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"Bearing" the Brunt? Exploring how Rwandese migrant women in Cape Town manage domestic- and child-care labour demands in the first year post-partum.

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SENATE PLAGIARISM POLICY

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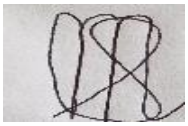
Signature: 

Date: 15 February 2022

Dedication

I would like to thank my loving, supportive and affirming parents, siblings and friends for helping me reach the stage of completion of my research study and report. Special thanks to my adorable young cat, Ponzu.

Warm hugs and thanks to Dr. Langelihle Mlotshwa – you have been such a kind, present and encouraging supervisor.

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ABSTRACT

This research study aims to understand demands in the home postpartum, how they are managed and how labour is divided, as well as the significance of gendered support networks. The study identifies and explores the support strategies that Rwandese migrant women (with one to two children between the ages of 0 and 6 years old) in Cape Town adopt in order to manage domestic labour and child-care demands in the first year postpartum. It employs a qualitative research design and uses two semi-structured face-to-face interviews per participant. Participants were sought using a snowball sampling technique. The significance of this study is that it contributes to an empirical gap concerning migrant women in South Africa, with a focus on the Rwandese population, and their postpartum experiences as it relates to household and child-care labour. The study sheds light on a demographic group that prioritises communal support, highlighting how experiences of migration, child-rearing, social support and access to institutional assistance intersect. The study finds that participants found solace during their incredibly demanding postpartum journeys through the use of religion as a personal stronghold and through seeking refuge in the presence and support of other women. The study also finds that participants were aware and acceptant of the ways that household labour and child-care responsibilities were skewed towards them (versus their husbands) in the first year postpartum, and that participants perceived early motherhood as a 'mixed bag'. Finally, the study finds that xenophobia functioned as the most apparent barrier to professional and humane medical treatment while the presence of free primary healthcare in South Africa was considered very important. Implications and recommendations for future research are provided.

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1. Introduction

Global debates surrounding the postpartum period suggest that it is a complex and potentially stressful time for parents, and that women tend to bear a heavier burden in navigating this period (Miller, et al., 2006). There is evidence that also points to the fact that migrant women tend to experience disproportionately more obstacles during the antenatal and postnatal period (Qureshi and Pacquiao, 2013). From a global perspective, there is a variety of evidence that shows that in the first year postpartum, parents, but especially mothers, experience increased stress as a result of having to care for themselves, their households and their baby, and that in that specific period they are most vulnerable to experiencing the harshest physical and psychological effects of childbirth (Oddi, et al., 2013; Vernon et al., 2010; Chang et al., 2021). Furthermore, there is global evidence that women rely more on various types of support systems – including marital, family and community support systems – in the first year postpartum in order to better navigate the challenges and stressors of this period (Nieh et al., 2021; Sampson et al., 2015; Suplee et al., 2015). Where migration intersects with the dynamics of maternal life, help-seeking and healthcare, there is diverse evidence showing that migrant women face more adverse challenges with regard to ante- and postnatal medical care, accessing institutional support, and balancing the postpartum load (Almeida and Caldas, 2013; Tang et al, 2019). When the lens further zooms into African migrants' experiences of issues related to having a child, the majority of self-proclaimed "global" studies look at African migrants in relatively high-income countries such as Australia, Canada and the United Kingdom (Ngongalah et al., 2018; Shewamene et al., 2020). Although this research contains important insights, there do not appear to be studies that consider, specifically or as part of a larger group, the maternal experience of Rwandese migrant women. Where these studies include East or Central African women, they are typically from Ethiopia, Eritrea, South Sudan, Sudan, or Kenya (Ngongalah et al., 2018). Even though Rwanda has a migrant diaspora community of over half a million people across the globe, research about Rwandan migrants and their lives, let alone their experiences of child-rearing, are jarringly sparse (Basabose, 2017).

Research emanating from the African continent regarding postpartum health and demands favours Western and Southern African regions (Barthel et al., 2016). This notwithstanding, there is a variety of evidence depicting the physical and mental health difficulties that African women, most evidently low-income women, are vulnerable to facing during the short- to medium-term postpartum period, with the most prevalent theme being that of postpartum depression (Harkness, 1987; Adewuya, 2005; Lugina and Sommerfeld, 1993; Barthel et al., 2016). This evidence mostly supports the trends in global research surrounding women and their postpartum experiences, especially women's increased dependence on different types of support and care during after giving birth and while seeing to their infants, and widespread experiences of increased mental and physical stress during especially the short-term postpartum period (Lugina and Sommerfeld, 1993). Where the perspective of migrant women is concerned, one is hard-pressed to find research that has been conducted on the antenatal and postnatal experiences of African migrants in Africa. Where these studies exist, they are typically based in Southern or West African countries, and do not include Rwandese women (Beard et al., 2005; Hiralal and Jinnah, 2018; Makandwa and Vearey, 2017; Hunter-Adams, 2016).

Southern Africa is a culturally rich and ethnically diverse region, with a sizeable population of domestic and transnational migrants (Clarke et al., 2016). It appears, however, that research concerning ante- and post-natal issues in Southern African contexts outside of the state of South Africa is saturated with research concerning HIV and AIDS (Mayondi et al., 2015; Collin et al., 2007; Hampanda and Rael, 2018; Warren et al., 2018). Outside of matters concerning HIV and AIDS, other prevalent issues in literature concerning postpartum matters and based in Southern African regions has to do with postpartum depression (similarly to more "continental" and "global" studies) and intimate partner violence (Warren et al., 2008; Shapiro et al., 2005; Reyes et al., 2020). The transnational migrant perspective is sometimes considered, but most commonly in studies based in South Africa specifically – arguably the largest receptor of African transnational migrants on the continent (Beard et al., 2005; Hiralal and Jinnah, 2018; Makandwa and Vearey, 2017; Hunter-Adams, 2016).

South Africa, while it hosts a large number of transnational migrants, is also known to be a hostile state towards them, both on an institutional and a social level (Everatt, 2011). For cross-border migrant women, having and raising a child in a country where they may not feel safe or welcomed, and where there are barriers to the types of support that they can readily access, can add to an already cumbersome set of pressures and responsibilities that they face. This study is concerned with how a specific group of migrant women manage the child-care and labour demands that they face in the first year postpartum. This research study sets itself in a notably multifaceted city: Cape Town. Since the political transition from Apartheid in 1994, Cape Town has attracted streams of migrants from many African countries (HSRC, 2018). This city serves as a relevant backdrop for a study that is concerned with a migrant perspective on an already deeply layered topic.

The rights of non-nationals in South Africa to access the national healthcare system is a complicated matter. In some cases, laws and policies clash, much to the confusion of healthcare workers, and in some cases, healthcare systems struggle to provide sufficient care to any person, regardless of their status (Rensburg, 2021). The country has a two-tiered healthcare system, and for the purposes of this study, the focus will be on the state-funded public sector, which caters to the majority of the population. Within this sector, there are clinics, which aim to treat more common health needs (known as 'primary healthcare'), community health centres, which functionally are large clinics, and public hospitals. The constitution of South Africa states that 'everyone has the right to access health care services, and no one may be refused emergency medical treatment' (Scalabrini, 2020). The National Health Act states that 'all persons in South Africa can access primary health care at clinics and community health centres', and that 'all pregnant or breastfeeding women and children under the age of six are entitled to health care services at any level' (Ibid.). The Refugees Act of South Africa states that 'refugees and asylum seekers have the same right to access healthcare as citizens', and this is echoed by a 2007 circular issued by the Department of Health (Ibid.). However, the Immigration Act notes that staff at clinics and hospitals must find out the legal status of patients before providing care, except in an emergency. Free services at clinics and means-testing at hospital applies to non-nationals as well, with the exception of undocumented people from outside the SADC region, and people on a tourists/visitor's visa (Scalabrini, 2020). Affirmative statements within national legislation do not prevent non-nationals from experiencing medical xenophobia or even being denied service on the basis of their status, but it is important to note

that the state does denote access to public health services for non-nationals who meet certain requirements.

The saying ‘it takes a village’ is not untrue as it relates to the demands of child-rearing. There is literature that looks at support systems amongst African migrant women in South Africa, as well as literature that considers the how couples manage the demands in the home after having a baby (Hiraral and Jinnah, 2018; Makandwa and Vearey, 2017; Hunter-Adams, 2016; Newkirk et al., 2017; Thomas and Hildingsson, 2009; Schmidt et al, 2019; Kim and Cheung, 2019). However, scholars have not looked at the growing population of Rwandese women in Cape Town, whose experiences can offer rich insights and unique perspectives in these areas.

What makes Rwandese women worth exploring is the philosophy of communal support and solidarity that they have valued and upheld for generations, an ethos that resonates with Rwandese people both in and outside of their home country (Hanbury and Indart, 2013). As a Rwandese woman herself, the author has observed through experience that Rwandese women (usually in similar age brackets) tend to view each other as ‘sister friends’ – someone one cares for like a sister, and with whom one can confide in and rely on for emotional and physical support. Studies amongst women of colour have shown the power of friendships in assisting women face, address and overcome major life issues such as stress or trauma (Bryant-Davis, 2013). Insights into the experience of Rwandese migrant mothers can offer the field a deeper understanding of the role that an ethos of sisterhood and a network of sororal support can play in the challenging lives of African migrant women mothers, and its consequent value. Furthermore, there is an ever-present need for context-specific research about and within African communities, as this creates the opportunity for more nuanced understandings of certain issues – in this case how a specific group of women respond to various postpartum demands – as well as allowing for more sensitive and appropriate policies, interventions and responses concerning vulnerable communities (Nkomo et al., 2015).

Drawing on theories of multidimensional care, migration and its influence on help-seeking and -giving as well as intersectional feminism, the aim of this research study is to identify and explore the support strategies that Rwandese migrant women in Cape Town adopt in response to their domestic-labour and child-care demands that they face during the first year after giving birth to their first child. African migrant women live complex, often marginal, lives, and their increasing presence and significance in Cape Town and South Africa more broadly needs to be documented and explored in migration themed knowledge production (Hunter-Adams and Rother, 2016).

2. Literature Review

This literature review aims to illustrate a set of complex experiences that pertain to Rwandese mothers in South Africa by instantiating the existence and significance of care in various forms, showing how inflexible gendered norms can lead to unequal power dynamics in the home, how support networks play a critical role in the lives of cross-border migrant women in South Africa, the challenges to accessing institutional support for maternal health as experienced by migrant women globally, and the complexities of post-partum life, including psychological issues and the negotiation of labour distribution. Limitations and gaps within the literature work to strengthen the relevance of this study.

(i) Care in its multidimensional form(s)

Medical care

This research study engages with the concept of "care" in certain dimensions: medical care, child care, and community care. "Medical care", a term frequently used in health sciences as well as social sciences, is defined by Donabedian as "the provision of what is necessary for a person's health and well-being by a doctor, nurse or other healthcare professional" (2005). In a paper that attempts to describe and evaluate methods for assessing the quality of medical care in disenfranchised communities, Donabedian argues that it is complicated to assess the "quality" of medical care that an individual can access as it is a subjective concept, ordinarily reflective of values and goals in a medical care system and the society it is aiming to serve (Ibid.). Even though empirical assessments of access to "quality" medical care are typically limited or narrow in some sense, they contribute to the discursive exploration of medical care by revealing structural disparities and discrepancies (Ibid.). In a scoping review that included 581 quantitative and qualitative studies published from 2010 to June 2019 concerning patient-centred care (PCC) involving adult immigrants or refugees, Filler et al. found that not only do migrants experience disparities in healthcare quality, but these disparities are especially present for women migrants (2020). The findings of the study showed that although different categories of migrants may have differing issues and access to health services, there were similar facilitators and barriers of medical care articulated across migrant groups (ibid.). Language, particularly, emerged as a key barrier of PCC, especially for those classed as refugees. This study is limited in that it only engaged with studies based in North America, and no such study based on the African continent or the Global South exists.

