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Exploration of Zimbabwean Migrant Women's Beliefs and Practices Surrounding Access, Utilisation of Contraceptives and Antenatal Services in South Africa

A Thesis submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in Fulfilment of the Requirements for the Degree of Master's in Migration and Displacement

Submitted: 22 June 2020

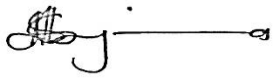
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DECLARATION

I declare that this dissertation is my own unaided work. It is being submitted for the degree of Master of Arts by Course Work & Research at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination by any other University.



_____ SIBONGINKOSI DUNJANA

22nd of June 2020

ABSTRACT

Maternal health of vulnerable populations including migrants remains poor, especially when compared with non-migrants in South Africa. However, over the past decades access to contraceptive issues and antenatal services have been placed at the periphery of reproductive health discourses. Using qualitative Socio-ecological and Intersectionality approaches, this study sought to contribute in closing this gap by investigating beliefs and practices surrounding contraceptives and antenatal care among Zimbabwean migrant women. In-depth interviews were conducted with 14 women in Johannesburg and Pretoria (South Africa), identified through purposive sampling and snowballing. Thematic analysis was used to analyse data. Evidence from the study reveals that there is prevalent use of the Zimbabwean oral pills among other multiple contraceptives used by nationals of this country who have migrated to South Africa. Participants reported that they preferred Zimbabwean contraceptives especially the oral pill over the South African ones, owing to the side effects experienced from local options. With regards to antenatal care, the study established that Zimbabwean migrant women use traditional medicine such as elephant dung and herbs in concurrence with biomedicine. This practice is founded on the fear of maternal and infant deaths which remains high in developing countries. They believe that the use of traditional medicine prevents labour complications that can lead to cesarean births, prolonged labour, maternal, foetal and neonatal mortality. More importantly, the study established that Zimbabwean migrant women's beliefs and practices relating to contraception or antenatal care are a continuation from their country of origin. These continuities are instituted and facilitated through a series of transnational activities, maintaining social ties, and communication. Findings show that although migration transforms some of the migrants' beliefs and practices, most of these socio-cultural aspects are deep rooted, enduring even after resettlement, regardless of available contraceptive options and antenatal care services in South Africa. The study further noted that, although there are commonalities among the women's beliefs and practices, their experiences of contraception and antenatal care are heterogeneous owing to the influences of multiple intersecting factors from the different levels of the socio-ecological framework such as class, documentation status and personal past experiences among other factors. The study concludes that Zimbabwean women's beliefs and practices surrounding contraceptives or antenatal care, are complex, multilayered, characterised by multiple intersections between personal, social, structural factors from both the country of origin and destination. Migrant transnationalism is, therefore, a resource which facilitates continuities with country of origin beliefs and practices surrounding contraception and antenatal care. These findings reflect a need for future research on experiences of other nationals with local contraceptives, and how they cope with the desire to use their country of origin contraceptive options or traditional medicine for antenatal care, considering the proximity of some of their countries with South Africa.

Keywords: migrants, contraceptives, antenatal care, traditional medicine, biomedicine, transnationalism.

DEDICATION

To my late parents, Stanley and Susan, who believed in me when I did not believe in myself
Who saw the best in me, and went against all odds to nurture it
Although it has been difficult to look beyond the sorrow of your departure
I will always look back, and cherish the seed of determination you sowed in me.
With you gone, it some what feels like the sun has gone down, but its gentle warmth still lingers on
Feels like that the music has stopped yet its echoes can still be heard in sweet refrains
Indeed, for every joy that passes something beautiful remains behind
This work is the result of your prodigious investment and firm belief in my potential
You ran a good race *mama lo tata*
Lalani ngokuthula bazali bami !
Ngiyihohlala ngilithanda, ngilikhumbula.

To my love, Nhamo Mukute, words are not enough to say thank you. You said to me when I submit this research report, you are going to get me a new birth certificate with the name Perseverance and replace Sibonginkosi, for you have never seen this level of persevering. Today, I say to you; there are people in life who make success both possible and rewarding. That is what you have been to me and much more.
Here is to more of these together, here is to our endless possibilities!
Uthandwa yimi!

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In the name of the most gracious God, with the submission of this research report, I have managed to satisfy all the requirements of a highly competitive Master's degree program at a prestigious institution, University of the Witwatersrand. There were times when the odds of completing appeared closer to null. Well, probabilility and statistics are faithless, but He [God], is faithful, for He cannot flout himself [2 Timothy 2 : 13]. Foremost, I thank Him, the 'great mentor' and 'promise keeper' for providing me with sufficient inspiration and strength to soldier on.

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List of Abbreviations and Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
CARMMA	Campaign on Accelerated Reduction of Maternal and Child Mortality
CBPR	Community -Based Participatory Research
CPR	Contraceptive Prevalence Rate
DRC	Democratic Republic of Congo
FP	Family Planning
HBM	Health Belief Model
HCPs	Health Care Professionals
HIV	Human Immuno Virus
HREC	Human Research Ethics Committee
IOM	International Organisation for Migration
LGBTI	Lesbians, Gay, Bisexual, Transgender and Intersex
MDGs	Millennium Development Goals
PLHIV	People Living with HIV
SADHS	South Africa Demographic and Health Survey

SDGs	Sustainable Development Goals
SDH	Social Determinants of Health
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
UNFPA	United Nations Fund for Population Activities
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation

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CHAPTER ONE : BACKGROUND

1.1 Introduction

Low and medium income countries have continuously failed to meet the healthcare needs of women at key moments of their lives, leading to high antenatal and maternal deaths (Mariani et al., 2017). With regards to international migration, which is conceptualized in this study as the movement of people from their countries of birth (United Nations,2017), female migrants when compared with non-migrants, often show worse health indicators (Rocha et al., 2010). Studies indicate that most women migrate during their child bearing stages and this exacerbates their social vulnerabilities especially in the aspect of sexual reproductive health (Kvamme & Ytrehus, 2015) and (Almeida et al., 2013). It has been noted that pregnant immigrant women delay accessing antenatal care and they do so after a series of weighing the value and consequences of accessing the services (Fair et al., 2020). This puts them at increased risk of pregnancy associated complications that can be detrimental to their lives and that of the unborn baby. Employing the qualitative socio-ecological (Bronfenbrenner, 1979) and intersectionality (Anthias & Yuval-Davis, 1983) approaches, I sought to gain an in-depth understanding of Zimbabwean migrant women's beliefs and practices regarding contraception and antenatal care. Moreover, I aimed at exploring the intersections between factors that influence issues of access and utilisation where contraceptives and antenatal care services are concerned.

Drawing from the women's narratives of their experiences during in-depth interviews and the observations I made during fieldwork in the first quarter of 2020, I will bring forward evidence that depicts the complexity and heterogeneity of their experiences. I argue that Zimbabwean migrant women's contraception and antenatal care beliefs and practices in South Africa cannot be understood in isolation of their country of origin context. Their experiences are a manifestation of the existing intersectional relationship between personal attributes such as age, class, level of education; relational influences like peer relations, marital/relationship status; socio-cultural aspects such as beliefs systems, cultural norms, religion; societal, structural and institutional arrangements like laws, regulations, policies, media and health systems. As Zimbabwean migrant women migrate to South Africa, they do so with their sexual and reproductive health beliefs and behaviours adopted from their home country. These

notions, practices regarding contraception and antenatal care constitute a critical component of how they later experience and navigate health care in South Africa.

1.2 Contextualisation

Studies have shown that an estimated 225 million women in developing regions have an unmet need for modern[1] contraception (Singh et al., 2017). These are women who are sexually active, who want to avoid unwanted pregnancies, yet they are not using safe and effective contraceptive methods due to various reasons. Consequences of the unmet need for modern contraceptives, include higher incidences of unsafe abortions, maternal, foetal and neonatal mortality (Cleland et al., 2015). In South Africa, it is estimated that every year, nearly 3,000 mothers and 40,000 children under five years die mainly from preventable causes relating to pregnancy and child birth (Bradshaw & Dorrington, 2012); (World Health Organization, 2012) and (Stats SA, 2014). It has been suggested by studies that contraceptive use reduces almost 230 million births every year and it remains the principal prevention strategy for unwanted pregnancies (Liu et al., 2008); (Singh et al., 2009). This is attained through the prevention of unwanted pregnancies, reduction of abortion, especially unsafe abortion and affording women an opportunity to determine the number and spacing of their children (World Health Organisation 2018). This implies that maternal, foetal and neonatal deaths can be prevented through women's access to appropriate sexual and reproductive health care and that includes contraceptives and antenatal care. This study is premised on a need for nuanced studies focusing on migrant's contraceptives and antenatal care access and utilisation. It aims to understand how their experiences are instituted and affected by varying intersecting socio-cultural factors in the context migration.

In this study, I focus on South Africa because the country is one of Africa's biggest economies and a major destination in the region, hosting 4.2 million which equates to 7.2 per cent of international migrants' stock (UNDESA, 2019). As migration has become one of the salient features of the 21st century, available data indicates that the rate of female migration is almost as high as that of males, making 48 per cent of the global migrants (O'Neil, Fleury, & Foresti,

[1] Hubacher &Trussell (2015) define modern contraceptive methods as the use of any medical procedure like sterilisation, subdermal implants, oral contraceptives, condoms, injectables, pills, patches, diaphragms and cervical caps, spermicidal agents, vaginal rings, sponge, etc.

2016). Women are increasingly migrating on their own; often to enhance economic opportunities by seeking jobs or education, a phenomenon labelled the "feminisation of migration" (Marchetti & Salih, 2017, p. 6). While globally, females comprise about half (130 million or 48 per cent) of the international migrant stock, in South African they constitute 44.4 per cent of international migrants (UNDESA, 2019). Concerning fertility rates, South Africa has experienced a marked fertility decline, with the total national fertility rate estimated at 2.43 births per woman in 2017, from an estimated 2.9 in a period of 20 years (World Bank, 2019). Despite the progress made, Lerch (2019) and Adebowale (2019) note that there exist variations in fertility rates across regions, urban-rural residence, and ethnic groups. Other studies that compare rural and urban residents have also noted that fertility and contraceptive preferences can be locale and group specific in most cases as result of lack of knowledge about other options or perceptions on efficacy or sides effects among other reasons (Bogale et al., 2011; Gebremariam & Addissie, 2014).

The variations in health outcomes between groups of women point to a need to investigate and understand migrant's experiences as a sub group of women. For an example, Jo and No (2014) observed that although Botswana, has huge investments in health care, there are disparities as far as access is concerned between citizens and foreigners, with the latter remaining increasingly marginalised and facing obstacles in meeting their desired reproductive health needs. As a result, due to their peculiar circumstances immigrants and refugees, present poor health outcomes as far as sexual and reproductive health is concerned. In view of this, I note that, although migration may present opportunities that can empower women such as education, employment and access to new resources with symbolic capital (Salih, 2011); it may conversely exacerbate their vulnerabilities, especially in terms of access to health.

Given this background and arguments by several studies, firstly, Mutombo et al., (2014), who posit that women's ability to plan when and if to have children is fundamental to their overall health, that of the child and is critical for sustainable development. Secondly, the assertion that promoting family planning and access to preferred contraceptives by women is essential to securing their well-being as well as their autonomy, while supporting community development (Rabiu & Rufa'i, 2018) and (WHO, 2018). Lastly, Topa et al., (2013), who hold that poor access to health care for migrants can reflect the failure of a health care system which claims to be democratic and inclusive. I, therefore, argue that there is need for nuanced studies which seek to understand the intersecting, multifaceted factors that influence Zimbabwean migrant

women's experiences of contraception and antenatal care in South Africa. Consequently, in this study, I examine and present findings on the multiple beliefs, practices surrounding Zimbabwean women's access, utilisation of contraceptives and antenatal care.

1.3 Research Question

What are the beliefs and practices surrounding access, utilisation of contraceptives and antenatal care services among Zimbabwean migrant women?

1.3.1 Study Objectives

This study seeks to:

- Investigate existing beliefs held by Zimbabwean migrant women surrounding contraceptives and antenatal care in Pretoria and Johannesburg (South Africa).

- Investigate existing practices regarding access and utilisation of contraceptives and antenatal care among Zimbabwean migrant women in Pretoria and Johannesburg (South Africa).

1.4 Conceptualisation of Terms

1.4.1 Contraceptives

In this research report, I make use of the delineation by Hubacher & Trussell (2015) on modern and non-modern contraceptives to demarcate between the types of contraceptives reported on by the study participants. Jain & Muralidhar (2011, p. 626) define contraception as "the intentional prevention of conception through the use of various devices, sexual practices, chemicals, drugs, or surgical procedures". They further enunciate that "any device or act whose purpose is to prevent a woman from becoming pregnant can be considered as a contraceptive" (Jain & Muralidhar, 2011, p. 626).

With regards to contraceptives, a demarcation is made between modern and non-modern methods, in some instances called traditional methods. Modern contraceptives refer to:

> *"Any medical procedure or products that interfere with reproduction such as sterilisation, subdermal implants, oral contraceptives, condoms, injectables, pills, patches, diaphragms and cervical caps, spermicidal agents, vaginal rings, sponge among others"* ***(Hubacher & Trussell, 2015, p. 420).***

On the other hand, non-modern methods of preventing pregnancy are said to include "fertility awareness approaches (standard days method), calendar rhythm method, ovulation method, withdrawal, lactational amenorrhea and abstinence" (Hubacher & Trussell, 2015, p. 420). Similarly, these are the distinctions I use in this study to elaborate on Zimbabwean women's contraception beliefs and practices as they live and work in South Africa.

1.4.2 Antenatal Care

In this study I draw from the World Health Organisation (WHO)'s conceptualisation of antenatal care as:

> *"Care that is provided by skilled health-care professionals to pregnant women in order to ensure the best health conditions for both mother and baby during pregnancy". (World Health Organization, 2016, p.1)*

The same report highlights that antenatal care includes a range of services like "risk identification; prevention and management of pregnancy-related or concurrent diseases; and health education and health promotion" (WHO, 2016, p.1). This, therefore, is how I ground my conceptualisation of antenatal care and services in this study.

1.4.3 Sexual and Reproductive Health

With regards to Sexual and Reproductive Health (SRH), I will draw from the United Nations Population Fund. (UNPFA, 2016)'s definition which is as follows:

> *"A state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so". (UNPFA, 2016, p.1)*

In a report by the Center for Health and Gender Equity (Change, 2008), three components of SRH are identified, namely, family planning, sexual health, and maternal health. Based on this report which remains particularly important over a decade later, in a context where women's SRH outcomes are still poor; in instances where there is no need to exclusively refer to contraception, antenatal care and sexual health, I will use the term SRH to collectively refer to all the three components.

1.4.4 Conceptualisation of Migrant Women

In this study, my focus is on migrant women, in particular those who are of Zimbabwean nationality. This is premised on the consideration that "women" is a broad social construct constituted by many sub groups, and studies note that there exist health disparities between subgroups of women, in this case, migrant and non-migrant women (Bogale et al., 2011); (Gebremariam & Addissie, 2014). In view of this, and for purposes of an in-depth understanding of the subject matter, also acknowledging that the scope of my research is limited to study "women" in their entirety, I will limit my focus to migrant women.

As mentioned earlier, an international migrant is a person who lives in a country where he or she was not born in (United Nations, 2017). The United Nations (UN) also reveals that worldwide, women make up 48 per cent of international migrants (UN, 2017). Of the 48 per cent of women who are international migrants, they have a median age of 29 to 43 years, meaning that a large number of them are of childbearing ages (OECD, 2013). These migrant women's sexual and reproductive health is of increasing concern to varying disciplines which include researchers, practitioners, and policymakers (Balaam et al., 2017). It is in view of these factors, that I form the basis of my focus, on women who are Zimbabwean nationals by origin and reside in a country other than their birth country, in this case South Africa. In this report I refer to them as 'migrant women".

1.4.5 Traditional Medicine and Indigenous Knowledge

To discuss findings relating to the use of traditional medicine, I adopted the definition of the concept that has been provided by the World Health Organisation (2019). Traditional medicine has been defined as:

> *"The sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness". (World Health Organization, 2019, p. 1)*

The WHO further defines complementary or alternative medicine (CM/AM) as:

> *"The broad set of health care practices that are not part of that country's own tradition or conventional medicine and are not fully integrated into the dominant health-care system. They are used interchangeably with traditional medicine in some countries". (World Health Organization, 2019, p. 1)*

It is further noted that "traditional and complementary medicine (T&CM) merges the terms traditional medicine (TM) and complementary medicine (CM), encompassing products, practices, and practitioners" (WHO, 2019, p.1). Based on this, I will use the phrases traditional, indigenous and complementary medicine" interchangeably to refer to any practice or product that is not encompassed in the South African and Zimbabwean's mainstream/conventional medicine.

1.4.6 Biomedicine

In 1979, Good and others posited "that there are two systems of health care in the developing world: one is traditional and prescientific; the other modern, scientific, and Western in derivation. The two exist side by side, yet remain functionally unrelated in any intentional sense" (Good et al., 1979, p. 141). It has been noted that western biomedical practices are based upon the principles of modern science. with Keating et al., (2003, p. 52) asserting that

"biomedicine, refers to clinical medicine based on the principles of physiology and biochemistry" In this study, I will therefore, use the same conceptualisation of biomedicine or biomedical health system to refer to clinical health options used by study participants

1.5 Structure of the Research Report

This report has five chapters. In the first chapter I present the background of the study focusing on women's fertility and maternal health in the South African context, also linking it with migration. The second chapter is about the literature review. In this chapter, I identify existing academic work on the subject, and I flag out the areas of merit beneficial to knowledge creation and studies like mine. I also flag out gaps that I seek to address through my study. I organise this section in three critical themes within which I locate my study namely, existing knowledge regarding the subject, methodological and theoretical limitations in similar studies that have been conducted. In chapter three I provide a detailed synopsis of the methods that I used to get an insight into the different views and experiences expressed by participants. I used qualitative methods, in particular in-depth interviews. The observation method also played a vital triangulation role, where women showed me the types of contraceptives they use, and traditional medicine for sexual purposes.

In the fourth chapter I present the research findings and discuss them. I provide evidence from the two selected study sites in South Africa (Johannesburg and Pretoria) which indicates how migrant women's sexual and reproductive health experiences are complex, heterogeneous. More importantly, I demonstrate how the women's beliefs and practices are influenced by factors assimilated from the country of origin in as much as destination country related issues. In the concluding fifth chapter of the report, I sum up the whole study by providing a summary of the key findings, and how it contributes to knowledge. I also provide a synopsis of my reflections on utility of the theories and methods that I employed, together with ethical issues. I finalise by providing recommendations, pointing out a need for future studies on the subject especially focusing on other nationals.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

In this chapter, I explore existing literature on the subject of sexual reproductive health, focusing on contraceptive use and experiences of antenatal care in the context of migration. I present an analysis of available literature, citing areas of commonality with my study and how my study will cement existing findings. In addition, I delve into gaps within existing literature, showing the knowledge, methodological and theoretical issues that my study aims to address. The literature review discussion also sets the agenda for the rationale of the study, where I present my research question, locate my study within existing knowledge, paradigms, and theoretical frameworks.

2.1.2 Sexual Reproductive Health (Contraception and Antenatal Care) in South Africa

South African laws and policies support a rights-based framework for SRH, as they are aligned with health and development frameworks like the Sustainable Development Goals (SDGs)[2] and Global Family Planning 2020 (Lince-Deroche et al., 2016). Similarly, Müller & Macgregor (2013, p. 4) posit that "South Africa' s constitutional and legal framework reflects the country's commitment to women's SRH, in line with international commitments". They suggest that this is reflected in existing policies that detail the provision of services around SRH namely, contraception, maternal, perinatal, and newborn health, sexually transmitted infections (STIs), including HIV, and cancers of the reproductive system. Despite these progressive legislations, Lince-Deroche et al., (2016) indicate that the country continues to experience high prevalence rates of SRH related problems such as high maternal deaths. They attribute this to policies that exist in a social setting of extreme inequality coupled with high rates of poverty and unemployment.

[2] These are a set of anti-poverty goals agreed by 189 countries in the year 2000, with the target of achieving universal access to reproductive health by 2015 as the target for the MDG number 5 (the Human Rights Watch Report 2011).

With regards to contraception, the South African government has in place National Contraceptive Policy Guidelines (Department of Health, 2012), focusing on women's access to a method of choice for preventing pregnancy and child spacing. These guidelines establish the importance of addressing women's contraceptive and fertility planning needs of people living with HIV (PLHIV), sex workers, lesbians, gay, bisexual, transgender, and intersex persons (LGBTI), migrants, people with disabilities, and adolescents. The South Africa Demographic and Health Survey (National Department of Health & ICF, 2019), reveals that the Contraceptive Prevalence Rate (CPR) among all women aged 15-49 is 48 per cent, with nearly all women (99 per cent) who use a contraceptive method reporting that they use a modern method. Furthermore, the country has an unmet need for contraception by sexually active women of 19 per cent (National Department of Health & ICF, 2019).

