p>3.2 <i>Inability to afford leisure activities</i></p>
4. Labour and childbirth challenges in Cape Town (public healthcare)	<p>Participants experienced childbirth in the host city as difficult, which was related to:</p> <p>4.1 <i>Lack of care from healthcare providers</i></p> <p>4.1.1 <i>Limited resources and space in birthing units</i></p> <p>4.2 <i>Implied bias of healthcare practitioners</i></p> <p>4.3 <i>Dehumanizing self on account of being an expatriate</i></p>

4.5.1 Main theme 1: Being an expatriate mother in the host city

All the participants highlighted their experiences of being a mother in the host city and their need for support during the period of pregnancy, childbirth and motherhood in Cape Town. The expatriate mothers were familiar with the traditional support from their communities; however, living in a host city, they felt alone and needed to find alternative support. Three sub-themes emerged from these narratives:

4.5.1.1 Sub-theme 1.1: *Feeling alone in the host city*

The participants all claimed to experience loneliness, and expressed the following sentiments of feeling alone in the host city:

Portia: *“My husband drives Uber. I think that’s why I am saying it’s getting tiresome because he is always busy, he works long*

hours. Which is making it difficult for me with the kids because most of my time even though I am also working I am alone. So, most of my time I am the person with the children because he wakes up early in the morning and comes late. He tries sometimes to make time for the kids, but his time is very little.”

Martha: *“So, I just stay in my house and when I want to go to my friend’s house and then I go there! [*indicates with hands that it is far]. When I don’t want, I just stay in my house until night when my husband comes otherwise; I just stay in my house until night when my husband comes.”*

For the expatriate mothers, feeling alone meant that throughout their pregnancy, childbirth and motherhood, they lacked the support, or companionship, which they would have in their home country. They experienced loneliness which was exacerbated by their living environments, as the participants reported the unsafe conditions, negative community attitudes (perceived and real), especially xenophobia in the low socio-economic communities.

The different languages were also a barrier to communication with neighbours, which contributed to the feeling of being alone/ loneliness, as stated in the following extract:

Martha: *“Yeah, in Malawi the neighbour is maybe you are sharing the same language, here in South Africa the neighbour is speaking Xhosa, me I don’t know Xhosa and the other neighbour is from Zimbabwe, me I don’t know Shona.”*

Another constant contributing factor, mentioned by all the participants, was their busy schedules.

Charity: *“With the life in Cape Town, you won’t expect anybody to come and see you ... People are too busy with their lives. That’s all I can say about Cape Town!”*

Their goal with migrating was to make a living, even if this meant working every day with no social interaction, which explains the expatriate mothers' tendency to rely only on their husbands for friendship, companionship, as well as a sense of belonging.

4.5.1.2 Sub-theme 1.2: Husband support

The expatriate mothers expressed that their husbands were their main support in Cape Town. The support needs included cooking, laundry, nutritional and financial support. The participants also depended on their husbands for emotional support.

For social integration into society, a sense of belonging is crucial (Tietjen & Bradley, 1985). The presence of their husbands made a sense of belonging possible in a host city environment. Their husbands appeared to have assumed the role of the older women and the extended family members. These are extracts from the participants:

Martha: *"I had pain in my abdomen as my husband was leaving to go to work and he says No! I can't leave you alone because here we don't have our parents, it's only neighbours. So, no! I am going to be with you, I'm going to tell my boss my wife is sick ...' He prepared tea for me to drink and I refused, and he took the bag, then he said, 'Let's go to the hospital'."*

Tsitsi: *"... I was just screaming as it was so painful, a horrible pain I had, but I could hear the lady calling me and my husband was there, luckily for me. I want to thank God because he [my husband] was there to support me."*

Gertrude: *"... I said we are going to take the baby to the crèche [at four months] and my husband said, 'No! I would rather stay with the baby here at home and then when you come back.' So, when I am at work my husband takes care of the baby and when I come back from work, I take over."*

Chrissy: “Oh for support, my husband is helping a lot, with our child he is just doing everything. Sometimes if I’m tired he washes the child also. He also gives the child porridge, yeah, he does everything, like the buying of stuff [household commodities] he can do everything.”

4.5.1.3 Sub-theme 1.3: Family and community support

The family and the community offer social support to the expatriate mothers. For this study, the family support system includes the expatriate mother’s immediate family members, who also reside in Cape Town.

Gertrude: “... if my husband has a busy schedule at work, I can always take my kids to my auntie. I can always call my aunt and say I am bringing your nephew there.”

Tsitsi: “It is sad man! Back home, we have aunties and it’s a big family, everybody is there! Here you pay to leave the child; here you pay as you cannot ask somebody just for nothing even if it’s your sister. It doesn’t feel right, you just think ‘let me pay this person to leave my baby with’, but back home, you can leave your child anywhere [with any relative], and they can be looked after by anybody.”

The expatriate mothers during pregnancy, childbirth and motherhood needed support from others like expatriate women and/or mothers who originate from the same country as the participant. Even though family and community members supported the expatriate mothers, transactional care was also considered. The following extracts of the participants’ narratives emerged from the conversations:

Chrissy: “Yeah, the lady who was here is Mrs Y [name]. She helps me a lot most of the time with the child, she spends time with her ... she is just my friend, we come from the same country, so she’s just a friend.”

Martha: *“I really thank my friends like X [name] she comes to visit, even when I was admitted in hospital. When I was admitted she was the first one to come and see me. Even when I am at home they come and help do chores in my home.”*

The participants also expressed how their lives have been affected, due to the absence of family and community support.

Grace: *“Yeah, when I came with my child to Cape Town, it took me time to get used because you know that when you’re at home there are people helping you even if you don’t have enough finances.”*

Portia: *“Like now life here it is getting a bit tough and tiring for me, because I am always with my kids everywhere I go. I am with them, like I do have friends, but everybody is working and it is different from home. When I gave birth to my first son at home the family was there and most of the things were like they were doing everything, everything for me. They were there for me but now it’s like I am doing everything for myself and it’s heavy and it’s tiring, it is tiring. I feel like, oh if I get someone from home maybe a sister or anyone who can sometimes come and help me because I really need someone to come and help me.”*

Martha: *“... I was not feeling good because my parents are in Malawi and here, I am alone, and my husband is at work ... it is difficult as everywhere you go you must carry your baby, so yes it’s difficult to raise my baby alone.”*

Gertrude: *“To be a mother here in Cape Town is not easy because unlike here most of your relatives there are in Zimbabwe, in Cape Town everyone is working so I can’t compare Zim [Zimbabwe] and Cape Town. When you’re in Zimbabwe everything is very easy because if you want to go back to work you just leave the baby by your mum or by your*

auntie or your grandma. There are lots of relatives but here in Cape Town it is very difficult because most of the people work and for me to take the baby to a crèche at this age, four months, it's not easy. So, yeah, for me home is the best cause there's always people who can take care of the baby than here in Cape Town."

Tsitsi: *"It's very tiresome, I'm telling you. You wake up, go to work, you come from work, but you want to see to him [baby], even at night time you must be awake, it's not like a full night of sleep because you sit up throughout. You must breastfeed, and you are always tired, you are always not yourself. You don't even feel like dressing up, you don't have time for friends or anybody; just you and the child, at home."*

Grace expressed that, while pregnant in her home country, she was given natural remedies by her family to help alleviate nausea during her first pregnancy; however, in her recent pregnancy, she was alone in Cape Town, and was admitted twice because of nausea and vomiting.

The voluntary role of the extended family has been replaced by a transactional nature of relationships in the host city, which has caused expatriate mothers to realise the important role their family fulfilled during pregnancy, childbirth and motherhood, in their home countries.

Some of the mothers verbalised this:

Chipo: *"But the experience here in Cape Town, when you want to ask someone to look after your baby and you want to go somewhere, you must pay. But in Zim sometimes you can ask your neighbour, please can you look after my baby. Then you will go and come back, and they don't even ask you for any money. But here, everyone is working. Even if they are not working, some people want money to look after your baby."*

4.5.2 Main theme 2: Organized antenatal healthcare and availability of necessary resources in Cape Town

All of the mothers described the antenatal healthcare services in Cape Town as very effective and reliable and three sub-themes emerged from these narratives:

4.5.2.1 Sub-theme 2.1: Access to and availability of antenatal healthcare

Antenatal healthcare was easily accessible in Cape Town, indicating that they were not rebuffed because of their residential status, and were treated with the same respect as their South African counterparts. They added that they did not encounter challenges when accessing public healthcare. The antenatal healthcare (ANC) for all pregnant mothers was free-of-charge, and there was availability of necessary resources such as ultrasound scans unlike in their original country, where they had to pay a registration fee. All they were required to do was present their passports. They described the ease of access for ANC as follows:

Charity: *“It was quite easy because like the clinics you just go in ... I just went for antenatal at our local clinic, which was quite easy, and the nurses were very professional.”*

Tsitsi: *“I was going here just across the road [to the clinic]. So, [access] it was fine.”*

Chrissy: *“... All of us were treated the same. They didn’t choose the colour of someone. Yeah, everything is nice and orderly.”*

The participants appreciated the availability of necessary resources that were not easily accessible in their home country, e.g. ultrasound and basic resources such as water.

Charity: *“I was attending the antenatal clinic and it was quite helpful because like, hm ... they do scans for you for free, they always do blood tests, they give you the supplements”*

[medicine], they give you a lot of things which I never had with my first and second child back home”.

Chrissy: *“It is at the MOU. They do a scan there, and they can tell whether your child is a baby girl or boy. We also didn’t have to wait long because there are a lot of sisters [nurses] there at MOU.”*

4.5.2.2 Sub-theme 2.2: Efficient antenatal healthcare services

The antenatal healthcare was efficient, there were no long queues and referrals were made when necessary, resulting in positive experiences. The following excerpts were expressed by the participants, regarding efficient healthcare:

Tsitsi: *“It was so efficient like this, if you were there at seven o’clock or before eight o’clock. The service was good, especially for pregnant people, they [midwives] see us so quickly. They made another container-like office [More office space to serve more clients and shorten long queue], it’s awesome there! You just go to the back to work and it’s quicker for pregnant people.”*

Chrissy: *“The time I was going early in the morning. Sometimes it’s full so I must go early. I was going there around seven o’clock. Most of the times I was being number four or number five. We didn’t wait long because there are a lot of sisters there at the MOU Hospital.”*

Prudence: *“There were no problems at all. After I registered at the [BANC] clinic, they asked me to go and register at the MOU as well. After being registered by those nurses from the MOU, I would do the ANC visit at regular intervals to see how I was doing [at the BANC]. When my due date was near, clinic nurses suggested, given the traumatic nature of my first childbirth, that I go for a check-up at the MOU, where I was*

advised to give birth at hospital. I delivered at hospital without any problems.”