Child care

The concept of "child care" is a crucial component of this research study. Colloquially, child care usually refers to the care of children typically by a creche, nursery or external childminder while the parents are working or otherwise occupied (Halsall, 2021). However, in this research study, as also seen in existing literature concerning children, "child-care" will be used to refer to the caring of a child by their biological parents or those known to the parents. Literature suggests that in South Africa, there is a striking gender imbalance in who assumes the most responsibility for caring for children (Hatch and Posel, 2018; Horwood et. al, 2009). A quantitative study conducted in 2018 uses national micro-data to show that across a variety of household types, women are the primary caregivers of children, even in situations when they are not a child's biological mother (Hatch and Posel, 2018; Horwood et. al, 2019). This study analyses both physical and financial care of children, showing that in the case of many black children in South Africa, both their physical and financial care is provided by women who are commonly the child's biological mother, as well as their grandmother or another woman relative (Ibid.). Although this study does not distinctly delineate between South African citizens and non-citizens, it still reveals a gendered imbalance in the care of children on a local level. Another important lens into child care is the economic one. A cross-sectional study amongst South African women who were informal workers based in Kwa-Zulu Natal and had children under the age of two showed that only a quarter of the women were able to take their child to work, and that most women had to leave their child with a relative or friend, typically also woman (Horwood et al., 2019). Despite having work, the majority of these woman reported food insecurity, and the inability to pay for child care (Ibid.). This study communicates with a randomized control trial study conducted at an informal settlement in Nairobi, Kenya, that demonstrated that limited access to affordable early childcare inhibits poor urban women's

participation in paid work by showing that mothers co-parenting their children with their spouses were offered more subsidized early childcare than single mothers (Clark et al., 2019). Both of these studies show that women's disproportionate childcare responsibilities act as a significant barrier to women's economic empowerment in Africa. A case study of Irish nurses in Britain shows how a group of migrant women would take turns helping each other with child care, as a result of not being able to afford professional child care, even whilst working full-time, shedding light on the layers of being a transnational migrant whilst being a working parent (Ryan, 2007). However, this study takes place in a white, British-Irish context. There is a paucity of literature about how the responsibility of child-care impacts specifically migrant women in the South African context, especially those which study the position of women who are unemployed or financially dependent on their partner.

Community care

In literary contexts, "community care" typically refers to the day-to-day assistance of elderly and disabled people (Finch, 1983). In this research study, "community care" refers to the support and assistance that women provide to and receive from other women, where communities are qualified as women-based solidarity networks (Sorde et al., 2014). The life-altering and demanding nature of pregnancy and childbirth add significance to the idea of community care. A study aimed at exploring South African women's perceptions and experiences of care and support during pregnancy showed that tapping into social relationships and social support played an important role in helping women manage their antenatal health problems (Mlotshwa, 2017). This study further showed that being isolated from community care led to women feeling increased levels of distress during pregnancy (Ibid.). The experience of pregnancy for these women appeared to be commensurate with the amount of support they were able to obtain from family, friends and social networks.

There is still limited attention in existing literature paid to how migrant women access and sustain social networks to facilitate day-to-day practical support, which is interesting as many studies on communities of migrant women implicitly illustrate their patterns of mutual support (Ryan, 2007). A substantial amount of literature exists on migrant women-based solidarity networks in Europe (Tazzioli and Walters, 2019; Siim and Meret, 2021; Christopoulou and Leonstini, 2017; Francisco and Rodriguez, 2014; Vacca et al, 2021; Sorde et al., 2014; Bhimji, 2020). However, the contrary is the case for African contexts.

In the lives of women who are migrants, as well as mothers, there are intersections between and across the ideas of medical care, child care as well as community care. A qualitative study amongst 14 Somali refugee women living in Minnesota who had given birth in the state illustrates how these forms of care communicate – although the women reported their experience of childbirth as positive overall, they reported racial stereotyping and issues with medical interpreters (shortcomings of the medical care they were receiving), felt that their attendance at prenatal appointments was adversely affected by their responsibility to care for their children at home or inability to be mobile with their children (a child-care issue), and relied on other women within their community for emotional support (a component of community care) (Herrel et al., 2004). Despite the limitations of the study, taking place in an American context, experience of these Somali women shows how the experience bearing and raising a child or children as a migrant woman is layered by the aforementioned three types of care.

Care in its multidimensional forms provides a solid foregrounding for the remainder of this literature review in that it functions inextricably from socio-culturally gendered norms and ideas, and how these play out within the home, illustrates the significance of support networks for migrant women in South Africa, reveals health inequities, and allows for a better understanding of the challenges of postpartum life.

(ii) Gendered norms and unequal power structures in the home

Gender norms continue to be deeply ingrained in Rwandese culture and are reinforced through both day-to-day interactions as well as core institutions such as marriage and education systems (McLean et al., 2019: 14). A qualitative research study conducted between 2014 and 2018 surrounding heterosexual couples who took part in a four-year gender-equity programme around Rwanda shows that there remains a strong belief amongst Rwandese adults across a vast range in ages that the primary role of the husband is to economically provide for his family, and that of the wife's is to tend to domestic duties and take care of the children (McLean et al., 2019). These findings suggest that unequal divisions of domestic and child-care labour are still prevalent amongst heterosexual Rwandese couples in Rwanda.

It is important to situate gender norms in the greater African literature about childbirth and childcare, and various research studies allow us to do so. The first is a qualitative study set in Sierra Leone, which analysed over 100 men's involvement in their partner's journey throughout pregnancy until childbirth. The study revealed that amongst the participants, pregnancy and childbirth were largely believed to be the domain of women, and men considered their primary role to be the provision of material resources for a safe and healthy birth, including ensuring their partners were eating a balanced diet, providing transport to healthcare facilities, and buying items to wash and dress the baby (McLean, 2020). This study highlights the existence and prevalence of gender norms around childbirth and -care, but also asserts how in many African contexts, material care constitutes a gendered and culturally valid form of male involvement. A qualitative study involving recent parents in rural Ghana echoed these sentiments, finding that when it came to caring for a newborn baby, women performed almost all tasks, whereas men took on the traditional responsibilities of economic providers and decision makers (Dumbaugh et al., 2014). Interestingly, most of the men in this study vocalised an interested in being more involved in newborn care, but identified gendered and generational divisions of labour and space as barriers to increased involvement (Ibid.).

The themes present in African literatures about gender norms within the home are mirrored in many non-African contexts. For example, an interpretive study published by Suzuki-Him and Gündüz-Hoşgör that concerns the reproductive practices of rural-urban, low-income migrant Kurdish women in Turkey, and how they respond to their patriarchal home structures, speaks to the rigidity of gendered roles in the home being a globally echoed sentiment. The authors argue that the patriarchy these women face was designed to minimise their autonomy as far as possible (2011). Additionally, Suzuki-Him and Gündüz-Hoşgör argue that the controlling, demanding nature of migrant Kurdish men have to do with cultural perceptions of women and their role in the home (Ibid.). The paper hones in to the struggles that these Kurdish women face to assert control on their own bodies and practice agency in the home. A limitation of this study is that it is focused on reproductive rights and labour, but pays scant attention to the post-natal period, only zoning in on pre-natal reproductive issues.

The two studies by Suzuki-Him and Gündüz-Hoşgör as well as McClean respectively suggest that rigid gender perceptions can contribute to unequal power dynamics in the home, in part by illustrating how patriarchal norms favour men and subordinate women, whether it be through the negotiation of reproductive agency, or through the performance of gendered household responsibilities (2011; 2019). The studies by McLean and Dumbaugh and others show how perceptions regarding gender roles influence the nature of men's involvement in caring for their pregnant partners and newborn children, in a number of African contexts (2020; 2014). There remains a gap in the literature as it relates and the how unequal power structures in the home play out in cross-border migrant households in South Africa specifically.

(iii) The significance of support networks to African migrant women in South Africa

There are some interesting studies in the area of support systems which concern migrant women from various African countries. In "Mobile Women: Negotiating Gendered Social Norms, Stereotypes and Relationships", a chapter in Gender and Mobility in Africa: Borders, Bodies and Boundaries, Sarah Matshaka highlights some of the challenges that Zimbabwean women in South Africa face (Hiralal and Jinnah, 2018). Matshaka argues that the various social networks that Zimbabwean migrant women create for themselves based on common areas of origin mitigate their ability to navigate their lives in South Africa, including the presence of material support as well as social support, such as shared childcare and aid during the journey towards and after childbirth (2018). These findings support those from a qualitative study conducted by Makandwa and Vearey exploring the maternal experiences of Zimbabwean women in South Africa, which reveals that when it came to decision-making and help-seeking during pregnancy and delivery, these women frequently tapped into their religious and social networks in the city (2017).

As evidenced by the studies by Matshaka as well as Makandwa and Vearey, support networks tend to play a crucial role in the lives of many cross-border migrant women in South Africa. There is literature that suggests that this phenomenon is also visible in the period after migrant women in South Africa give birth. In "Mourning the Support of Women Postpartum,", Hunter-Adams engages with Somali, Congolese and Zimbabwean women in Cape Town who have had children, and shows how all of these women have felt the absence of postpartum social support they would have access to in their home countries (2016). Hunter-Adams reveals that family and community structures have important implications for the health of women during and after pregnancy, and that these women emphatically long for support in the form of fellow mothers, elder non-working women, in-laws and women in the community in general (Ibid.). She suggests that the absence of this support adds vulnerability to their already vulnerable situations. The women involved in the study reported the main reasons for struggling to cope with the demands of a new baby as: the absence of elder community members, limited connection to extended family via phone and text message, perceptions of extensive birth support systems in their countries of origin as well as an overall lack of support in South Africa (Ibid.).

Although the study uses the postpartum lens to convincingly show that when absent, African migrant women in South Africa usually long for their support networks, the study does not engage with Rwandese women, whose ethos of mutual support and solidarity may shed more light into the value of a postpartum support network (Hanbury and Indart, 2013).

(iv) Migrant women's experience of barriers to health equity in the form of institutional support and care

There are obstacles that many migrant women face concerning accessing institutional support, and this intersects with their experiences of reproductive and maternal health. These obstacles can be linked to the prevalence and necessity for community support networks amongst these women. Barriers to certain types of access can have far-reaching consequences for the physical and psychological health of women and any children they might have or want.

Medical xenophobia in South Africa is a consistent barrier for migrant women, tainting their ability to access healthcare in a dignified and humane manner. Medical xenophobia can be described as 'negative attitudes and practices of South African healthcare professionals towards refugees and migrants, including but not limited to the denial of access to medical treatment and care' (Vanyoro, 2019). A study aiming to explore experiences of medical xenophobia amongst refugees from the Democratic Republic of Congo who were residing in Durban found that the participants faced medical xenophobia during their encounters with healthcare workers, with language barriers and documentation as major obstacles to accessing medical care (Zihindula et al., 2015). The participants also reported facing prejudicial violence in the form of ethnic slurs, rude and inappropriate comments and exclusionary practices, including the unjustified denial of care (Ibid.). This study supports the findings of one published one year prior, which revealed that Zimbabwean migrants in Johannesburg faced varying degrees of xenophobia when trying to access medical care at public healthcare facilities (Crush and Tawodzera, 2014).

A systematic review study aimed at locating, selecting and critically assessing scientific evidence regarding the factors influencing migrants' sexual and reproductive health outcomes in comparison with native populations indicated that migrants tend to underuse maternal health services and have an increased risk of undesirable sexual and reproductive health outcomes (Alarcão, et al., 2021). Supporting the findings from the systematic review study, a cohort study on all births recorded in the Swedish Medical Birth Register from 2000 – 2014 showed that migrant women with insecure residency status (undocumented migrants and asylum seekers, who were denied or were waiting for authorized residency) had increased risk of severe maternal morbidity (Liu, et al., 2020). Barriers to accessing antenatal care, mainly due legal status, was noted as a component of the results – Sweden only started offering universal access to free non-emergency maternity care in 2013 (Ibid.). These results correspond with a cohort study conducted in Australia from 2004 – 2013, which concluded that compared to Australian-born infants, infants of mothers from Africa, Asia and the Middle East had between approximately 15% and 48% elevated risk for stillbirth, preterm delivery or low Agpar score. These migrant mothers were reported to be less likely to receive adequate maternity care due to language or logistic barriers, lack of culturally sensitive maternity services, or familiarity with the health care system (Ibid.). The correlation of the results of these studies suggests a global pattern of migrant women's restricted access to institutional support as it relates to antenatal care, reproductive health and issues of maternity. Both the Swedish as well as the Australian study involved mostly Somali women, where African migrant women were concerned. Rwanda and Somalia are in the same general region of the continent, and have similar population sizes, but the relative difference in the amount of maternal literature concerning women from these two countries may be related to the fact that there is said to be over two million people in the Somalian diaspora, and only half a million people in the

Rwandese diaspora (Kleist and Abdi, 2022; Basabose, 2017). Insight into the experience of Somali migrant women is important, but is not a one-size-fits-all perspective.