Although these figures indicate a high magnitude of contraceptive use by women in South Africa, it however does not portray the dynamics of access for instance, challenges associated with access, women's preferences, and differences amongst different groups of women. Lince-Deroche et al., (2016) argued that this relatively high contraceptive prevalence rate masks problems with service delivery, equitable access, and correct, consistent, and continuous use of contraception especially among certain groups such as young or rural women. Moreover, Anthias & Yuval-Davis (1983) contended that it is not appropriate to view "women" as a unitary group with a shared experience without acknowledging their heterogeneity. It is in view of these factors that I sought to conduct this study and respond to questions relating to factors that influence women's access and utilisation of contraceptives, with a focus on migrant women who live and work in South Africa, while they are of Zimbabwean nationality.

With reference to antenatal care, in 2017, South Africa recorded a maternal mortality ratio of 119 deaths per 100,000 live births down from 122 deaths per 100,000 live births the previous year, marking a 2.46 per cent change, for the better (World Data Atlas, 2019) and (CIA World Fact Book, 2019). Although this reduction indicates desired progress made towards improving women's health, it is worth noting that the realities of people's lives cannot be summed up and reduced to figures. While figures will tell a story about the magnitude of a problem, they do not reveal the underlying causes owing to a phenomenon, achievement, or challenge.

Citing examples such as (Makandwa & Vearey, 2017) who posit that socioeconomic status, health care provider-patient interaction, institutional administration, language barrier and

nationality are major factors that influence access to maternal health care by Zimbabwean migrant women. I maintain that although studies have been conducted on women's maternal health in South Africa, the areas of focus have been different from the focus area of this study. Using the social determinants of health conceptual framework (SDH 2010), this study (Makandwa & Vearey, 2017) remarkably delves into factors that influence maternal health particularly from a host country environment. To complement this, as I have indicated earlier, I seek to investigate factors such beliefs, and practices relating to contraception and antenatal care among Zimbabwean migrants.

2.1.3 The South African Policy on Health of International Migrants

Vigneswaran (2011, p. 105) observed that the South African government "has been struggling to develop a coherent response to migration for more than a decade". Arguably, this is still the case nearly a decade later after his observations, which has given room to "simultaneous informal implementation of migration and refugee policies by street-level bureaucrats" (Moyo & Zanker, 2020, p. 7). Although the country has a statutory commitment to ensure that all people have access to health care, as embodied by the Constitution of South Africa (1996), the National Health Act (2003), the Immigration Act (2002) and the Refugees Act (1998); the "multiple pieces of legislation and guidelines can be confusing" (Vearey, 2011, p. 124). For instance, according to the South African Constitution (Section 27) and the National Health Act (2003), everyone has a right to access health care services and this includes South African citizens and non-citizens. In terms of contraception and fertility planning in relation to migrants, the National Health Act (2003) is guided by South Africa's constitutional and legal framework, with its emphasis on human rights. However, the key elements therein (National Health Act, 2003), include categorising migrants and "offering them differing rights to access free public healthcare services" (Vearey, 2011, p. 124). Consequently, asylum seekers and refugees are governed by the Refugee Act (1998) and other cross-border migrants are governed by the Immigration Act (2002).

While the Refugee Act, 1998 (Act No. 130), provides for an equal treatment of refugees and asylum seekers with South African citizens, in terms of access to free public healthcare; the Immigration Act (2002) is however, different. The Immigration Act (2002) states that health care officers at clinics and hospitals must first find out the legal status of patients before

providing care, except in emergency situations (Immigration Act (2002). From these provisions, it is evident as cited by Vearey (2011), how different categories of regional migrants are granted differential rights to access free public healthcare services.

Despite the provisions of the Refugee Act, 1998 (Act No. 130), as stated above, (Munyaneza & Mhlongo, 2019) observe that refugees have protracted negative encounters with the South African health care system when compared with positive ones, as they seek to access sexual reproductive health. They cite medical xenophobia, language barrier, financial challenges, religious and cultural hegemony as some of the negative factors characterising health care access of refugees in Durban (South Africa). This study contributes to the body of knowledge on the lived realities of refugees who are of the Democratic Republic of Congo, Rwandese, and Burundian nationality, by reflecting the discrepancies between policy provisions and experiences. However, little is known about Zimbabwean migrant women's experiences. This study, therefore, seeks to explore experiences of Zimbabwean nationalities in Gauteng province, thus bridging the knowledge gap on the subject and this group of nationals.

Drawing from the assertion that South Africa struggles with incoherent policies in response to migration (Vigneswaran, 2011) and that the existing pieces of legislation are confusing (Vearey, 2011), an inference can be made that these policy gaps permeates vulnerabilities and challenges faced by migrant women in terms of health. These vulnerabilities and challenges include prejudice and or refusal of health care at health facilities, fear of seeking health care for migrants without documents, high susceptibility to sexual abuse and sexual exploitation (Munyewende et al., 2011). Migrants also experience "medical xenophobia", which refers to "the negative attitudes and practices of health sector personnel to migrants and refugees based on their migration status while on the job" (Crush & Tawodzera; 2014, p. 1). It is against this background that this study is premised.

2.1.4 Contraception Beliefs and Practices in the Context of Migration

A few years ago, Vearey et al., (2017) argued that migration and health have become a priority all over the globe, owing to the recognition that migration is a determinant of health. Yet of note, a number of migration studies have "widely examined the phenomenon from historical, social, economic, and cultural perspectives while health and healthcare perspectives are

understudied" (Marceca, 2017, p. 104). Arguably, fertility and antenatal health of migrants is important but under researched in Sub Saharan Africa. Available literature on the health of migrant women has mainly focused on their experiences of sexual abuse and issues related to.HIV/ AIDS, with examples like Faturiyele et al., (2018); (Govender et al., 2019) and (de Gruchy & Vearey, 2020). Few studies may however be singled out like Makandwa & Vearey (2017); Munyaneza & Mhlongo (2019); Mengesha et al., (2017) and Rocha et al., (2010), who have investigated how migrants experience SRH under different contexts, broadly including contraception and maternal health. These studies add to the body of knowledge regarding the subject of contraception and maternal health, while at the same time, setting the scene for further studies to either bridge the gaps resulting from their limitations, or to play a complementary role where need be. Consequently, this has necessitated my study, and, in this section, I explore how I locate my study within similar studies on the subject.

Munyaneza & Mhlongo (2019), underscored that cultural and religious hegemony affects use of contraceptives and other SRH services by Rwandese, Burundian, and Congolese refugee women in Durban, South Africa. In their study, they documented the following statement from one of the respondents and note that it was a common sentiment shared amongst many respondents:

> *"Family planning is not allowed; it is considered as a sin. If you are using it, you are a sinner; you are killing babies. But if you use it you hide; you only tell your family. Things like abortion and sex before marriage also not allowed. So, no one talks about family planning when you are not married. Abortion you can't even mention it". (Munyaneza & Mhlongo, 2019:5)*

This evidence reiterates findings by Kiura (2012), regarding cultural and religious beliefs among Somalian women in a refugee camp in Kenya. Women in this study also attributed their poor use of contraception methods to the cultural and religious perception, which considers family planning as an act of murder. Existing literature thus points to the role of cultural and religious beliefs as influences of migrant's engagement with contraception, maternal health together with other SRH components.

Still on the same note, in the study of refugee women in Durban regarding their engagement with SRH, it emerged that the prevalent cultural and religious dogmas which they held, and were critical in influencing their practices are beliefs that:

> *"God wants people to multiply as long as they are married, no sex before marriage, abortion is taboo, suggesting the use of condoms in a marriage implies that the wife has been unfaithful to her husband and that treatment of infertility is not allowed because God will make things happen in due time". (Munyaneza & Mhlongo, 2019:7)*

This study reflects the complexities that cloud contraceptive access and utilisation by refugee women, coupled with other SRH services. It indicates how even in a context where other determinants of health may be addressed, the environment made conducive for these groups of women to access services, uptake may remain low. The study, however, captures the perspectives of refugee women, whose countries of origin are Rwanda, Burundi, and the Democratic Republic of Congo (DRC). Their experiences, may be similar or may not be similar to other women, originating from different contexts and with different beliefs. For purposes of knowledge generation on the subject, it is therefore prudent, to conduct further studies with a different group of women and understand areas of commonalities and differences.

Álvarez Nieto et al., (2015) investigated SRH beliefs and practices of female immigrants in Spain. Although this study was conducted in Spain, it is particularly important to review studies from elsewhere, as posited by Gushulak & MacPherson, (2011, p. 1) that "although migrant populations are extremely diverse, the processes of migration include certain characteristics shared by all migrants". Therefore, lessons may be drawn from studies conducted in other contexts. Their findings indicate that women acknowledged the importance of contraception and its role in controlling their desired number of children. This study established that the easily accessible contraceptives were the commonly used among their target group. In this study, they posit that popular use of an easily accessible contraceptive option "does not mean that it is the appropriate contraceptive method for all women" (Álvarez Nieto et al., 2015, p. 6). Some of the reported beliefs in the same study, surrounding contraceptive use include the belief that contraceptive use is the duty of a woman, hence it is their decision which type they choose to

use. Male's involvement was said to be prevalent in instances where they refuse use of some methods like condoms.

Existing literature indicates that historic social, economic, and political marginalisation from the country of origin has an influence on how women's SRH outcomes fare in the host country. This was particularly illuminated in a study by Espinoza and others on cultural perceptions and negotiations surrounding sexual and reproductive health among migrants (those who migrate to the United States of America) and non-migrant indigenous (those who remain in their rural community) Mexican women (Espinoza et al., 2014). Although they studied SRH in its broad sense, their findings elucidated how:

> *"Historic social, economic, and political marginalisation from the country of origin inequalities continue to influence health behaviors and access to health services in Mexico as much as in context of international migration, also compounded by ethnic, cultural and linguistic differences". (Espinoza et al., 2014, p. 357)*

Drawing from this findings, this study notes that:

> *"Gendered power imbalances, socio-cultural expectations, perceived lack of trust of health systems shape these indigenous women's sexual and reproductive health perceptions and behaviors, while migration may further complicate access to care as female migrants navigate new health care environments". (Espinoza et al., 2014, p. 363)*

The above literature suggests a link between gendered conceptions of womanhood and women's practices, where the former determines Mexican immigrant women's practices. Arguably, these beliefs about womanhood adopted from the country of origin play a role in women's decisions to seek preventive and timely sexual health care even post migration (Espinoza et al., 2014). Notably, such beliefs and practices play a pivotal role in influencing issues of access and utilisation contraceptives even in a context where policies and health systems are accommodating to migrants. It is worth noting that there is a gap in knowledge on how migrants in the South African context who are of Zimbabwean origin experience SRH.

There is also a gap in knowledge on how historic factors like beliefs from country of origin and migration related issues influence migrant women's SRH experiences.

Rocha et al., (2010) investigated knowledge of contraceptive methods and sexual transmitted diseases prevention among Portugal migrant women. They identified "legality issues, economic constraints, and health professionals' attitudes as barriers to access and utilization of health services by migrants" (Rocha et al., 2010, p. 1003). They further pointed to the role of perceptions, knowledge, and attitudes concerning SRH in influencing uptake of health services (Rocha et al., 2010). This is one of the few studies which explore how utilisation of health services among immigrants is a resultant of a complex interaction among multiple factors. In as much as they underscore the importance of understanding the interconnectedness of migrant's SRH with public health, and the socio-economic development of their origin and destination countries, also echoed in other studies like Mutombo et al., (2014); Topa et al., (2013) and Marchetti & Salih (2017); there remains a gap on similar studies in the South African context. Moreover, the location and context of their study population may make their narratives different from the Zimbabwean migrant women who live in South Africa. This is in view of the fact that constructs such as knowledge, perceptions, attitudes, beliefs, and practices may be group, location, and context specific as posited by (Bogale et al., 2011) and (Gebremariam & Addissie, 2014).

Mengesha et al., (2017) conducted a study on refugee and migrant women's engagement with sexual and reproductive health care in the Australian context. In this study, they interviewed health care professionals (HCPs) who interface with these women and recorded findings from these professional's perspective. They reported that refugee and migrant women have little knowledge about different contraceptive options available and where to seek assistance compared to Australian born counterparts. Furthermore, owing to the prescribed gender roles from their countries of origin, some women could not decide when to have children and choose their desired spacing of pregnancies, because this was considered to be the role of their husbands. This was despite having knowledge about available contraception options and where to access them.

Although this study makes an interesting and critical contribution to the subject from the view point of health care professionals; I argue that it is critical to complement such studies with views from the actual population who live the reality (migrants). Additionally, the differences

in the contexts between Australia and South Africa, the refugees referred to and Zimbabwean women necessitates the need for complementary studies that focus on Zimbabwean migrants in the South African context. The experiences of the study populations might be different as a result of contextual differences and the heterogeneity that exists between migrants. Fang et al., (2015) insist that research has identified health care barriers to equitable access such as language difficulties, it has not considered the broader social contexts of marginalisation experienced through the dynamics of othering. In this instance, they explore the role of societal relations in inhibiting access to health-related services and conclude that barriers to access to health among Iraq and Somali refugees include language barrier and legal status. These studies explore the intricate role of the social context/environment in shaping access to health care by migrants. To complement literature on the role of social context/environment in influencing migrant's access to health service, I argue that there is need for studies about personal attributes such as beliefs. I underscore the need for studies that explore the intersections between personal/individual factors and the broader context where the individuals are located.

As seen from the review of literature above, research on migrants beliefs, and engagement with contraception and antenatal care is scant globally, more so in the South African context. In instances where factors relating to migrant's health have been investigated, greater focus has been on migration and HIV/AIDS, and other studies, although focusing on SRH; the context has been different. Additionally, as shown in the discussion, existing literature cites challenges encountered by migrants in accessing health care and remains silent on their coping mechanisms (practices) to bridge the gap of failure to access. Consequently, there remains a big question on how migrants navigate the health systems in the face of challenges that they encounter in trying to access services. There is need for studies which explore migrant's practices and coping strategies, as failure to access services or encountering challenges in accessing public health care may not be synonymous with not using at all. These considerations form important gaps, in literature which have informed the rationale for my study.

2.1.5 Antenatal Care Beliefs and Practices in the Context of Migration

A significant body of studies have often focused on how the migration process affects migrant's health, socio-economic status, identity and relationships among other factors with examples such as (Bauer et al., 2020); (Landau, 2017); (Spoel et al., 2019) and (Vearey et al., 2014). However, little is known about migrant's beliefs, values, and how these change as a result of migration (Williams et al., 2014). This is despite the observation that values and beliefs play an important role in the well-being of individuals as drivers of behaviors or interactions between individuals and institutions that surround them (Lesthaeghe, 2010). Notably,

> *"Interactions with people at their destinations and with people at their origins, might be one of the strongest catalysts of social change in host and origin countries. Thus understanding migrant values and how they change is key to understanding migrant well-being and social change in general. (Williams et al., 2014, p. 1)*

Coupled with these considerations, literature has shown that investing in migrant women's health during their migration trajectories produces ripple effects that benefit families, communities, nations and saves lives. It has been observed that the inclusion of migrant's needs and the consideration of their peculiar situations can result in real and lasting change as far as their, and the public's health outcomes are concerned (de Gruchy & Vearey2020).

> *"Pregnancy is a period of increased vulnerability for migrant women, and access to healthcare, use and quality of care provided during this period are important aspects to characterize the support provided to this population". Almeida et al., (2013, p. 1346)*

However, there remains a paucity of studies that document antenatal care beliefs and practices among migrant women, within the Southern African region especially in South Africa. Only a few studies can be singled out namely; Makandwa & Vearey (2017); Munyaneza & Mhlongo (2019) and Lindsay et al., (2012). Most studies that have explored the subject of African

women's beliefs and practices surrounding maternal health have focused on women as a collective, which leaves a gap on similar studies in the context of migration, for example (Sabe et al., 2017); (Hlatywayo, 2017) and (Ngomane & Mulaudzi, 2010). However, for a detailed discussion on beliefs and practices that pertain to maternal health, I will make reference to some of these studies outside the context of migration. This paucity of studies on the subject and within the context of migration evidently justifies the need for studies like mine, which seeks to explore differences in women's experiences of contraception and antenatal care, also roping in the migration context.

Makandwa & Vearey (2017) document maternal experiences of Zimbabwean women in Johannesburg. They argue that, due to the nature of their employment, which in most cases is informal and the pressure to meet other socio-economic needs, these women delay accessing antenatal care services coupled with missing appointments. Tied to this, in a study conducted in Australia by Mengesha et al., (2017), it was detailed how after settlement, migrants are too busy with meeting the demands of settling in a new place. These demands were said to include housing, employment, income, and childcare responsibilities. Consequently, "migrant and refugee women reactively access SRH care rather than engaging with preventive services, for example they access medical care only in the case of emergency rather than early antenatal care or reproductive screening" (Mengesha et al., 2017, p. 10). They argued that these practices, their knowledge about available options and where to access them, seemed to improve the longer these women lived in Australia. This suggests that the length of stay in the destination country has an influence on migrant's SRH knowledge and practices.

The treatment of migrants by health care professionals has been underscored to be an important factor in shaping their perceptions about, and experiences of maternal health care (Fair et al., 2020). These authors present that, feelings of lack of respect to their customs and culture by health care providers left them feeling isolated (Fair et al., 2020). Owing to this, the study concludes that women's confidence to attend antenatal care visits is dependent on and improved in instances where they are attended by friendly, unhurried health care professionals. The authors submit that "migrant women need culturally-competent healthcare providers who provide equitable, high quality and trauma-informed maternity care" (Fair et al., 2020, p. 2). This study adds an interesting contribution to the body of knowledge regarding patient and health care worker relations. This has been discussed extensively in other South African literature as well (*see* Crush et al., 2017); (Makandwa & Vearey, 2017) and (Zihindula et al.,

2017). However, more needs to be known on how the aspect of patient- health care worker relations intersect with other variables such as migrant's beliefs on antenatal care. In addition. how these experiences vary across migrants, considering that they are not a unitary group (Anthias & Yuval-Davis, 1983).

On a related issue, Ngomane & Mulaudzi (2010) submit that ill treatment by health workers results in women resorting to using traditional remedies during pregnancy instead of visiting health facilities. They report that participants in their study indicated reluctance to go to the clinic due to attitudes from the nurses, who scold them hence making them scared to suggest what makes them comfortable. In view of this, a question arises regarding similarities and differences between experiences of local women and migrants, more so, in a context rife with medical xenophobia and language barriers. If local women resort to using traditional medicine, traditional healers, and village-based midwifery, how then do migrant women cope when such need arises. Such nuances are vaguely documented in literature, thus reflecting a glaring gap in knowledge regarding the subject.

Although there is a noticeable gap in literature regarding access and use of traditional medicine among women who have migrated, few studies are worth noting that have made strides towards bridging that gap. For example, Sabe et al., (2017) undertook a systematic review of the use of traditional medicine to address maternal and reproductive health issues by African women who have either migrated to the diaspora or have not migrated. They reveal that they found no literature relating to use of traditional methods for maternal purposes in the diaspora, while 80 per cent prevalence use was recorded among African women not in the diaspora. Those who were classified as users of traditional methods were "pregnant women with no formal education, low income, and living far from public health facilities" (Sabe et al., 2017:1). They attribute the practice largely, to lack of access to the mainstream maternity care, the belief that traditional methods were more effective than western medicine, as well as cheaper and easier accessibility.

Similarly, Mureyi et al., (2012) reported high prevalence in the use of traditional medicine among expecting women in the city of Harare (Zimbabwe). They associated this with residing in a particular high-density suburb located in close proximity to informal traders of traditional medicines. They indicate that this practice was done to:

> *"Induce labour, avoid perineal tearing and improve the safety of their delivery process. They further outline that participants who reported not using any traditional medicine during pregnancy reported experiencing significantly more adverse events, mainly perineal tearing during delivery". (Mureyi et al., 2012:1)*

This study, like the ones presented above by Ngomane & Mulaudzi (2010) and Sabe et al., (2017), suggests prevalent use of traditional medicines by women during pregnancy, especially if they are closer to the sources of medicine. Owing to the issue of proximity to the source of traditional medicine, Sabe et al., (2017) found no reports of use among African women in the diaspora. In Mureyi et al., (2012), the incidence of using traditional medicine increased with close proximity to the market where the medicine is sold and decreased among women who resided further away from the source. These findings suggest that migration can potentially affect women's capacity to use traditional medicine. Even though evidence already suggests this, this inference needs to be backed by evidence, gathered through exploring how Zimbabweans in South Africa perform on this aspect. This follows a consideration that these countries are bordering each other, and although there is a distance of up-to 1 091km between the two countries' capital cities (Pretoria and Harare) for example, there is heavy traffic of human mobility across the Beitbridge border post (bordering these two countries). This changes the dynamics between migrants in this context and those in other contexts presented in literature. Consequently, a study that focusses on Zimbabwean women in South Africa is important.