Sufficient midwives were available, which was important to the expatriate mothers, as they were not compelled to spend the whole day at the clinic and could return to their jobs. There was consensus regarding the timeous and efficient antenatal services, and satisfaction about the availability of resources.

4.5.2.3 Sub-theme 2.3: Participants experienced the healthcare workers (HCW) as respectful and connecting

The expatriate mothers, who received antenatal healthcare at Midwife Obstetric Units (MOU) and BANC clinics, reported that the midwives in Cape Town were skilled and respectful towards them. The following statements illustrate the care received:

Gertrude: *“The nurse also gave me her number, she said that if I had any concerns that I should just give her a call or just text” ... “And the other thing was the SMSs (MomConnect¹⁰) from the clinic that I am still receiving.”*

Grace: *“They are nice. They welcomed me very well. They didn’t despise me ... if some other people don’t speak English, they ask for an interpreter to interpret for them.”*

The midwives provided support and created a comfortable environment for expatriate mothers to access healthcare services, as the following extract describes:

Gertrude: *I don’t think anyone gave me that kind of treatment like that sister. So, we went there to register for maternity ...*

¹⁰ MomConnect is a South African National Department of Health initiative, which promotes maternal health, through cellphone-based technologies, integrated into maternal and child health services. The services are free to the user, and messages are available in all 11 official SA languages. MomConnect is voluntary and pregnant women can opt out at any time. Midwives register pregnant clients to receive information that is related to their pregnancy stage (Barron, Pillay, Fernandes, Sebidi, & Allen, 2016). Link: <http://www.health.gov.za/index.php/mom-connect>

the nurse that I told you was my nurse, she was just like my mum.”

Even though they struggled socially these [expatriate] mothers expressed how antenatal care was supportive of them during pregnancy.

4.5.3 Main theme 3: High cost of living in Cape Town

The participants complained about the high cost of living in Cape Town. They stated that the cost of living forces them to do all kinds of jobs, as landing jobs they desired was a challenge. The jobs they could secure could not be permanent because of their immigrant status, as well as the lack of papers (work permit, asylum and status). The participants also had a responsibility of sending funds back to their families, who were experiencing economic hardships in their home country (Moorhouse & Cunningham, 2012).

The high cost of living was mentioned by all the participants. Currently, it is being filled by transactional support that required payment, from immediate family members, which made the support conditional making life in Cape Town very expensive. The following extracts refer:

Gertrude: *“To be a mother here in Cape Town is not easy because most of your relatives are in Zim and in Cape Town everyone is working, so I can’t compare Zim and Cape Town. When you’re in Zim, everything is very easy because if you want to go back to work, you just leave the baby by your mum or by your auntie or your grandma. There are lots of relatives, but here in Cape Town, it is very difficult because most of the people work and for me to take the baby to a crèche at this age: four months, it’s not easy!”*

Chrissy: *“It’s not easy because there are lots of things, there are lots of things like you must buy. The nappies it’s very expensive, especially if you’re not working you can’t just depend on your husband. While there are other people at home that are depending on you, so it’s not easy.”*

Gertrude explained her regret of not being in her home country, and receiving her family's unconditional support a regret that all mothers voiced.

The high costs of living emerged from two sub-themes from these narratives:

4.5.3.1 Sub-theme 3.1: Need to access adequately remunerated and reliable work

To the participants, reliable employment implied jobs that were permanent, decently paid, covered for maternity leave through the Unemployment Insurance Fund (UIF¹¹), with maternity leave, and workers' benefits like those of their South African counterparts. The expatriate mothers reported being employed in menial jobs and paid less than South African citizens. In addition, they were not entitled to claim for basic maternity benefits during their maternity leave because their employers did not register them for the Unemployment Insurance Fund (UIF) nor made the necessary payments. The high cost of living was not only exacerbated by the low-paid, menial jobs, it also included the need for a work permit, which would allow them to procure employment in their professional capacities. The expatriate mothers expressed that they had both [husband and wife] resorted to working menial jobs to *earn* a living as expressed in the extracts from the following participants:

Prudence: *“I work at least five days but if I find more days then I'll go to work for more days because we need the money. Everything here is very expensive, and everything requires money so if the two of you are working it becomes better.”*

Tsitsi: *“You have to work. You cannot be a stay at home mother and expect everything that you need to be there! It needs money ... The money is not enough even if we're both*

¹¹ UIF eligibility: You are a South African citizen in possession of a valid green bar-coded ID book. When one is a foreign national with a valid passport and meets basic UIF Maternity Benefit criteria. You pay UIF contributions on a monthly basis (RSA, Department of Employment & Labour. 2020).

working. The money isn't quite a lot. It's not working out that way."

Most of the participants highlighted the importance of, and need for reliable, steady work, as currently, they were unable to secure formal employment and also, they did not have any maternity leave benefits. The following extracts refer:

Chrissy: *"I'm looking for domestic work, but I can't find it. I'm looking for a job, but I can't find it!"*

Portia: *"I am a pre-school teacher ... I was working as a pre-school teacher, I left last year because of some low payment ... [because she has no papers] Now I'm working in the houses [suburbs] for white people just for a trial and see how things go but I love my profession."*

Tsitsi: *"With your qualifications, one expects to come up with and do something that works, that just makes you earn a decent income, I suppose. Maybe if I were back home, maybe I could be doing office work, but ah nothing, I am just a cleaner here."*

4.5.3.1.1 The lack of maternity benefits

Even when they had jobs they could still not qualify for any maternity benefits because they were not legally documented in South Africa and therefore their employers were not contributing to the fund. The following extracts describe this:

Charity: *"Okay, at that time I was studying so I was just done with my studies and I wasn't permanently employed yet. So, I was still working locums [agent shift work]. So, I just actually had to stop because there was nothing, no maternity leave or benefits for me to take. I just told the unit manager there I was going away" [to give birth]. ... "So, there were actually no maternity benefits."*

Gertrude: *“It was unpaid maternity leave because our permits were expired; they need to be renewed so it was unpaid.”*

Seven participants of the nine had low paying or informal jobs. Some complained about not being able to finish tertiary education to get better jobs, while others lamented not being employed in their qualified professions, which resulted with them securing the only available low paying jobs, making life expensive.

4.5.3.1.2 The pressure of repatriating funds

All of the participants verbalised sending money home as an obligation. They had to take care of their families and homes they had left in their home country. This is expressed:

Tsitsi: *“So, the little that you are having, you need to send it home. Now you think how can you study whilst others are suffering back at home, with no food? You then say, let me take that money and **sommer** [so] send it back home and **sommer**, you just work and work.”*

Prudence: *We also must send money back home to maintain our house and pay the woman who’s staying there to make sure that everything is fixed up so every month so it’s not easy to leave here but it’s better than being home right now.*

4.5.3.2 Sub-theme 3.2: Inability to afford leisure activities

The participants migrated to South Africa in anticipation of a better life, fleeing the economic and political difficulties in their countries of origin. However, most of the expatriate mothers declared that after arriving in Cape Town, they realised that a luxurious lifestyle was an illusion. Often, they had to settle in low socio-economic areas, in an environment they

considered unsafe, and they had no money or time for leisure activities. The expatriate mothers voiced their opinions as follows:

Tsitsi: “... I don’t really go out a lot and we can’t afford to eat out.”

Grace: *While here, while here you must focus your time to take care of your children because you want to work for food. You must take your child to school even if they are young [because she has to work].*”

Chrissy: “Nothing. I just watch TV, nothing else.”

Tsitsi: “You are always tired, you are always not yourself. You don’t even feel like dressing up, you don’t have time for friends or anybody; just you and your child, at home.”

Prudence: “No! No one comes here expecting to live like this, no one! But, we have food, and we are here together with our children, which is better than other families that have been separated when parents have moved to South Africa. The neighbourhood is not safe or friendly. A lot of things happen in this neighbourhood, no one is completely safe!”

To most expatriate mothers, it was a challenge to incorporate leisure into their lives, as the cost of living in Cape Town was high. The participants explained that finding employment was demanding. However, after securing a job, they were too exhausted for leisure time, and their circumstances dictated their need to be working. In addition, they perceived leisure activities as costly, which they could not afford.

4.5.4 Main theme 4: Labour and childbirth challenges in Cape Town (public healthcare)

Although their living conditions were challenging, the participants received sound antenatal healthcare services, which were adequately resourced. Other

challenges were mainly associated with healthcare providers during labour, and the lack of space for labouring and beds post-delivery surfaced.

4.5.4.1 Sub-theme 4.1: Lack of care from healthcare workers

The mothers sensed that they were being neglected, when in labour, because of their expatriate status. The lack of care was revealed in the following ways; leaving a woman alone in labour, with no observation, no emotional support was provided. There was no provision of pain medication or non-medical pain control measures (back massage, warm shower), as well as the failure to conduct the prescribed midwifery checks during labour and postpartum. The expatriate mothers articulated that the midwives displayed a lack of empathy towards them, while they were in labour. The following excerpts refer:

Chrissy: *“... they checked me and said you can stay on the bed. I waited there on the bed, but they didn’t call me from 12 o’clock. I was just sitting there. They didn’t call me and at four in the morning I found a lot of blood is coming out [*frown on her face] and I couldn’t keep quiet! Then I went to ask them.”*

Charity: *“My water broke for the first time and I was just sitting on the chair and I’m wet everywhere, I wasn’t feeling comfortable at all. I then took my bag and I went inside. So, this is what happened, the nurses just left me like that. Even when the nurses were now doing changeover of shift, the other nurse came to me and just said, this one we don’t even know why she’s here. But I was a patient sitting on the chair, my water broke, nobody even bothered to look at how I was doing!”*

4.5.4.1.1 Limited resources and space in birthing units

The participants reported the lack of resources, space and beds at the birthing units. Even though the antenatal units were well resourced and decentralised, the birthing units suffered from

overcrowding, as the participants had to sleep in chairs and labour in the waiting rooms of the birthing units.