There is literature that reveals similar themes in a South African context. A qualitative study amongst cross-border migrant men and women in South Africa showed that due to language and communication barriers, access to professional antenatal care was impeded, resulting in stereotyping and labelling by staff, medical procedures performed without the patient's consent and feelings of fear and frustration amongst migrant women and their partners (Hunter-Adams and Rother, 2017). A gap in this research is the explicit exploration of how these barriers to institutional support relate to the existence and function of intra-migrant community support networks.

There is evidence that points to the contrary of these patterns, however. A cross-sectional data analysis study conducted amongst mothers in Togo aged 15 – 49 who had recently given birth suggests that those in households with relatives who were international migrants had more access to professional prenatal, delivery and postnatal care, as well as preventative health inputs for their children such as postnatal checks and vaccinations than those in households with no migrant relatives (Atake, 2018). This, according to the study, is due to remittances, which made up almost 10% of the gross domestic product in Togo in 2014. Despite the tension that this study adds to the topic, it does not consider how families who do not receive remittances, but even perhaps have to pay remittances, navigate this financial strain, particularly as it relates to access to institutional care.

(v) <u>The difficulties of postpartum life and the division of domestic- and child-care labour between couples postpartum</u>

The initial postpartum period in a parent's life is notoriously stressful. A cross-sectional study based in England shows that psychological issues such as depression, anxiety and overall postnatal maladjustment are widespread amongst people in the period postpartum, with women being statistically more affected by these issues than men (Miller, et al., 2006). The disproportionate effects of postpartum psychological tolls are not just based on gender, however. A study conducted in the U.S. in 2015 amongst 2344 women who had recently given birth showed that postpartum stress, depression and loss of interest were more visible in African American, Latin American and Asian/Pacific Islander women than in White women, in part due to financial stressors (Liu et al., 2016). This suggests that marginalised communities, who are statistically less financially secure, are at risk of experiencing more adverse effects of postpartum psychological difficulties.

It is argued that the way that domestic- and child-care labour is divided between couples becomes especially pronounced during the transition to parenthood, when the addition of a baby adds to their workload in and around the home (Newkirk et al., 2017). There is a variety of literature which explores labour along domestic and child-care lines in a (heterosexual) couple's transition to being parents. The first study is a qualitative study examining the relationship between the division of domestic- and child-care labour amongst first time parents in the United States, and their personal perceptions of fairness within their relationship, where couples were interviewed at five points from the third trimester across the first year of parenthood (Ibid.). The researchers worked with working-class, dual-earner, predominantly white American couples. The results found that mothers who performed a greater share of domestic and child-care labour perceived the division of labour as unfair, which led to high

levels of relationship conflict postpartum (Ibid.). The emphasis the authors put on looking at domestic-labour and child-care as different categories of work is significant, as their findings showed that they have different meanings for each individual in the relationship (Ibid.). The study is however limited due to the demographic of the sample (dual-earner, primarily white couples) as well as because the data was collected in 2000 (even though the article was published in 2017), and so it may not fully capture more current socio-political and -economic contexts.

The second study, conducted in Sweden around 2009, uses data from a national survey of Swedish women 1 year after childbirth to assess whether division of labour varies depending on certain factors, including women's parental leave status, education or number of children (Thomas and Hildingsson, 2009). The study finds that men only contribute equally to household domestic labour and daily child-care tasks if their partner has returned to work full time, and that inequalities in sharing of 'housework' and child-care duties continue to exist after having a child, with women doing the bulk of both (Ibid). A significant component of this article is that the authors advocate for measuring child-care and house-work tasks separately to more accurately capture the ways in which fathers participate in domestic work (Ibid). The study also distinguishes between first-time mothers and repeat mothers, finding that repeat mothers more frequently did not go back to work after having a child than first-time mothers (Ibid.). The scope of this study is limited to women who are employed, both part- and full-time in the formal sector, and it does not include unemployed women, or women employed in the informal sector, which disadvantages the generalizability of its findings.

The third study, conducted around 2019, takes the form of a qualitative, longitudinal multiple case study of the division of labour across the transition to parenthood in South-Brazilian families (Schmidt et al). The authors argue that the transition to parenthood is a 'pivotal point of renegotiation in the way couples divide labour' (2019). They go on to argue that mother's experience more prevalent life changes across the transition to parenthood, firstly in a biological sense, and secondly because they are usually the main person responsible for childcare tasks and household chores, which supports the findings of the study conducted in Sweden ten years prior (Schmidt et al, 2019; Thomas and Hildingsson, 2009). The study finds that the first few days postpartum notwithstanding, there exists a consistently unequal division of house- and child-care related labour amongst parents, with mothers taking on the most labour across families of different class- and external-support structures (Ibid.). The authors cite gender roles (the fact that household chores are widely considered activities for women in Brazilian culture) as one of the reasons why even postpartum, prevailing socio-cultural norms meant that women were doing more housework (Ibid.). The biggest limitation of this study, however, is that the sample was White, highly-educated, first time parents in middle- or upper-middle-class nuclear families in the South of Brazil (Ibid.). A more diverse sample may have led to more far-reaching outcomes.

The fourth study is a quantitative study using trends from the 2007, 2008 and 2010 Korean Longitudinal Survey assessing how the transition to parenthood affects wives' and husbands' provision of 'household labour' and how their employment status moderates this relationship (Kim and Cheung, 2019). The results of this study reveal that in most cases, the gendered nature of household labour was unequal even before the birth of the child(ren), which reinforces the findings of the aforementioned Brazilian study (Kim and Cheung, 2019; Schmidt et al, 2019). In a similar fashion as the Swedish study described above, this study distinguishes between

first time and repeat mothers. The results of the study show that regardless of the women's employment status, inequality of household labour increased significantly with first children, but not as significantly with additional children (Ibid.; Thomas and Hildingsson, 2009). The biggest limitations of this study are that exclusively survey data is analysed, and that in the surveys, child-care is grouped with domestic labour as 'household labour', failing to capture the layered differences between these two types of work.

Postpartum stress is a widespread phenomenon, and addition of a child to a home can bring about a dramatic shift in the level of responsibility expected from each parent. The couples-based studies considered in this section of the literature review have certain overlapping themes, but also each bring a different layer of perspective into how domestic and child-care is divided between (heterosexual, usually married) couples after childbirth. The study by Newkirk et al. shows how unequal division of labour postpartum can affect relationship satisfaction levels of each parent, potentially leading to relationship conflict (2017). The study by Thomas and Hildingsson shows how first-time mothers and repeat mothers can experience postpartum demands differently (2009). The study by Schmidt et al support the idea that there is a connection between socio-cultural gender perceptions and the unequal distribution of labour around the home, through the postpartum lens (2019). The study by Kim and Cheung shows how the first child can bring dramatic shifts of household labour that may become less significant with subsequent children (2019). The most visible gaps in this series of literature are the lack of interrogation of postpartum labour divisions in cross-border migrant households, and a local or continental perspective of how layers of privilege such as ethnicity and class status influence the level of a parent's postpartum stress.

3. Conceptual Framework

The conceptual framework of this research study is rooted in three concepts: multidimensional forms of care, migration and its influence on help-seeking and help-giving, and intersectional feminist theory.

(i) Multidimensional forms of care

As explored in the literature review, multifaceted nature of care and care networks is invaluable to this research study. The dimensions of care that this research study is most concerned with are as follows: "child care", referring to the caring of a child or children, "community care", as defined by the support and assistance that women provide and receive from women, and "medical care", extending to the medical attention and treatment that the research participants engaged with during the antenatal, but more emphatically the postnatal period (Sorde et al., 2014; Donabedian, 2005). With regard to "community care", a gendered perspective will be adopted. Focusing on gender when analysing a socio-political issue illuminates accounts that would otherwise remain invisible (Palmary et al., 2010). Support networks in the form of family and friends are a form of care that is usually guided by gendered norms (Abboud and Liamputtong, 2005). Furthermore, the gendered gap in family care-giving is an established research finding: men have been shown to dedicate less time to care-giving and provide specific gendered types of help (Kruijswijk, et al., 2015).

(ii) Migration and its influence on help-seeking and help-giving

Not only is the gendered element of help-giving important in framing this study, but so is the element of migration, particularly how it influences help-giving and help-seeking. There are

underlying economic, political and social structures that produce particular patterns of help-seeking and -giving among transnational migrants as it relates to psychological and physical health (Sargent and Larchanché, 2011). Ideas of otherness and community, both pertinent in framing this study, underlie the production and management of immigrant health in its different forms (Ibid.).

(iii) Intersectional feminist theory

This study will adopt an intersectional feminist theoretical framework to aid its research objectives. Intersectionality is a body of thought that emerged during the 1980s as a specific approach in feminist theory to understanding the complex origins of multiple sources of women's oppression (Crenshaw, 1991; Bastia, 2014). This will aid in highlighting how intersectional stigma, discrimination and social structures can impede marginalised persons' ability to access certain types of care and assistance. As a framework, it also aims to analyse how different forms of disadvantage intersect, hereby explaining the particular experience of certain groups of women on the basis of gender, race, class and other factors simultaneously (Ibid.). In other words, intersectional feminist theory considers the individual lived experience of someone as being influenced by the different ways that systems of privilege and subjugation function in their lives. For example, a Rwandese migrant woman in Cape Town may face discrimination on the basis of her race, her migrant status and her class status. An intersectional feminist theory lens allows researchers to align their perspective on women as agents, and assess the impact of a particular issue or set of issues on the woman as an individual, on her well-being, her relationship to her loved ones and her personal goals (Hiralal and Jinnah, 2018). It also aims to honour the participants' agency and voice throughout the process (Ibid.).

The three concepts explored here are significant individually, but also in how they speak to each other. The participants in this study engage with different types of care in their day-to-day lives, including, but not limited to, soliciting and providing help to the women in their nuclear community. The overarching presence of different forms of oppression and privilege informs how these women access different types of care, as well as their desire and capacity to receive and give assistance to themselves and others.

4. Rationale

There is an inadequate amount of literary dialogue between the concepts of migration, support networks and postpartum journeys. Exploring this dialogue can allow for more opportunities for migration, care networks and maternal health research practice and policy work. There is also a striking absence of literature on Rwandese migrants in Cape Town, let alone nuanced studies that speak to the structures of, and issues within, this community. Of particular interest to this research study is the jarring gap in literature that tries to understand how Rwandese migrant women, in particular, navigate the ups and downs of everyday life in South Africa. The production of knowledge in this area is important because of the current paucity of literature that captures and unpacks the complexities of the everyday lives of migrant women while respecting and celebrating their agency (Hiraral and Jinnah, 2018).

In the context of widespread post-traumatic stress, Rwandese women have been reported to seek help by building and tapping into large support networks (Hanbury and Indart, 2013). The author argues, however, that it is not only in this context that this mechanism applies to Rwandese women, who have been shown to hold social support and connectedness as a

fundamental personal and community value (Ibid.). The philosophy of mutual care and support amongst Rwandese women (especially amongst those with a common factor, such as a similar age or a shared religious affiliation) is something that the author has observed her entire life as a fascinating and layered phenomenon. This research study is significant because exploring how this philosophy functions in aiding a stressful and complicated period such as postpartum, compounded with the context of having migrated to a country which treats many African migrants with hostility and offers limited institutional support, has the potential to create new opportunities for research and practice.

The focus on migrant women in particular in this study is inspired by Belinda Dodson's argument, which states that insights into the daily lives of African immigrants add 'motive and impetuses' to intellectual and political grappling with certain issues, and that they challenge researchers to enquire more deeply into these issues, revealing particular truths (2010). This allows readers and policymakers to recognise and engage with the complexities embedded in the lives of African migrants in Africa. In the social sciences, Rwandese women have mainly been studied in the context of the 1994 genocide, with prominent examples being their traumatic experiences during the genocide and their role in the post-genocide peace-building process (Issifu, 2015). It is necessary for a body of knowledge to emerge that tries to engage with Rwandese women outside of this painful and predictable context. In the school of thought that looks at how domestic and child-care labour is divided after a couple has a child, Rwandese women have not yet been engaged with, and their experiences as firm believers in certain principles of intra-communal support and care can provide scholars with new opportunities for analysis. The fact that these women may also use their support networks to help them navigate the challenges of not being able to access consistent institutional support, can lead to more nuanced research on how migrants cope with barriers to access, leading to more effective practice and possibly leading to changes in policy relating to health equity and migrant support.

5. Research Question

What support strategies do Rwandese migrant women in Cape Town adopt in response to domestic-labour and child-care demands during the first year postpartum?