Although these studies present valuable knowledge regarding how women comprehend pregnancy, and the management of pregnancy related complications, most of them lack or are scant on the subject within the context of migration. The scope of the vast majority of these studies is somewhat generic to African women, hence documented beliefs and practices may not be applicable to migrant women. Salih, (2011) posits that migration may present opportunities that can empower women such as education, employment, and access to new resources with symbolic capital. These opportunities and even challenges presented by migration may alter migrant women's beliefs and practices and hence change what they used to do prior to migration. This calls for studies located within the migration field, to interrogate how this process affects migrant women's beliefs, practices, and experiences of antenatal care after resettlement. It is also imperative to investigate how migrants cope with changes that

come with mobility, moreover, the uniqueness and heterogeneity between migrant's experiences as a result of multifaceted factors specific to individuals.

2.1.6 Transnationalism and Migration

Studies have noted that migrants engage in what has been termed transnationalism, for example Maphosa (2010); Crush et al., (2017) and Moyo (2017). Maphosa (2010, p. 346) asserts that, "a prominent feature of current international migration trends is that migrants do not cut ties with their countries of origin but maintain close contact with both the host and the home country"**.** Transnationalism has been defined as:

> *"A process of movement and settlement across international borders in which individuals maintain or build multiple networks of connection to their country of origin while at the same time settling in a new country". (Fouron & Glick-Schiller, 2001; 60)*

Transnationalism is a phenomenon that has been widely studied from an economic and social perspective focusing on transnational remitting, identity issues and social networks for example Normandy et al., (2003), Moyo (2017) and Adugna (2019). Few studies have also examined transnationalism and health care in South Africa, however, from an HIV/AIDS and antiretroviral therapy perspective, see (Faturiyele et al., 2018) and (Vearey, 2012). Maphosa has made significant contributions on the subject regarding cultural and the religious aspects, especially focusing on Zimbabwean migrants, noting that:

> *"The contemporary phenomenon of transnationalism is as much a cultural as economic phenomenon, as transnational linkages encourage the emergence and consolidation of hybrid identities, merging cultural resources and practices from both origin and destination societies". (Maphosa, 2010, p. 353)*

Considering these arguments, and the paucity of literature which focusses on transnational socio-cultural practices and health care, the focus of this study on these aspects, will contribute to the body of knowledge on the subject.

A plethora of literature has shown that migrants often rely on transnational health care to meet their HIV/AIDS health care needs as a result of health systems and interventions that are not inclusive to migrants (Vearey et al., 2017) and (Faturiyele et al., 2018). In a study that sought to assess healthcare needs, preferences and accessibility barriers among HIV-infected patients of Lesotho origin who are migrants in South Africa (Faturiyele et al., 2018) found that migrant patients preferred collecting their ARVs in Lesotho than in South Africa. This was attributed to the side effects they experienced from taking the South African regimen. It was also because of the perception that drugs from Lesotho are more effective than those dispensed in South Africa. Consequently, the study recorded higher defaulting among migrants than non-migrants, owing to the challenges associated with distance and travel costs associated with the collection of drugs in Lesotho. If it is documented that there is high incidence of treatment defaulting among HIV/AIDS migrant patients, which retrogresses ART programmes. I argue that it is only prudent to investigate if similar issues are pertinent to access and utilisation of contraception, and understand how practices may potentially regress family planning goals.

On a related matter, Vearey (2014, p. 663) cites that "HIV prevention, testing and treatment responses within public health systems fail to engage with migration", resulting in mobile populations sometimes experiencing challenges in accessing chronic medication. With regards to maternal health, Vearey, uncovers that:

> "*Pregnant women also face challenges; they may attend antenatal care in one location, go 'home' to have the baby, then return again to the first location". (Vearey et al., 2017, p. 92)*

Following these observations, the authors attribute these transnational practices by those seeking health care to structural challenges, especially interventions and policies that are discriminatory to migrants. They recommend a need for the harmonisation of HIV/AIDS treatment and training protocols to accommodate people on the move. Firstly, considering that health behaviours and outcomes are a result of many social determinants, referred to as the conditions in which people are born, grow, live, work and age in (WHO, 2008). Secondly, the socio-ecological framework supposes that health behaviours are located and shaped by an interaction between individual, relational, community and societal factors. Lastly, the intersectionality theory, which advocates for a consideration of the full diversity of women's sources of disadvantage in understanding their experiences. In this study I, therefore, seek to

explore other multifaceted conditions and individual related factors such as beliefs that result in migrant's engagement in transnational health care, as observed in existing literature.

As members of transnational communities travel between the destination and country of origin, they carry cultural and political currents in both directions, citing language, dress, and cultural beliefs as examples (Maphosa, 2010). In his study on Zimbabwean migrants in South Africa, partcicipants outlined that they speak at least more than one language for purposes of belonging. With regards to religious transnationalism, the study found that there is a proliferation of Zimbabwean Pentecostal churches in South Africa. He terms this the "transnationalisation of religion" (Maphosa, 2010, p. 355) and cites African spiritual types of churches known as *"ziyoni or zayoni"* (Zion Christian Church) as the booming ones in South Africa. Maphosa asserts that owing to the havoc caused by HIV and AIDS limited access to medical facilities, migrants who are infected turn to spiritual healing as a solution.

Based on these studies, it is evident that transnational migration is prevalent in South Africa, manifesting in different forms such as medical, cultural, and religious besides the commonly studied economic and social activities. However, there is a glaring literature gap on the status quo regarding health care transnationalism in relation to contraception and antenatal care, with relatively more studies focusing on HIV/AIDS treatment. In view of the assertion by Faturiyele et al., (2018, p. 1) that "HIV treatment and care for migrants is affected by their mobility and interaction with HIV treatment programs and health care systems in different countries". I argue that there is need to understand the interface between mobility and other health issues, as well as the navigation strategies employed by migrants, because HIV/AIDS treatment constitutes only a part of health care needs for migrants.

Linked to this, a decade ago, Lima (2010, p. 1) noted that "transnationalism is not characteristic of all immigrant groups and it varies across and within groups with significant differences in the scope and range of transnational activities". Furthermore, the author affirmed that "transnationalism challenges traditional theories of assimilation, which assume that immigrants who are more fully integrated into their host societies are less likely to continue to involve themselves in the economic, social, and political spheres of their countries of origin" (Lima, 2010, p. 2). The distinction between assimilation and transnationalism being that, the former sees migrants as letting go off country of origin identity, traditions as well as other aspects, and adopting that of the host country, while the latter recognises that migrants present

hybrid identities that are a combination of home and host. (Crush & McDonald,2002). These literature debates and knowledge gaps, notably some of the literature is relatively old, shows that there is need for new evidence, drawn from contemporary studies to back these discourses (transnationalism or assimilation), thus necessitating studies like this one.

2.1.7 Contraception and Antenatal Care in Migration Research: Methods and Theoretical Issues

The way in which research is conducted with immigrant populations broadly impacts the effectiveness of subsequent interventions designed to address their needs for example healthcare needs (Murphy et al., 2012:91). In the same excerpt, Murphy and others further underline that "the analysis and interpretation of immigrant health research affects the understanding of how to best optimize health outcomes within a population" (Murphy et al., 2012, p. 91). Similarly, Gombachika and others made an assertion that:

> *"The exploration of the barriers to accessing sexual and reproductive health involves sensitive, emotive, and personal topics that can be best captured through careful probing using qualitative in-depth interviews". Gombachika et al., (2012, p. 3)*

In view of this, I single out a few studies like Richter et al., (2014), Walker et al., (2017) and Dias et al., (2010), that have employed judicious methods in studying such a broad, emotive, and personal phenomenon like SRH. This section explores how this study will complement similar studies, and also shows how it will bridge the gap in instances where methodological limitations have been identified in other studies that have focused on migrant's SRH.

In their study on migrant women who sell sex in Johannesburg, Walker et al., (2017, p. 91) explore the "intersecting vulnerabilities" in the lives of these women, owing to the work that they do, policy environment pertaining to sex work, compounded by being migrants. They further present that, these vulnerabilities manifest inform of "abuse, discrimination, criminalisation, and multiple levels of structural and direct violence, stigma, moralising associated with the illegal sale of sex, being foreign, and being a single parent" **(**Walker et al.,

2017, p. 91). On a similar note, Richter et al., (2014) explore the intersections between migration and sex work amongst women in Johannesburg, Rustenburg and Cape Town, suggesting that this area of study is underexplored in southern Africa. They argue that "cross-border sex workers have lower health service contact, less frequent condom use than non-migrants and require increased health service contact, hence a need for migrant-sensitive sex work-specific health care and health education" (Richter et al., 2014, p. 13).

Of major interests about these studies, is that they explore the intersectional nature of migration, sex work which forms part of sexual and reproductive health issues. Using the intersectional approach in these studies enabled an exploration of the interconnectedness and complexity of factors surrounding migrants' SRH experiences. Similarly, as I sought to study an equally complex issue, contraception and antenatal care, these studies provide a basis to draw theoretical lessons. While these studies bridge the knowledge gap on SRH, their areas of focus are SRH and sex work. Based on the broad nature of SRH which includes prevention of pregnancy and antenatal care among other aspects, I argue that there is need for studies which similarly explore intersections between factors that shape migrant's SRH experience particularly contraception and antenatal care aspects.

Employing the cross- sectional survey method, Sebo et al., (2011) investigated sexual and reproductive health behaviors of undocumented migrants in Geneva. They argued that:

> *"Undocumented migrants engage in frequent and high risk sexual intercourse with insufficient use of contraceptive methods and suboptimal strategies of prevention against STIs, and they underline a need for specific sexual and reproductive educational programs targeting this hard to reach population". (Sebo et al., 2011, p. 510)*

This study makes a critical contribution to the body of knowledge regarding undocumented migrants' experiences, a claim which they also put across, citing that "few previous studies provide information on the sexual and reproductive health of undocumented migrants" (Sebo et al., 2011, p. 515). Nevertheless, I find the use of a survey study design problematic. I contend that to best understand social behaviour and unearth the complexities or the interdependence between factors that shape health related behaviour, there is need to use qualitative methods which are exploratory in nature. I premise my argument on the assertion by Gombachika et al.,

(2013), who maintain that "where there is little knowledge regarding an issue under study, qualitative approaches are deemed most appropriate because they allow for an in-depth exploration and probing of a phenomenon in an interactive way, thus enabling clarification of issues during the interview" (Gombachika et al., 2013, p. 3).

Arguing from a theoretical perspective, I maintain that the comparison between categories of women (migrants and non-migrants), in the same study by Sebo et al., (2011), presents a limitation where categories are centralised, thus over simplifying human experiences. While this categorisation may reflect commonalities between a particular group, there is need to go beyond these and show differences, uniqueness and the heterogeneity that exist among these women and their experiences, even within the same category. This is in sync with what has been argued by intersectionality theorists (Crenshaw, 1991) and (Yuval-Davis, 2006), that categorisation creates binary data. As a result, McCall (2005, p. 1773) calls for "methodologies that deconstruct analytical categories".

In this study, I therefore seek to illuminate factors that shape and influence women's experiences through conducting an explorative study to gather rich information, outside the confines of preset categories. It is only after being informed by the findings, that I will ascertain if migration status is a factor that can inform contraception and antenatal care experiences of migrants in a certain way. In a study on the socio-cultural dimensions that shape perceptions and decision-making surrounding sexual health, Espinoza et al., (2014) applied a modified framework of the Theory of Gender and Power (Connell, 1987). I am however, of the view that the theoretical framework which they applied has some limitations. I make reference to McCall (2005), who argued that theorizations based on power and gender categories are too simplistic to capture the complexity of lived experiences. I maintain that sources of disadvantage stem from a complex array of factors beyond power and gender dynamics. This justifies the need for an intersectional approach in exploring factors that influence migrant women's experiences beyond power and gender dynamics. Bürkner (2012) and Bastia (2014) contend that using the lens of intersectionality approach:

> "*Has opened up new spaces for challenging the primary focus on gender in the migration literature, which in turn allows for the emergence of new understandings of how gender is also constituted by class, race, ethnicity and informed by normative notions of sexuality".* (*Bastia, 2014:3)*

Arguably, gender and power dynamics might actually change as a result of the migration process, hence the intersectionality approach "provides means by which these concepts are grouped together and analysed as intersecting, not essentialised categories" (Bastia, 2014, p. 7). Drawing from this, in this study I employ the intersectionality approach in understanding Zimbabwean migrant women's beliefs and practices that surround contraception and antenatal care.

Keygnaert et al., (2014) conducted a comprehensive study on exploring how refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands define sexual health, search for sexual health information, and perceive sexual health determinants. To achieve this, they conducted a community -based participatory research (CBPR) and employed a conceptual framework based on three theoretical stances, with the socio-ecological framework as one of them. They maintained that the use of the socio-ecological framework was premised on "the need for a better understanding of health complexity through the identification of determinants at the individual, interpersonal, organisational and societal level" (Keygnaert et al., 2014, p. 3).

Their findings depict an array of individual, interpersonal, organisational and societal factors that affect refugees, asylum seekers and undocumented migrants SRH experiences. The use of the socio-ecological theory provides rich data ranging from factors related to the individual such as demographic attributes, attitudes, beliefs, and knowledge. Added to that, an interrogation on factors within the environment in which an individual operates, provides valuable information on how complex and intertwined migrant's experiences are. It is particularly important to appreciate that individual experiences are shaped and influenced through the reciprocal or back and forth relationship between behaviour, personal factors and the environment, which (Bandura, 1978) termed reciprocal determinism.

2.2 Theoretical Framework

In this study, I integrated the socio-ecological theoretical framework (Bronfenbrenner, 1979) and intersectionality theory (Crenshaw, 1991). It has been suggested that:

> *"A theoretical framework provides a structure for thought processes, what to look for in the data, discussing findings in light of what existing theories say and to substantiate an argument". (Kivunja, 2018, p. 47)*

Employing the socio-ecological and intersectionality theory, as theoretical frameworks for this study, helped me to comprehensively unpack and make meaning of the results. I will first discuss them separately, then highlighting the points of convergence between the two and how I am going to use them in this study.

2.2.1 The Socio-Ecological Framework

For decades, Urie Bronfenbrenner's ecological framework (Bronfenbrenner, 1979) has been used "to inform public health research and interventions due to its ability to observe dynamic and reciprocal relationships between people and their environment" (Jennings 2017, p. 21). Its guiding principle is that, in as much as individuals are responsible for behavioral change to reduce risk and improve health, there are many other factors at different levels of the socio-ecological framework that influence their behavior (Elder et al., 2007). These levels include the individual level, which encompasses (knowledge, beliefs, attitudes, skills); interpersonal (person's relationships with other people, family, friends); community (schools, workplaces); organisational (embracing social structures, major institutions of the society such as media and health facilities, public agencies); and policy level (governing bodies encompassing blueprints of a particular society such as laws, regulations, policies, cultural norms and the belief system). Ecological models have been widely used in studies on Social Determinants of Health because they provide a foundation for understanding the linkages between multifaceted factors that influence health behaviour (Enyia et al., 2014) and (Jennings, 2017). Below is a pictorial model depicting the foundations of socio-ecological framework.



Figure 1: The Socio-Ecological Model

One of the benefits of using the socio-ecological framework in understanding health issues is that it enables an investigation of how individual related, and other factors at different levels influence health behaviour (Jennings, 2017). The socio-ecological perspective fits well in my study as it offers me a way to simultaneously explore individual factors and the interactions with contextual issues that influence Zimbabwean migrant women's contraception and antenatal care experiences.

2.2.2 The Intersectionality Theory

The intersectionality theory by Anthias & Yuval-Davis (1983) and Crenshaw (1991) has its roots in feminism and its emergence sought to question the appropriateness of treating women as a unitary group with a shared experience. Bowleg observes that:

> *"Intersectionality theory asserts multiple social identities such as race, ethnicity, gender, and sexual orientation interact on an individual level (micro level) and reflect interlocking social-structural level (macro level) inequalities". (Bowleg, 2012, p. 1267)*

Intersectionality theory therefore enables an understanding of different sources of disadvantage or privilege among women, and capturing multiple positionalities among social groups (Davis, 2008).

In this research, the application of intersectionality provided lenses with which to view the intersections between factors such as being a woman, at child bearing age, who is a migrant, possessing a certain level of education, doing a certain job, belonging in a certain socio-economic status among other factors. It also enabled me to explore beliefs that are held by individuals and the variations of those beliefs across different people. Moreover, I was able to interrogate how these intersecting factors converge with individual beliefs and subsequently shape migrant's contraception and antenatal care experiences. I was able to move beyond investigating factors at individual, relational, community and structural levels, which have an effect on migrant women's experiences of contraception and antenatal care (Socio-ecological theory). Rather, I paid attention to the interdependencies between social identities, how they influence the way people construct meaning and make decisions that shape their life experiences.

Secondly, as argued by Goethals et al., (2015, p. 78) "intersectionality offers us a lens through which categories are viewed as mutually constituting processes". This means that rather than simply adding categories to one another, intersectionality strives to understand the people's unique experiences and perspectives as influenced by several social or cultural categories (Goethals et al., 2015). In this study for example, I demonstrate that people have multiple roles and identities, the study participants are not just female migrants, documented or undocumented as these categories have been centralised in other studies. "A pitfall with such an approach is that prominence is assigned to a certain category, it uses an additive approach which entails looking at various variables as isolated and dichotomous rather than interactive and mutually interdependent" (Goethals et al., 2015, p. 75). Applying this to this study, enabled me to scrutinise how individual women's identities intersect with other varying factors, and the effect that these intersections have on beliefs, practices, and experiences surrounding contraception as well as antenatal care.

2.2.3 Why Use Both the Socio-Ecological Framework and Intersectionality Theory?

It has been contended by researchers that harmonising two methods or frameworks in a study facilitates a detailed understanding of people's lived experiences (Jennings, 2017) and (Gilbert et al., 2016). This includes the use of the Socio-ecological framework and the Intersectionality theory (Jennings, 2017). Drawing from the claim by (Jennings, 2017); (Enyia et al., 2014) and (Scott & Wilson, 2011) that the Socio-ecological framework has been widely used for purposes of providing lenses with which to explore health perceptions and health behaviour. Similarly, I employed the same approach in this study. Interrogating and interpreting results within this framework provided me with a foundation to examine individual factors such as beliefs and the multifaceted community conditions like health facilities, policies that influence certain practices regarding contraception and antenatal care by migrants.

Based on the realisation that this study does not center on public health issues only, but intersects public health with gender and migration, I employed the intersectionality theory for its versatility in examining the complexities that exist at the nexus of these identities (gender and migration). Intersectionality theory has been central to theorisation of gender and migration research and serves the purpose of disrupting views that regard women or female migrants as a homogenous collective (Bastia, 2014). I examined how diverse factors among individual women, such as age, class, marital status, religion among other characteristics interdependently intersect with being a female migrant and influence the decisions they make regarding contraception and antenatal care services. Using these two theoretical underpinnings was useful in creating an understanding that Zimbabwean migrant women's experiences of contraception and antenatal care in South Africa are complex and formed through a series inextricable, intertwined, and simultaneous factors. This provided a holistic exploration of migrant women's experiences regarding access and utilisation of contraceptives as well as antenatal services while they live and work in South Africa.

2.3 Summary of the Chapter

In this section I have explored and presented the gaps in knowledge, methods and theoretical underpinnings relating to the study of migrant's contraception and antenatal care particularly, in the South African context. Although beliefs and practices presented in this chapter relating to maternal health may not be an unusual occurrence among African women, what remains to be ascertained are the different ways the process of migration precisely alters migrant women's experiences in a foreign country. More so, with the realisation that South Africa is home to most migrants in the Sub Saharan region, hosting 4.2 million (7.2 per cent) of international migrants' stock (UNDESA, 2019). Available literature has tended to focus more on resettlement related structural concerns, and HIV/AIDS health needs, while aspects such as migrant's beliefs and maternal health practices are scant.