Chipso: *“And then they gave me the bed, they just left me there. They didn’t even come to check me. I was shouting, I was crying because of the pain, but no-one came. After maybe like an hour, another lady came. She was pregnant, and she was in labour, maybe she wanted to deliver. And they said to me, you must go and sit outside, because we want to help this lady. I was in pain, I couldn’t even walk, I was holding the walls, but they said I must go outside and sit because they want to help that lady.”*

Gertrude: *“So, they take us upstairs and when we go there is no bed at all! No beds in that hospital. They had to put me in a chair for the whole night because they were saying the beds are very full.”*

Out of the nine mothers, only two experienced decent nursing care, while in labour. The seven complainants expressed how the nurses were negligent, rude, and seemed to suppose that the foreign mothers were giving birth too often and using up all their resources. On night duty, some of the healthcare practitioners abandoned one mother, who was already in active labour for over three hours, without checking up on her. These nurses failed to display empathy and respectful care. The participant mentioned that one midwife was busy on the phone, while another was reading a book.

4.5.4.2 Sub-theme 4.2: Implied bias of healthcare practitioners

The implied bias mentioned by these participants, was that they were treated adversely, as expatriates. The participants were told directly by midwives that they dislike expatriate mothers accessing South African services, and stated that they were using up the already limited healthcare resources. One of the midwives suggested that Martha, a mother of three,

have her tubes tied¹². Others reported that midwives often attempted to impose contraception on them. Participants' perceptions of what the health care workers think, is that foreign mothers are continually falling pregnant, resulting in large families in South Africa, and depleting the country's resources. The following extracts capture this:

Martha: "... the others [nurses] they say they want to give me ¹³Norplant to which I refuse and explain that I am going to take family planning pills. They say, yeah, you're going to have another baby. Hey, you! Do you come from your country to have babies here?"

Prudence: "Yes they actually mentioned that! Yes, you foreigners give birth too much even when you have a small little baby like seven months [*points at her baby] so now they're not very happy about us giving birth. So yeah, they have a problem. So, me, when I went there today just for a check-up it was not great".

4.5.4.3 Sub-theme 4.3: Dehumanising self on account of being an expatriate

Dehumanising self refers to demonstrating extreme humility in the presence of the nurses, for example thanking them more often than is required; accepting whatever care they provide, with excessive gratitude; and leaving, even when they have not understood the healthcare received. Other expatriates had advised them to adopt this strategy to receive better nursing care, and so they had adopted this behaviour. The participants were not prepared to admit explicitly being dehumanised by the nurses, and instead tried to justify the nurses' poor behaviour, as the following extracts confirm:

¹² Tubal ligation is a surgical procedure, employed as permanent birth control (Babigumira, Vlassoff, Ahimbisibwe, & Stergachis, 2015).

¹³ Norplant is a subcutaneous contraceptive with levonorgestrel (Kato, Joachim, Nielsen, & Habib, 1995).

Prudence: “... If sometimes some people [nurses] may just handle you differently and others may not be very kind, but I think it’s normal when you are working that things like that happened. So sometimes you meet these people [nurses] and it challenges you.”

Prudence: “When living in somebody else’s country you just have to be humble and tolerate some of the hostility.”

Tsitsi: “I was shocked when people talked about the service. That’s why I was nervous. That’s why I was like, I don’t wanna [I won’t say anything to the nurse except to be very humble] if she says anything, the next word is thank you.”

4.6 Summary of the findings

The findings provide a story of expatriate mothers who migrated in search of a better future. The dismal economy and lack of jobs in their original country compelled them to migrate to South Africa. On arrival, they realised job opportunities were limited especially if they were undocumented, and their ambitious expectations could not be fulfilled. Despite holding higher education qualifications as well as being skilled, some expatriate mothers adopted informal employment as domestic workers, cleaners and cashiers. Due to the limited job opportunities, they found the cost of living to be very high. Therefore, both spouses were required to be earning an income, to meet their financial obligations in Cape Town as well as in their countries of origin.

During pregnancy and childbirth, the participants established that the healthcare services in the antenatal care facilities were better than the facilities in their countries of origin. The resources were adequate, and their experiences with the ANC/BANC care were satisfactory. However, the expatriate mothers expressed personal challenges that they had faced postnatally. These included the lack of older women to give support, the lack of extended family for support, and expensive childcare transactional services. The participants experienced the care they received quite differently- some found the nurse/midwives welcoming and friendly while others had

negative experiences and expressed a sense of being denied their humanity. Other general challenges that all mothers faced in Cape Town public facilities included the overcrowding of hospitals, the lack of beds for labouring, and the opportunity to rest after giving birth.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

In this chapter, the findings of the study are discussed. The discussion and interaction with literature that were reviewed in this current study either support the findings, or do not. Four main themes emerged from the information analysis, along with related sub-themes. The literature search was expanded to scrutinise and support the findings (2.2.2), as well as looking for research that showed alternative findings. Thereafter strengths and limitations are presented, before the chapter is concluded.

5.2 The four main themes

The findings of this research established four main themes from expatriate mothers living in Cape Town:

1. Being an expatriate mother in the host city
2. Organised antenatal healthcare and availability of necessary resources
3. High cost of living
4. Labour and childbirth challenges in public healthcare

5.2.1 Main theme 1: Being an expatriate mother in the host city

The participants voiced how they experienced a subsequent pregnancy, labour and mothering in a host city, and what support they required from the community. A community is defined as a group of people that lives in the same place, or shares common characteristics (English Oxford Living Dictionaries, 2019). Every mother who has experienced childbirth needs support to adjust to this maternal role. Traditionally, women have been surrounded by family and older woman supporters (Benza & Liamputtong, 2014). This traditional care was provided to assist them, and to teach them how to care for their new born child. The care was also done to allow the mothers to rest their body that would

be physically exhausted, and experiencing hormonal changes (Lowdermilk et al., 2016). However, due to migration, women have to rely mostly on the local support, namely their husbands, as well as other available immediate family support, which most mothers in this current study found to be conditional, or circumstantial.

5.2.1.1 Sub-theme 1.1: feeling alone in the host city

The mothers felt alone in the host city which resulted in loneliness. Loneliness is defined as an emotional state, in which an individual is aware of the sense of being apart from another, or others, along with the experience of a vague need for individuals (Copel, 1988, pp. 14-19; English Oxford Living Dictionaries, 2019). Sullivan (1953) and the English Oxford Living Dictionaries (2019) propose that humans are social animals with a need for contact, and that loneliness is the result of this unfulfilled need. Authors suggest that expatriate mothers experience psychosocial loneliness due to situational changes, or temporary separation, while residing in the host city (Bekhet, Zauszniewski & Nakhla, 2008; Wittkowski et al., 2017). Most of the participants in this current study admitted to feeling lonely and isolated. Some of them are scared to walk around in their residential neighbourhoods as they consider them unsafe. This has contributed to their loneliness.

South Africa is perceived to be a country that is hostile towards foreign nationals (Crush & Tawodzera, 2014; United Nations, 2016a), thus expatriate mothers live in constant fear for their lives, safety and family welfare, due to xenophobia (Smit, 2015). Language is also an isolating factor, which limits expatriate mothers from engaging with people, because communication would be difficult. All these conditions contribute to the expatriate mothers' feeling of loneliness.

Maternal emotional support is common in many African cultures as mothers would have encountered traditional practices, which aids them to settle into motherhood again (Wittkowski et. al., 2017). The mothers verbalised feeling lonely, isolated and having to rely mostly, if not only, on

their husbands for physical, emotional and social support, as well as a sense of belonging, which was not enough for them, to which Smit and Rugunanan (2015) concur. Hunter-Adams (2016) revealed that immigrant mothers disclosed feeling isolated as a couple, and not being able to cope. Consequently, they are at risk of developing depression, as well as other psychological illnesses, in some of the high crime communities, in which they reside (Moorhouse & Cunningham, 2012).

Further, trying to socialise with other expatriates in their communities failed, as life in Cape Town was so busy for them, as well as their compatriots, that they barely had time to visit one another. However, when they did find the time to visit, their friends and relatives lived considerable distances from them, and the thought of travelling involved time and expenses that they could not afford. In addition, the fact that they lived in dangerous townships caused the mothers and their families to be even less social. They simply worked and sent funds back home to support their relatives in their countries of origin, in economic crisis (Moorhouse & Cunningham, 2012; Smit, 2015).

Due to the economic crisis in their home country, mothers worked until very late in their pregnancy to send money to their relatives. For these mothers, support implied providing financial assistance to relatives back home. Some mothers arranged for relatives to come and assist them in Cape Town; however, this was done mainly so that they could go back to work. The support these immigrant mothers required included assistance with cooking; cleaning, as well as advice from older women and emotional support.

The lack of such support, reportedly, has a profound impact on the mother's psychological wellbeing (Hunter-Adams, 2016). Benza and Liamputtong (2014) mentioned that the lack of support from extended family members could cause mothers to feel isolated, lonely and unable to cope with their new born children. The participants reported having to rely solely on their husband for support. In addition, Immigrant mothers,

without the emotional presence of their family support, are lonely and anxious, predisposing them to a five-times-greater likelihood of developing postpartum depression (Wittkowski et al., 2017). Therefore, the need to address this pertinent issue of loneliness, which expatriate mothers face in Cape Town, appears to be crucial.

5.2.1.2 Sub-theme 1.2: Husband support

The expatriate mothers in this current study all migrated to follow their husbands, looking for a better life, which supports the notion of the woman passive migration phenomenon and increases their vulnerability. The main support for the nine mothers was their husbands, who were relied upon for physical, emotional, social support, as well as for the feeling of belonging in a host country. One of the Malawian mothers, Martha, expressed that she only had her husband to rely on for everything she needs. Gertrude mentioned that she and her husband have to work as a tag team, to accommodate childcare.

In recent times, the husbands of migrant mothers are present during labour and at birth, which is a recent social trait that has been adopted and practiced in recent evidence, yet not observed in their countries of origin (Benza & Liamputtong, 2014). Some of the participants mentioned that having only their partners present during the process of pregnancy and childbirth in a foreign country, was a good experience for them, as they considered it more personal, and felt more connected to their husbands afterwards.

Benza and Liamputtong (2014) assert that the African women have adopted the Western custom of having their husbands present during childbirth, as this practice did not happen in their home country, and there is a suggestion that this helped with the provision of emotional and physical support during the birth of the child. Having their husbands' support was culturally not an option in their countries of origin. However, because they had no one else in a foreign country, these mothers had no choice but to rely on their husbands for support.