Sub-questions:

1. What coping mechanisms do Rwandese migrant women make use of to manage the demands in the home immediately after having a child?

2. How do Rwandese women feel about how domestic- and child-care responsibilities are divided between them and their partners after childbirth?

3. What is the role that external support networks play during a period of increased stress such as early postpartum?

4. How do the barriers to institutional support that Rwandese migrant women face relate to the existence and significance of gendered community support networks?

Research Objectives

1. To understand how Rwandese migrant women adapt to the increased labour-demands that occur in the domestic and child-care spheres in the first year after having their first child.

2. To explore the nature and extent of the gendered division of domestic and child-care labour between Rwandese migrant women and their partners in the first year postpartum.

3. To contribute to a gap in literature that emphasises the significance of support networks (rooted in community) for new mothers, by exploring a demographic that has been underrepresented in the discursive nexus of maternal health and migration.

4. To explore how cross-border migrant women respond to barriers to institutional support that they may face by utilising gendered community support networks to aid them in managing the postpartum period.

6. Research Method

(i) Case Selection

According to 2011 Census data, 12% of all migrants living in South Africa reside in Cape Town (Ibid.). The census also showed that migrants from Africa and Asia make up at least 3.5% of the population in Cape Town (Ibid.). This number has most likely grown since the 2011 census, according to settlement patterns of migrants from other areas of the country, who move to Cape Town for reasons including economic opportunities and interpersonal support networks (HSRC, 2018). There are no specific statistics on the Rwandese population in South Africa, but has been said that since 2000, the Rwandese community in Cape Town has steadily risen (Sokoloff, 2014).

(ii) Sample

Research participants were selected using the snowball sampling technique. 'Snowball' sampling or 'Chain-referral-sampling' begins with a convenience sample of the initial subject (Etikan et al., 2015). This initial subject serves as a "seed," through which wave 1 subject is recruited; wave 1 subject in turn recruits wave 2 subjects; and the sample consequently expands wave by wave like a snowball growing in size as it rolls down a hill (Ibid.). In the case of this study, the author's informant goes to a predominantly Rwandese church in an area of Cape Town, and so knew of several Rwandese women with young children. The author asked the informant to refer her to two Rwandese women who have had their first child in the last two years, and then she (the author) asked these two women to each refer her to another woman each, and so on, until the planned number of participants was reached. The researcher then contacted each participant that had been referred via phonecall to secure the dates of the first interview.

The proposed research sample in this study were Rwandese migrant women in Cape Town, South Africa, who have had their first child no longer than a year ago – in order to avoid recall bias. Various studies suggest that the shift in labour within the home after having a child is more significant with the first child than it is with subsequent children (Thomas and Hildingsson, 2009; Kim and Cheung, 2019). This informs the focus on the year postpartum after having the first child, even if the participant has had a subsequent child within this time period. During the snowball sampling process, however, there was a miscommunication between the researcher and the two initial women (who met the original sample requirements), and this resulted in the final three members of the sample not meeting the original sample requirements. More specifically, the two initial women of the sample were migrant Rwandese women who had had their first child in June 2021 and January 2021 respectively, but during

the snowballing process, these two women reached out to Rwandese migrant women who had two children. The final sample ended up being Rwandese migrant women based in Cape Town with one to two children under the age of six.

(iii) Approach to data collection and analysis

The data collection method of this study consisted of two semi-structured interviews (SSIs) per participant, conducted over two months. This means that 10 interviews were conducted in total. The first interview was used to build rapport with participants, considering the sensitive nature of the issues being explored, and the second interview was to allow the author to explore issues that might have been left out in the first interview, as well as to probe more deeply into the themes that had emerged in the first interview (McIntosh and Morse, 2015). There is also literature that suggests that conducting two interviews with participants as opposed to one provides them with an opportunity to recall information that they did not mention the first time around (Odinot, et. al, 2013). Also, because of the sensitive nature of the questions, participants may have felt more comfortable with sharing information with me the second time around that they were reluctant to share. The research study opted for only two interviews, one to two months apart. The interviews were be conducted in English.

Due to the semi-relaxed restrictions on gatherings under Levels 2 and 3 lockdown, and the sensitive nature of the questions, the researcher opted to conduct the interviews face-to-face, with all COVID-19 protocols being strictly observed and adhered to. The setting of the interviews were the homes of each respective participant. Semi-structured interviews are able to be empathetic and politically engaged, and it is argued that the type of data derived from SSIs cannot be easily obtained using other qualitative measures (McIntsosh and Morse, 2015). It is argued that studies based on small samples and in-depth interviews often have issues that limit their ability to fulfil the demands of academic credibility and responsible advocacy, and this study recognises this as a limitation but also appreciates the time constraints which inform this method (Jacobsen and Landau, 2003).

(iv) Distress Protocol

The participants were informed in person and on the participation information sheet that the questions asked are of a sensitive nature and that they may experience emotional distress. An hour after each interview, the researcher contacted the participant over WhatsApp and asked them how they felt about the interview. The reason why the author decided to this specifically an hour after the interview was that this gave her enough time to travel back home from the participant's residence, and in order to give the participant some time to process the interview process and how it made them feel (Nawaz, 2019). The researcher also made an arrangement with a trained counsellor based in Parow that had offered to provide each participant with up to two one-hour long counselling sessions up to six months after the interview if they so wish (letter attached in appendix). The researcher also offered to get in touch with the counsellor on a participant's behalf to organise the sessions if they so wished.

Over WhatsApp, each participant was asked how they felt about the research process and encouraged to respond either by text or 'voice-note' (to these they were encouraged to respond in Kinyarwanda, which the author has basic fluency in). There are ethical questions that come with talking to participants over chat apps and the need to keep in place the boundaries of the researcher-research participant relationship (Barbosa and Milan, 2019). Although WhatsApp

claims to encrypt its chats, the author chose to delete the messages between her and the participants from her WhatsApp repository after each debrief.

(v) Reflexivity

A core component of research, especially that which concerns sensitive topics, is how the author engages with and negotiates their positionality – their insider and/or outsider status. Researchers usually possess 'outsider' status in relation to their research participants, which may aid in ensuring a credible level of 'objectivity' and distance from the contents of the study (Mlotshwa et al., 2017). However, 'outsider' status can produce and reflect the power of the researcher in relation to their study participants (Ibid.). In the case of this study, the author possesses both 'outsider' and 'insider' status in relation to her research participants. She is a young woman no children, which may aid the notion of 'objectivity', but on the other hand may affect her ability to fully engage with the participants or may sway the participants' willingness to share certain things. She is an 'insider' in the sense that she is black and Rwandese, which may allow for the women to trust her, but conversely may lead to a stronger sense of distrust from the participants given the following reasons: she is not completely fluent in Kinyarwanda will primarily address the participants in English and she was born and raised in South Africa so she might not be considered authentically Rwandese. Her 'insider' status has also informed the convenience of asking her step-mother to introduce her to two women whom will form the first wave of her snowball sampling, which may otherwise have been a bit more difficult to navigate.

(vi) Ethical Considerations

Ethics in social sciences research abides by the philosophy of 'do no harm', which aims to recognise that the rights and interests of the research participants must be primary, and that to ensure that the research participants are protected from harm that might result from their participation in the research (Hugman et al., 2011). It is argued, however, that the historical idea of seeking to 'do no harm' in the field of migration is insufficient to ensure ethically sound research practice (Hugman et al., 2011; Jacobsen and Landau, 2003). The problem of "do no harm" in migration research is difficult to anticipate or control, but it is incumbent on researchers to take thorough ethical considerations, and be explicit about these considerations as well as their limitations (Jacobsen and Landau, 2003).

Before beginning the data collection process of this study, the author had to apply for and obtain ethical clearance from the Human Research Ethics Committee at the University of Witwatersrand. The author did so, and after submitting revisions to the HREC, received the go-ahead to begin data collection at the end of October 2021. Before conducting the interviews, written informed consent was obtained from each participant (available in the appendix). It is argued that there are practical and theoretical issues in achieving informed consent from participants who may be in vulnerable conditions, mainly related to the challenge of ensuring that the human agency of the participant is sustained and promoted (Hugman et al., 2011). This author will engage with this issue by providing each participant with a consent form and making it clear that they can revoke their consent at any point in the research process. Each participant will also be anonymised with pseudonyms, and their documentation status will not be asked for.

The process of "exiting from the research site" also needs to be considered through an ethical lens (Jacobsen and Landau, 2003). This is why the author set up a layered distress protocol. The interviews were audio-recorded, and the researcher after each interview chose to delete the recordings from her phone after storing the interview files in a password protected folder on her personal laptop.

(vii) Interview Timetable

Participant Pseudonym	Date of First Interview	Date of Second Interview
1. Odette	11/11/2021	03/01/2022
2. Camille	16/11/2021	07/01/2022
3. Elise	19/11/2021	04/01/2022
4. Oceane	25/11/2021	06/01/2022
5. Adrienne	03/12/2021	05/01/2022

7. Research Data Analysis

This research study has adopted a thematic analysis of the interview data through coding, which assists in achieving the aims of thematic analysis, mainly examining commonality, examining differences and examining relationships (Harding, 2014). The coding process that this research study has adopted is empirical coding, which are is derived after data evidence has been collected. Harding's process of using empirical codes consists of four steps, which have guided this research study's data analysis process: identifying initial categories based on reading the interview transcripts, writing codes alongside the transcripts, reviewing the list of codes and revising the list of categories, and lastly, looking for themes in each category (Ibid.).

(i) Identifying initial categories based on reading the transcripts

After several read-throughs of the interview transcripts, the researcher identified certain categories that codes can be placed into, by creating broad subject areas under which data could be grouped. The initial category list looked as follows:

Coping mechanisms postpartum
Division of child-care and household labour between couple in the 1st year postpartum
Experiences of medical "care" during and after pregnancy
Existence of gendered support networks in the 1st year postpartum

(ii) Writing codes alongside the transcripts

After the emergence of the initial list of categories, the author opted to use abbreviations to code the data, and write these abbreviations in the margins of the physical transcripts as a coding method. Additionally, the author decided to assign each abbreviated code a colour, in order to make referring back to the different codes on the transcripts easier. These were as follows:

Category	Abbreviation	Colour

Coping mechanisms postpartum	CM	Yellow
Division of child-care and household labour between couple in the 1st year postpartum	L	Pink
Experiences of medical "care" during and after pregnancy	MC	Blue
Existence of support networks in the 1st year postpartum	SN	Green

(iii) Reviewing the List of Codes and Revising the List of Categories

As the author was analysing the data, she modified the initial list of categories, simply by expanding them by one category, as follows:

Category	Abbreviation	Colour
Coping mechanisms postpartum	CM	Yellow
Division of child-care and household labour between the couple in the 1st year postpartum	L	Pink
Experiences of medical "care" during and after pregnancy	MC	Blue
Existence of support networks in the 1st year postpartum	SN	Green
General moral solidarity and support amongst Rwandese migrant women	W	Red

(iv) Looking for themes in each category

When identifying themes in each category, the author chose to adopt the approach argued for by Gibson and Brown in *Working with Qualitative Data*, which was to examine commonalities within categories, examine differences between categories and examine relationships within

categories (2009). The table below shows the author's process of identifying the categories. The findings are reported in the following section.