In summary, the following limitations stand out; (a) limited studies investigating contraception and antenatal care within the migration context, mores so, in South Africa and among Zimbabwean migrants (b) use of methodologies that explore the issues in an in-depth manner, allowing for participants to explain their lived realities in a conversational approach without the limits of a structured survey; and (c) use of theoretical frameworks that recognise the multifaceted influence of factors at the different levels of the socio-ecology. Above all, recognising that women are not a homogenous group with a common experience. Although it has been acknowledged that effective management of migration and migrant's health is good for social and economic development (Vearey et al., 2017), this needs to be backed by more evidence from studies which are issue specific for purposes of adequately informing policy or interventions.

I, therefore, call for studies whose methodological and theoretical approaches recognise that there exists black African women, as a broader category, within that there is a Zimbabwean woman, that Zimbabwean woman is a migrant in South Africa and that migrant is at her child bearing age. Her experiences of contraception and antenatal care maybe fundamentally different from other women with differing locations, such as race, ethnicity, and migration position among other factors. This foregrounds the need for my study on Zimbabwean migrant women's beliefs and practices regarding sexual reproductive health, in particular, contraceptive use and access to antenatal health care in South Africa.

CHAPTER THREE: METHODOLOGY

In this chapter I discuss in detail the research paradigm which I adopted in this study. I also detail the different steps which I undertook to carry out this study with the intent of responding to the research question as outlined in the previous chapter.

3.1 Research Paradigm

Of interest and relevant to this study is the constructivists paradigm. "Constructivism is an approach that asserts that people construct their own understanding and knowledge of the world through experiencing things and reflecting on those experiences" (Adom et al., 2016, p. 2). In view of this, researchers should attempt to understand people's realities and its complexities from the point of view of those who live it (Schwandt, 2000). Thus, to the constructivist, constructing meaning is learning, and through research, which is a way of experimentation, the process learning happens when information is unearthed (Adom et al., 2016). Guided by these fundamentals of the constructivists paradigm, a researcher undertakes a research to learn about a phenomenon from those who live the reality, in various ways that they attach meaning to events or experiences. Hence, there are multiple social constructions of meaning and knowledge. It is therefore against these exponents of the constructivist research paradigm that I am affiliated to it. In the different sections of the methodology section, I will demonstrate the connections between the constructivist research paradigm and how I conducted the study.

3.2 Methodological Approach

In this study I employed qualitative methods particularly, in-depth interviews and observations. I selected this method of enquiry based on its amenability to the socio-ecological and intersectionality frameworks. As I stated earlier, in unison, these frameworks are concerned with investigating the multi-faceted nature of individuals' lives, how they interpret and navigate their day-to-day experiences (McCall, 2005). Moreover, based on the fact that there is scant literature on these issues under study I deemed that using an exploratory approach was most appropriate. This approach allowed me to have in-depth conversations with the participants and use observation to triangulate data gathered through interviews, as will be reflected later in this chapter. I argue that using the qualitative approach helped me to

understand the complexities that surround beliefs and practices as well contradictions in the lives of migrant women.

3.3 Data Collection

Guided by the fundamentals of the constructivist paradigm, that through research, both the researcher and the participants are engaged in a mutual social process of creating knowledge, and understanding experiences from the point of view of those who live it (Schwandt, 2000). I, therefore, opted for explorative and interactive data collection techniques. This study was primarily qualitative, where I gathered data through one-on-one in-depth interviews and observation. In-depth interviewing has been defined as:

> *"A qualitative research technique that involves conducting intensive individual interviews to explore respondent's perspectives on a particular idea, program, or situation". (Boyce & Neale, 2006, p. 3)*

Using in-depth interviews as an interviewing technique was beneficial to the study in that, due to its personal, interactive nature, respondents were able to talk about other issues not necessarily solicited by the interview guide **(See attached Annexure E),** but however linked to topic under discussion. To illustrate this, during the interviewing process I followed up emerging issues which were not captured by the interview guide. The flow of the interview was natural and determined by upcoming responses as opposed to the sequence of questions in the guide. This enabled participants to volunteer more information like showing me samples of the contraceptive pills that they use. In one of the interviews, the depth of the conversation went as far as discussing sexual life and the practices they engage on. The participant divulged that she uses herbs and therapies such as soaking peanuts in water overnight and drinking that water to shrink the size of her vagina to improve sexual pleasure. Apparently, at the time of the interview she had just bought the peanuts for use that evening which she willingly showed to me. Observing, therefore, enabled me to triangulate what the participants had reported, and hence providing me with rich data on participant's sexuality, contraception, and antenatal care practices. Observation has been underscored as:

> *"One of the oldest and most fundamental research methods approaches which involves collecting data using one's senses, especially looking and listening in a systematic and meaningful way". (McKechnie, 2008, p 573)*

One of the fundamentals of qualitative research is that the interview questions cannot be conclusively established before the study begins; rather, they will evolve and change as the study progresses (Mertens, 2014). This was typically the case during my interviews. Owing to the names that the respondent used in reference to the contraceptives that they use or know of, I eventually had an additional conversation with a pharmacist. For instance, several respondents were talking about contraceptives called *"no plant," "control" and "secure".* Efforts to get from them, standard names which I, and an international audience that will read my work can relate to, were futile because they knew the colloquial names which they used. Essentially, the flexibility of qualitative approach enabled me to respond to my research question with depth.

In addition to the in-depth interviews and observation method, I administered a socio demographic questionnaire **(Annexure D).** I used this tool to collect participant's demographic information such as age, marital status, level of education, religion, number of children and the duration stayed in South Africa. I used this information to profile the participants in order to better understand similarities and differences in their beliefs and practices surrounding access to contraceptives and utilization of antenatal care services across their different attributes.

3.4 Location

I conducted this study in Pretoria and Johannesburg, which are metropolitan cities in South Africa's Gauteng Province. The province hosts about 47.5 per cent of international migrants (Statistics South Africa, 2018). Owing to the economic and political crisis in Zimbabwe since 2000, South Africa has seen an increase in mixed migration flows of Zimbabweans largely coming in as labour migrants among other reasons (Crush et al., 2017). These migrants are drawn from every sector of society, and from all education and skills levels (Crush et al., 2017). In view of this, study participants were drawn from these two cities and not limited to specific residential communities within Johannesburg and Pretoria.

The process of migration results in many different migrant groups being found in cities (Vearey et al., 2014).This heterogeneity among different migrants, also found in the study participants helped illuminate the variations in migrants women's beliefs and practices regarding contraception and antenatal care in South Africa. This was in-fact, the whole purpose of the study; to explore multifaceted experiences of contraception and antenatal care among this population.

3.5 Study Population

Study participants encompassed 14 Zimbabwean migrant women of child-bearing ages from 24 to 40 years. Of these respondents, six lived and worked in Johannesburg while eight were based in Pretoria. The Socio-Ecological Framework demands multilevel analyses of factors at individual, interpersonal, community, societal levels on how they interdependently influence health behaviour (Gombachika et al., 2012). Intersectionality theory on the other hand, demands a profound thought process and analysis of the intersections between specific combinations of social categories (Hunting, 2014). To aid these analytical processes, I purposively sampled the 14 women, which I figured will be a manageable number to work with in a study of this scope, while also getting the diversity that I required. Such considerations enabled me to extensively reveal aspects such as beliefs and practices that exist surrounding contraceptives and antenatal care among migrant women in a given context.

It is worth noting that the study design did not incorporate voices from the health care providers as it sought to understand migrant's experiences from their perspectives. However, to have a better understanding of contraceptives that they were referring to in instances where they used colloquial names, I had an additional *"conversation"* with a pharmacist. I deliberately use the word *"conversation"* instead of interview to demonstrate that this was an informal discussion, solely for a better understanding of what the study participants were talking about. It was not meant to triangulate what the women reported or to look for the "Truth" from an expert in a positivist approach. It essentially was a form of conversational literature review, so to say. This pharmacist is of Zimbabwean origin, trained in Zimbabwe but currently works in South Africa. This gave him a vantage point to discern what women were talking about and put it in context through providing equivalent standard/clinical names. This is important as I am writing for a wide audience. This also helped me in my analysis to make sense of some of the differences between Zimbabwean and South African contraceptives, which the respondents alluded to.

3.5.1 Description of Study Participants

Participant	Age	Marital Status	Level of Education	Occupation	Religion Sect	Number of children	Length of stay in SA in years	Contraceptive user/non user	Type of Contraceptive
Abigal	24	Single	Secondary	Domestic worker	Pentecostal	0	4	User	Zimbabwean Pill
Batsirai	25	Married	Secondary	General hand	Protestant	1	5	User	Zimbabwean Pill
Choice	26	Married	Secondary	Domestic worker	Apostolic	2	2	User	Zimbabwean Pill
Diana	26	Married	Tertiary	Waitress	Protestant	2	4	User	South African Depo
Emihle	27	Single	Secondary	Domestic worker	Pentecostal	0	6	User	Zimbabwean Pill
Fatima	28	Married	Secondary	Entrepreneur	Pentecostal	2	5	User	Zimbabwean Pill
Gugu	30	Married	Tertiary	Teacher	Protestant	1	8	User	South African Pill
Hloniphani	31	Divorced	Tertiary	Waitress	Catholic	1	6	User	Zimbabwean Loop
Irene	32	Married	Secondary	Till operator	Protestant	2	4	User	Zimbabwean Jadelle

Participant	Age	Marital Status	Level of Education	Occupation	Religion Sect	Number of children	Length of stay in SA in years	Contraceptive user/non user	Type of Contraceptive
Janet	34	Married	Tertiary	Teacher	Pentecostal	2	7	User	Zimbabwean Pill
Kumbirai	34	Married	Tertiary	Student	Pentecostal	1	5	User	South African Loop
Lisa	36	Married	Tertiary	Student	Protestant	2	4	User	South African Loop
Martha	40	Divorced	Secondary	Administrator	Apostolic	2	12	User	Condoms
Nonhlanhla	40	Married	Secondary	Domestic worker	Muslim	1	15	User	Traditional method

Table 1: Study Participants Demographic Classification

3.6 Sampling

I used purposive sampling to recruit the first five (5) study participants for the identification and selection of information-rich cases related to the subject under study. My choice of a sampling technique was informed by Patton's point that:

> *"The logic and power of purposeful sampling lie in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry, thus the term purposeful sampling. Studying information-rich cases yields insights and in-depth understanding rather than empirical generalizations". (Patton, 2014, p. 230)*

In view of the above, coupled with what has been put forward by Bernard (2017) and Spradley (2016) about the importance of availability, willingness to participate, and openly share experiences, I approached the first five study participants from my social networks. These were people that I knew were migrants from Zimbabwe, of child-bearing ages, and could openly share their beliefs and practices if they agree to participate in the study. Of these five, I knew three of them from Zimbabwe dating back to a time that we were all there, that is before migrating. The other two were people I got acquainted to in South Africa. Based on this, the study participants were varied in the sense that while they were all either neighbourhood or schooling colleagues, they were from different contexts in my life in terms of time and setting in life.

Although some of my participants were people that I knew, I still requested the women to consent to participate in the study (discussed in detail in the coming sections on research ethics). I then used the snow-balling technique to get more interviewees, through requesting interviewees to refer me to other potential participants. I was referred to six more women, and it is worth mentioning that these were people that I did not have previous contact with. Two women that I had made contact with through snowballing also referred me to three other participants from their social networks. While purposive sampling could have locked me into my social networks and minimise the heterogeneity of study participants, the snowballing technique enabled me to introduce

variations in my study population. The technique facilitated reach to new people that I did not know. "Information richness is often the most important factor in the selection of samples" (Manson, 2014, p. 32), and it is on this note that I regarded the combination of purposive sampling and snowballing the most suitable for this study because it allowed me to have wider diversity of experiences.

3.7 Ethics in Research

> *"We suggest that there are at least two major dimensions of ethics in qualitative research. These are (a) procedural ethics, which usually involves seeking approval from a relevant ethics committee to undertake research involving humans; and (b) 'ethics in practice' or the everyday ethical issues that arise in the doing of research". (Guillemin & Gillam, 2004, p. 263)*

Drawing from the above excerpt by Guillemin and Gillam (2004), which makes a distinction between two equally important dimensions of research ethics, I argue that the protection of study partcicipants through the application of appropriate ethical principles should take center stage when conducting research. Guided by the same assertion presented above by (Guillemin & Gillam, 2004), in this I section I discuss how I observed both ethical procedures and practice in this study.

3.7.1 Procedural Ethics (Annexure A).

The study followed due procedure as required by the university Human Research Ethics Committee (HREC) Non- Medical. Prior to conducting interviews, I applied for an ethics clearance certificate which was granted by the HREC numbered **Protocol H19/07/41 (Annexure A)**. This application required me to provide details on how this study was going to proceed for example, the study location, identification of participants, duration of the interviews and methods of data collection among other aspects. Importantly, it required an outline on how the study was not going to harm study participants in anyway. This is despite the complexity of ethical principles in real life, particularly when something unusual and unexpected occurs (Ritchie et al., 2013). I will

discuss the procedures that I put in place for the protection of study participants under ethical practice, in view of the "the day-to-day ethical issues that arise in the doing of research" (Guillemin & Gillam, 2004, p. 264).

One example of the ethical codes that I constantly negotiated on an individual case to case basis in my research is that of conducting the interviews in a private setting for confidentiality purposes. I conducted most interviews in coffee shops or food courts upon the migrant women's requests. In most cases they explained that it was a better choice for them than having me coming to their workplaces during their lunch breaks or homes. *"Better"* was assessed on the basis of an uninterrupted interview without the intrusion of their bosses, co-workers, or families. Although this was the case, I made strides to keep the conversations private by working together with the study participant to pick restaurants that were not busy and identifying corners that were far from other patrons. This was aimed at keeping the contents of our discussions to us only.

3.7.2 Informed Consent (Annexure B)

I approached the issue of consent with the view that when doing research, one may be confronted with ethical dilemmas. In my case the dilemma was on the consenting process. Standard practice within social science research is that participants are required to give written consent, through signing the informed consent form (Jennings, 2017). Studies have however shown that asking for written consent may shun potential participants from participating in the interviews (Singer, 2003). This can be particularly problematic for vulnerable groups, in this case migrants. To address this, I kept the consenting process verbal since all the study participants were over the age 18 years. I chose verbal consenting so that participants do not feel as if their anonymity is threatened by writing their names or putting signatures on a piece of paper. More so, in this study I was dealing with migrants who might have been documented or undocumented and would have wanted to protect their identity. In South Africa, undocumented migrants are regularly arrested, sent to detention facilities while awaiting deportation to their home countries, and also succumb to abuse by law enforcement agencies (Hiropoulos, 2017) and (Klaaren & Ramji, 2001). Consenting to audio recording of the interview was done separately from that of participating in the study. First,

I asked them for consent to participate in the study. Upon agreeing, I then asked for consent to audio record the conversation. Again, consenting to have the interview recorded was verbal. This resonates with (Ritchie et al., 2013, p. 88), that "a staged approach to negotiating consent is therefore dynamic and responsive to the needs of participants throughout the research process".

3.7.3 Information Sheet (Annexure C).

Before I started interviewing each of the migrant women, I shared information about the study with them through reading together the participant information sheet **(Annexure C)**. The participant information sheet included information on the time that I expected the interview to take, issues of confidentiality, anonymity, possible discomforts, and counseling services in case traumatic experiences are rekindled. The participant information sheet also detailed that there are no direct benefits from participating in the study, but information gathered will be used for generating knowledge on the subject matter for academic purposes. In this study, the information sheet was instrumental in dispelling any thought by a participant that she did not have the capacity to respond to the questions. I achieved this through a clause in the information sheet stating that there are no right or wrong answers, the discussion is open, where they share what they have experienced, their, beliefs, and practices regarding the subject. Once they became aware of this, they warmed up to the idea of participating in the study.

3.7.4. Confidentiality and Anonymity

I conducted one-on-one interviews to ensure a conducive environment for study participants to feel free to respond to questions on their contraception and antenatal care issues, which are sensitive topics. Furthermore, by conducting one-on-one interviews, I also aimed at eliminating any chance of an outsider discussing the interview content with other people. Although I knew participants by their real names, during the interviews I constantly reflected on ethical practices and made sure I do not address them by those names to keep them anonymous. I assigned the women pseudo names to identify their interview scripts, and for the ease of attaching the experiences they shared to an individual, thus making the understanding of findings vivid. This

speaks to issues pertaining to reflexivity, meaning a continual internal dialogue, reflection or critical self-evaluation of researcher's sensitivities and explicit recognition that this position may affect the research process and outcome (Berger, 2013) and (Guillemin & Gillam, 2004). In this regard my position as partially an insider, who knew some of the participants very well, and had a personal relationship with some of them, could potentially stifle their voices if I used real names during the interviews, particularly without express request by them that I do so. This justified the assignment of pseudo names which I used throughout the research process. I will further discuss more on reflexivity at a later stage in this chapter. With regards to the original interview scripts, I kept them safely where they cannot be accessed by unauthorized people. I will destroy these scripts twelve months after data collection.

3.7.5 Data Analysis

To analyse the data, I mainly employed thematic analysis. Additionally, I analysed the emerging themes in relation to prominent or prevailing discourses regarding an issue. To demonstrate this in brief, a pertinent theme in the study was that migrants continue using Zimbabwean contraceptives, traditional medicines for antenatal purposes, and with the tradition of going back home to one's mother for care in the advanced stages of pregnancy till after delivery. Continuity with these practices carried from form Zimbabwe meant that some Zimbabwean migrants did not use the available health care options available in South Africa. This subsequently contradicted the prevalent discourse around migrants burdening the South African health care system, including maternal services and the prominently held view on medical tourism. Contrary to these discourses, findings from this study showed that the South African health system sometimes does not offer migrants what they want. In turn, they access that from their country of origin which is in contrast with the belief that they burden the local health system.

The process of analysing data was multi staged, which allowed it to be iterative. I began with transcribing audio recordings. I transcribed the interviews as data collection progressed, not having to wait until I have completed conducting all the interviews. This meant that engaging with data during transcribing was the first point of data analysis. At that point, I began to make sense of what came out of the interviews, identified gaps, and made a note to ask questions that addressed those

gaps in the next interviews. the process was therefore, iterative in that I engaged in a "process of continuous meaning-making and progressive focusing" (Srivastava & Hopwood, 2009, p. 77). After conducting and transcribing all interviews I began coding data from the interview scripts. This is a process of assigning descriptive concepts to capture the essence of the data (Theron, 2015). After coding, I engaged in thematic analysis, where I put coded data with similar message or meaning into themes. This process was iterative, in that I picked similar, repetitious concepts and grouped them together. It was also reductive; whereby I identified concepts and put them in simplified way, not seeking to deduce any theories.

3.8 Reflexivity and Positionality

Reflexivity has been defined as "the active acknowledgement by the researcher that her/his own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation" Horsburgh (2003, p. 308). In view of this definition, my positioning as a researcher in this study is shaped by personal characteristics, such as my gender (female), race (black), immigration status (being Zimbabwean with a valid study permit legalising me to study in South Africa), personal experiences (being pregnant and giving birth twice: first in Zimbabwe then secondly in South Africa), linguistic tradition (fluently speaking major Zimbabwean indigenous languages: Ndebele and Shona) and also as a user of maternal health services in both Zimbabwe and South Africa. It has been noted that**:**

> *"Reflexivity is crucial throughout all phases of the research process, including the formulation of a research question, collection and analysis of data, and drawing conclusions". (Berger, 2013, p. 221)*

Thus, for example, my personal knowledge about Zimbabwean migrants' practice of procuring the contraception pill from Zimbabwe to use in South Africa triggered my interests in this study. This meant that as I conducted my interviews, the question on "what contraceptives they were using and where they were sourcing them from" was of key interest. It is important to note that this self-awareness and interest in certain issues does not make my data less valid, rather it helped me

unearth sensitive information that might not have been uncovered by someone else with different positionality. This cements a point made by Berger (2013) in his study of immigrant women in the United States on how his positionality as migrant from Israel positively contributed to the rich data he gathered in that study. He stated the following:

> *"Coming from the 'shard experience' position, I was better equipped with insights and the ability to understand implied content and was more sensitized to certain dimensions of the data. I was familiar with the 'immigration language' and aware of potential sensitivities, thus I knew what to ask and how to ask it as well as understood the responses in a nuanced and multileveled way. I was able to hear the unsaid, probe more efficiently, and ferret out hints that others might miss". (Berger, 2013, p. 223)*

In my case, my positionality also assisted me to recruit study participants, and it made getting them to open up about their contraception and antenatal care experiences easy. To illustrate this, most respondents openly disclosed that they use Zimbabwean oral contraceptives which they access through illegal channels. This is sensitive information which could lead to the arrest of perpetrators and I believe they would not have ordinarily shared it with any other person that they perceived as either a threat or an outsider. Arguably, as a result my position as a Zimbabwean migrant woman talking to my compatriots in the same generation, I managed to unearth rich data on this topic. This was largely because respondents were willing to share their experiences with me as a researcher. They probably assumed or perceived that, since I am also a foreigner in South Africa like them, I was obviously aware from personal experience, that sometimes being a migrant presents challenges that one has to find a way to deal with at all costs. This includes at times, using illegal or unconventional ways in order to overcome some challenges in the destination country (*see* Mahati, 2015).