The husband's support during pregnancy, childbirth and motherhood is of the utmost importance to the mother and the child as they are alone and isolated from their family (Liamputtong & Naksook, 2003). Hunter-Adams (2016) states that migrant couples have well-defined boundaries of support, which confirmed that the primary support for antenatal and postpartum mothers was their male partners/husbands when away from the home country, which was confirmed in this study. However, in the cultural context [home country], the role of husbands is hardly constant (Redshaw & Henderson, 2013). In many traditions, antenatally and postnatally, the husband assists the wife (expatriate mother) to adapt psychologically to the pregnancy and childbirth process, as a facilitator (Redshaw & Henderson, 2013). In many countries, men are the key decision makers and chief economic providers, in terms of women's access to healthcare and economic resources (Yargawa & Leonardi-Bee, 2015).

Benza and Liamputtong (2014) mention that for expatriate mothers, the husband had become the main support (practical, emotional and family), thereby fulfilling the role of the extended family and the older women, which had been disrupted due to migration. In addition, these authors assert that the expatriate mothers needed their husbands' presence for security purposes, especially those living in unsafe environments. However, Wittkowski, Patel and Fox (2017) observed in their study that, often, husbands were unable to provide the emotional support their wives desired, such as working long hours, and not being physically present.

Liamputtong and Naksook (2003) confirm that the husbands' involvement and support are crucial to immigrant mothers in a host city, implying that the husbands' role changes when living in a foreign country. However, Benza and Liamputtong (2014) assert that immigrant mothers develop a dependency on their husbands for support, which could lead to conflict between them. For husbands, this new role, which changes their

traditional role in child rearing, may become overwhelming, as the extended family would have provided support in their countries of origin.

5.2.1.3 Sub-theme 1.3: Family and community support

Immediate family support is discussed in the following clusters: i) intermittent support and transactional support; ii) geographic family; and iii) the lack of family support. Traditionally, a family is known “as a unit of two or more persons united by marriage, blood, adoption or consensual union, in general consisting of a single household, interacting and communicating with each other” (Sonawat, 2001, pp. 177–186). Wittkowski et al. (2017), in their meta-analysis, clarify how traditional practices provided physical guidance and social support that facilitated the adaptation to motherhood.

In a study conducted by Murray, Windsor, Parker and Tewfik (2010), the expatriate mothers in Brisbane, Australia described their previous births from pregnancies, childbirths and adaptation to motherhood. The authors reflected how the participants missed being surrounded by family: the massages and the stipulated 40 days of rest in their home country. However, in the host cities, the expatriate mothers were faced with an environment that lacks traditional rituals, which usually would have allowed for rest (physical and emotional) and support during their postpartum phase.

Extended family support, therefore, is important during pregnancy, childbirth and postpartum. Wittkowski et al. (2017) posit that the physical presence for the extended family implied that the family tradition, which was to protect the mother’s wellbeing throughout pregnancy, childbirth and motherhood, was being practiced. This support also involved the mother taking time away from her husband and other children, as tradition required, to allow the mother time to heal and rest (Benza & Liamputtong, 2014).

Literature supports the importance of the physical presence of family for any mother going through pregnancy, childbirth and motherhood. Some women reported experiencing ill health after childbirth, which they attributed to not having an opportunity to enjoy the postpartum traditional practice of a confinement period in their culture (Liamputtong & Naksook, 2003). Grewal, Bhagat and Balneaves (2008), and DeSouza (2006), in their studies described the period of rest after childbirth as a cultural practice that enhanced the woman's healing process to regain her strength.

The participants mostly reported to have replaced family support with community support. In this current study, the community that is referred to, is their immediate family and other expatriate mothers, who are present and provide these expatriate mothers with support [physically, childminding and emotionally] antenatal and post-partum.

The physical support for childcare, or home maintenance that immediate family (sister, or other expatriate mothers), provided to the participants was transactional. As these expatriate mothers were away from home, there was a need of older woman support in the antenatal and post-partum phases as also indicated by Ghani, Crowther, Karnal & Wahab (2019). Ultimately, the mothers need the support, and cannot do without it, whereas in their home country, it would have been provided freely by the older women (Benza & Liamputtong, 2014). Hunter-Adams (2016) supports the notion that older women play a central role during pregnancy, labour and postpartum, by offering support in multiple ways such as cooking, cleaning and psychosocial support to the new mother. Immigrant mothers in their postpartum phase are often at risk of developing emotional distress and low sense of emotional wellbeing (Smit & Rugunanan, 2015). These mothers are predisposed to health ailments, merely by virtue of migrating to a foreign country (Hunter-Adams, 2016). The participants in this current study mentioned a small group of people who supported them. This support was often conditional on the expatriate mothers' paying or sustaining the wellbeing of the community members.

A close relationship with a primary healthcare giver and older women support in many cultures has been documented to assist the mother to cope with the physical, emotional and hormonal changes occurring in her life and body (Ghani et al., 2019; Razurel et al., 2011). Hunter-Adams (2016) emphasises the importance of maintaining a strong support network for immigrants, as it has health benefits for the mother. The mothers in this current study disclosed that they were lonely and isolated due to the loss of the older women support, as well as the presence of a huge extended family with whom they were familiar. The mother needed to obtain the much-needed physical and emotional support in her postnatal phase, which was not available in the host city, because other expatriates who lived close by, were all busy employed and had no time to socialise.

Social support is a process through which social relationships promote the health and wellbeing of mothers (Cohen, Underwood & Gottlieb, 2000). Social support from extended family members has been associated with positive psychological health (Wittkowski et al., 2017). The lack of this support that the expatriate mothers experience, as well as the loneliness and isolation, could contribute to postnatal depression, while the presence of family could reduce negative pregnancy, childbirth and motherhood experiences (Wittkowski et al., 2017). In addition, extended family support provides mothers with a sense of purpose, security, belonging and a source of information from other mothers, which could help to minimise stress and reduce loneliness (Hunter-Adams, 2016; Wittkowski et al., 2017). The expatriate mothers in this study all expressed the availability of family support back in their home country; therefore, they felt their lack of support in Cape Town.

5.2.2 Main theme 2: Organised antenatal healthcare and availability of necessary resources in Cape Town

The importance of organised antenatal healthcare for expatriate mothers, who had accessed public sector health services, was verbalised. The mothers

reported the easy access to antenatal care, as well as the presence of supportive healthcare providers, which led to this main theme, that was developed from the following three sub-themes under discussion:

5.2.2.1 Sub-theme 2.1: Access to antenatal care

The participants had geographical and organisational access to readily available healthcare resources, which they did not receive in their home countries. These accounts of accessible antenatal care are commendable for midwives in Cape Town. The healthcare resources that the participants accessed, while birthing in Cape Town, are better-structured antenatal healthcare than back home, for example: the availability of healthcare resources, such as, ultrasound scan machines for screening and diagnosis; the availability of blood tests, information and booklets; compassionate antenatal healthcare providers; good service (timeous and non-discriminatory care); and the availability of medication.

They experienced equitability as the “provision of care that does not vary in quality because of personal characteristics, such as, ethnicity, geographic location and socio-economic status.” This is consistent with a meta-analysis study, conducted by Benza and Liamputtong (2014), who state that the migrant mothers were surprised at the good antenatal services they received in their host country, as they had expected substandard care, because of their immigration status.

South Africa is part of the UN Sustainable Development Goals 2030 Agenda and Goal 3, which aims to improve the geographic and organisational accessibility of health to reproductive women despite their nationality or race (UNDP & RSA, 2017). This has seen the Western Cape Government Department of Health, along with other provinces in South Africa, implementing the BANC approach at the end of 2008, in an attempt to decentralise, as well as make ANC services accessible for all mothers, irrespective of their age, race, nationality and religion. Cape Town has a BANC system and midwifery obstetric led units (RSA & WCGH, 2018) that allow better accessible and decentralised reproductive

health services for pregnant and child birthing mothers, at their different levels of health risk and need. This project was established by the government to reduce maternal mortality and morbidity. The expatriate mothers all agree that accessing antenatal healthcare services in Cape Town is not a problem, in terms of the geographic location, transportation, early hours of opening, and financially, as they were not expected to pay for the services. The participants all reported that the hours of opening were excellent, and the services swift, allowing them to return to work soon after care. These mothers also mentioned that the sisters, or midwives, were professional and supportive during this entry [ANC] stage into the public healthcare facilities.

‘Better healthcare resources than back home,’ was a phrase that most of the participants often expressed, as they appreciated the availability of screening services in Cape Town. The participants reported that they had no access to resources, such as Ultra Sound Scan [USS] in their countries of origin, where some of them were giving birth to undiagnosed twins, and experiencing breech deliveries.

Most of the participants reported that their HIV-status was unknown back in their home country, as they were never tested. The comprehensive physical health assessment and screening, and healthcare provider initiated testing (HCT) are done routinely with an opt-out option. Other basic resources, such as water, electricity and delivery packs [these also included razor blades or scissors for umbilical cord cutting] were not available in their home country, as the mothers were required to bring along candles and water (in containers), when they were due for their delivery. This was unlike Cape Town facilities, where basic resources, such as the above-mentioned, were readily available.

These positive experiences of expatriate mothers were due to BANC & MOU that decentralised antenatal care. As South Africa is a signatory to UN international legislation, which assists marginalised populations, such as expatriates, to access reproductive healthcare with a goal was to

reduce morbidity and mortality during pregnancy (Human Rights Watch, 2009; RSA & WCGH, 2018). Late booking, or not accessing antenatal health services, are risk factors for maternal mortality and morbidity and having decentralised centres seems to have helped organisational and geographical access for the participants in this study.

Despite this progress and positive uptake, there is evidence that some expatriate mothers in other settings are still reticent to access public antenatal healthcare services. This situation has been documented by authors in low middle-income countries (LMIC), as well as developed countries, citing that immigrant mothers are fearful because of their lack of documentation, the language barrier, the fear of deportation, and the negative healthcare workers' attitude towards expatriate mothers (Balaam et al., 2013; Crush & Tawodzera, 2014; Moodley, Fawcus & Pattinson, 2018).