Example of Selected Phrase	Code	Sub-Theme	Main Theme
"When I feel like I have problems or stress, I kneel here in my house and I pray. Or I'll go to church and I tell the Lord my problems." – Elise (35)	Coping Mechanisms Postpartum	Religion as a personal stronghold	Finding solace in the midst of incredibly demanding lives
"Except that before you have a child, there's really no way to know what to expect, or what's going to happen. It hurts, it's tiring, it's overwhelming, but after a while you understand what it's about and you get used to it." – Adrienne (40)	Coping Mechanisms Postpartum	None	Experiences of early motherhood as a 'mixed bag'
"It was only me, because he woke up early in the morning to go to work, and then he would come home late at night. And when he comes back, he's tired. I can't tell him to do anything. He was working from seven 'o clock until seven." – Oceane (37)	Division of child-care and household labour between the couple in the 1st year postpartum	Participants doing the majority of household and childcare labour in the first year postpartum	Resigned attitudes towards overall divisions of labour between participants and their husbands
"But there by the [Somerset] hospital, they didn't treat me nicely. Because I didn't know English, that time. They would say "do this" and I wouldn't understand. And then they show me, and I didn't understand, they shout me, they pull even my hair, yhu, it was bad. They even beat me!" – Oceane (37)	Experiences of medical "care" during and after pregnancy	Xenophobia as the most apparent barrier to quality and humane medical treatment	Basic public health services and its implications

"In Rwanda you must pay for the check up. Here I didn't pay for the pregnancy check ups…like I said in Rwanda you must have money to pay. For them to give your baby check up, or if your baby is sick, is not free like here." – Odette (33)	Experiences of medical "care" during and after pregnancy	The significance of 'free' physical health services	Basic public health services and its implications
"No it was not for the same the way I would do my job at home, because of that C-section. But I'm lucky I have my sister there, she would sometimes come and help me, also my husband until the baby was two months old." – Odette (33)	Existence of gendered support networks in the 1st year postpartum	Seeking refuge in the presence, support and community of other women	Finding solace in the midst of incredibly demanding lives
"For me…Rwandese women, we help each other. If I'm sick, someone will come visit me and come help me, bring me medicine or make me food or tea. If I'm having a party and I need to cook a lot, then they must come and help me….[this is important] because a woman must always do more, and the work never stops. So if you do everything alone you'll really suffer. You need people who can support you." – Adrienne (40)	General moral solidarity and support amongst Rwandese migrant women	Seeking refuge in the presence, support and community of other women	Finding solace in the midst of incredibly demanding lives

8. Findings

(i) Participants' Demographical Information

All of the participants of this research study were women. All of them were between 30 and 40 years old. They had all been in South Africa for more than four years. All of them had one to two children, between the ages of 0 and 6 years old. Two women had only one child, and both of these children were under the age of one years old at the time of the second interview. Three

women had two children, between the ages of one and six years old. Four of the five women were unemployed during the first year postpartum after having their first child. One woman was self-employed during the first year postpartum after having her first child. All of the women were married and living with their husband and child(ren).

	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
Pseudonym	Odette	Camille	Elise	Oceane	Adrienne
Age	33	37	35	37	40
Number of children	1	1	2	2	2
Year they arrived in South Africa	2009	2017	2010	2014	2014
Date of Birth First Child	06/2021	01/2021	10/2018	11/2017	09/2016
Date of Birth Second Child	N/A	N/A	01/2020	07/2020	07/2020
Marital Status	Married	Married	Married	Married	Married
Whom they stay with	Husband, child	Husband, child	Husband, child	Husband, children	Husband, children
Employment Status when child nr. one > 1 years old	Unemployed	Unemployed	Unemployed (obtained employment briefly when child was over 1 year old)	Unemployed	Self-employed from home: part time seamstress/tailor
Employment status when child nr. two > 1 years old	N/A	N/A	Unemployed	Unemployed	Self-employed from home: part time seamstress/tailor

(ii) Interactions with non-Rwandese people

Where interactions with non-Rwandese people were concerned, the interviews mainly explored them within a healthcare setting. Typically, the participants were treated by non-Rwandese healthcare professionals, most commonly South Africans. Outside of the healthcare setting, the participants engaged with non-Rwandese people in their neighbourhoods, for example at their local supermarkets. Three of the participants lived on properties where one or more large home was divided into several smaller living units, and the people that they stayed alongside were also Rwandese. However, in these cases, the people that resided in the surrounding properties were either African migrants who were not from Rwanda, or South Africans. Most of the participants went to churches that consisted of mostly Rwandese people, but some went to mixed-nationality churches. A common place where these participants regularly engaged with

non-Rwandese people was at their child(ren)'s schools, where there were students, parents and staff of diverse national and cultural backgrounds.

(iii) Themes

Adopting Harding's method of data interpretation, which argues for looking for themes within and across categories, the author has identified certain themes based on the data analysis above and the transcript data more broadly (2015). Four main themes emerged during the data analysis process, namely finding solace in the midst of incredibly demanding lives, resigned attitudes towards overall divisions of labour between participants and their husbands, basic public health services and its implications and finally, experiences of early motherhood as a mixed bag.

Theme 1: Finding solace in the midst of incredibly demanding lives

During the interviews, each participant described feeling stress, fatigue and frustration at different points during the first year postpartum with their first child. It was clear that having a child was demanding on their side. Participants chose to seek solace in their lives in different ways. Two sub-themes emerged as part of this main theme: religion as a personal stronghold, and seeking refuge in the presence, support and community of other women.

Sub-theme 1: Religion as a personal stronghold

"Yes. I go to a Rwandan church, so my friends from church are my support network. My church is my community." – Adrienne (40)

When asked about their coping mechanisms, all of the participants mentioned a religious aspect in their response – whether it be going to church, fasting and praying or singing gospel songs. All of the women mentioned attending church on a frequent basis, and many of them described meeting many or all of their Rwandese friends at or through church.

"I liked to sing. And when I sing, I pray, and then the stress goes away." – Oceane (37)

"For me, what helps me to go through life is to pray. When I feel something is not going well, I go to my room and pray. I can even take days and fast." – Camille (37)

When it came to overcoming pregnancy and postpartum related issues, some of this research study's participants felt that their faith and belief in God's power had led to the resolution of these issues.

Elise (35): … Then I was thinking that my children would not be normal, because I weak and I was not eating. Then the Pastor prayed for me, he read the Word of God, and we prayed. When he started praying, a word from God came to him, it said "Don't worry, I love you. I'm the one who starts, and I will finish." And then it felt like something came out of me. I suddenly felt strong, I could eat, everything was new from me. It was a miracle. Then I got the C-section, and I got my baby boy. God is good.

Other coping mechanisms that participants reported turning to when feeling tired, frustrated or stressed in the face of the high levels of demand in the arenas of child-care and house-hold upkeep were diverse. Some participants reported sleeping, some preferred sitting in a silent space away from their children, some chose to consume media, such as watching television or scrolling on their phone. When asked to elaborate on why they chose specific coping

mechanisms, the participants had a range of motivations: some chose their coping mechanisms because they are uplifting, some because they are calming, some because they are cathartic, and some because they were distracting (naturally, various of these ticked more than one box).

"…If I'm watching the movies, I'm standing in one place. Not thinking "What am I gonna do, what am I gonna cook?". I'm sitting in one place and relaxing and watching only the movie." – Odette (33)

"…Because when I sing, I feel happy. I feel happiness and content. And then the tears come, I cry, and then I sleep." – Adrienne (40)

Sub-theme 2: Seeking refuge in the presence, support and community of other women

(i) Support during the first year postpartum

Whether it be at church meetings or home visits, all of the women described finding solace in the company of other women. The nature and existence of gendered support networks for the participants of this study in the first year postpartum reinforced the theories of "community care" – the support and assistance that women provide and receive from women – and threaded the experiences of the participants together (Sorde et al., 2014).

Support networks in the 1st year postpartum prevalently took the form of one or more "sisters" who would assist with household and child-care labour, most intensively in the first few months postpartum, while the participants were recovering from childbirth (most prevalently, C-section surgery).

Participants reported being assisted by neighbours and friends from church, always women, and there was a consensus that this type of support made a big difference in helping the women who could access it balance their responsibilities. Their "sisters" would visit them several times a week, most frequently when their baby was a new-born but consistently for the first year, and assist the participants with household labour, such as washing dishes or cooking, and baby-care, such as bathing the baby.

Participants who during their first postpartum experience were not able to access the consistent assistance of women, reported feelings of sadness and isolation at this circumstance.

"Sometimes it was terrible, especially the first few months, because I only had that friend I told you about. It made me remember how I was running behind my sister in laws when they'd go to the hospital. I was helping them. So by the time I got my child, I was crying. I wanted help. Especially in those first months. But it was not possible." – Camille (37)

"I was really missing [communal support]. It's the type of thing that makes you miss your country. You start thinking "If I was in still in Rwanda, I would have people that would visit me, that would help me, to make porridge or something." Ya. And here you have to take your baby on your back everywhere. You can't leave your baby at home…" – Adrienne (40)

Some, who were able to access support, noted the plight of those who could not.

"Yes. Because I like told you before, I have other friends who stay far away from me who told me that when they gave birth, no one came to help them, no one came to cook for me, now I have neck problems because I have to do everything. But for me, I'm lucky because I have the sisters, I have friends who come to help me. It makes a big difference." – Odette (33)

(ii) "Sisterhood" as a personal and collective value

Research centred on black women has found that friendships amongst black women can improve the physical and emotional health and wellbeing of women (Bryant-Davis, 2013). When asked about their concept of "sisterhood" and its importance, all of the participants expressed the value of having a community of women that can be accessed for support, or relief, sometimes framed around explicitly ethno-cultural lines. The necessity and value of having "sister friends" was emphasized by each participant, and they spoke lovingly about being able to seek refuge, comfort and advise in the company of their women friends.

"Yes. I go to a Rwandan church, so my friends from church are my support network. My church is my community. So when my second child was a baby, a lot of women from my church came to visit me and to help me." – Adrienne (40)

The participations associated "sisterhood" with being able to depend on other women for relief, advice, joy and emotional and physical support. Every participant described how much stress they endured to be a "good" mother and wife, and saw "sisterhood" as a means to help deal with this stress.

"Because like I said, as a woman and a mother you have a lot of stress. So having your sisters around you helps you forget about the stress." – Odette (33)

The majority of participants felt that they *needed* a community of other women, and felt that they could find this support in other Rwandese women, especially given their similar experiences and cultural backgrounds. Many participants felt as though this "sisterhood" was valuable because it also allowed them to share and learn skills with other women.

"Because us as women we need each other. We do, even if some people don't think so." – Oceane (37)

Theme 2: Resigned attitudes towards overall divisions of labour between participants and their husbands

During the first interview, when asked how they felt about the contribution their husband's provided to the household and childcare duties in the first year postpartum, the participants' responses ranged from satisfied to simply resigned. Participants appeared to accept the reality that, overall, in the first year postpartum, they would perform the majority of the household and child-care labour necessary, and felt it was not necessary or even appropriate to ask their partners to increase their contribution. One sub-theme that emerged as part of this theme was the pattern of participants doing the majority of household and childcare labour during the first year postpartum (versus their husbands). During the second interviews, it became apparent that the majority of participants desired more domestic and child-related assistance from their partners, but felt that this was out of the question due to cultural gender norms and roles.

"What I think the role of the woman is, is to take care of the house but not always doing everything, doing everything. The man has to help. For the marriage to be nice, the woman must not be too tired. Because women, we get so tired. We even get headaches, and we get stress, because we have too much things to do. So I think the role of the woman is to do what she can, and then her partner helps her. So that the household can go well. But men know that women are taught to do everything, so they don't help. Even if you're not feeling well, you must

still do it. This is why us women don't enjoy marriage nicely, because we're doing too much." – Adrienne (40)

Theories behind help-seeking and help-giving in transnational households argue that social structures produce certain patterns of help-seeking and -giving (Sargent and Larchanché, 2011). The interviews confirmed these ideas: the social norms and cultural beliefs amongst the participants and their husbands created particular types of dynamics around how participants received "help" from their partners.

Sub-theme 1: Participants doing the majority of household and childcare labour in the first year postpartum

Most of the participants reported doing the vast majority of household and child-care labour versus their husbands. Many participants, however, reported that their husbands provided *some* assistance within the initial one to three months postpartum, but then this assistance gradually decreased.

"No [at the beginning], he was just helping where he could. I was still doing most of the work. When you give birth, your back really hurts. So bending over to wash clothes is painful. So my husband was helping me with washing clothes. Anything that makes you bend over, it hurt me. But I did most of it. After three months I felt like I could bend more…[As the months passed] I was strong. He wasn't helping me. He was working so much, and I felt bad about asking him to do things when I knew how hard he was working. I felt like he was tired more than me. I felt like asking him for help at that point would be burdening him." – Adrienne (40)

"After I recovered, it's like he stopped doing anything, it was mainly me again."– Camille (37)

Participants' husbands appeared to do the most housework and child-care labour when their wives were seriously incapacitated. Some participants who reported that their husbands were doing more household labour than them, reported that this occurred in the first one to three months postpartum, as they were recovering from C-section surgery.

"Uh, for the first month, my husband was helping me, especially because I had the C-section wound, it was not good to make me do a lot of work. He tried to help me…He was doing more than me." – Camille (37)

"Oh. Yoh. For me I did nothing around the home for the first month. Only going to the hospital and come back and relax because of the wound of the C-section. My husband was doing everything for me, and also my sisters. I couldn't do anything." – Odette (33)

Ultimately, the extent to which participants' husbands provided "help" to them was not homogenous across households. For example, some participants reported that the husbands provided no assistance at all within the first year postpartum.