A sharp contrast can be made between my case, on the added advantage granted by my positionality and Pérez (2006)'s encounter with interviewing migrants as a native citizen in Spain. He posits that his position as a researcher in that context was controversial and concludes that immigrants are a difficult population to interview owing to their socio-economic position, their

cultural difference, and their legality as tenants. Also standing in contrast to Perez's experience is Berger (2013) who interviewed migrants as a migrant himself and outlined the following regarding reflexivity in relation to immigration research:

> *"I found recruiting and studying immigrants quite easy and never encountered a suspicious or reluctant response. Conceivably, my own immigration status evident by my foreign accent bridged over the immigrant–nonimmigrant cleavage and contributed to this". (Berger, 2013, p. 7)*

From the above, it is evident how one's positionality in relation to insider status to the group under investigation, can be an asset to the study, which was the case in my engagement with participants. However, there were times when the divulgence on illegal activities, raised tensions in me, where I was divided between documenting those activities or omitting them for the protection of my respondents. It took a while for me to resolve these tensions. I however, decided to document the activities after considering that nothing points out to the individuals who reported the activities. I have used no names at all anywhere in my field notes.

More importantly, my positionality as Zimbabwean woman sharing linguistic characteristics with the participants, fluently speaking both *Shona, and Ndebele,* the major Zimbabwean languages, was of great benefit to the study. Besides being able to understand the nuances in their views, asking participants about their awareness of what contraceptives and antenatal care, as well as practices related to their private lives, was not an easy and straight forward exercise. This emanated from that, there are no known precise words for the concepts in Zimbabwean vernacular languages of *Ndebele and Shona.* So, to ask the question regarding their understanding of the concepts, I unpacked them and used the phrases that denote the actions. For instance, when referring to contraceptives I used the phrases *"indlela zokuvikela ukuzithwala"* in Ndebele and *"nzira dzekudzivirira kuzvitakura"* in Shona. Translated to English, these phrases mean "ways to prevent pregnancy". When referring to antenatal care, I used the phrase *"impilakakhle ephathelane lesikhathi sokuzithwala"* in Ndebele, and *"hutano unechikuyita nenguva yekuzvitakura"* in Shona. Both the phrases meant "health care relating to pregnancy".

My knowledge of words that I could put together in both languages to bring out the meaning of the concepts contraceptives and antenatal care facilitated productive interviews, where respondents succinctly understood the subject of discussion and gave relevant responses. These factors benefited the research in a fashion that maintained validity and accuracy of results. Berger (2013) challenges the view that knowledge production is independent of the researcher producing it, and my study cements his view by evidencing how the success of this study rested upon my positionality as the interviewer, to navigate spaces and negotiate engagements.

3.9 Limitations of the Study

One of the limitations of this study is its scope. The study was conducted on 14 participants, focusing specifically on Zimbabwean migrants, and limited to Pretoria and Johannesburg. Due to limited time and resources required to do postgraduate research, it was not possible to conduct a bigger qualitative study, which could include many participants, other nationalities, or extended study area. However, it is important to note that the size of the study population and selected study sites still enabled me to delve on issues in detail, which is the gist of qualitative research.

In this study, I employed purposive sampling to identify the initial few study participants. This approach can potentially lock down a researcher in a social network of people with similar views. In addition, doing a research on a sensitive topic whilst being an insider can result in the interviewees being shy or reluctant to divulge experience, they feel are too personal (discussed in detail in preceding sections). To avoid those potential challenges, I used dual methods of sampling, that is, purposive sampling and snowballing. This enabled me to reach other participants whom I did not know and were not within my network. I considered this a suitable strategy to address potential insider limitations that could have arisen, relating to withholding of information by participants I personally knew or participants who regarded me as one of their own.

3.9.1 Summary of the Chapter

Using qualitative methodology in form of one-on one in-depth interviews and observations enabled me to have an extensive exploration of participant's lived experiences with regards to contraception and antenatal care in South Africa. In addition, I used two sampling strategies, purposive sampling, and snowballing, which facilitated for capturing of views from a diverse group of Zimbabwean women. Coupled with my position as a Zimbabwean migrant woman too, who knew some of the women before the study, which made me an insider, I was able to explore the multi-dimensional nature of individuals' beliefs and practices pertaining to how they navigate their day-to-day experiences of contraception together with antenatal care. This was particularly exhibited by how participants warmed up to me and the discussion. Consequently, they delved in-depth into their experiences, shared information about their sexuality and sexual practices. Furthermore, they divulged their illicit dealings such as smuggling, selling of Zimbabwean contraceptive pills and using fake identity documentation in hospitals to access delivery services. Using verbal consenting for both the interview and audio recording, coupled with assigning them pseudo names also contributed to the trust that I earned, making them at ease to have an open discussion.

CHAPTER FOUR: RESULTS

4.1 INTRODUCTION

In this chapter I present evidence from Johannesburg and Pretoria collected in a qualitative study on beliefs and practices of Zimbabwean women regarding contraception and antenatal care. I also analyse the interactions between intersecting and multilayered social processes that inform these women's decisions regarding contraception and antenatal care. I analyse and present the study findings thematically, under the main theme of migrant transnationalism and its subthemes. This theme centers on continuities and discontinuities that surround migrants' beliefs and practices after resettlement. I also present findings under the theme of nationality and access to health care in South Africa. This theme focuses on migrant's practices surrounding the navigation of the health care system within a continuum of economic and policy factors in the destination country. Essentially, the evidence which I present in this chapter shows that migrants' beliefs and practices regarding contraception and antenatal care are complex, multifaceted, and intertwined. They are influenced by factors at the different levels of the socio-ecological framework. Owing to the intricate relationship and the intersectional nature of factors that surround the women's beliefs and practices, there are numerous overlaps between evidence from the participants' narratives and the themes evoked by those narratives. Typically, that is the nature of Zimbabwean migrant women's contraception and antenatal care experience in South Africa; contradictory, complex and heterogeneous.

4.2 Migrant Transnationalism

Findings from the study pointed out that participants engaged in an array of transnational activities or behaviours exhibited in form of keeping of family ties and maintaining communication with relatives or friends back in Zimbabwe. Evidence from the study also revealed that these women migrated with their cultural, religious, and health related beliefs which they held in Zimbabwe, on contraception and antenatal care. Furthermore, the narratives shared by women demonstrated that, even after resettlement, study participants continued practicing what they learnt or did in

Zimbabwe relating to contraception and antenatal care, regardless of the duration that one has lived in South Africa. Although the processes of migration altered and constrained some of the beliefs and practices, most of these aspects however remained unchanged. These findings add on to the body of knowledge on migrant transnationalism, which has been widely studied from an economic perspective focusing on remittances, and the social perspective that centers on identity and social networks. These findings also contribute to academic debates surrounding transnationalism vs assimilation and demonstrates that Zimbabwean migrant women do not shed off their beliefs and practices from their country of origin and assimilate into the dominant host society's socio-cultural and health care systems. To illustrate this, I will present the varying forms through which migrant transnationalism was assumed among participants in this study.

4.2.1 Transnationalism and Contraception

Evidence gathered from the study reveals that Zimbabwean migrant women engage in transnational health practices with regards to contraceptive choice and access. Additionally, their knowledge about contraceptives and preferences are transnational resources. This means that most participants in the study migrated with knowledge about contraceptive options and their preferred choices from Zimbabwe. These aspects, knowledge, and preference continue informing their decision-making regarding contraception in South Africa. I found that knowledge about a contraceptive option, how it works and what side effects it might or might not cause in one ones' body were key factors that migrant women considered when deciding which method to use. Interestingly, they attributed their knowledge to Zimbabwean institutions and colleagues. Kumbirai, a 34-year-old, mother of one, who lives and studies at a university in Johannesburg narrated her experiences:

> *"Mina kimi kwabalula ukuthi ngisebenzise iloop ye South Africa ngoba ngasengizwile ngomgane wami esivela sonke ekhaya ukuthi ayikho hormonal so ayisoze iphambanise lutho emzimbeni wami. Ngisuka eZimbabwe ngangisebenzisa amaphilisi kodwa ngeza lapha ngehlukene lendoda so angizange ngifike ngiqale ukusebenzisa something sengilapha. Sithe sesibuyelelana about three years later ngaqala uku stresser ukuthi*

ngizasebenzisani. Ngacabanga idepo yalapha ukuthi ibenzani abantu njengoba sihlala sibabona sebekhuluphele nje, amaphilisi batsho okunengi ngawo vele abantu basekhaya abawasebenzisi. Ngasengicabanga lokuya ekhaya ukuyafaka I jadelle yasekhaya ngoba vele ngingasathembi lutho lwalapha. Then ngathi ngixoxa lomunye umgane wami esifunda sonke wangitshela nge loop ukuthi yona ayikho hormonal so ayisoze itshitshe lutho emzimbeni wami. Ngahle ngagijima ngayafaka yona and iyangisebenzela kuhle". ***(It was easy for me to use the South African loop because I had heard that it is non hormonal from my friend who is also from Zimbabwe, so it was not going to change anything in my body. When I was still in Zimbabwe, I was using pills but because I had divorced with my husband, I stopped. I then relocated to South Africa and when I got here, I was not using anything at the time. Three years later we got back together with my husband, and I started stressing about what to use. I considered the depo but the thought of how it makes people gain weight as we see them around, pushed me away, as for pills there is a lot that is said about them and many people from Zimbabwe do not use them. I also did not trust the local jadelle, so I was considering going back to Zimbabwe to insert the jadelle there. Then one day when I was chatting with a friend of mine whom I study with, she told me that the loop is non hormonal so it will not affect my body in anyway. I then rushed to insert it and it works perfectly for me).***

(Kumbirai – 25.02.2020)

Since the sampling strategy in this study was snowballing, Kumbirai, referred me to her friend who had told her about the loop. Lisa was the name of her friend and she shared a similar story that finding comfort in using a local contraceptive was premised on the knowledge that the loop is non-hormonal. She highlighted that she had always known about the loop, and that it is non-hormonal from the time she was in Zimbabwe through pamphlets and health education on radios and clinics there. Like others, her fear of using other methods revolved around perceived side effects that may result from using the contraceptives.

These reports by these two women point out to the transnational nature of contraceptive health care among Zimbabwean migrant women, as informed by their transnational knowledge. Their choice of contraceptive was informed by knowledge they had gained from Zimbabwean sources about the loop, its non-hormonal nature vs other contraceptives that are hormonal. This finding is an important contribution to the body of knowledge regarding migrant's access to health care experiences. Most studies largely attribute the practice of not using local health facilities and medication by migrants to barriers such as their socio-economic status, documentation issues, attitudes by health care professionals, policies that are not inclusive to migrants among other factors (Spitzer et al., 2019); (Marceca, 2017) and (Vearey et al., 2014). This study however, points to the role of migrant's transnational resources such as knowledge, beliefs, and preferences as some of the reasons that inform their practices regarding access and utilisation of available local health care options. This cements what has been observed that, "previous research on migrant women's sexual health has focused on their higher risk of difficulties, or barriers to service use, rather than their construction or understanding of sexuality and sexual health, which may influence service use and outcomes" (Ussher et al., 2017, p. 1901).

Interestingly, all the women I interviewed demonstrated knowledge about different ways of preventing pregnancy, attributing this to different sources of information they had in Zimbabwe. Hloniphani, a divorced 31-year-old waitress in Johannesburg revealed the following:

> *"Mina ngazi amaphilisi amacontrol le secure, ijekiseni, ijadelle kumbe i no plant, iloop, lendlela zesintu kodwa ngizisebenzisela iloop. Iphilisi linathwa elilodwa kanye ngelanga, idepo iyahlatshwa, kuthi I jadelle ungayifaka ihlala 5 years then iloop ngeye 10 years, efakwa esibelethweni ukuvikela ukuhlangana kwenhlanyelo. Ulwazi olunengi abanengi bethu siluthole ezibhedlela ngemva kokubeletha umtwana wakuqala, usutshelwa ngendlela ezikhona zokusebenzisa ukuvikela ukuthatha esinye isisu. Yebo kambe esikolo kwakufundiswa lakwezinye inhlelo kumaradio so umuntu ubukhula nje ulolwazi oluthile nje ngezokuvikela ukuzithwala".* ***(I know the pills, the control and secure, injection, jadelle or no plant and the loop. The pill is taken one tablet daily, the depo is injected, the jadelle is a five-year method and the loop is for***

10 years. The loop is a barrier inserted in the cervix to prevent the sperm and egg from meeting. Most of us got a lot of knowledge at the health centers after delivering our first baby. We were presented with possible options to use to prevent falling pregnancy. Of course, it was taught in schools as well and some radio programmes, so we grew up with some knowledge about pregnancy prevention).

(Hloniphani - 23.02.2020)

The words that Hloniphani and other respondents used to refer to some contraceptives, were colloquial and not standard names known by some people including myself. As I indicated earlier, to avoid confusion, and to create a common understanding of the contraceptives they mentioned, so that every reader can relate; I asked for the standard or clinical names from a pharmacist who trained and worked in Zimbabwe, before migrating to South Africa. The pharmacist clarified that:

"These methods amaphilisi, icontrol le secure, ijekiseni, ijadelle, iloop fall into different classes namely, Oral contraception, Contraceptive injection/injectable and the Levonorgestrel Implants. Amaphilisi or mapiritsi are clinically known as the oral contraceptive pill, with its two types, the control and secure. The control pill is the one used by women who are not breast feeding and the secure is for breast feeding women. Depo is clinically known as the Depo Provera falling under the contraceptive injection/injectable. The Loop is what is clinically known as the Intrauterine device (IUD) and what they referred to as the Jadelle or no-plant is clinically known as Jadelle Implants which falls under Levonorgestrel Implants".

(Pharmacist – 03.03.2020)

Notably, the Zimbabwean contraceptives mentioned by the Zimbabwean migrant women are also available in the South African market. For example, contraceptives pills, the depo provera, the loop and implants are all available in South Africa. However, evidence from Johannesburg and Pretoria indicates that most migrant women continue to use the Zimbabwean contraception pill for prevention of pregnancy even after migrating to South Africa. Interestingly, I found that the duration of stay in South Africa is not a deterring factor that could stop women from using the pills

from Zimbabwe or lead them to a change to local options. For example, this situation is illustrated by Martha, a 40-year-old divorcee who has lived in Johannesburg for 12 years. She narrated her story as follows:

> *"Mina ngihlalile shemu emaphilisini asekhaya, iminyaka edlula 10. Ngabuya lapha eGoli ngivele ngisebenzisa wona sengizele umtwana wakuqala, ngafika ngaqhubeka ngisebenzisa wona. Ngaqalisa ngisaphathelwa ekhaya ngabanawabami nxa bezovakatsha bebuya lawama six months ngithi ngingakawaqedi kubesokuze amanye, angithi ekhaya ayevele ephiwa mahara emakhaya noma uthenga ayetshiphe kakhulu, angisazi kodwa ukuthi ayeyimalini ngokutshintsha kwemali zekhaya lokhu. Ngokuhlala ngicelwa ngabanye emaflatini lapha nxa sebephelelwe ngaze ngabona ukuthi ngingawathengisa ngenze imali. Ngaqala kanjalo nje ukuwathengisa R15 packet*[3]*. Lapho ke ngasengiyenza ukuwathengelwa emanengi khonale ngiphathiselwe kumalayitsha ngoba amacustomer ami ayemanengi ethengwa ngitsho langabantu base Malawi lase Mozambique. Ngimile nje nge divorce ukuwasebenzisa ngingasela ndoda yansuku zonke ngazisebenzisela amacondom, ngahle ngama lokudayisa vele sebebanengi abantu abawadayisayo".* ***(I stayed a long time indeed on the Zimbabwean pill for over 10 years. I came to Johannesburg already using them after delivering my first child. At first, my sisters would bring me a supply of about six months when they visit and before I even exhaust that, I will receive another batch. They were being given for free back in Zimbabwe or sold cheap, but I do not remember how much exactly with the ever-changing currencies there. So, because people around the flats here would always borrow from me when they ran out, I then saw an opportunity to make money. That is how I started selling them at R15 a packet and at that time they would get them in bulk for me and send to me through cross border commuter omnibuses. I had a lot of customers, including people from Malawi and Mozambique. I stopped using them when I divorced because I no longer had a daily husband and I changed to condoms. I also stopped selling and anyway, there are many people selling them now). Martha - 29.02.2020)***

[3] Each packet contains a supply of one full month.

Asked as to why she continued using Zimbabwean pills for such a long time after migrating to South Africa in 2008, the participant replied:

> *"Amaphilisi alapha ayagulisa, wonke umuntu wayetsho njalo ethi aqeda amandla, uzizwe sengani uyomula".* ***(Local pills make you feel sick and weak, everyone was saying they make you feel as if you have morning sickness).***
>
> ***(Martha – 29.02.2020)***

While Martha shared details of using the Zimbabwean pill for over a decade whilst based in South Africa, Abigal, a 24-year-old single woman who works as domestic worker had a similar narrative from her four years in South Africa. She outlined the following:

> *"Ngizisebenzisela amaphilisi esekhaya, ngiyawasebenzisa konke lokuwathengisa. Kodwa ungangibophisi phela (enyenyeza kancane). Ngavela ngaqala ukusebenzisa amaphilisi ngisesekhaya. Angithi uyazi ekhaya sifundswa ukuthi umuntu nxa engakazali kumele asebenzise amaphilisi ngoba okunye kungakwenza uhle ungasazali. Ngathi ngifika lapha ngezwa wonke umuntu wasekhaya engangimazi ethi usebenzisa amaphilisi asekhaya awalapha awayenzi kakhle lami ngavela ngaqhubeka ngawo. Ngiwawoda ekhaya bangiphathisele ngamabhasi. Amawalapha abantu abawafuni, so bayawathenga okuzwayo lawa (engitshengisa amapackets amaphilisi ase Zimbabwe). Yibusiness enhle okunye ngoba bangavele bazi ukuthi ulawo awahlali, ashesha aphele. Mina angikaze ngawazame awalapha angifuni kukuqambela amanga, njalo angiphuphi ngiwazama vele. Bathi awalapha ayagulisa, abanye bathi ayahlanzisa abanye bathi aqeda amandla".* ***(I use the pill from Zimbabwe, I use and sell it. But do not get me arrested (whispering a bit). I started using the pill back in Zimbabwe. You know in Zimbabwe we are taught that the pill is the best contraceptive to use before you have your first child because the other methods can make you barren. So, when I came here everyone that I knew from home was using the Zimbabwean pill and they were saying the local ones are not good, so I just continued with them too. I procure them in bulk from Zimbabwe and have them sent to me through buses.***

People do not want the local pill, so they buy these ones (showing me packets of Zimbabwean pills). It is actually good business because once people know you have them, then they do not last. I have never tried the local ones; I do not want to lie to you, and I do not dream of doing that. They say the local ones make you sick, some say they make you vomit, and some say they make you feel weak).

(Abigal – 15.02.2020)

Abigal went on to show me two different types of the contraceptive pills, leading me to probe about the differences. This is what I found out:

"Wonke ngaweZimbabwe, angithengisi awalapha. Lawa amanengi yilawo athathwa ngumuntu ongamunyisiyo. Hanti uyabona ale line eyi brown leyi eyenza ukuthi umuntu aye enyangeni. Then lawa ayiwhite kuphela ngawabamunyisayo. Lawa ngilamaclient ami amalutshwana awasebenzisayo so ngi wodela bona yikho emalutshwana uyeza so umnikazi ukuzowathatha". ***(They are all Zimbabwean pills; I do not sell the local ones. These ones, which are plenty are used by any woman who is not breast feeding. As you can see, they have this line of brown ones which make one menstruate. These few ones that are all white are for breast feeding women. So, I have a few clients that I procure these for. So, the owner of this order is coming to collect it).***

(Abigal – 15.02.2020)

Pictures of the contraceptives pills shown below.