5.2.2.2 Sub-theme 2.2: Efficient antenatal healthcare services

The expatriate mothers expressed how antenatal healthcare services were efficient in Cape Town, allowing them to return to work after their routine visits. Efficient healthcare services that are timely meant that there was “reduced waiting periods and sometimes the harmful delays for both those who receive and those who give care” were not present (Erasmus, Poluta & Weeks, 2012). Efficient healthcare is seen as; “avoiding waste, including waste of equipment, supplies, ideas, time and energy” or just working in a well-organised and competent way.

The expatriate mothers attended all their antenatal care visits after experiencing efficient care. Murray et al. (2010) support efficient care and easy accessible ANC for immigrant mothers. The former authors find that timeous care was available to immigrant mothers. However, these authors also mentioned that often the resources that are available for the immigrant mothers are not fully utilised because of the immigrant mothers' lack of knowledge and preconceived perceptions of access to healthcare in a host city. The participants in this study, when asked why they delayed

going to the clinic during the antenatal period, some of the participants replied that they could not afford to be waiting at the clinic for the day. According to Hunter-Adams and Rother (2017), as well as Tebid et al. (2011), expatriate mothers still struggle to access efficient antenatal healthcare in South Africa due to the language barrier, lack of knowledge about how to access healthcare, as well as the perceived xenophobia by healthcare professionals.

5.2.2.3 Sub-theme 2.3: Participants experienced healthcare workers as respectful and connecting

Respectful and skilled midwives combine clinical knowledge and skills, with interpersonal and cultural competence. In addition, they observe respect, care, communication, community knowledge and understanding, tailored to the women's circumstances and needs (Renfrew et al., 2014). Antenatal Care (ANC) midwives displayed professionalism, humanity to all the participants, which demonstrated that they were skilled, and provided respectful care to mothers, despite their expatriate status.

According to Tebid et al. (2011), a mother-midwife relationship includes care for, support of, and communication with, immigrant mothers while accessing public reproductive healthcare services. The midwives' good relationships with the participants in this current study encouraged the women to access healthcare services. Tebid et al. (2011) encouraged migrants reproductive healthcare services access, and were unhappy about the plight of certain immigrants who were refused services by healthcare workers in Johannesburg, due to the lack of documentation. The midwife's responsibility is to support (any) mother psychologically, emotionally and physically throughout her pregnancy, childbirth and motherhood, even when she does not possess the relevant documentation, as stipulated in the South African Constitution (Susuman, 2015; Tebid et al., 2011).

The expatriate mothers appreciated the organised care in Cape Town. Literature reveals the lack of resources in public healthcare facilities in

countries that are struggling, politically and economically, such as their home country (Crush & Tawodzera, 2014; IOM, 2017; Smit, 2015). Hynes et al. (2012, p. 205) mention that countries that experience civil conflict, do not have resources to cater for reproductive healthcare which may lead to a high maternal morbidity and mortality. This is because of the lack of health infrastructure and social networks as resources may be diverted from health care to defence. However, these displaced mothers tend to have better access to quality health care, in foreign countries and hence have better maternal outcomes and experiences.

5.2.3 Main theme 3: High cost of living

The expatriate mothers verbalised the lack of decent housing, which is also reported by migrant mothers in Johannesburg, as they reported having irregular income, resulting in being unable to secure decent housing in safer neighbourhoods (Smit, 2015). The participants needed to access adequately remunerated and reliable work and their resultant inability to afford leisure activities in Cape Town led the mothers to experience high cost of living. The high cost of living for these mothers pertained to the amount of money needed to afford necessities, such as housing, food, clothes and healthcare.

5.2.3.1. Sub-theme 3.1: Need to access adequately remunerated and reliable work

The United Nations (2016a) report on migration in South Africa states that immigrant women work mainly as petty traders, food vendors, catering assistants, porters and shop assistants. This population comprises of professionals who have resorted to working menial jobs, which Moorhouse and Cunningham (2012, p. 501) refer to as 'brain waste'; however, the women viewed these jobs as vital for the survival of their families. Additionally, these authors assert that this type of informal labour, which immigrant mothers are forced by circumstances to do, falls outside of the labour protection of the Immigration Act (Republic of South Africa [RSA]. Act No. 13 of 2002). However, because of their illegal status

in South Africa, it exposes this marginalised, vulnerable population to more risks of unregulated remuneration. These migrants are excluded from the provisions and protections of the Labour Relations Act (Republic of South Africa. Act No. 13 of 2002). The expatriate mothers' challenge to find employment in a foreign country is not unique to South Africa, as 70% of immigrants in Canada strive to find formal employment, due to their qualifications not being recognised, or the lack of documentation, such as work visas, their refugee status and other factors (Collins & Bertone, 2017; Suto, 2009).

The issue of xenophobic attacks that occurred in 2008 and other sporadic attacks occurring since then has instilled fear in immigrants (Crush & Tawodzera, 2014; IOM, 2017; Smit, 2015). The attacks were due to the assumption that most immigrants were stealing jobs from the locals, but the International Immigration Report 2015 states that, "Preliminary research in South Africa shows that immigrant entrepreneurship creates opportunities that have important implications for the country's economy. By contributing to job creation and innovation, immigrant entrepreneurs can play a role in the reduction of inequality and poverty and be a positive factor for the economic growth of South Africa" (United Nations, 2016a).

5.2.3.1.1 Lack of access of maternity benefits

The migrant mothers have no formal work, which means that they may struggle to secure maternal leave benefits as expatriates, and may not have the legal documents to acquire such benefits. "In Western nations, family-friendly employer policies such as parental leave, flexible working hours and childcare information or provision have an established impact on employees' attitudes towards and behaviours at work. For example, the availability of such policies has been shown to predict individuals' attraction to organizations," state Khokher and Beauregard (2014, p. 143). This is not available for the participants in this study and contributes to lack of income security.

5.2.3.2 Sub-theme 3.2: Inability to afford leisure

Most of the expatriate mothers in the study were hoping to secure more days to work, as the remuneration from the menial jobs was not sufficient for their needs. The thought of leisure was far from their minds, as it was an unaffordable luxury. The participants in a study conducted by Hunter-Adams (2016) considered leisure activities to visit family unaffordable, due to the high unemployment rate in South Africa, the scarcity of resources, the high transport costs, and the time involved, as these activities often included using multiple sources of transport. The priority for the immigrant participants, in most studies, was to put food on the table, as well as send some money back to relatives in their countries of origin, making leisure a luxury that they could not afford (Hunter-Adams, 2016; Smit & Rugunanan, 2015). The two expatriate mothers, who could afford to have leisure time, were too lonely as they did not have any family or friends living in the greater Cape Town.

5.2.4. Main theme 4: Labour and childbirth challenges in Cape Town (public healthcare):

Migrant mothers experiencing difficulty during labour and childbirth is not a new issue locally and globally (Benza & Liamputtong, 2014). The participants verbalised many challenges that are articulated following three sub-themes under discussion:

5.2.4.1 Sub-theme 4.1: Lack of care from healthcare providers

The mothers reported challenges with the lack of care from nurses/midwives. They wondered if this treatment was associated with their being expatriates. All were hesitant to state their thoughts that the lack of care was associated with their foreign status, which is consistent with the findings of a study that was conducted with vulnerable teenage mothers, who experienced a similar lack of care, but could not verbalise their thoughts explicitly, because of their vulnerability (Füzy, 2016). The lack of care, treatment in which the patients were “dehumanised” (Füzy, 2016, p. 100), is not new in South African labour wards/hospitals (Jewkes & Penn-Kekana, 2015; Silal, Penn-Kekana, Harris, Birch & McIntyre, 2012). In

Füzy's study (2016, p. 142), the participants "felt unimportant, ignored, victimised and disrespected by nurses in the public health sector". Both the groups of women (expatriates and adolescent girls) were vulnerable but for different reasons, yet they experienced the same emotions associated with vulnerability. This implies that the problem may not be general but it is directed to women accessing public healthcare.

In this current study, the lack of care during labour resulted in a poor outcome for maternal experiences for most of the mothers. The mothers narrated that the midwives did not pay attention to women in labour, they did not support them, or do the routine vital checks, instead they shouted and disregarded the mothers while they were in labour. The midwives displayed a lack of professional conduct, respectful care and empathy, which was highlighted in previous research conducted in South Africa (Tebid et al., 2011). These authors also highlighted how their study participants felt isolated and uncared for by the midwives during their labour process, as the midwives demonstrated no empathy.

The lack of care and empathy while in labour has been reported to increase the pain of labouring mothers (Macdonald & Magill-Cuerden, 2011). These mothers are in a foreign country, may be in the country illegally, and do not speak the local language when they access healthcare. They were having fear of the unknown while accessing healthcare. Therefore, when they encounter uncaring healthcare professionals, their bodies tense up with fear, which has been documented to prolong labour and cause more pain, with a resultant traumatic experience embedded in their memories (Benza & Liamputtong, 2014). The lack of care and support for expatriate mothers during labour has been documented worldwide (Correa-Velez, Gifford, & Bice, 2005; Davies & Bath, 2001; Murray et al., 2010). These authors assert that the lack of care was apparent for various reasons, at the core of which was the language barrier, cultural insensitivity, or the lack of knowledge regarding diverse cultural birthing beliefs, as well as busy hospital routines (Correa-Velez et al., 2005; Davies & Bath, 2001; Murray et al., 2010).

In South Africa, the general lack of care has been associated with healthcare workers' burnout, and overcrowded public reproductive healthcare units (Van der Colff & Rothman, 2014). In addition, for expatriate mothers, the lack of care has been linked to medical xenophobia, as nurses assume that the expatriates are depleting the country's healthcare resources (Crush & Tawodzera, 2014). The abuse encountered has been documented by the Human Rights Watch (2009), who refers to two broad sets of abuses that affect migrants' health in South Africa, namely, i) abuses leading to health vulnerability, and ii) barriers to access to healthcare.

This confirms that no empathy was displayed, and highlights the lack of respectful maternal care for these mothers, after she had given birth while in hospital. Which is contrary to the values of the Midwifery model of care, which stipulates that midwives should strive to provide women, who are going through their childbirth, with a positive experience through the emotional, spiritual, social and cultural impacts of childbirth (ICM, 2014; Renfrew et al., 2014). The midwives, who assisted the participants to give birth, failed to uphold these values. They neglected to treat the mothers as autonomous women who deserved their respect. The mothers had narratives of fear, feelings of trauma, as well as being dehumanised.