Additionally, in the majority of couples, any labour assistance provided by the husband during the first year postpartum was related to household chores, as opposed to childcare responsibilities. Husbands who helped their wives with child-care for the full first year postpartum were few – some began to help as the baby developed from new-born to status to being a few months old, some only helped with child-care as their wives recovered from surgery, and some did not help at all with childcare. The majority of participants reported choosing to accept this reality, even when they did not feel satisfied about it.

"Uh, for the first month, my husband was helping me, especially because I had the C-section wound, it was not good to make me do a lot of work. He tried to help me… In terms of the child, when the baby was a new-born, some men don't know how to care for the child. They're scared. So he was not doing anything for the baby. When he became bigger, like four or five months, my husband started doing more, like bathing him, and changing nappies." – Camille (37)

Theme 3: Basic public health services and its implications

In the interviews with participants, medical "care" was explored at length. Even though all of the participants had engaged with medical attention and treatment during their pregnancy and postpartum journeys, their experiences varied. As intersectional feminist theory suggests, the participants' experiences converged and diverged according to their individual relationships to structures of privilege and oppression (Bastia, 2014). The two sub-themes that emerged as part of this category were xenophobia as the most apparent barrier to quality and humane medical treatment, and the significance of no-cost physical health services.

Sub-theme 1: Xenophobia as the most apparent barrier to quality and humane medical treatment

All of the participants reported observing or experiencing xenophobic behaviour, with varying levels of intensity. Some reported experiencing medical xenophobia at the time of pregnancy, childbirth and post-birth. These experiences included humiliation, rudeness and in one instance, deliberate neglect and physical violence. One participant recalled a painful and protracted experience being humiliated after contesting a diagnosis, which ended up being a misdiagnosis that seriously impacted the health of her young child. The participants in this study were visibly pained by their experiences of medical xenophobia.

"So to get the message about what they were talking was not easy at all. The second challenge I had was that you know we have different cultures in Africa. So maybe you can see my body, my skin if I remove the clothes you can find something different. So I met one nurse, when she saw my body she didn't accept [the cultural marks on my body], she was calling others to come and see me, "come and see, come and look!". So, I was shocked." – Camille (37)

Some reported experiencing medical xenophobia outside of their pregnancies, on a more general level. They reported being treated rudely by medical staff, their names being deliberately mispronounced, being shouted at and being chased away from clinics for no apparent reason. Some acknowledged that incidents of positive or neutral treatment from staff as contingent on them being able to speak English and possessing the proper "papers".

"For me, ya I can say [the quality of healthcare I can access] it's not bad. When I first came it was bad, because I couldn't understand what they told me at the clinic, and sometimes I could see the nurses giving me a bad look or gossiping about me in their language. But now my English is good, I have no problems. Sometimes the nurse is still rude when she sees my papers but I don't care, because anyway she must do her job." – Odette (33)

Sub-theme 2: The significance of no-cost physical health services

All of the participants reported being able to access their necessary medical appointments in the ante- and post-natal period. These appointments took place at public hospitals and clinics in and around Cape Town, including Somerset Hospital, Somerset Clinic, Karl Bremer

Hospital, Retreat Hospital, Tygerberg Hospital, Elsies Clinic, Bellville South Clinic and Parow Clinic.

The majority of the participants touched on the fact that South African public clinics are primarily free, as opposed to Rwandan public clinics, which require payment. There was a sense of relief and gratitude at this reality.

"[I prefer to raise a child in South Africa than in Rwanda] for the health care. In Rwanda you must pay for everything. Nothing is free. Here at least the clinic is free. It's better than in Rwanda." – Camille (37)

The majority of the participants felt that during the time of their pregnancy, they could trust the medical staff that they were engaging with at public clinics in Cape Town. Some participants reported feeling confident in the expertise of certain medical practitioners, some felt that their faith in God's power led to them trusting the medical practitioners, and some cited that kind and empathetic treatment from medical practitioners during stressful times made them feel able to rely on medical staff.

Odette (33): The way they care about the mommies who are pregnant. It makes you feel like you can trust them and what they tell you. And the Doctor does all the stuff and he knows what he's doing. That's why I feel like I can trust them.

Adrienne (40): Yes. [The way I was treated] was okay. Even while I was giving birth, I remember the nurse was so kind to me, she started singing very nice gospel songs.

Due to experiencing negative treatment from medical staff, however, some participants felt that they could not fully trust or rely on said staff during their pregnancies. They held reservations about the trustworthiness of medical practitioners before, during and after childbirth because they had historically been disrespected and mistreated at medical facilities.

Theme 4: Experiences of early motherhood as a 'mixed bag'

A theme that ran through the data like a fine but tangible thread was the experience of early motherhood as a 'mixed bag'. The multi-dimensionality of the postpartum experience was explored at length during the interviews. At several points, all of the participants described extreme challenges related to their childbearing journeys – stressful and painful operations, violent xenophobia, pre- and post-birth health scares, protracted misdiagnoses, feelings of heightened anxiety, loneliness, being constantly overwhelmed, confusion, and frustration. However, these same participants also described joy, fulfilment, and contentment as feelings they felt as mothers, and expressed pride and happiness at the fact that they had had children, some noting that it had been a long-term dream of theirs. Despite the difficulties incurred during the 1st year postpartum with their children, the women felt elated about their babies and beamed while describing what they enjoyed most about having children. Some dreamed of having more in the future, and others felt that they were content with the children they had.

"For now, I'm stressed, as well as happy. I wonder about this child, and the school fees, and whether he is always gonna be healthy. So that stresses me out. But when I'm with him, and he starts laughing, I'm happy for that. It's stress but also happiness." – Odette 33

9. Discussion

The findings of this study, as presented and described above, are vast, layered and informative. Below, the author aims to evaluate these findings and situate them in the broader frame of the study. The main tenets to be discussed can be categorised as follows: religion as an emotional aid and a source of community, women-based support and solidarity networks, gender roles and unequal divisions of labour, pervasive medical xenophobia as a dark shadow to no-cost primary healthcare in South Africa and lastly, the melange of early motherhood.

(i) Religion as an emotional aid and a source of community

Faith and church play an important role in many people's lives, but can be particularly crucial as a coping mechanism for those who endure and have endured longstanding, difficult circumstances. A study conducted amongst Sub-Saharan African migrant women in Belgium who all had chronic diseases found that spirituality/religion served important roles in coping, survival and maintaining overall wellbeing for this group of women (Arrey et. al, 2016). Participants in this study believed that spiritual/religious activities including prayer, meditation, regular church services and religious activities and deep faith in God's power helped them cope with challenges related to their day-today lives, as well as their chronic illness (Ibid.). A similar trend was observed in a life-history approach study set in Soweto, South Africa, that explored incident HIV in pregnant women and sexual risk behaviours and practices (Mlotshwa, 2021). The study found that, most prevalently in the face of compromised emotional support systems, pregnant women turned to the church (Ibid.). A separate study by the same author revealed that church or religion was a source of direct and indirect support for expectant mothers, usually in the form of guidance and assistance by older women (Mlotshwa et al., 2017).

The religious beliefs and practices of the participants in this study appeared to be a source of therapy for many of them, and also appeared to help them find meaning and acceptance under challenging circumstances. All of the participants demonstrate a steadfast commitment to their faith – all belonging to the same Pentecostal church in Cape Town, one whose services take place exclusively in Kinyarwanda. This means that the church as a physical space also functions as a familiar, communal one, bringing a range of Rwandese migrant individuals and families together. This concept was foregrounded in the literature, where Zimbabwean women in South Africa tapped into religious networks as a help-seeking and community-building strategy (Makandwa and Vearey, 2017).

A unique perspective that this research study provides is that not only does it reveal and engage with church, and religion more broadly, as a coping mechanism and source of emotional support for the participants, but it shows that for many migrant Rwandese woman who are mothers to young children or babies, church is synonymous with community – it is a space where participants can connect to other Rwandese people and expand their support networks and it is a familiar meeting point for women with similar values and intersecting experiences.

(ii) Women-based support and solidarity networks

The pattern of participants in this study finding solace in the company of women pertained to both the challenges of household and child-care labour demands postpartum, as well as on a broader, more existential level. It was apparent that all of the participants experienced stress, fatigue and anxiety while navigating their day-to-day challenges, certainly not limited to their

responsibilities as mothers and home-makers, and that spending time with other women (not entirely exclusive to Rwandese women, but always African migrant women), provided them with joy and relief. This reinforces the argument by Thema Bryant-Davis, touched on in the introduction of this study, which asserts that amongst black women, sister friends can be vital in assisting women in facing, addressing and overcoming major stressors, traumas and obstacles (2013).

The results regarding the participants finding solace in the company and support of other women supports what the literature explored in the review suggested about African migrant women relying on women in their community for support in various ways, as evidenced by the study of Somali migrant women in Minnesota who used women-based solidarity networks as an aid in navigating their day-to-day obstacles and existential desire for a social network (Sorde et al., 2014; Herrel et al., 2004). As foregrounded by the literature, a postpartum context, Rwandese women in this study relied on their support networks to assist with household and child-care labour, and where these networks were absent or inaccessible, it took a physical and emotional toll on these women (Hunter-Adams, 2016; Matshaka, 2018). The emotional distress of the participants in this study who did not have access to "community care" networks when caring for their first child at some point during the first year postpartum is similar to that revealed in a qualitative study based in Cape Town, where African migrant women experienced more feelings of stress and vulnerability when they did not have women to assist and support them with caring for their new-born infants (Hunter-Adams, 2016).

The conceptual framework of this study explored diverse forms of care, help-seeking and -giving as well as intersectional feminist theory, all three of which are apparent in the women-based support and solidarity networks amongst the participants of this study. Intersectional feminist theory allows us to unpack the types of discrimination and oppression that these women consistently face, many of which are influenced by the fact that these women are migrants, low-income and black African. Concepts of care and help-seeking and -giving underline the ways that these women show up for each other.

A new lens that this research study brings to ideas of gendered support networks and woman-based solidarity networks is that it uses women's experiences postpartum to show that "sisterhood" as experienced by Rwandese women is a cultural philosophy that transcends borders, ethnic groups and to an extent, age. It also showed that by being physically and emotionally assisted by women during the first year postpartum, and being willing to show up for other women in similar ways, Rwandese migrant women engage with gendered networks as a form of both help-seeking and help-giving.

(iii) Gender roles and unequal divisions of labour

The participants' accounts reflect the arguments portrayed in the literature regarding the beliefs held amongst Rwandese adults in Rwanda, who, similarly to the participants in this study, believed that the primary role of the husband is to economically provide for his family, and that that of the wife is to tend to domestic duties and take care of the children (McLean et al., 2019). This mirrors the themes which emerged in the studies based in Sierra Leone and Ghana, which found that women performed most of the labour regarding caring for their newborn children, while men believed their role to be about contributing in an exclusively material capacity (McLean, 2020: Dumbaugh et al., 2014).

Unequal divisions of labour within the home is an issue that was also foregrounded in the literature, where various studies showed that women performed much higher amounts of domestic and child-care labour than their husbands in both the first year postpartum, and as a broader relationship dynamic (Newkirk et al., 2017; Thomas and Hildingsson, 2009; Kim and Cheung, 2019). However, the literature reviewed did not foreground the participants' beliefs that despite these primary roles, the husband should try and assist his wife where possible in order to lighten her load, as well as routinely checking in on the wife to ensure that she is emotionally and physically content.

This research study has provided fresh insight by showing that women's feelings towards their husbands' contributions to child-care and house-hold labour are not only multi-dimensional and layered, but that they can even be conflicting. There were some women who voiced feeling satisfied with how much their husbands assisted with domestic and child duties, but then later voiced the desire for their husbands to provide more help and do more in these areas.

(iv) Pervasive medical xenophobia as a dark shadow to no-cost primary healthcare in South Africa

Medical xenophobia refers to the negative attitudes and practices of health professionals and employees towards 'migrants and refugees' based purely on their identity as non-South African (Crush and Tawodzera, 2013). Despite mostly being able to access antenatal and post-natal services from public clinics and hospitals in Cape Town, xenophobia emerged as something which affected the quality or nature of the medical services these participants received. As foregrounded in the literature, language barriers, lack of culturally sensitive knowledge and being coded as refugees led to most- participants having experiences of feeling disrespected, violated, dehumanised and undermined while trying to access maternity services (Liu et al., 2020). Others who felt they had received satisfactory maternity services, reported experiencing or observing xenophobia more generally whilst trying to access health services in South Africa. On a more general level, all of the participants had at some point or another been victims of medical xenophobia. Participants reported being shouted at, humiliated, physically chased away, neglected, body-shamed and even physically abused. The language barrier and documentation issues emerged as further obstacles to "professional" treatment at healthcare facilities.