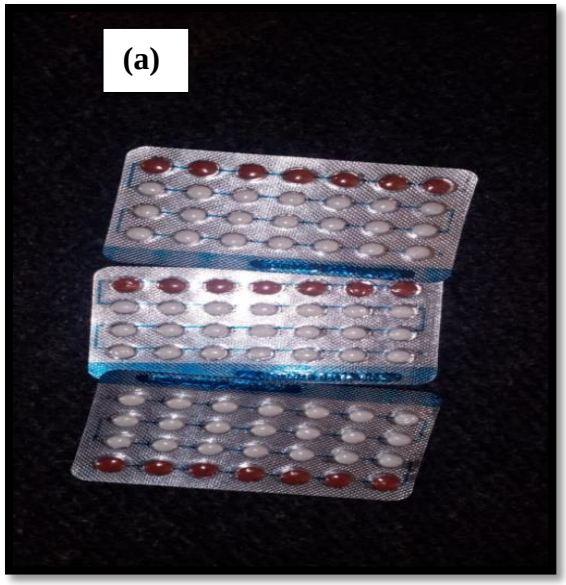




Figure 2: Picture (a) of the Zimbabwean control pills.

Figure 3: Picture (b) of the Zimbabwean secure pills.

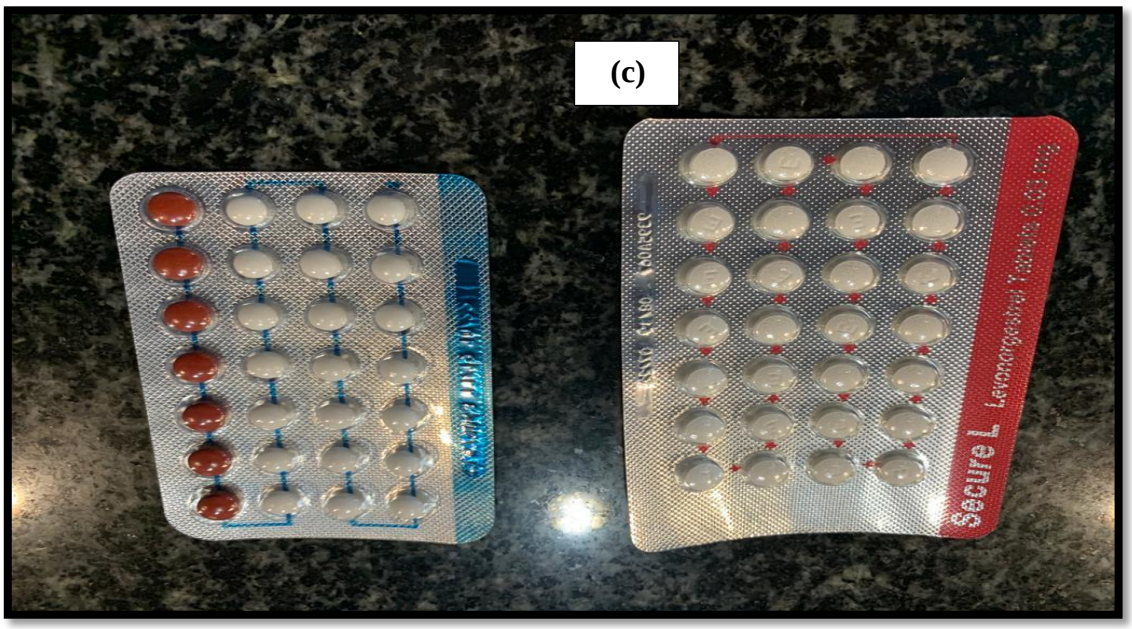


Figure 4: Picture (c) of both the Zimbabwean control and secure pills.

The above narratives by Martha and Abigal, together with those shared by other women who reported using the Zimbabwean contraceptive pill revealed an interesting practice, which is not reported in the available South African literature, although noted in studies conducted elsewhere for example Hilfinger Messias (2002) and Åkerman et al., (2017). Most studies in the South African literature have documented the practice of getting medication from the country of origin in relation to HIV/AIDS antiretroviral therapy (see Vearey et al., 2017) and (Faturiyele et al., 2018). Health risk associated with this practice have been reported to include defaulting treatment due to delays in accessing medication. Evidently, from the findings in this study, access to contraception back in Zimbabwe is not an easy endeavor. Some women reported that they either buy the pills from local dealers like Martha and Abigal, while some bring several packets for personal use when they visit Zimbabwe. Choice, who also uses the Zimbabwean contraception pill and has been in South Africa for two years narrated her experience:

> *"Gore rakapera ndayinyanyoyenda kumusha nekuti tayivaka saka kuti tigarise tese nemurume pasina ambonokanda ziso zvayisabuda. Saka ndayiti garegare ndombomhanya ko. Saka ndayiti pese pandayenda ndotowuya nemamwe mamwe asati apera. Sekuti kunepamwe pandakambowuya nezvima packet six ndikambochobva six months. Dzisati dzapera ndikadzokera paEaster paye ndikanowuya ne eight pakatosvika December ndichinawo. Chero iyezvino ndichiribho hangu saka ini hangu pamakore andagara muno ndandisati ndatenga kunevanotengesa muno***". (The previous year, I frequently visited Zimbabwe because we had a building project so we, me, and my husband, could not stay long without one of us going to check on progress. So, each time I went there, I would return with several packets, like the other time I brought six packets and I went for six months with those. Before they ran out, I had another trip during Easter holidays, and I brought back eight packets. I got to December with those. So even right now I am still sorted. So, in the two years that I have lived here, I personally have never bought from those that sell them here).***
>
> ***(Choice - 16.02.2020)***

Choice's narrative, including reports by Martha and Abigal reveal strategies that they have to employ to meet personal contraception needs and those of their clients. Most of these strategies are illicit and involve smuggling, putting them at risk of getting arrested. Furthermore, Martha indicated that she would sometimes run out of stock, meaning that clients would sometimes go without. Moreover, buying in bulk also puts them at a health risk of using drugs that have expired or even stored under conditions that are not suitable for drugs, which might cause them contraindications. In line with this finding, Åkerman et al., (2017) found that in Thailand migrants living in Sweden obtained medicines such as contraceptives from their home country instead of getting them from Swedish healthcare services. In this study it is further reported that due to this practice, "others stopped using them when they ran out, despite not wanting to become pregnant" (Akerman et al., 2017, p. 200).

Drawing from these findings, in a context where unwanted pregnancies continue to rise, maternal and infant mortality remains high (WHO, 2018), women, particularly migrants who are within the child bearing ages have poor health outcomes (Kvamme & Ytrehus, 2015) and (Almeida et al., 2013), these findings point to a need for interventions which address underlying causes leading migrants to opt for country of origin contraceptive options. If the majority of Zimbabwean migrants, and some from countries like Mozambique and Malawi do not rely on South African options for contraception, despite the challenges presented by that practice such as running out of supply and risking having unwanted pregnancies when they have to go for days without, I maintain that it signals existence of real concerns with the local contraceptive options, especially the pill. These findings therefore, point to a need for research on the scale of Zimbabweans or other foreign migrants' use of imported contraceptives, and the magnitude of women who are having unwanted pregnancies together with experiencing some side effects from using South African contraceptives, if efforts aimed at reducing unwanted pregnancies, maternal and child mortality are to succeed.

These troubles that the women were prepared to go through to access the Zimbabwean contraceptives, got me interested in knowing the differences between those and the South African options. Surely, there had to be a reason why they strongly felt that way, and from my assessment it was beyond the structural barriers to health care access which are often encountered by migrants

in the host countries, because not a single woman mentioned those. However, my inquiry from the women yielded nothing more than that the pills are different as determined by how they feel after taking them. The conversation with the pharmacist, definitely helped me understand their experiences much more as it buttressed what they had reported. The pharmacists outlined the following:

> "*The Zimbabwean pill is clinically known as the Marvelon and it is distributed for free in Zimbabwean public hospitals. Here in South Africa, the pill that is distributed for free at public hospitals is called the Oralcon. What differentiates these drugs are the active ingredients whereby, in the Marvelon there is desogestrel and ethinylestradiol. Oralcon on the other hand has levonorgestrel and ethinylestradiol as active ingredients. The doses are however the same. Simply put, the only difference is that Marvelon contains desogestrel, while Oralcon contains levonorgestrel. These are simply two different forms of the hormone progesterone. There is supposed to be no detected differences for the person taking the pills".*
>
> ***(Pharmacist – 03.03.20202)***

Interestingly, when I asked why South Africa does not provide the same drug that is equivalent to the Marvelon pill in public hospitals, the pharmacist pointed out that the drug is actually available in South Africa but it is sold in pharmacies at an average of R180 a packet which is arguably beyond the reach of many. Note that even after being imported by the traders who sell the Zimbabwean pills in South Africa, it still remains very lowly priced at R15 a rand a packet compared to R180 in pharmacies. This is mainly as a result that in Zimbabwe, contraceptives are provided for free in public hospitals including the Marvelon pill. As a result, these differences relating to the types of contraceptives provided for free in Zimbabwean and South African public hospitals facilitates the practice of importing the pills by migrant women. It remains cost effective for them to engage in that rather than getting the pills from local pharmacies if they do not like the options which are available for free in South African public hospitals.

Using the intersectionality approach, these findings illuminated how factors such as being a migrant and social class intersect, and subsequently influence varied practices across migrants surrounding access to contraceptives. For example, I was able to draw a sharp contrast between Gugu, who indicted that she uses the local pill and other women who have continued using the Zimbabwean one. The following is part of my interview with Gugu in which she explains why she takes the South African pills.

Question: *Phakathi kwendlela zokuvikela ukuzithwala lezi oziqambileyo, wena usebenzisa yiphi?* ***(From these methods that you mentioned, which one do you use).***

Gugu: *Mina ngisebenzisa amaphilisi alapha eSouth Africa.* ***(I use the pill, the South African one).***

Question: *Uqale nini ukuwasebenzisa wona?* ***(When did you start using them?).***

Gugu: *Ngingathi ngile eight years, ngoba lami ngile eight years ngilapha. Ngasuka eZimbabwe ngisebenzisa ngivele ngisebenzisa amaphilisi ngafika lapha ngatshintshela kwawalapha.* ***(I can say eight years because I have been here for eight years now. When I left Zimbabwe, I was using the pill and when I got here, I just changed to the local one).***

Question: *Wona akuphethe njani awalapha?* ***(How are you reacting to them?).***

Gugu: *Angila nkinga lawo, awangigulisi njengalokhu engizwa abanye abantu besithi ayakwenza. Kumbe kwenziwa yikutshiyana kwemzimba yethu kumbe wona ayatshiyana asazi.* ***(I do not have any problems with them, they do not make me sick like I hear other people say, maybe it depends on differences with people's bodies or maybe they are different).***

Question: *Wena wakwazi njani ukukhetha ahambelana lawe?* ***(How did you know how to choose the right type for your body?).***

Gugu: *Mina ngavela ngathi ekufikeni kwami sengizaphelelwa ngawasekhaya ngaya epharmacy ukuyathenga ngoba ngingazi lokuthi vele ngingawathola kuphi lama paper aqondileyo ngingakabi lawo ukuthi ngingaya esibhedlela ngavele nje ngaziqondela epharmacy. Ngafika ngabuzwa ukuthi ngifuna aphi ngoba kulemhlobo eminengi ngathi ngizaphenduka lephepha lalawo ebengiwasebenzisa lakanye ngeza lawo bawabona bangipha ke umhlobo wakhona. Kusuka lapho yiwo vele engiwasebenzisayo lokhe ngisawathenga e pharmacy R220 ipacket le30.* ***(When I arrived here and I was about to run out of those that I had from Zimbabwe I went to the pharmacy because I did not know where else to get them and I did not have the right papers to go to the hospital, so I went straight to the pharmacy. They asked which type I wanted because they are different. So, I returned with the packaging sample of those that I had, and they gave me the ones that I use even now. I still buy from the pharmacies at R220 per packet).***

(Gugu – 23.02.2020

Gugu's actions which are in contrast to other migrant women from Zimbabwe should be understood in context. She is a 30-year-old young mother, who works as a teacher, and is married to a relatively financially well-off husband. Drawing form Gugu's case, arguably social class, for example her financial status seen from the ability to buy from a pharmacy and spending R220 a month for eight years contributes to the difference in her choice of contraception, which set her apart from other women. Not only was social class a probable key factor in influencing Gugu's choice, but also the fact that as a newcomer she did not know where to access contraceptives, and she had a perception that since she did not have proper documentation she cannot access a public hospital. She thus went straight to the pharmacy, where her money was sufficient to get her what she needed even without documentation. These interesting factors account for the variation of her experience from others who reported using the Zimbabwean pill. This case demonstrates the heterogeneity of migrant's practices or experiences as a result of their subsequent heterogeneous positionalities, and class is one of them. These differences among migrant women and their experiences could otherwise be overlooked if they are treated as a unitary group of women and or

migrants. Using the intersectionality approach enabled me to explore how women's practices are differentiated as a result of intersections between class and migration among other factors.

In a country like South Africa where 17,2 per cent of migrants are either informally employed or run informal businesses and 17,1 per cent are employed in private households (South African Census, 2011), the unaffordability of contraceptive options that meet migrant's needs is an issue of concern. Most migrants are at the lower stratum of income levels and live precarious lifestyles to afford spending between R180- R220 per month on the cost of contraceptives that satisfy their needs. This does not affect Zimbabwean migrants only, but even other migrants from across the region who were reported to use the pill from Zimbabwe. This calls for a regional approach into addressing this issue, through a standardisation of contraceptives distributed in public hospitals across the SADC region. Lessons can be drawn from HIV/AIDS interventions as advocated by Vearey et al., (2017), that South Africa should adopt a migrant aware health system, that takes into account the mobility of people across the region, making it possible for individuals who move to be able to access refills of their medication everywhere. In cognisance of the assertion by the World Health Organisation that:

> *"Migrants travel with their epidemiological profiles, their level of exposure to infectious agents, their susceptibility to certain conditions, and their genetic and lifestyle-related risk factors, along with their culture-based health beliefs. They also travel with their sexual histories and SRH notions and practices". (WHO, 2008)*

This study, therefore, reveals how migrant's practices or health seeking behaviours are complex and should be seen, not just as resulting from anti-migrant structural issues in the host country. Rather, considerations should be made relating to the country of origin related factors which migrants migrate with and continue to practice or inform their decisions as they take an active role in taking care of their health needs, exercising agency. This bolsters the argument that:

> *"Transnationalism is an outcome of societal dynamics at both ends of the migration process. Transnational practices and social relations evolve according to the opportunities, resources and constraints implied by migrants". Lacroix (2012, p. 26)*

Furthermore, these findings on the transnational nature of migrant's knowledge, beliefs, preferences and practices surrounding contraception advance the "country of origin" discourse as suggested by Mengesha et al., (2017, p. 6). They posit that women's experiences in accessing health care in their country of origin influenced their access and utilisation of care after resettlement. Similarly, as shown from the evidence in this study, most participants were using the contraceptive pill even before leaving Zimbabwe. They, therefore, preferred continuing with it even in a context where the available options were incompatible with them, rather than switching to other local contraceptive options.

4.2.2 Transnationalism and Pluralistic Health Care

Evidence from this study revealed that although migration is a determinant of health as propounded in the Social Determinants of Health perspective (SDH; 2010), which essentially means migrant's health behaviour and outcomes are altered as a result of migration; most practices, traditions and beliefs amongst the studied group, have however continued beyond the border. This group of women, therefore, engages in transnational antenatal health care, where they access medicinal products and health care from both the host and country of origin. It was particularly interesting to note that migrant women engaged in more than transnational antenatal health care practices. Due to various factors which I will shortly present and discuss, these women engage in transnational pluralistic antenatal health care practices. This means the coexistence or use of biomedicine with traditional medicine (Baer, 2018), in most cases, having accessed the traditional products from Zimbabwe. Interestingly, in instances when they used traditional medicines they sourced in South Africa; the practice was often founded on knowledge gained from their country of origin.

As previously mentioned, the World Health Organisation (2008; 2013) defines traditional medicine as:

> *"The sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness". (WHO, 2013, p.15)*

Of note, I will use the phrases traditional, indigenous, and complementary medicine interchangeably to refer to any practice or product that is not encompassed in the South African and Zimbabwean's mainstream/conventional biomedicine.

The following except by Fatima, a 28-year-old woman who lives and runs a small vending business at the market place[4] in Pretoria illuminates migrant women's understanding of SRH including contraceptives in traditional terms and their preferences. Fatima said:

> *"Chimwe chibereko chinozvirerera kana uchiyamwisa hawuyendi kumwedzi saka hawutombotsvagi kushandisa zvekudzivirira pamuviri senge mapiritsi, depo, zvanajadelle nezvakadaro-daro zvekuchipatara. Ini ndinotoshuwira kuti dai ndakatodaro, zvemapiritsi izvi zvinozvobhowha nekuti panotoyita chisingafambidzane zvakanaka nemuviri wako".* ***(Some wombs do the self-timing of when to have another baby. This happens when one is breastfeeding and not menstruating, so you will not need to take contraceptives like pills, depo, jadelle and others like that from the hospital. I wish I had that lucky too. Taking contraceptive pills is sometimes not a good experience because there is always something that is not compatible with your body).***
>
> ***(Fatima – 21.02.2020)***

[4] This a place in Pretoria North where women who are searching for casual jobs or piece jobs as commonly known amongst them come to sit and wait for potential employers who come to hire from there. Women mostly found here are of Zimbabwean nationality with a few from Lesotho as well.

Although the biomedical system maybe be the conventional one in both South Africa and Zimbabwe, with its range of contraceptives, Fatima expressed her profound preference for traditional methods due to her perceived side effects that are caused by biomedical methods. In this study, I found that women embrace traditonal ways of preventing pregnancy even after emigrating to South Africa. In this same regard, Nonhlanhla a practicing Muslim[5], presented her personal experience of using a traditional method for 15 years, which according to her, has not failed her. The 40-year-old mother narrated her experiences:

> *"Amatraditional methods ayasebenza kuhle sibili, mina nginje sengiyisebenzise okwe 15 years nanku lokhe ngilomtwana oyedwa, babengamaphahla kodwa omunye wabhubha. Ngakhetha indlela leyi ngoba ngeyeminyaka eminengi njalo uyazikhethela ukuthi wena ufuna ukungazali okwesikhathi esinganani. Mina njengomuntu owazala esemcane ngangifuna ukuhlala ngingazali ngondle amaphahla ami. Thina amaMuslim siyawasebenzisa kakhulu amatraditional. Zinengi indlela zakhona, kuleyokuthatha imithi yesintu ihlanganiswe lamaxolo esihlahla. Amaxolo lawo kumele abeyi number yeminyaka ofuna ukuhlala ungayizali. Kuthi kungahlanganiswa lokhu sokuvalelwa egabheni kugqitshelwe phansi lapho ongasoze ulibale khona. Inkinga yikuthi ungalibala nxa usufuna ukuzala iminyaka yakhona ingakapheli awusoze ukuthole ukuze ukuvule ukuchithe. Nxa kungachithekanga awuzali iminyaka yakhona ize ikwane".* ***(Traditional herbs work very well; I use them, and I have not fallen pregnant for the past 15 years after having my only child. In fact, I had twins but the other one passed on. I chose this method because it is long term and you choose how long you want it to last. I chose 15 years because I had children when I was young, I wanted to stay long before falling pregnant again. We, Muslims use them a lot and there are many ways. One of them is preparing herbs by mixing pieces of off cuts from tree barks. The number of offcuts from the tree barks that one puts in the mixture determines how long one will stay before conceiving. This mixture is then tightly sealed in a container and buried underground at a site you must not forget. The problem is if you forget the location and you have decided to have a child***

[5] Zimbabwe has a small population of Moslems. These are commonly called amaTshawa in Zimbabwe.

before the lapse of the years that you initially chose you will not be able to conceive until the chosen years lapse). ***(Nonhlanhla – 29.02.2020)***

Nonhlanhla's account presents a synopsis of multiple intersecting factors that had an influene on her choice of contraception, long before she migrated. Firtsly, her religion. In her narration she says *"thina amaMuslim siyawasebenzisa kakhulu"* which means, *"we as Muslims use them a lot"*, referring to the traditional methods. Already, she locates her beliefs and practices within the discourse of religion. She indicated that she had her first children, the twins, at an early age which made her desire not to have more children imminently, hence she wanted a long-term method. In addition, she had knowledge that had been imparted in her upbringing, about the long life span of the traditional method, and lack of knowledge about biomedical methods that are also long term. Therefore, decision making regarding her choice of contraception is situated at the nexus of these intersecting factors namely; religion, upbringing, exposure, more knowldge about traditional methods and less knolwdge about long term biomedical options. Reporting on other women's practices, Nonhlanhla added on to say this:

"Abanye basebenzisa intanga zensango. Zona uyaziginya njengamaphilisi, unatha amanzi. Nxa ungaginya ezingu six kutsho ukuthi awusoze uzale for six years". Abanye njalo futhi basebenzisa amanzi echurch athandazelwe ngumfundisi. Hayi mina leyi indlela angazi kumbe iyasebenza njengalezi eze tradition". ***(Some women use cannabis seeds. These seeds are swallowed with water like pills once off, and you will not fall pregnant for the number of years equivalent to the number of seeds swallowed. This means that swallowing for example six seeds will mean no conception for six years. Some say they use religious based methods, for example drinking water which has been prayed for by the church prophet. As for those ones, I do not know if they work like the traditional ones).***

(Nonhlanhla – 29.02.2020)

These findings suggest that despite being aware of many biomedical contraceptives available in South Africa which are also accessible to migrants, the choice of what to use is an outcome of multiple intersecting factors. Women who used traditional contraceptive methods continued with this practice they had learnt in their home country Zimbabwe. They also continued to have low confidence in biomedical ways of preventing pregnancy whilst away from home. Similarly, when it came to other SRH related issues besides contraceptives and antenatal care, I found a profound preference of traditional remedies over visiting health facilities at certain moments. For example, Irene, aged 32 years, who worships in the Apostolic church and is a secondary school graduate explained her experiences with using one of the traditional medicines and its purposes:

> *"Kana lemon zvaro rinodzora size yenhengo yesikarudzi asi rinorwadza 'maiwhee' (achisunga kumeso kuratidza kurwadziwa). Rinorapa futi chibereko, mazuva apera ndandichinzva chibereko ndikawudzwa kuti ndikaboiler mvura inelemon ndochizodhasharara pairi kuti steam iya ipinde mukati ichiyenda ikoko chibereko chinopora, ndikatozviyita ndikapora, andina kutozo yenda kuclinic".* ***(Even a lemon reduces the size of the vagina, but it is very painful (as she makes a sound which explains pain and flinches her face). It also heals the uterus. A few days ago, my uterus was painful. I was told that if I can boil water with a lemon and steam the vagina with that water so that the steam penetrates to the uterus, I will be fine. I did that and it worked. I did not go to the hospital).***
>
> ***(Irene – 24.02.2020)***

In response to the question why she used that method instead of going to the clinic, she answered:

> *"Chivanhu chedu, and zvinotoshanda, hawungayenderi kuchipatara zvinhu zvinorapika zviri nyore-nyore kumba, uyezve tinenge tirikumabasa saka nguva yekumbotora zuva rekuyenda kuclinic unoyiwanepi".* ***(It is our tradition. It works. One cannot just go to a clinic/hospital for things that can easily be cured at home, also we go to work so that makes it difficult to find a day to go to the clinic).***
>
> ***(Irene – 24.02.2020)***

It is worth noting that Irene like other migrant women, due to a number of factors like work commitments trivialise certain health conditions. Consequently, they do not find it necessary to seek medical help in clinics and hospitals. Women see it worthwhile to visit clinics and hospitals if they regard the health condition as serious. This is in line with the Health Belief Model (HBM) developed of 1950s which posits that the key elements to taking health actions are the individual's perceptions of susceptibility, severity, benefits, and barriers in regard to their health (Jones et al., 2015) and (Orji et al., 2012). Study findings therefore show that Zimbabwean migrant women's decision making relating to sexual reproductive health is largely a calculated move, based on perceived profitability, barriers and inconveniences presented by taking certain health seeking actions. This hierarchisation of illness and medical knowledge which is subjective can potentially be putting their health at risk.

This revelation by Irene, is in contrast to the observation that was made by Makhubele slightly less than a decade ago, that "with the emergence of Western systems of knowledge, indigenous knowledge has been regarded as a pagan practice and therefore, relegated to the lower level"(Makhubele, 2011, p. 10). Irene and many other participants who shared similar views as I am going to demonstrate, present a different picture from (Grenier, 1998)'s earlier elucidation that, there has been neglect of indigenous knowledge, depicting it as primitive, simple, static, and this has led to a decline in its use and application. In this study, I rather found that indigenous knowledge still has a profound influence on migrant women's beliefs and practices relating to SRH broadly. Indigenous medicines are widely used, valued and ironically by some health workers too as I will discuss later. These findings also contrast literature suggesting that "in instances wherein if one is confronted with a sexual or health problem, without thinking about possible indigenous intervention, one resorts to western methods of intervention (Makhubele, 2011, p. 11). In contrast, Irene's story reveals how, due to its ready availability, the use and preference of traditional remedies, remains prevalent among Zimbabwean migrant women. Thus, in instances where the traditional medicinal option is easily accessible, they opt to use that without any disruptions to their work schedules as opposed to visiting health facilities.

Just to cement the discussion on how work interests make it difficult to easily seek health care by migrant women, these findings are in sync with Mengesha et al., (2017) and Lazar et al., (2013)'s assertion that, refugee and migrant women's primary focus after resettlement is mainly finding employment, securing housing, schooling for children, and meeting family responsibilities. These responsibilities therefore make it difficult for refugee and migrant women to consider reaching out for appropriate SRH care, thus it may compromise their overall health. This also cements, existing literature regarding Zimbabwean women living in Johannesburg as documented by Makandwa a few years ago that:

> *"The majority of these women find themselves in the lower positions of the social strata where the search for livelihoods overrides all other facets of life, and this militate against their access to health during maternal period through delaying seeking health care"*
>
> ***(Makandwa, 2014, p. 61)***

Based on the narratives shared by Irene and Nonhlanhla as depicted above, this study evidenced how Zimbabwean migrant women's contraception practices coupled with other SRH components are influenced by an array of diverse and complex factors. Employing the intersectionality approach, I established that there is an intersection between transnational knowledge, beliefs, practices regarding the use and efficacy of traditional methods with post resettlement related factors. Additionally, despite the dominance of biomedical medicine, and the reported neglect of traditional remedies, women continue to use both options in concurrence to complement each other, depending on preferences. These findings demonstrate the complexities, the intersections, and the different factors from the levels of the socio-ecological framework that surround Zimbabwean migrant women's contraception experiences in South Africa. Makhubele also notes that:

> *"Contrary to claims and thinking that indigenous knowledge is inferior to Western knowledge and a hindrance to development, the existence and survival of the people*

in rural communities without basic amenities is a testament to the value of their indigenous knowledge as they continue to thrive with the Mother Nature".

(Makhubele, 2011, p. 17)

With regards to antenatal care, this assertion by Makhubele proved to be in line with Zimbabwean migrant women's lives in reference to what grounds their profound beliefs in traditional medicine. Participants reported having used a form of traditional medicine during pregnancy or child birth, out of their strong convictions that these methods prevented labour complications, maternal and infant mortalities. Twenty-five (25) years old Batsirai, who is married, a mother of one, was pregnant during the time of the interviews and works as a general hand at a car wash, said:

"Ini ndinotoshandisa mishonga yechibhoyi nekuti vanhu vakawanda varikutoshaya vachizvarwa nekuti mwana anenge ashaya nzira, kana kuti mhunu wakasungwa nevavengi kuti usazvare. Saka kumwa mishonga yechibhoyi kunotobatsira kuti chero chipi chusungo chinoshaya basa". ***(I use traditional herbs because a lot of people are dying during child birth because the unborn baby fails to find a way out. This sometimes happens as a result of enemies casting spells so that you fail to deliver. Drinking traditional herbs is an antidote to whatever spells that might be there).***

(Batsirai – 16.02.2020)

Batsirai and other women outlined that they used traditional medicine because of their conviction that they are effective in preventing caesarean deliveries, help one to have a natural birthing without suturing, prevent maternal mortality and prolonged labour. On a related issue, Emihle aged 27 years, who is single, with no children and works as a domestic worker buttressed this idea that indigenous methods have it all that relates to their birthing needs as women, which could not be offered by biomedical options. Although not speaking from experience, as someone who had not yet given birth, she clearly indicated that indigenous knowledge is deep rooted and valued amongst migrant women, highlighting that:

"Imithi yesintu ilakho konke umuntu angakudinga, kuleyokuvula indlela yomtwana kukhona njalo eyokubisela inyama endaweni nxa usubelethile". ***(Traditional herbs have everything needed by women. There are herbs for paving the way for the baby, and there are those herbs for shrinking the vagina after delivery).***

(Emihle – 20.02.2020)

These cases challenge the discourse that traditional medicine is in most cases used by African rural women as an alternative to the biomedical option, due to the remoteness of their communities in relation to distances from health facilities, the costs of accessing clinics or hospitals and inferior treatment from health care workers (*see* Fair et al., 2020) and Ngomane & Mulaudzi (2010). Shewamene et al., (2020) found that there are no studies documenting use of traditional medicine among African women in the diaspora, in a desk review study they conducted. They thus, concluded that the wide use of traditional medicine by African women for maternal and reproductive health issues is as a result of lack of access to the mainstream maternity care.

Yet in contrast, in this study, I found that even when presented with the option of biomedical health care, without access related challenges such transport and other costs; Zimbabwean migrant women held strong beliefs that there are benefits of using traditional medicine. As illustrated by the experiences of Batsirai, Irene, Gugu and Emihle above, they held a conviction that they could not get those benefits offered by traditional medicine from the biomedical system. On a similar note, Falisse et al., (2018, p. 483) found the existence of "pluralistic patterns of health-care seeking behaviour, which are not primarily based on economic convenience or level of education", among women in a study conducted in Burundi. This reflects that the use of traditional medicine among African cultures cannot only be understood in terms of a reaction to structural hinderances that make access to mainstream biomedical care difficult for women. Rather, as a result of multifaceted intersecting factors, among which there is a strong conviction on the efficacy of these medicines.

Gugu, who at the time of fieldwork was 30 years old and had one child narrated her ordeal that reinforced her belief in traditional medicine. She revealed that she could be having two children but sadly her first child passed on two days after delivery due to labour complications some nine years ago, while still living in Zimbabwe. Gugu narrated her ordeal:

"Mina ngingumuntu owayengazikholelwa ezemithi yesintu lezi kodwa khathesi angeke ngathatha amachance emva kokuthi ngabhujelwa ngumtanami wakuqala ele two days isisusa kuyikuthi ngaba lomhelo omude kakhulu okwe 3 days. Ngalezo three days ngangisesibhedlela kodwa labesibhedlela abangisizanga ngokungi inducer noma ukwenza ireferral kusibhedlela esikhulu ukuthi ngiyekwnziwa ioperation. Kuthe nge third day sengibelethile kodwa umtwana etshisa esiba lama fits babiza udokotela wafika wakhangela umtwana wathi umtwana lo uhlale kakhulu esiswini, le labour yami was too long waze waba lebrain damage wadeveloper amafits. Bazama ukumelapha kodwa ngemva kwe three days wasweleka. Mina ngikholwa ukuthi ngangibotshiwe yizitha yikho ngaba lomhelo omude kwaze kwaphambanisa umtwana njalo khonokho ukuthi esibhedlela bangigcina insuku zonke lezo bengenzi imizamo yokubiza udokotela, ukuthi ngithole induction noma ukungisa esibhedlela esikhulu ukuthi ngiyethola ioperation kutshengisa ukuthi kwakulesibopho esenza wonke umuntu wavaleka amehlo lomqondo wakhe. Kwasuka kwaba kubi kakhulu futhi ukuthi ngangiyinathanga imithi yesintu ekhulula izibopho yikho nje khathesi angisathathi amachance ngiyayinatha". ***(I am that person who used not to believe in these traditional herbs but now I do not take any chances, I use them. This came after losing my first child when she was two days old, some nine years ago when I was living in Zimbabwe. The main reason that led to her death was because I had a long labour of three days and during those three days I was at hospital, no one thought of inducing me or referring me to a bigger hospital for an operation. When I finally delivered, the baby's temperature was high, and she was having fits. They called the doctor and upon looking at the baby, he said that the baby over stayed in the womb and I had prolonged labour which led to the baby to have brain damage and develop fits. They tried treating the baby but unfortunately, I lost her two days later. I believe that a spell was cast on me by enemies no wonder I had prolonged labour. The very fact that during those three days no one thought of calling the doctor, inducing me, or referring me for a cesarean delivery shows that there was a spell and it kept people***

from thinking. Unfortunately, I had not taken any traditional medicine that casts the spells away and so now I never take any chances).

(Gugu – 23.02.2020)

As a result of the unfortunate experience, Gugu vowed to never go into labour without using traditional medicine, which according to her, has the power to break spells that western medicine could not. Even after her eight years in South Africa, she still believed and practiced what she had learnt before she migrated from her country of origin, Zimbabwe and made sure that the migration process does not alter her access to herbs before labour. The strong conviction held by Gugu and other women on the efficacy of traditional medicine, is despite the association of this practice with adverse pregnancy outcomes. It has been noted in literature (Zamawe et al., 2018); (WHO; 2014) and (Teoh et al., 2013), that although some pregnant women consider the use of traditional medicines safe, this claim is not supported by scientific evidence. Yet according to Lisa, a 36-year-old mother of two, who at the time of fieldwork was a student at a tertiary institution in Johannesburg, the complexity and intersectionality nature of factors that foreground individual's beliefs and perceptions regarding traditional medicine, go beyond scientific evidence. The evidence she provided reveals that even some health care workers believe in the efficacy of traditional medicine although they are the frontline officials of the biomedical health system. Her "life changing" ordeal as she referred to it, transpired as follows:

"Mina ngafunda isifundo sami ekuzaleni umtwana wakuqala, ngathi anginathi lutho lwesintu plus vele ngekhaya singabantu bechurch asisebenzisi imithi kwahlangana lokufunda lokhu kuyakwenza ukhangelele isintu phansi ngakho akula ngitsho noma yini engayenzayo, noma ukusebenzisa isepa ukuvula indlela. Ngithe sengibeletha ngaphosa ngafa, ngaba lelong labour ye over 17 hours isisu sihela kodwa umtwana engabuyi. Amanurse esibhedlela bazebabuza umama ukuthi wangipha yini imithi yesintu wathi hayi, bamtshela ukuthi uzazibulalisela umtanakhe ngendaba zechurch. Khonapha kwakuseZimbabwe ama nurse acina semsiza ukudinga okunye okuyisibungu okuthwa kuhamba lendluyakho ukuthi bangiphe ngiphuze. Behluleka nje ukungifikisa lowo muthi ngoba unurse owayezangibelethisa kazange aphume ewardini

ngaze ngabeletha. Ekubeletheni kwakhona indlela yayincane umtwana emkhulu ngenziwa amastitch amanengi ngathwala nzima ukuthi aphole. Ngithe sengizala umtwana wesibili ngaleso sikhathi sengihlala eGoli ngathi lokhuyana akuphindwa, ngahle ngathi umamomcane wami owazi ngezemithi yesintu angithumele imithi lakanye bangithumela ngamabhasi. Lanxa ngingasawunathanga kakhulu ngoba wasuka wangigulisa futhi kodwa wangisiza ngoba ilabour yami ayizange ibende kumbe yaba zi three hours kuphela ngazibelethela. Ngenziwa kodwa amastitch ngoba angisebenzisanga isepa ukuvula ngaphansi noma ukudla idelele". ***(I learnt a lesson when I had my first child as I had not used herbs. I did not believe in them. I also came from a family that goes to church and does not use herbs, worse when you a learned a bit you tend to look down upon tradition. As a result, I almost died as I was in labour for over 17 hours. For many hours I just experienced labour pains but the baby would not come out. Some of the nurses in the maternity ward ended up asking my mother if she had given me some herbs. My mother told them she had not done so. The nurses told my mother that she risks losing her daughter to death because of her church beliefs. The nurses then helped my mother to find a particular insect which is said to be an antidote to labour complications. This insect is supposed to be put in water and left to stay, then the person drinks the water. They found the insect, but she did not get a chance to come and give me the concoction because the nurse who was going to assist me to deliver the baby only left the room after I had delivered. As I had not used soap to stretch the muscles of my vagina when I was pregnant, the nurse had to do an incision on my vagina to open the way for the baby's head. I was heavily sutured, and it was a struggle to heal. I had my second baby when I had moved to Johannesburg. Then, I told myself I will not have a repeat of that bad experience. So, I asked my aunt who is good with these traditional medicines to send me the herbs from Zimbabwe and they were delivered by bus drivers. However, I did not drink too much of it because it made me sick. Nevertheless, it helped me because this time I had a shorter and easier labour of about three hours. I was just sutured because I had not used soap or eaten okra to stretch the muscles of my vagina). (Lisa – 27.02.2020)***

Lisa' s experience, reveals an interesting and striking finding about the health worker's discreet endorsement of traditional methods, which is a conflict of interest with her work within a health system that is dominantly biomedical. Although a bigger study has to be carried out to establish the extent of the practice by health workers, of calling for the use of traditional medicines and the implications on women's SRH, this finding is in stark contrast with what has been documented in most studies (Krah et al., (2018); Lampiao et al., (2019) and Moshabela & Zuma (2016), that biomedical staff mostly mistrust, exhibit tension and are hesitant towards traditional medicine or healing. Drawing from a study conducted in Ghana, literature shows that, in worse scenarios:

> *"Some biomedical health care workers linked TM with being underdeveloped or "backward." Also, patients mentioned insults and the denial of care at biomedical facilities in case of exhibiting signs of the use of TM". (Krah et al., 2018, p. 159)*

Despite this dominant discourse in existing literature regarding the tensions between biomedical and traditional medical systems, Lisa's story reflects the intersectionality, complexity, contradictory nature of individual beliefs and perceptions towards these health systems. For example, in her case the aspect of religion intersected with her upbringing and her level of education, thus foregrounding her indifference towards traditional medicine. However, at some point in life all those intersecting factors did not matter as she felt that the situation, she was in required her to change her perception towards traditional medicine. It is particularly important to note how some health care workers hold two contrasting belief systems influenced by intersections between professional demands, secondary education, and personal beliefs. This is in sync with findings from a study conducted in Burundi where it was found that biomedical practitioners informally referred patients to traditional healers. The authors highlight the following:

> *"One doctor pointed out that: one day, a couple came to me because they could not have children, I tried different things in vain, so I told them to see a healer in Tanzania". (Falisse et al., 2018, p. 489)*

Based on these findings, there is evidence of differences between beliefs held by health practitioners in their capacity as individuals and as health care workers, regarding traditional medicine. In a context where the high prevalence of using traditional medicine during pregnancy has been associated with poor maternal and neonatal outcomes (World Health Organization, 2015), women's narratives reflecting their conviction on the efficacy of traditional medicine, shows that the practice of engaging in pluralistic health care by these migrant populations is set to continue for a long time. This points to a need for more robust efforts in establishing the association between traditional medicine with the benefits that the women claim, and the adverse outcomes cited in literature. Zamawe et al., (2018) note that such studies on the safety of traditional medicine have been mostly restricted to high and upper middle-income countries.

An interview held with Diana a 26- year old mother of two, who is a tertiary graduate, who has lived in South Africa for four (4) years working as a waitress, raised an important point about disruptions and potential discontinuities of some of these practices as a result of migration. Diana said:

> *"Hayi uyaqalisa noma masinya kulalapho kodwa mina yikuthi nje ngangingazi ukuthi ngizakuthola ngaphi lapha eSouth Africa so ngaze ngaqalisa sengihambe ekhaya e Zimbabwe ukuya beletha, lapho ke umama wangidingela. Kodwa ukube ngangisazi lapha engangingawuthola khona ngiselapha ngangizaqala masinya".* ***(I started taking the herbs at seven months pregnant because I did not know where to get the herbs here in South Africa. At the time that I started, I had gone back to Zimbabwe to give birth and so my mother got me the herbs, otherwise I would have begun earlier).***
>
> ***(Diana – 18.02.2020)***

With regards to Diana's experience, a key question has been raised in literature regarding the changes that result in migrant's practices as a result of migration. de Medeiros et al., (2012) highlight that one of the issues that arise from studies that investigate use of traditional medicine among migrants is how and what changes occur after migration. Diana's experience reflects the

challenges that migrants face in the destination countries regarding where to access the traditional medicine they might require. Migration may, therefore, lead to a disruption and potential discontinuity of these practices especially amongst those that do not know what to look for and are far from their country of origin for them to go back at a time of need.

This cements findings by Mureyi et al., (2012) in a study conducted in Zimbabwe on the use of traditional medicine by pregnant women. They established that the nearer the women lived to the market place where the traditional herbs were sold, the higher the prevalence of use and vice versa across women attending antenatal care at a clinic in Mbare (Harare). Similarly, from Diana's case, migration has a similar effect. With these considerations, it is imperative for proponents of traditional medicine to consider documentation of traditional medicine, setting up of formal and publicised points of sale, to provide a reference point while improving accessibility for those who might want to access these helpful remedies when they are away from home.