Some mothers attempted various approaches to obtain better care from their attending midwives, for example, by acting extra humble, which is the advice they received from other women in the community, who, previously, had accessed public healthcare, both expatriates and citizens. Additionally, it appeared that not only expatriate mothers received sub-standard care, disrespectful treatment, and abuse during labour, but also all mothers, who were exposed to the public healthcare system, where such healthcare providers were employed. This was also observed in other South African and international studies (Füzy, 2016; Koneshe, 2016; Lukasse et al., 2015; Makandwa & Vearey, 2017; McMahon et al., 2014).

When these mothers were fortunate enough to encounter caring healthcare professionals, they felt informed and experienced labour in a positive manner. The midwife and mother worked as a team, resulting in the mother feeling empowered. Renfrew et al (2014, p. 4) found that “women want healthcare professionals who combined clinical with interpersonal and cultural knowledge and skills.”

5.2.4.1.1 Limited resources and space in birthing units

Other issues, such as overcrowding in the hospitals, no available beds for them to lie on while in labour and immediately postpartum, contributed to a negative experience. Some reported having to labour in the waiting room, sitting on hospital benches, at a secondary hospital. They also mentioned that post-delivery, they would sit in the waiting room again, for at least two hours, before they could be allocated a chair or bed, to rest for the night. In the literature that I sourced, I did not find mention of this except when Silal et al (2012) compared rural and urban access and the resultant “negative provider-patient interactions, including staff inattentiveness, turning away women in early-labour, shouting at patients.” However, there have been discussions of nurses being overworked and experiencing burnout in public hospitals leading to negative attitudes (Van der Colff & Rothmann, 2014).

Even though the expatriate mothers reported that there are good resources in Cape Town, Hunter-Adams and Rother (2017) mention that, the resources in the public health sector are stretched and overburdened. According to Hunter-Adams and Rother (2017), the main reason that expatriate mothers consider these resources adequate, is because in comparison to their home countries, whose governments have prioritised other issues like war, and response to famine, and/or drought over healthcare services, rendering their public healthcare services as a low priority. Therefore, what South African citizens may consider a compromised health system is more care than these mothers have ever received from their countries of origin. However, they should be treated with respect and care as per the nurses’ pledge and midwifery

recommendations for midwives (ICM, 2014; South African Nursing Council, 2013).

While language did not emerge as a theme in this current study, there was mention of communication being an identifier of expatriate mothers, which placed them in a different queue for care, compared to local citizen mothers. Communication, or the lack thereof, is a hindrance to receiving good quality healthcare, which is supported by the findings of Hunter-Adams and Rother (2017). The mothers valued the support of their husbands with language/ communication problems, as some mothers disclosed that when they were in pain, they could only converse in their mother tongue, which the midwives could not understand. So, they felt fortunate that their husbands could translate their needs to the nurses, as they feared exclusion from healthcare decisions, and the negligence of healthcare providers. The language of communication during childbirth should be emotional, physical, spiritual and cultural support from the midwife, without discrimination against any mother (Lowdermilk et al, 2016).

5.2.4.2 Sub-theme 4.2: Implied bias in healthcare practitioners

Most of the participants reported the implied bias displayed by midwives. Some of them were reticent to verbalise these attitudes, while others boldly expressed their concerns. The attitudes that the nurses displayed, are in conflict with the nursing pledge of service (South African Nursing Council [SANC], 2013) as well as the provision of respectful maternity care to mothers accessing healthcare, during this vulnerable time in their lives. The nursing pledge states that nurses, “will not permit consideration of religion, nationality, race or social standing to intervene between my duty and my patient” (SANC, 2013).

The implied bias of healthcare workers, believing that expatriate mothers overburden the South African healthcare system, has been confirmed in various studies (Crush & Tawodzera, 2014; Makandwa & Vearey, 2017; Tebid et al., 2011). This implied bias also takes place in township clinics,

where the on-duty nurses only converse in their local languages (Makandwa & Vearey, 2017). Other studies reveal nurses' implied bias as, ignoring expatriate mothers in labour, or sending them back home because of the lack of documentation, when they are in active labour (Makandwa & Vearey, 2017). These published studies were conducted mostly in Johannesburg, and this current study also reports this in Cape Town public healthcare services and for these mothers the best way to receive care was to dehumanise them.

5.2.4.3 Sub-theme 4.3: "Dehumanising self" on account of being an expatriate

Dehumanisation takes on different forms for the expatriate mother. In this current study, it is in the healthcare interaction with the system where mothers dehumanise themselves to access and receive care. Benza and Liamputtong (2014) mention dehumanising self as a coping mechanism for migrant mothers in healthcare facilities. The former authors cite that migrant mothers access healthcare facilities, expecting to be treated adversely; already resenting the healthcare system and with feelings of inadequacy, because they have already experienced social oppression. The sense of not deserving or not belonging is common among expatriate mothers when accessing healthcare in a foreign country (Crush & Tawodzera, 2014). Additionally, these authors explain that, in South Africa, dehumanising self is exacerbated by remarks from healthcare workers that migrant women are depleting the resources.

The Constitution of South Africa states that all mothers, despite their nationality, can access public reproductive healthcare in South Africa (RSA, Act 108 of 1996). The Human Rights Watch (2011, p. 1) mentions that expatriate mothers "experience specific abuses such as active discrimination and delayed or denied care in addition to the systemic failures that affect all patients, compounding the vulnerability they already face." The Human Rights Watch (2011) asserts that the destructive behaviour of nurses indelibly affects expatriate mothers psychologically, which discourages them from seeking care, leading to delayed diagnosis

and treatment, or even increased morbidity and mortality. This, in turn, depreciates the lives of these expatriate mothers.

The depreciation of the mothers' lives is also seen in their social-economic context where they are living below the poverty datum line. Their inability to use their qualifications, forces them to work menial jobs, which is a role they take as migrants. Additionally, their inability to obtain work permits or legal residency subjects mothers to dehumanisation by virtue of their legal status. Suto (2009, p. 418) mentioned that "the transition from being employed in their home country to having one's work history questioned and devalued, can marginalize migrants and prompt acceptance of less desirable jobs." The expatriate mothers with low-paying jobs live in poverty-stricken conditions, without any physical and emotional security. They report financial stressors, such as the need to send money to their relatives back in their home country, as well as the expensive childcare and children's requirements. The financial burden falls on their partners to support them, when they go on maternity leave without a salary, and the expectation of their jobs being unavailable, when they return. Smit and Rugunanan (2015) mention that the lack of security for most immigrants is due to South Africa's high crime rate, and the sporadic incidences of xenophobic violence, which deprives many immigrant mothers of peace of mind in the present, and confidence in the future.

Therefore, these expatriate mothers live in a temporary state, always hoping that one day they will be able to go back home to their home country, as soon as the economic and political situation changes (Human Rights Watch, 2009).

5.3 Strengths

The strength of this current study is that it was focussed on expatriate mothers' experiences of pregnancy, childbirth and motherhood, which is an under-researched field. The transition to motherhood was not the focus, as is often the case in other

studies. This current study provides insight into and knowledge about expatriate mothers' dynamics and experience of pregnancy, childbirth and motherhood in an unfamiliar setting.

A qualitative, descriptive approach was appropriate for this study, as it enabled me as a novice researcher to collect the information from the participants' setting, which allowed them to be more relaxed and open to participate in the study. As a midwife and an expatriate mother, I was able to use appropriate questions to obtain rich information during the conversations. It also allowed the participants to better relate to me, and feel comfortable to interact freely, than if I had been a South African citizen. The use of semi-structured conversation, with open-ended questions, allowed the collection of in-depth information, and for me to understand the experiences of these mothers.

The findings of this current study have highlighted the benefits of decentralised BANC care in Cape Town. It has also revealed that there is skilled care in antenatal units in Cape Town, but a lack of attention, empathy and caring midwives/nurses in birthing units/labour wards. This study also confirms the ongoing abusive nursing care in South African maternity units that has been mentioned in many studies, (Füzy, 2016; Hunter-Adams & Rother, 2017; Makandwa & Veary, 2017).

The study has also identified the overcrowding of hospitals that provide labour and childbirth care for mothers in Cape Town. There has been decentralising of the ANC, but no expansion of the units where these mothers are being referred to, which will require attention from the Western Cape Government Department of Health.

The mothers felt some sense of importance although this was not designed with any therapeutic intentions, after sharing their experiences, as mentioned at the end of the conversation, by one of the participants, who suffered a traumatic experience. The following extract refers:

Chipo: *“So now, I am free now. I am free; I want to thank you for helping us, to at least say something and open to you because I was ... angry. Now she’s (the baby) three years, but every time I was like thinking about*

this thing. I was angry that I almost lost my baby, but now, no. I'm okay now."

5.4 Limitations

As a novice researcher conducting research in the field for the first time, there have been some obstacles. I had not anticipated that recruiting the participants would be as challenging. Very few expatriate mothers were willing to participate in the study, which limited the number of mothers to six, who met the inclusion criteria at the beginning of the study. The inclusion criteria initially required the Cape Town born child to be up to one year of age as the original reason for setting fairly narrow criteria was to enhance recollection. However, when information saturation was not achieved this needed to be reconsidered. The literature supported good recall of pregnancy and childbirth events up to 20 years (Lundgren, Karlsdottir, & Bondas, T, 2009). Therefore, an amendment to this specific criterion was motivated to the HREC and they supported an expanded inclusion criterion to include more participating mothers.

Another limitation was that some of the mothers agreed to participate, but when they sat down with their husbands to discuss their participation, their partners refused the mother's involvement. In retrospect, it might have been beneficial to include the husbands in the conversations, as this would have allowed access to the mothers, who observe traditional gender rules although this might have introduced other barriers to transparent communication.

I had not anticipated that some expatriate mothers would refuse to talk to me, when I was recruiting, especially since I was also an expatriate. Some of the mothers had a high level of distrust when I offered to do the conversations at the University of Cape Town's old main building. They refused to travel for various reasons, probably related to safety and trust.

The use of English as the language of choice for the conversations was a limitation that did not allow a fuller understanding and description of the participants' experiences, as English was a second or third language to them. This also led to the

exclusion of many immigrants, who were living in low socio-economic dwellings, and who mostly accessed the public healthcare services. It was also my second language.

Some of the mothers who were in South Africa illegally became very nervous, when I took out paperwork (consent form) for them to sign, which was for their consent to participate in this current study. They immediately withdrew, as they suspected me to be associated with the Department of Home Affairs, an undercover agent, who might report them, and have them deported.