These findings align with those of a qualitative study undertaken to explore experiences of xenophobia by refugees from the Democratic Republic of Congo (DRC) with the health care system in Durban, South Africa (Zihindula, et al., 2015). The study found that language barriers and documentation were a major stumbling block in the migrants' efforts to seek health care services (Ibid.). The rifeness of xenophobia was also experienced by participants in prejudice evident in ethnic slurs, unwelcome and insensitive comments and discriminatory practices, which included the denial of treatment (Ibid.). These results are jarringly similar to those in this research study, despite the two studies being set in different cities, with a different migrant population.

A study based on primary research with Zimbabwean migrants who tried to access the South African medical system showed that the majority of participants reported experiencing medical xenophobia at a South African medical institution (Crush and Tawodzera, 2013). As argued by the paper, medical xenophobia is deeply entrenched in the South African public health system despite being a core breach of the constitution and Bill of Rights of the country, as well as

being against international human rights obligations and the existence of professional codes of ethics governing the treatment of patients (Ibid.).

There is a policy of free primary healthcare for all in South Africa, as outlined in Constitution and the National Health Act (Walls et al., 2016). The majority of participants in this study emphasised the fact that they could access basic services related to their antenatal and postnatal journeys, as well as for their children, at public health institutions, especially day clinics, for no cost. As low-income women, it appeared to be a relief that they were able to access basic healthcare for themselves (despite occurrences of xenophobic violence and discrimination) and for their children. All of them expressed that they felt the clinic and hospital treatment was more positive and professional towards their children than themselves, but still spoke positively about the financial accessibility of free basic healthcare in South Africa, as opposed to having to always pay for medical "care" in Rwanda. Every participant was able to access antenatal as well as postnatal medical services for themselves and their child, and every participant reported feeling satisfied with the quality of healthcare that their child(ren) could access.

There is evidence suggesting that non-nationals in South Africa face challenges when accessing healthcare services compared to citizens (Walls et al., 2016). Participants in this study's experiences of medical xenophobia and exclusion based on documentation status and language issues show that despite what is written in the Constitution and National Health Act, the implementation of these guidelines are not adequately inclusive (Ibid.).

This research study introduces a new lens to understandings of medical xenophobia and migrants' access to basic healthcare in South Africa by engaging with the duality of the participants' experience. Examples are how all of the participants had historical experiences of medical xenophobia, but many still reported to feel able to trust and depend on the medical practitioners that were seeing them during their antenatal and postnatal journeys, how participants expressed gratitude and relief and the existence of no-cost primary healthcare whilst noting that medical xenophobia was a virtually inevitable reality for them, and how despite their deep-rooted, strong reservations and critiques about the quality of primary healthcare in South Africa, they felt that their children were accessing high quality healthcare nonetheless.

(v) <u>The melange of early motherhood</u>

The literature reviewed does not explicitly delve into the "mixed" experience of motherhood, but there is literature that supports this idea. For example, a qualitative study of low-income first-time mothers in a suburb in Dar-es-Salaam showed that the women's experiences in the first year postpartum were filled with high levels of both joy and struggle (Mbekenga et. al, 2011). Similarly to this research study, the mothers relied on an informal support network, and ensured that they put efforts into attaining both theirs' and their infants' health needs (Ibid.). A qualitative study that concerned 11 low-income mothers in South Africa showed that while adjusting to motherhood, women described feeling overwhelmed, fatigued and ambivalent towards motherhood, while simultaneously experiencing gratitude towards being mothers (Du Toit, 2017).

This study offers a unique perspective by engaging with the extent of its participants mixed feelings towards early motherhood. The findings of this research study show feelings about

motherhood as a spectrum, reinforcing the notion that motherhood is a deeply personal experience.

10. Conclusion

This research study has revealed religion as not only a source of emotional support and meaning-making for its participants, but also as a point of connection and community. This study has also engaged with gendered support networks amongst Rwandese migrant women as a form of both help-seeking and -giving by illustrating the importance that the participants placed on emotionally and physically "showing up" for other women and being "showed up" for in times of need, such as after the birth of a child. This piece of research has also considered the dual nature of migrant women and mothers' perceptions and experiences of healthcare in South Africa. This is important because it shows that vulnerable groups experience structures in deeply layered ways, ways that should not be homogenised or simplified.

Drawing on theories of multidimensional care, migration and its influence on help-seeking and -giving as well as intersectional feminism, the aim of this research study was to identify and explore the support strategies that Rwandese migrant women in Cape Town adopt in response to their domestic-labour and child-care demands that they face during the first year after giving birth to their first child. The study has found that as part of the support strategies they adopt to manage domestic-labour and child-care demands in this period, participants - low-income, middle-aged Rwandese migrant women - use religion as a personal stronghold and seek refuge in the presence, support and community of other women, typically other Rwandese women. The participants of this study also held mostly resigned and layered attitudes between the general division of labour between them and their husbands and described their experiences of motherhood as a "mixed bag". The study has also found that medical xenophobia was experienced by participants as the biggest barrier to experiencing quality (humane and professional) treatment in healthcare facilities, and that participants placed great significance on the existence of free primary healthcare in South Africa.

The primary argument of this research study was that the perspectives of Rwandese migrant women in Cape Town offer valuable insights to the study of maternal health and migration and are worth exploring in part because hold a deeply-rooted cultural philosophy of communal support and solidary, especially amongst women – an argument that has been reinforced by the findings of this study (Hanbury and Indart, 2013). The secondary argument of this research study was that African migrant women in South Africa live complex, often marginal lives, and that more nuanced and context-specific research has to be produced on these groups in order to create more appropriate and sensitive understandings and responses (Nkomo et al., 2015; Hunter-Adams and Rother, 2016).

11. Limitations

(1) Implications of this proposed sample group not being met

As was described earlier, the initial proposed sample was not met, and the author was not able to find five women with one child under the age of one as initially hoped. The final sample, which included women with one to two children ranging from 5 months old to six years old, is quite varied and may have negatively affected the study and its findings.

(2) Women of a similar age range

The final sample included women aged 33 to 40, which is a rather limited age range.

(3) Exclusively cisgendered, heterosexual married couples

The final sample included only cis-heterosexual married women, which may have limited the scope of the findings.

(4) Exclusively English-fluent participants

Due to the fact that the author has only a basic fluency in Kinyarwanda, the interviews had to be conducted in English. Which means the study was limited to fluently English-speaking Rwandese women, which may have limited the depth of the findings. The study may have yielded different results had the author interviewed the participants in their first language and allowed them to respond in such, and this may have influenced the sample, given that "English-fluency" was a core requirement for participants of this study (Richards, 1971).

(5) Exclusively participants who had access to a smartphone/WhatsApp compatible device

In order to participate in the debriefs that were part of the distress protocol of this study, and hence the study as a whole, participants had to have access to a personal WhatsApp account via which we could debrief. This therefore included any person who did not have access to a personal WhatsApp account, limiting the reach of the study.

(6) Second interview did not feel as generative as the author would have hoped

Even though the second interview allowed the author to probe into certain topics and themes, the existence of a second interview and the spacing between interviews did not allow for the participants to open up as much as the author had hoped.

(7) Because of initial sample, focus skewed on first children

Due to the specifications on the initial proposed sample, the author framed the first interview questions to focus on first children. Even though the second interview probed more into second children for the participants with two children, the data was focused more on first children. Additionally, some of the participants had their first child as far back as 2016, meaning that recall bias may have affected their responses (Huttly et al., 1990).

(8) One class level

All of the participants in this research study are of low-income status. This means that from an intersectional standpoint, the applicability of the findings is rather limited.

12. Final Remarks

(i) Recommendations for future interventions and research

For future interventions, the author of this study recommends that policymakers in the public health sector consider creating compulsory cultural sensitivity training workshops for all medical practitioners, considering the pervasiveness and harm of medical xenophobia. The author also recommends that language interpreters be instated in large public health institutions, such as major hospitals and clinics, in order to better ensure that non-South African

language fluent individuals are not excluded from receiving medical attention on the basis of a language barrier.

For future research, the author recommends that studies which aim to understand how different groups of migrant women and their partners cope with the household-labour and child-care demands postpartum consider having a sample with an expansive personal age range, and a smaller age range of children. The author also recommends considering couples with the same number of children. From an intersectional feminist standpoint, the author recommends that future studies include more or only queer and trans migrant parents and couples, couples with a greater variety of economic backgrounds as well as single parents. The author also recommends that future studies interview both parents. Future studies should also take a deeper delve into mental health and access to psychological support as a migrant in South Africa. The author would also suggest that researchers consider conducting focus groups instead of or alongside interviews as an idea to increase interaction and engagement during data collection.

(ii) How the findings of this study speak to the research objectives set at the beginning of this study, and their implications for future research

1. To understand how Rwandese migrant women adapt to the increased labour-demands that occur in the domestic and child-care spheres in the first year after having their first child.

This research study has shown that in the first year postpartum, Rwandese migrant women maintain a variety of coping mechanisms to adapt and respond to the increased labour demands that they encounter during early child-rearing – these include rest, singing, praying and taking time and space away from their child(ren).

This research study has also shown that Rwandese migrant women use their faith and commitment to a religious entity, typically a Christian God, as a spiritual tool and means of engaging with, processing and accepting the demands that befall them as mothers of young children and babies.

When available and accessible, these women also utilise networks of support during the postpartum period, typically taking the form of one or more women consistently visiting them to assist with especially household, and to a lesser extent, child-care responsibilities.

This research study has also revealed that Rwandese migrant women exercise a thorough awareness and acceptance that child-bearing and -rearing comes with inevitable challenges.

The generalizability of these findings, however, are limited due to all of the participants of this research study being between ages 30 and 40, married, heterosexual, fluently-English speaking and of low-income status.

2. To explore the nature and extent of the gendered division of domestic and child-care labour between Rwandese migrant women and their partners in the first year postpartum.

This research study found that, overall, in the first year postpartum, participants performed the majority of household and child-care labour versus their husbands.

Where husbands did assist, it was typically during the first one to two months postpartum, and in cases where participants were recovering from child-birth related surgeries.

Outside of the first year postpartum, household and child-care labour and duties were heavily skewed towards women in the marriage, with some women reporting that generally, they did the entirety of household and child-care duties versus their husbands.

This study showed that with several women, there was an avid desire for their husbands to play a bigger role in contributing to household and child-care duties, but as well a mainly resigned attitude about the status-quo.

This research study could have better fulfilled the above research objective had it not only focused on the women's perspective: the exploration of the nature and extent of the gendered division of labour may have benefitted from a probe into perspective of the husbands, or more broadly, Rwandese migrant men with young children.

3. To propose to contribute to a gap in literature that emphasises the significance of support networks rooted in community for new mothers (by exploring a demographic that has been underrepresented in the discursive nexus of maternal health and migration).

This research study has shown how there is a paucity in literature about Rwandese migrant women in particular and their experiences of motherhood, migration, and help-seeking. The author then responded to this gap by delving into the lives and experiences of Rwandese migrant women in Cape Town with young children, and has shown the following:

- How support networks provide these women with household and child-care assistance, a sense of community as well as a source of joy and relief.

- How significant the existence of gendered support networks has been to women who could access these, particularly after giving birth.

- How the absence of these support networks led to higher instances of loneliness, sadness and overwhelmingness in women who were unable to access them.

- How Rwandese migrant women in Cape Town, similar to other migrant groups explored in literature, foster and utilise community as a means to help navigate the challenges they incur.

By shedding light on the above areas, this study and its findings form a contribution to the aforementioned gap in the literature in a useful (producing knowledge in an area where it has been insufficient/non-existent) and meaningful (nuance or layers that can be compounded with existing literature, forming a departure point for more studies about the demographic in question) manner. However, this research study certainly possesses shortcomings and limitations, which can be improved on or engaged with in future studies/research.

4. To explore how cross-border migrant women respond to barriers to institutional support that they may face by utilising gendered community support networks to aid them in managing the postpartum period.

This research study has shown how medical xenophobia that is experienced, observed or predicted by this group of migrant women can function as a barrier to institutional "support" in the form of medical care.