5.5 Conclusion

The expatriate mothers in this study had positive and negative pregnancy, childbirth and motherhood experiences in Cape Town. Their accounts of accessible antenatal care are commendable for midwives, who are in the first phase of care. The midwives in BANCs and antenatal care displayed professionalism and humanity, while observing of constitutional rights that the South African Health Charter has legislated, to provide health for all. BANC units have decentralised care for pregnant mothers, but it appears that there is a need to investigate the birthing/labouring units, to which these mothers are referred for the accommodation of those in labour.

However, there were accounts of negative labour and childbirth experiences from most of the participants. The expatriate women lacked autonomy in healthcare decisions, and experienced a lack of care during labour. The midwives treated them in a dehumanising manner, and confirmed the reputation of uncaring treatment in local birthing units (Füzy, 2016; Makandwa & Vearey, 2017). There was also the issue of the overcrowding at birthing units in Cape Town, reported by most of the expatriate mothers, as they experienced a shortage of rooms for labour, or sleep after giving birth.

In the communities where they reside, expatriate mothers have a need for support, as well as a place to socialise, to mitigate the feelings of isolation and loneliness. Cape Town is very costly for the expatriate mothers, which is exacerbated by poor remuneration in menial jobs, as well as the lack of recognition of their professional

status and qualifications. All the above have contributed to the context that parenting away from home was a challenge for all the expatriate mothers who participated.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter concludes the study and provides recommendations for future research. In addition, the recommendations provided, may be beneficial to healthcare facilities in Cape Town, particularly concerning expatriate mothers' pregnancy, childbirth and motherhood experiences.

6.2 Conclusion

Maternal healthcare is a global concern. Therefore, with the increase in migrating women of reproductive age, the need to explore this population's experiences seemed significant. This current study was aimed at exploring expatriate mothers' pregnancy, childbirth and motherhood experiences in Cape Town. The experiences of these mothers revealed various concerns about healthcare and living and working in Cape Town.

It revealed that the antenatal care facilities were achieving their goal of equitable and accessible healthcare. However, it also revealed overcrowding, as well as disparities in care at birthing units, where the need to allocate more resources and space for intrapartum and postpartum care, was necessary. The negative experiences were common to all the participants particularly when accessing intrapartum and postpartum healthcare services in Cape Town.

Parenting away from home was articulated as a challenge for all the participants in this current study, and having a profession or adequate income did not ease the frustration. In the communities where they reside, the expatriate mothers expressed the need for older women, as well as extended family support. They expressed a need for places to socialise, as well as an environment in which they do not feel isolated, lonely or unsafe.

Ultimately, the findings of this current study revealed that information and education were essential to enable women to learn how to build on their own strengths, as well as access services, in a timely manner. In addition, the findings revealed that women anticipated services to be provided in a respectful manner by staff who engendered trust, empathy and kindness, with care, personalised to their individual needs. Consequently, it appears that women favoured health professionals who could combine clinical with interpersonal skills, as well as cultural sensitivity.

This research was necessary to gain a descriptive insight into the lived childbirth experiences of expatriate mothers. It was significant to conduct this research in Cape Town, with its large, growing population of expatriates, who access public healthcare services (Crush & Tawodzera, 2014).

6.3 Recommendations

Based on the findings of this current study, I make the following recommendations:

6.3.1 Midwifery education

- Midwifery educators to teach and place greater emphasis on transcultural care and empathy in midwifery care.
- There is a need for in-service training to upskill midwives in labour wards. This will provide confidence to women, accessing labour wards; and provide a positive image for midwives, which might reduce the delays with accessing public reproductive healthcare.

6.3.2 Midwifery practice

- Midwifery managers should provide respectful maternity care training for midwives and staff working in the hospitals.
- Midwifery managers should strive to have debriefing sessions with their midwife staff, to implement ways in which patients' experiences could be improved.
- There is a need for a guideline or policy in hospitals, to inform midwives on how the expatriate community can access reproductive healthcare in

Cape Town and also how this information can be available to expatriates.

6.3.3 Future research

- Innovative approach by involving midwives in finding a solution for the current non-compassionate care reputation that communities and studies are reporting in South African midwifery care.
- Establish data relating to morbidity and mortality specifically among expatriate women.
- To reach women of other language capacities to learn about their experiences regarding their experiences of pregnancy, childbirth and motherhood by including translators in the conversations.
- To explore the reasons why midwives are reported to be providing poor treatment to pregnant women in labour and postpartum settings in Cape Town.
- To research and address the pertinent issue of loneliness, emotional and mental health which expatriate mothers face in Cape Town, appear to be crucial.
- The difference between primary (BANC) care and secondary services was disturbing in this context and deserves further research.

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APPENDICES

Appendix I: Ethics approval letter

	<p style="text-align: center;">UNIVERSITY OF CAPE TOWN Faculty of Health Sciences Human Research Ethics Committee</p>	
		<p>Room E53-46 Old Main Building Groote Schuur Hospital Observatory 7925 Telephone [021] 406 6492 Email: samayah.ardiefelen@uct.ac.za Website: www.health.uct.ac.za/fhs/research/humanethics/forms</p>

28 June 2018

HREC REF: 359/2018

A/Prof S Clow
Division of Nursing & Midwifery
Health & Rehab Sciences-
F-45-OMB

Dear A/Prof Clow

PROJECT TITLE: EXPATRIATE MOTHERS' EXPERIENCE OF PREGNANCY AND CHILDBIRTH IN A HOST CITY CAPE TOWN, SOUTH AFRICA (MSc candidate - Ms A Penduka)

Thank you for your response letter dated 14 June 2018, addressing the issues raised by the Human Research Ethics Committee.

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

Approval is granted for one year until the 30 June 2019.

Please submit a progress form, using the standardised Annual Report Form 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)


We acknowledge that the student: Annaliese Penduka will also be involved in this study.

Please quote the HREC REF in all your correspondence.

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

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

Yours sincerely



PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

Appendix II: Poster of invitation to participate



Your Childbirth experiences are worth being told!

Are you an Expatriate (Foreigner) mother ? And did you have a baby in your home country?

Have you given birth to a child in a Cape Town public health care facility in the past twelve months?

Do you want an opportunity to verbalise your experience?

Participate in our study as we conduct research exploring childbirth experiences of second-time expatriate mothers living in Cape Town who have already given birth to a baby in their country of origin.

This study is being done through the University of Cape Town and approved by Human research committee.

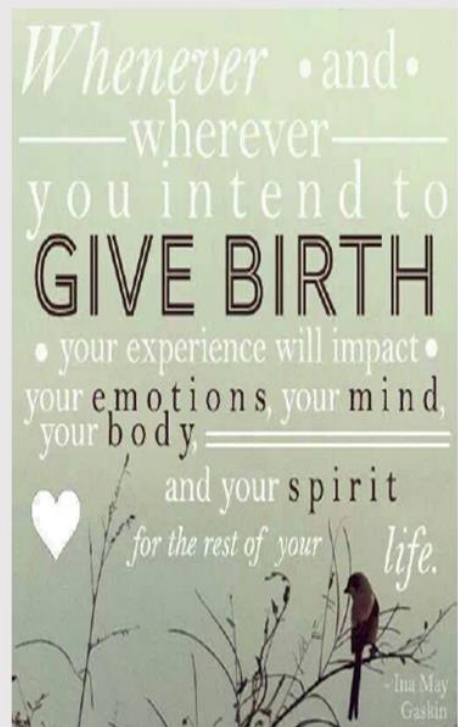
If interested, please contact Annaloice via SMS, WhatsApp or call: 078 065 2965.

OR via email at

annalonyasha@yahoo.co.uk

Pictures Reference: (Moms Supporting Moms, 2016)

Picture 2: (Gaskin, 2017)



Appendix III: Conversation guide

Conversation process

Researcher competence – Declaration of Helsinki clause 15 (World Medical Association, 2013).

The researcher is competent to conduct the qualitative conversations because:

- She is an advanced midwife who conducts conversations on a day-to-day basis in her professional capacity.
- She has attained conversation skills in a professional development course during her postgraduate diploma studies at UCT where she was taught and tested on how to do qualitative conversations.
- During the course of this Masters' degree (2016), the researcher has done genetic counselling skills part A and B in which she attained a pass and acquired the skills in non-directive counselling.

Conversation environment

The setting of an environment will set an overall tone for the conversation, hence:

The researcher will prepare the allocated room with her permission (at the participant's house if it is in a safe environment that does not put the researcher in danger or arrangements to transport participant to the Old Main Building Nursing Division if there is no availability of privacy) with two chairs that are facing each other. That way, it is easier to read reactions and body language. The table should have a box of tissues, a jug of water and water mugs. Finger food to be provided during the conversation period since researcher is encroaching on the participant's schedule.

To minimise distractions, phones are to be switched off, a "please do not disturb" sign is to be put outside the door. The consent form should be signed by the participant before placing the recorder in a place where it does not obstruct the conversation with its presence.

The researcher should present self in smart casual clothing to reduce the power dynamic of a professional uniform or attire that might make the participant feel unequal, intimidated or of lesser power.

Introduction

Greet the participant, and introduce self and ask the participant how they wish to be addressed.

Clarify from the beginning the amount of time you have together (one hour 30 minutes at most) and emphasise confidentiality. Start to build a relationship with the participant and maintain a rapport and trust throughout the conversation.

To enable a productive conversation that captures the information required, the researcher and the participants will make rules for their session, for example, how much small talk, phones to be off and no interruptions or people coming into the room. The researcher is to approach the conversation process in an ethical way that is autonomous, anonymous, beneficent, non-maleficent and just. Remembering that qualitative research focuses on the process rather than the endpoint, it is an inductive and question generating, in-depth process rather than generalisation. The conversation will use easily understandable vocabulary. A semi-structured conversation allows for a more flexible way of obtaining data while allowing the participant to have and feel some sense of control. The questions can be designed by the researcher but the sequencing of questions will not be the same as it depends on the participants response (Holloway & Wheeler, 2010). A semi-structured conversation allows for probing and it ensures that the guide used by the researcher collects similar types of data from all informants (Holloway & Wheeler, 2010).

Note taking will be minimal throughout the conversation but vital information or notes will be recorded, as one will go back to those notes and cross check with recordings to see if there is a consistent understanding emanating from the data.

Demographic Data for determining inclusion in the study

The study that is being conducted requires you to answer a few questions that will allow the researcher to select people that fit the required criteria for the study. Your input into this study is valuable.

What is your name? _____

Where were you born and where do you come from? _____

How long have you been residing in Cape Town? _____

What is your age range?

18-23 _____

24-35 _____

How many children do you have? _____

Did you give birth to (a) child (ren) in your country of origin? _____

Did you have any of your children in Cape Town within the last twelve months?

During your pregnancy you had in Cape Town, did you experience any complication/s? If yes, please state. _____

How long did you carry the Cape Town pregnancy: term _____ / preterm _____ / post-term _____?

Appendix IV: Semi-structured conversation

Data collection tool

Participants pseudonym _____

Date: _____

Nurse researcher: A Penduka

Address: University of Cape Town Department of Health and Rehabilitation Sciences

Old Main Building

Telephone number: 078 065 2965

Supervisor: Professor S Clow – UCT Health and Rehabilitation science

Co-supervisor: Doctor N Fouché – UCT Health and Rehabilitation science

Conversation guide

The leading questions to the semi-structured conversation:

What was your childbirth experience like back in your country?

How does it compare to this experience now?

Please describe your experience of childbirth as an expatriate mother here in Cape Town.

The conversation prompts to expand on the initial answers to be used as necessary:

How easy was it to locate an antenatal clinic or hospital in Cape Town and how did you find that experience?

What would you say about your experience of labour: Positive? ii) Any negative experience? And why?

When you brought your child home, how did you feel (in the first 2 weeks, 4 weeks, 6 months, and now)?

How did you come to the decision to stay at home full time? Has it affected your finances? How do you feel about it? Are there more things you want to share with me about your life as a full-time mother?

Tell me more about your job/ occupation (either part time or full time)? Again, how did you come to the decision to work? What's life like as a working mother?

What about household responsibilities? Tell me a bit about who undertakes the housework in your household. Are you happy/unhappy with the amount your spouse does/does not do?

Would you tell me more about your friends and family that are involved in your most daily routines here in Cape Town?

Is motherhood in a host country what you expected? What has the cultural, emotional and/or physical impact on you been since you had your child/children?

What challenges have you faced in the public healthcare system as an expatriate mother? And how long have you lived in Cape Town?

Is there anything else you'd like to tell me about your experience of motherhood in a foreign city?

Tell me about your social, religious and cultural tradition.

All the participants will be asked the same questions.

Appendix V: Ethics amendment letter of approval



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



Room E53-46 Old Main Building
Grote Schuur Hospital
Observatory 792
Telephone (021) 406 631
Email: hmess.embjedi@uct.ac.za

Website: www.health.uct.ac.za/fhs/research/humanethics/ocrr

08 November 2018

HREC REF: 359/2018

A/Prof S Clow
Division of Nursing & Midwifery
Health & Rehab Sciences-
F-45-OMB

Dear A/Prof Clow

PROJECT TITLE: EXPATRIATE MOTHERS' EXPERIENCE OF PREGNANCY AND CHILDBIRTH IN A HOST CITY CAPE TOWN, SOUTH AFRICA (MSc candidate - Ms A Penduka)

Thank you for your letter to the Faculty of Health Sciences Human Research Ethics Committee dated 02 November 2018.

The HREC has approved the amendment of your protocol to expand your inclusion criteria from mothers that give birth in Cape Town within the last year to mothers that give birth in Cape Town within the last three years.

Yours sincerely


PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Appendix VI: Information sheet

Project title: The expatriate mothers' experiences regarding pregnancy, childbirth and motherhood in the host city Cape Town, South Africa.

Dear Expatriate Mother,

My name is Annaloice Penduka, a Master of Nursing Science student in the Department of Health and Rehabilitation at the University of Cape Town. I am undertaking a study about the pregnancy and childbirth experiences of expatriate mothers living in Cape Town.

The purpose of the study is to have a better understanding of how expatriate women access healthcare facilities and how they adapt to motherhood in an environmental context other than their country of origin. We also hope to identify gaps in healthcare access, if any, so that we can better inform healthcare workers and policy makers.

This study will use face-to-face conversations, which will be conducted by the researcher to collect information using a voice recorder and writing notes during the conversation. This research study is being conducted through the University of Cape Town, therefore ethical principles are being adhered to [with permission and supervision ethics number 359/2018].

You are invited to participate in the study looking at the childbirth experiences of expatriate mothers living in Cape Town. The initial conversation should take 45 minutes to one and a half hours at most. A follow up conversation lasting about 45 minutes will be conducted to check with you that the information [themes] that I would have identified from the first conversation are well represented.

The study has no anticipated risk, if you experience any emotional distress associated with relating your experience of childbirth, we can stop the conversation and choose another mutually convenient time. If necessary or if you request this, you may be referred to a public health facility that offers counselling and advisory services.

Participation in this study is voluntary and you can withdraw, without giving a reason and without penalty at any time.

There are no direct benefits to you for participating in this research, however, this information gathered will help in getting direct descriptions of expatriates' lived experiences in a foreign city, thereby providing this information to health stakeholders (practitioners and policy makers) and other expatriate women living and arriving in South Africa.

The information that you will provide will be kept confidential. First, the voice recorder will be stored in a lockable cupboard which only the researchers [student, and the supervisors named below] have access to; the conversation will be downloaded onto the researcher's computer which is password protected. Secondly, your name will be changed to maintain confidentiality and pseudonyms [a false name] will be assigned to your conversations. A coding system will be used on the data collection material so that your details cannot be traced back to you. Only I will be able to link your data information to your identity. When I publish a report or article about this research project, your identity will be protected, as your name will not be mentioned.

The description or stories you provide will form part of the report, which will be submitted as the master's dissertation and scientific journal articles.

Inclusion criteria

- Expatriate mothers who have given birth in their own cultural context and have now had another child in the host city (Cape Town).
- Mothers who have had a neonate of more than 37 to 40 weeks gestation (duration of normal pregnancy), without complications or hospitalisation.
- Mothers who have given birth in a public health sector facility within the last year.
- Expatriate mothers who are either married or in a long-term partnership with the same partner living together in the same country.
- Mothers aged between 18 and 35 years.

- Mothers who can speak and write English and Shona.

Exclusion criteria

- Mothers who have only given birth once and the child is no longer alive.
- Women with chronic illnesses or mental health problems.

Thank you

Please indicate on the attached form if you are willing to have the conversation or if you are interested in getting more information about the study _____
(Yes/ No)

If you have any questions about the research study itself, please feel free to contact:

Supervisor: Professor S Clow

email: sheila.clow@uct.ac.za

telephone number via Remo van der Horst: 021 406 6205

OR

Co-supervisor: Doctor N Fouché

email: nicki.fouche@uct.ac.za

telephone number: 021 406 6272.

University of Cape Town

Faculty of Health Sciences

School of Health & Rehabilitation Sciences

Division of Nursing & Midwifery

F56 Old Main Building, Ntshona Wing

Groote Schuur Hospital

Observatory 7925

Should you have any questions regarding your rights as a research participant, or if you wish to report any problems you have experienced related to the study, please contact:

Professor Marc Blockman
Chairperson
The Human Research Ethics Committee
Old Main Building Groote Schuur Hospital
Floor E52 room 23
Observatory 7925
Telephone: +27 21 406 6492

Thank you for considering the opportunity to contribute to this study.

Annaloice Penduka
Researcher: Master of Nursing Science Student.
Contact: pndann002@myuct.ac.za
Cell number: 078 065 2965.

Appendix VII: Consent form

The participant's name: _____

Date _____

Research topic: The expatriate mothers' experiences regarding pregnancy childbirth and motherhood in Cape Town, South Africa.

Name of researcher: ANNALOICE PENDUKA

Student number: PNDANN002

Position: Master of Science in Nursing candidate, University of Cape Town.

Supervisor: Professor Sheila E. Clow

Co-Supervisor: Doctor Nicki A. Fouché

Please tick on each statement you agree WITH Example AP initials

I confirm that I fully understand the explanation that the researcher gave me about the above study and have had a chance to ask questions. I have read and understood the information sheet. _____initial

I understand that the aim of the study is to describe childbirth experiences of expatriate mothers living in Cape Town. _____initial

I understand that the conversation will be audio recorded and that I can choose a pseudonym to keep my own name anonymous. _____ Initial

I understand that the findings from this study could contribute to better understanding of the experiences of expatriates living in Cape Town, South Africa and how they access healthcare. _____initial

The researcher regards the proposed study to have minimal risk to the participants and described the level of risk as low. The researcher also explained that if I become emotionally distressed I can stop the conversation until I am ready to continue, either on the same day or at another time that is mutually convenient. _____ initial.

I may receive formal counselling through the formal public health facility protocol if need be, should I experience any emotional distress as a result of questions asked that is not relieved in the debriefing session. _____ initial.

I understand that my participation is voluntary, and I may withdraw from the study without penalty at any time.

_____	_____	_____
Name of participant	Signature	Date

_____	_____	_____
Name of researcher	Signature	Date

_____	_____	_____
Name of witness	Signature	Date

Appendix VIII: Contact forms

Project title: The expatriate mothers' experiences regarding pregnancy, childbirth and motherhood in a host city, Cape Town, South Africa.

Researcher: Annaloice Penduka PNDANN002

Contact form

I am interested in learning more about this study with a view to participating. Please contact me:

Name _____

Preferred contact method:

Phone 1: _____

Phone 2: _____

Email address: _____

Signature

Date

Appendix IX: Researcher safety protocol

In planning for the interviews I had my personal check list to guide my safety protocol.

Checklist clarifying responsibilities

- Budgeting for safety

I put aside money for an Uber to accompany me everywhere since all the participants preferred to be interviewed at home. The Uber driver travelled with me and waited for me to finish and drove me home.

- Planning for safety in research design

My recruitment methods allow for prior telephone contact. This provides an opportunity for me to assess the respondent/ participants and their circumstances.

- Risk assessment

I went for a pre-visit to the participants' home to determine what safety precautions I needed for myself and for them.

- Interview precautions

I avoided going by foot as mentioned above to reduce the feeling of vulnerability.

I dress inconspicuously taking account of cultural norms of the environment and my participant. I kept my recorder, cellphone and valuable items out of sight.

- Debriefing and support after the event

I would sit down with my supervisors and debrief on my experiences and raise (if) any difficulties or concerns were encountered of which I had none. I was also required to do reflections on each interview by my supervisor which was helpful as I was able to recall thoughts and details that I had missed and added this to my data analysis.