This study has shown that cross-border migrant women who are documented and can speak English (two major and layered prerequisites) are generally able to access ante-natal and post-natal physical medical treatment and care.

The study has shown that when it comes to managing the postpartum period, Rwandese migrant women utilise community support networks to aid them.

These insights notwithstanding, this research study has not met this research objective to the extent that the other three have been met. One major reason for this was the conceptualisation as "barriers to institutional support" in this study as mainly 'physical' support – in the form of 'physical' medical attention. According to the Constitution and National Health Act, nationals and documented non-nationals can access free healthcare services for pregnant and lactating women and children under 6 years of age and free primary healthcare (Walls et al., 2016). This only extends to "physical" medical treatment. However, comprehensive medical "care" for migrants has to factor in mental health services. Given the effect that migration, xenophobia, low-income status as well as child-bearing and -rearing can have on mental health, it is not sufficient for documented migrants to have access to free or subsidized physical health services, but this should also apply to mental health services and education (Gavin et al., 2016).However, mental health and potential barriers to institutional support pertaining to mental health care and support was deeply under-explored in this research study, to the detriment of this research objective and the research study as a whole. However, future studies in this arena can build on these findings, or the limitations thereof, in their exploration of mental health support and how accessible this is to migrant women.

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Appendix

1. Letter from Counsellor

Room 314, 3rd Floor

Montana Office Suites

c/o De La Rey Street &Voortrekker Rd

Parow

7500

To whom it may concern,

My name is Albert Murekatete. I am a trained counsellor with a B. Psych from the University of Cape Town and MA in Public Health at the University of Stellenbosch. I have been practicing since 2015, and my office is based in Parow, Cape Town. I work with adults, conducting both online and face-to-face counselling. I do mental health intervention, supportive counselling, psychological education and group sessions.

This letter is to confirm that Sandrine Mpazayabo has reached out to me, and that I have agreed to offer up to two one-hour length sessions (either online or face-to-face) to all of her research participants at any point up to six months after their interviews with her. I will be offering these sessions free of charge to the participants.

Signed,

A Murekatete

Tel: +27 (84) 956-6274

Office: 021 388 4270

2. Anonymised Participant Consent Forms: (2.1) Participant One

CONSENT FORM

Title of project: *"Bearing" the Brunt? Exploring how Rwandese migrant women in Cape Town manage domestic- and child-care labour demands in the first year postpartum.*

Name of researcher: Sandrine Mpazayabo

I, [redacted]....., agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle the relevant options below).

I agree that my participation will remain anonymous	(YES)	NO
I agree that the researcher may use anonymous quotes in his / her research report	(YES)	NO
I agree that the interview may be audio recorded	(YES)	NO
I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by this researcher or other researchers, subject to their own ethics clearance being obtained.	(YES)	NO
I agree that the researcher will have access to my name and telephone number in order to contact me via phone-call to schedule the interviews, and to contact	(YES)	NO

me via WhatsApp for the post-interview debrief.

[redacted] (signature)

[redacted] (name of participant)

25/11/2021 (date)

(signature)

Sandrine (name of person seeking consent)

25.11.2021 (date)

(2.2) Participant Two

CONSENT FORM

Title of project: *"Bearing" the Brunt? Exploring how Rwandese migrant women in Cape Town manage domestic- and child-care labour demands in the first year postpartum.*

Name of researcher: Sandrine Mpazayabo

I, [redacted]....., agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle the relevant options below).

I agree that my participation will remain anonymous	(YES)	NO
I agree that the researcher may use anonymous quotes in his / her research report	(YES)	NO
I agree that the interview may be audio recorded	(YES)	NO
I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by this researcher or other researchers, subject to their own ethics clearance being obtained.	(YES)	NO
I agree that the researcher will have access to my name and telephone number in order to contact me via phone-call to schedule the interviews, and to contact	(YES)	NO

me via WhatsApp for the post-interview debrief.

[redacted] (signature)

[redacted] (name of participant)

19.11.2021 (date)

(signature)

Sandine (name of person seeking consent)

19.11.2021 (date)

(2.3) Participant Three

CONSENT FORM

Title of project: *"Bearing" the Brunt? Exploring how Rwandese migrant women in Cape Town manage domestic- and child-care labour demands in the first year postpartum.*

Name of researcher: Sandrine Mpazayabo

I, [redacted]....., agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle the relevant options below).

I agree that my participation will remain anonymous	(YES)	NO
I agree that the researcher may use anonymous quotes in his / her research report	(YES)	NO
I agree that the interview may be audio recorded	(YES)	NO
I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by this researcher or other researchers, subject to their own ethics clearance being obtained.	(YES)	NO
I agree that the researcher will have access to my name and telephone number in order to contact me via phone-call to schedule the interviews, and to contact	(YES)	NO

me via WhatsApp for the post-interview debrief.

[redacted] ..... (signature)

[redacted] ..... (name of participant)

11 · 11 · 2021 ..... (date)

..... (signature)

Sandrine ..... (name of person seeking consent)

11 · 11 · 2021 ..... (date)

(2.4) Participant Four

CONSENT FORM

Title of project: *"Bearing" the Brunt? Exploring how Rwandese migrant women in Cape Town manage domestic- and child-care labour demands in the first year postpartum.*

Name of researcher: Sandrine Mpazayabo

I, [redacted]....., agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle the relevant options below).

I agree that my participation will remain anonymous	YES	NO
I agree that the researcher may use anonymous quotes in his / her research report	YES	NO
I agree that the interview may be audio recorded	YES	NO
I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by this researcher or other researchers, subject to their own ethics clearance being obtained.	YES	NO
I agree that the researcher will have access to my name and telephone number in order to contact me via phone-call to schedule the interviews, and to contact	YES	NO

me via WhatsApp for the post-interview debrief.

[redacted] (signature)

[redacted] (name of participant)

NOVEMBER 16th 2021 (date)

(signature)

Sandrine (name of person seeking consent)

16.11.2021 (date)

(2.5) Participant Five

CONSENT FORM

Title of project: *"Bearing" the Brunt? Exploring how Rwandese migrant women in Cape Town manage domestic- and child-care labour demands in the first year postpartum.*

Name of researcher: Sandrine Mpazayabo

I, [redacted]....., agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle the relevant options below).

I agree that my participation will remain anonymous	(YES)	NO
I agree that the researcher may use anonymous quotes in his / her research report	(YES)	NO
I agree that the interview may be audio recorded	(YES)	NO
I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by this researcher or other researchers, subject to their own ethics clearance being obtained.	(YES)	NO
I agree that the researcher will have access to my name and telephone number in order to contact me via phone-call to schedule the interviews, and to contact	(YES)	NO

me via WhatsApp for the post-interview debrief.

[redacted] ..... (signature)

[redacted] ..... (name of participant)

3.12.2021 ..... (date)

..... (signature)

Sandrine ..... (name of person seeking consent)

3.12.2021 ..... (date)

PARTICIPANT INFORMATION SHEET

Good day,

My name is Sandrine Mpazayabo and I am a Masters student in Migration and Displacement Studies at the University of the Witwatersrand, Johannesburg. As part of my studies, I have to undertake a research project, and I my research study is concerned with exploring how Rwandese migrant women manage demands around the home in the first year after having their first child. The supervisors on this research study are Dr. Langelihle Mlotshwa and Associate Professor Jo Vearey. Drawing on various theories within the social sciences, the aim of this research study is to identify and explore the support strategies that Rwandese migrant women in Cape Town adopt in response to their domestic-labour and child-care demands that they face during the first year after giving birth to their first child.

As part of this project, I would like to invite you to take part in two semi-structured interviews (in English) and a personal debrief over WhatsApp (which can take place in English or Kinyarwanda) after each interview. The interviews will take place face-to-face in a socially distanced manner, and the setting will either be at my home in Gardens, at your home or a third location, such as a park, depending on wherever you will feel most comfortable and safe. Each interview will be between 30 and 90 minutes long. If you agree to be part of my study, I will cover any transport or logistics costs you incur and will also buy you data for the WhatsApp 'debrief'. The 'debrief' will consist of me contacting you via WhatsApp an hour after your interview and asking how you felt about the interview. With your permission, I would also like to audio record the interviews using mobile software. After each interview, this recording will be deleted off my phone and stored in a password protected folder on my laptop, with all identifying features removed. If you do not feel comfortable conducting the interviews face-to-face, I am happy to conduct them over the phone. I will cover any airtime or data costs that you may incur.

There will be no personal costs to you if you participate in this project. You will not receive any direct benefits from participation but there are no disadvantages or penalties if you do not choose to participate or if you withdraw from the study. You may withdraw at any time or not answer any question if you do not want to. The interviews will be completely confidential and anonymous as I will not be asking for your name or any identifying information, and the information you give to me will be held securely and not disclosed to anyone else. For the WhatsApp debriefs, I will have your telephone numbers, but will delete the 'chat' after your final interview. I will be using a pseudonym (false name) to represent your participation in my final research report. If you experience any distress or discomfort at any point in this process, we will stop the interview or resume another time. Some of the interview questions may be of a sensitive nature and you may experience emotional distress. If you would like any specialized support or counselling services following the interview, I have arranged for you to access up to two one-hour long sessions with a trained counsellor based in Parow (for up to six months after the final interview). His name is Albert Murekatete and his contact details are listed below. I can also arrange the sessions for you if you would prefer this.

If you have any questions during or afterwards about this research, feel free to contact me on the details listed below this. This study will be written up as a research report which will be available online through the university library website. If you would like to receive a summary of this report, I will be happy to send it to you. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrecnon-medical@wits.ac.za

Yours sincerely,

Researcher:

Sandrine Mpazayabo

E-mail: 2455461@students.wits.ac.za

Tel: 0623658220

Trained counsellor:

Albert Murekatete

Tel: +27 (84) 956-6274

Office: 021 388 4270

Address: Room 314, 3rd Floor

Montana Office Suites

c/o De La Rey Street & Voortrekker Rd

Parow

7500

Supervisors:

1. Dr Langelihle Mlotshwa
   E-mail: Langelihle.Mlotshwa@wits.ac.za
   Wits phone number: 011 717 9999

2. Assoc. Prof. Jo Vearey
   E-mail: jo.vearey@wits.ac.za
   Wits phone number: +27(0)11 717 4041

INTERVIEW GUIDE

Section A: Demographic Questions

	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
1. Age					
2. Year of arrival in South Africa					
3. Total number of children					
4. Year and month of first child's birth					
5. Year and month of most recent child's birth (if applicable)					
6. Who they live with					
7. Relationship status					

Section B: Thematic Questions

8. What has your overall child-rearing experience been like with your first child?
9. How did you feel physically in the first month after having your first child?
10. How did you feel emotionally in the first month after having your first child?
11. Were you able to access professional medical support while you were pregnant?
12. Did you feel you could rely on this professional support during your pregnancy? Why or why not?
13. Did you notice an increased level of household work (for example, chores) responsibility or demand in the home after giving birth? In what way?

14. In the first month after having your first child, how much 'housework' or work around the home did you do versus your partner?
15. In the first month after having your first child, how much housework did people outside of you and your partner contribute (if any)?
16. How do you feel about how housework was divided between you and your partner in this first month? Why do you think you feel that way?
17. As the months progressed up until a year after giving birth, how much housework did you contribute versus your partner?
18. As the months progressed up until a year after giving birth, how much housework did people outside you and your partner contribute?
19. How do you feel about how housework was divided overall between you and your partner in the first year after having your child? Why do you think you feel that way?
20. In the first month after having your first child, how much work related to caring for your new born did you do versus your partner?
21. What about caring for your other children? (If applicable)
22. In the first month after having your first child, how much work related to child-care did people outside of you and your partner contribute (if any)?
23. As the months progressed up until a year after giving birth, how much work related to child-care in the home did you contribute versus your partner?
24. As the months progressed up until a year after giving birth, how much work related to child-care did people outside you and your partner contribute?
25. During the year after giving birth, did you feel that you could access a clinic, or hospital, or medical professional for help or support? Why or why not?
26. If yes, did you choose to seek professional support? Examples would be going for postnatal check-ups, visiting a psychiatrist or hiring a nanny. Why or why not?
27. What kinds of support networks, if any, were present during this period?
28. Why do you think these were the kinds of support networks that were present?
29. What kinds of support did you rely on most during this period? How so?
30. What difference would you say these types of support made during this period?
31. What would you describe as your coping mechanisms during this period, if any?
32. Why do you think these were your coping mechanisms during this period?
33. Are there any other thoughts or feelings related to your first postpartum experience that you would like to share?