In summary, drawing on women's accounts in this section, it was interesting to note that in a context where there is a pathologisation of traditional herbs, being labelled backward as noted by Makhubele (2011), which are also reported to be causing adverse outcomes for pregnant women in Zamawe et al., (2018); the use of these remedies continues to be rife amongst migrant women. Ironically, it is evident that the use of traditional herbs is also endorsed by the medical workers in hospitals to those that they trust and have social relations with. Essentially, it demonstrates that beyond the realm of their work within a system that is predominantly biomedical, some health workers hold beliefs that traditional medicines are useful and presumably use them personally. These practices are premised on the belief that indigenous remedies complement western ones, and there are benefits associated with using them, such as the stretching of vaginal muscles to eliminate the chances of tearing, need for suturing, paving a way out for the infant, elimination of high incidence of caesarean deliveries and maternal mortality. The efficacy of a number of these traditional herbs still remains to be scientifically tested. These accounts also show the continuities in the practice of using traditional herbs by migrant women. Of note being away from Zimbabwe did not deter them from using means necessary like using cross border drivers to get traditional herbs from their relatives back in Zimbabwe.

Contrary to popular beliefs that migrants rely on the South African public health facility, hence burdening an already oberburded health care system, findings from the study suggested that migrant women did not soley rely on biomedicine or the health system to meet their health needs. Women's practices surrounding the used of traditional herbs for varying purposes such as contraception, antenatal care and tratement of ailments demonstrated how infact, migrants could manage some ailments without the need for visiting a health facility but using traditional remedies. The diverse experiences of Zimbabwean migrant women explored above reflect that while being a migrant may redefine how women experience contraception and antenatal care after resettlement, most of their beliefs and practices adopted from their country of origin remain the same. As a result, engaging in transnational pluralistic health care is a common feature which characterizes migrant's practices surrounding contraception and antenatal care, while embedded in South African communities. There also exist multiple intersecting factors at different levels of the socioecological framework that variedly affect each woman's experiences such as knowledge about where to source the herbs in a foreign land, religion, level of education, among others.

4.2.3 Transnationalism, Cultural and Religious Reproduction

Migrant women who participated in this study reproduced their religious and cultural practices surrounding contraceptives and antenatal care in South Africa. James and Scerri define culture as:

> *"A social domain that emphasizes the practices, discourses and material expressions, which, over time, express the continuities and discontinuities of social meaning of a life held in common". (James & Scerri, 2016, p. 53)*

Simply put, this that means culture is a set of shared patterns of practices, interactions, beliefs which guides people's ways of doing things. Religion on the other hand, has been defined as belief systems that define what people consider to be revered or spiritual (Fasching & deChant 2001).

The subject of abortion brought an interesting dynamic in the discussion on beliefs about what is right or wrong, and how migrants make decisions on what to do when they find themselves with unwanted pregnancies. Findings in this study resonated with the argument that migrant's experiences in the country of origin and destination are intertwined which consequently shapes their practices in the destination country. For example, Emihle, a single 27-year-old woman who is a secondary school graduate, advanced the view that although South Africa has more progressive policies, including those on health, in comparison with her home country Zimbabwe, citing the decriminalisation of abortion in the former, some migrants still die from illegal abortion complications in their houses. Emihle opened up and said she almost died in Zimbabwe after having an unsafe abortion as she, like some women are aware that abortion is prohibited in that country, coupled with anti-abortion cultural and religious beliefs. These compounded factors often leave young women in her position with no support structure regarding the abortion decision that they would like to take. Below is part of the interview I had with her, where she shared insights of her experiences and other women in both countries:

Interviewer: *Ngombono wakho kuyini okuhle ngokusebenzisa indlela zokuvikela ukuzithwala ama contraceptives?* ***(In your opinion, what do you believe is good/benefits or bad/disadvantages relating to use of methods of preventing pregnancy, contraceptives?)***

Emihle: *Amacontraceptives a sharp kabi, mina ngiyawathanda ngoba ayavikela ukuzithwala umuntu ungaplananga, noma kanjani angikhohlwa ukunatha amaphilisi ami. Kungela macontraceptives ngabe abantwana abanengi sebephelile ngokufa. Kodwa lapha eGoli angeke baphela ngoba ukukhipha isisu kuyavunyelwa hayi okweZimbabwe ngaphandle nje kwabalutshwana nje abesabayo belokhu bebona sengani lapha kuseZimbabwe, abanye bayabe bengazi lokuthi baqonde ngaphi abanye bacabange indaba yokungabi lamaphepha khonapha engela mali yokuya ko private doctor. Kodwa inkinga enkulu kakhulu ngibona sengani yimthetho yesintu leye church kweZimbabwe okwenza umuntu lanxa eselapha eGoli okulendlela ezisemthethweni zokukhipha isisu akubone njengento embi okumele ayenze ekufihlekeni ukuze kungaziwa ukuthi ukwenzile njalo abantu bangamahluleli. Ngiyakutshela so, ukuthi osisi abanengi beZimbabwe abawasebenzisi amabortion services*

alapha bayesaba ngoba bakholwa ukuthi kubi, yisono njalo abantu bazakwehlulela. Abanye bacina besifa besenza ngendlela engayisiyo abanye bagcine izisu abangazifuniyo. Njengo munye untombazana engangimazi owashonayo khonapha emaflatini eHillbrow ngisanda ukufika mina ngapha. Washona ekhipha isisu ngendlela zemakhaya okweZimbabwe, mhlawumbe wayesenziwa zindaba zamaphepha. Kodwa ngibona sengani khona nje ukuthi bazongibheka kanjani, bazothini, yikubulala ngcono ngikwenze ngedwa. Mina ngaphosa ngafa lami kodwa eZimbabwe ngokuyimthetho kwelizwe lako sathane leliyana. ***(Contraceptives are good, and I like them because they prevent unwanted pregnancy. I never forget to take my pill daily no-matter what. Had it not been for contraceptives, a lot of young girls could be dying, but since this is South Africa, maybe they would not die because abortion is legal here. It is different from Zimbabwe, except for a few who will be thinking that the South African stance on abortion is like the Zimbabwean one, or they do not know where to go and they are afraid because of the issue of documentation. But what I think is a major problem are cultural norms and religious beliefs in Zimbabwe. These make a person, even after migrating to South Africa and being presented with legal ways to have an abortion, still resort to illegal ways because they believe abortion is bad and should be done in privacy, without people knowing so that no one judges you. I can tell you that a lot of women from Zimbabwe do not use abortion services in South Africa because they believe it is bad, sinful and people will judge you. Some end up dying because they are doing it the wrong way, while some end up keeping pregnancies that they do not want. Like this girl that I used to know, who died in her flat in Hillbrow trying to have an abortion the illegal rural way that people practice illicitly. I think of her. The reason she took that route was due to documentation issues, but also the thought that how will people look at me, what will they say, it like murder so I better do it alone. It was back then when I had just arrived here. I almost died there because of their oppressive laws, that country is evil).***

Interviewer: *Yindaba usithi lilizwe lako sathane, kuyini okwaphosa kwakubalisa eZimbabwe?* ***(Why are you referring to it as an evil country, what almost killed you there?)***

Emihle: *Ngakhipha isisu okwe underground, ngithengiselwe amaphilisi akhona ngomkoto epharmacy ngazifaka kodwa maybe agifakanga kuhle kwaphuma okunye kodwa okunye kutsho ukuthi kwasalela ngagula ama days alandelayo kwabakubi ngaze ngathwalelwa esibhedlela, ngayageziswa isibeletho ngaphiwa lama injection. Lapho vele kwahle kwabheda ngoba esibhedlela babakwazi ukuthi ngikhiphe isisu lanxa bathi bengibuza ngaphika ngemba phansi ngoba ijele lalibhekane lami. Abangkhaya bathe bekuzwa lokhu bangizonda bangenyaya bangi judger kodwa mina ngangisazi ukuthi impilo yami yayizamosheka ngabe ngasigcina ngoba umnikazi wayesala ngapha ngimcane ngile 21 years. Vele ukukhangelwa engangikwenziwa ngomama labanye nje izihlobo labe church ababekwazi nje kwahle kwangeza ngithi ngcono ngizibuyele eGoli. Ngangisenza ama lessons kweyinye iprivate college ukuthi ngibhale iMaths le English ngengezelele i "O" level yami ngatshiya endleleni.* ***(I had an illegal abortion after I illicitly bought some drugs at a pharmacy. I inserted it myself but maybe I did not do it the right way and so the abortion happened but not everything came out. After some few days I fell seriously ill and I was rushed to hospital. They cleaned my cervix and I received some injections. That was when things went haywire because at the hospital, they discovered that I had an abortion and they questioned me, I denied because that would have meant that I might be sent to prison. What made matters worse was that my parents got to know about the abortion, and they hated me for that. They were disgusted by what I had done and judged me. I had good reason to do it because the person who had impregnated me was denying responsibility and I was young too. I was 21 years old. The way my parents looked at me with disgust, together with other relatives and people from church who got to know about it, made me realise that I have to leave Zimbabwe. During that time, I was doing English and Maths lessons at some private college so that I could add on to my "O" levels. I just left everything and came here).***

Interviewer: *Ngokubona kwakho kuyini okwenza abazali bakho, izihlobo labe nsontweni bakuphatha kanjalo?* ***(In your opinion, what do you think were the reasons your parents, relatives and church members treated you the way they did?)***

Emihle: *Bahle bangiphumela egcekeni bathi ngingumbulali. Mina abazali bami ngamakholwa, babelezikhundla echurch. So lanxa babethaba ukuthi ngisaphila angifanga kodwa ihlazo ababalalo yilo elenza ukuthi bangizondele ngoba indaba zokukhipha isisu echurch lawe uyakwazi uhle uthwe ungu cousin kasathane (etsho ehleka kancane).* ***(They were frank with me and told me that I am a murderer. My parents are staunch Christians and they hold positions in church. Even if they were happy that I had not died, but because of the shame that it brought them they just had to be mad at me. You know abortion issues and church do not go together; they just term you the devil's cousin (giggling a bit).***

(Emihle – 20.02.2020)

Emihle revealed a striking story, which although transpired in Zimbabwe, depicts a reproduction of pregnancy, abortion related practices that are influenced by cultural and religious beliefs from the migrant's home country. Besides indicating the emotional traumatic experience she still has away from home, this narrative also reflects the complexity and plurality of factors that intersect across the different levels of the socio-ecological framework in both the home and the destination countries, to create multiple challenges which limit women's choices, causing difficulties in their lives. Consequently, as illustrated by Emihle's case, migrant women's pregnancy and abortion practices in South Africa are influenced by pervasive cultural norms and beliefs from the country of origin. Even when presented with the option of a legal abortion in the host country, some women still resort to illicit ways, thus leading to loss of life. I have to reiterate that pre-departure experiences are as equally important as transit and destination factors in shaping migrant's experiences in the post migration context. This finding cements Gushulak and MacPherson's argument that:

> *"Experiences and exposures at a place of origin can influence migrants' health throughout the process of mobility, which may include transition, temporary residence, and arrival at a destination". (Gushulak & MacPherson, 2011, p. 1)*

Emihle's story also evidences how multiple factors at the different levels of the socio-ecological framework intersect, and at the nexus of those intersections, influence women's experiences of

pregnancy related health, in this case abortion. For instance, the criminalisation of abortion in Zimbabwe, which is a policy issue located in the macro level of societal factors. This is coupled with cultural and religious norms that prohibit abortion. These multiple level intersecting factors contributed to her ordeal which almost killed her. In several ways, Emihle's story validates literature which states that:

> *"Religious dogmas as well as other traditional, cultural values related to gender and sexuality being in some instances, in subtle ways, at odds with the idea of sexual rights, complicate efforts to improve sexual and reproductive health". Cense et al., (2018, p. 3)*

The author also adds on that "culture and religion resonate in the laws of a country, for instance in facilitative or restrictive ways"(Cense et al., 2018, p. 6). In this case, the criminalisation of abortion in Zimbabwe. Crossing over to South Africa, contradictory national policies on both migration and the health of migrants present additional obstacles. As shown in the discussion of literature, there exist disparities between the Immigration Act (2002) which requires migrants to have documentation for one to receive health services at a public facility, and the National Health Policy (2003) or the Constitution (1996) that guarantee health for all regardless of one's nationality or documentation status. These disparities present ambiguities that often allow health care workers to be xenophobic in their conduct with migrants. Subsequently, migrants especially those without documentation are deterred from seeking medical help. They resort illicit solutions which are a threat to their health. According to Emihle, this contributed to the demise of her friend.

More importantly, consistent with findings in the study by Munyaneza & Mhlongo (2019) on engagement with SRH among refuges in Durban, Zimbabwean women's accounts are illustrative of the intersectionality of factors which inform migrant's practices beyond categories. For example, migrants from Zimbabwe and refugees from DRC, Rwanda, Burundi indicated that cultural and religious beliefs surrounding abortion or contraception are what informs their decision making on access and utilisation of these services. Yet often times in literature and policy engagements, a demarcation is made between categories of migrants, portraying them as different

and offering them differential privileges. For example, in South Africa the Refugee Act, 1998 (Act No. 130), provides for an equal treatment of refugees and asylum seekers with South African citizens, in terms of access to free public healthcare which is not the case with the Immigration Act (2002) which governs the treatment of migrants. Such approaches towards the treatment of migrant populations obscures the complexities that surround their access to health care behaviours beyond categories and policies.

Gugu, a married mother of two as indicated earlier, shared an experience of giving birth to her second child in South Africa, after her first loss in Zimbabwe due to labour complications. She revealed the following:

> *"Kulo owesi two umtwana ngasengilapha eGoli. Umama wami weza sengizabeletha wangiphathela ngayiphuza. Weza lengqwatshi yedonkey and angizange ngibelandaba ukuthi ngiyenyanya, ngacimeza kuphela ngaphuza amanzi akhona, alapha esasiyifake khona. Lanxa kunjalo ngenziwa ioperation kodwa uyabona kungcono babona masinya inkinga bangipha usizo, kwasebenza. Asazi kwakuzazalankomoni ngabe ngingayinathanga yikho nje ngingathathi amachance".* ***(With this second one, I was here in South Africa. My mother came here when I was towards delivery and she brought me the dried placenta of a donkey. It did not matter that it felt disgusting drinking it, I just drank the water in which it was dissolved. Although I had a cesarean delivery with this one, it was better because at least this time when they saw I had challenges, they thought of the alternatives. I wonder what would have happened if I had not taken the concoction. So, I do not take chances at all).***
>
> ***(Gugu - 23.02.2020)***

Beyond the belief on the benefits of using traditional medicine for a safe delivery, Gugu's story brought to the fore other continuities that characterise Zimbabwean migrant women's experiences of antenatal care and birthing in South Africa. For example, a transnational support system, manifesting through having her mother come to South Africa to take care of her at the advanced

stages of pregnancy and post-delivery. This follows and borrows from an old tradition practiced in Zimbabwe called *"masungiro".* Hlatywayo (2017) explains the masungiro practice as follows:

> *"Among other ethnic peoples in Zimbabwe, and most notably the Shona, masungiro is done in the last trimester of pregnancy and the pregnant woman remains at her parents' home until she delivers. The daughter-in-law is handed over to her family until she gives birth […]. After the masungiro ceremony, the first time pregnant woman is handed over to her family to be physically, socially and spiritually prepared for childbirth". (Hlatywayo, 2017, p. 146)*

Notably, although the *"masungiro"* practice originated from the Shona tribe, it has been copied by other tribes across the country, especially the Ndebele. In addition, although the *"masungiro"* practice was initiated as a practice for first time expectant mothers resulting from the belief that she needs to learn what to do during this important time in her life, there has been a general tendency that expecting women seek their mothers' care even for subsequent pregnancies. However, there is no ceremony for those other pregnancies, and it can go either way, for example her mother can come and take care of her at her house or vice versa. With the changes that came with urbanization and going to work, nowadays, most women prefer having their mothers come over to them rather than them going to their mother's homes, as some have to work until the final days of pregnancy before going on maternity leave. Gugu's story, therefore, reveals how some migrants have preserved this practice and still practice it in South Africa.

It is however, worth noting that such practices are experienced differently by migrants of differing socio-economic status, thus making class an important factor of influence in migrant women's antenatal are experiences. A sharp contrast can be drawn between Gugu's story and Diana's, who because of her socio-economic status could not afford to invite her mother to come and help her during her pregnancy and delivery in South Africa. However, because the tradition of receiving care from the maternal mother during this period remains significant among migrants despite, having moved away from home, the epicenter of these traditions, Diana had to find a way to be with her mother and be cared for. She had this to say:

"Kuthe ngoba ngangihlala ku one room lendoda yami futhi ngizadinga usizo lukamama ngomtwana, kwakungayenzi ukuthi umama abuye ngapha, kwakuemele mina ngiyezalela ekhaya kumama. Ngahamba ekhaya sengile seven". ***(So, since because I lived in a one roomed housed with my husband and I was going to need the help of my mother with baby after delivery, it meant that I needed to go back to Zimbabwe for delivery. I went there when I was seven months pregnant).***

(Diana – 18.02.2020)

Employing the intersectionality approach and the socio-ecological theory in understanding Diana's experiences, enabled me to uncover the multiple intricately intertwined ways that influenced her practices. Diana, a tertiary graduate, who works as a waitress and is married to a security guard, in comparison with Gugu, a teacher, who is married to a financially stable husband, as she revealed, could not afford to invite her mother to South Africa to come and help her. This shows the importance of social class in understanding the differences between experiences of migrant women. Both their experiences are reflective of the important role of socio-cultural roles; the role of a mother in supporting her daughter during and after pregnancy. This is a traditional practice they have adopted from Zimbabwe, yet it continues to influence their practices in different ways after migration. Diana's experience reflects how gender norms, relational and economic factors are intricately intertwined as she considers how unconducive her space of residence is to have her mother and her husband under the same roof, especially at a time when she has to meet her conjugal obligations.

The findings detailed above suggest that migrant's practices are a consequence of intersecting, varying factors at different levels of social-ecological framework. According to socio-ecological framework, these levels include individual beliefs, class; interpersonal factors such as person's relationships with family, friends); community (schools, workplaces); organisational (social structures, major institutions like health facilities); and policy level (governing bodies encompassing blueprints of a particular society such as laws, regulations, policies, cultural norms and the belief system). These two women's scenarios, evidence how migration intersects with

one's socio-economic status, the beliefs that they hold, cultural practices and relational issues like the role of a mother in advancing these beliefs and cultural practices; thus leading to differentiated engagement with antenatal care, across migrants.

4.2.4 Transnational Communication and Social Ties

Tied to the themes of transnational health care, transnational economy, cultural and religious reproduction, findings revealed that Zimbabwean migrant women's transnational practices are instigated through the maintenance of social ties and communication with friends and family in Zimbabwe. I found the cultivation and maintenance of transnational ties to be the vehicle that facilitates continuities with transnational health care, transactional economy, socio-cultural and religious reproduction. As evidenced in the interview excerpts, participants outlined that one of the ways they access Zimbabwean contraceptives and traditional herbs is through being sent by their relatives. Recapturing from the narratives shared in other sections of the report by Abigal, Martha and Gugu in relation to their use of Zimbabwean contraceptives or traditional medicines, the following statements which allude to ways of access were said:

> *"Ngiwawoda ekhaya bangiphathisele ngamabhasi".* ***(I procure them in bulk from Zimbabwe and have them sent to me through buses).***
>
> ***(Abigal – 15.02.2020)***

> *"Ngaqalisa ngisaphathelwa ekhaya ngabanawabami nxa bezovakatsha bebuya lawama six months ngithi ngingakawaqedi kubesokuze amanye".* ***(At first, my sisters would bring me a supply of about six months when they visit and before I even exhaust that, I will receive another batch).***
>
> ***(Martha - 29.02.2020)***

> *"Kulo owesi two umtwana ngasengilapha eGoli. Umama wami weza sengizabeletha wangiphathela ngayiphuza. Weza lengqwatshi yedonki".* ***(With this second one, I was***

here in South Africa. My mother came here when I was towards delivery and she brought me the dried placenta of a donkey).

(Gugu - 23.02.2020)

From the above statements, it emerged that migrants' families who are left behind in Zimbabwe are active players in facilitating migrant transnationalism and influencing the women's contraception or antenatal care practices. This is achieved through sending Zimbabwean products to the migrant women in South Africa, and in other instances, personally bringing along the products when they come to visit. This is consistent with Adugna (2019), who observed that migrant's families left behind in the country of origin are often considered as passive recipients of remittances, yet they are important proxies who actively engage in maintaining and building transnational networks with their families or friends who have migrated. They also play a critical role of sending reverse remittances mainly in the form of goods to their networks in the destination countries (Adugna, 2019). In view of this, it has been recommended in the same study by Adugna (2019) and drawing on Orozco (2005), that non migrants, referring the migrant's kin and social networks left behind in the country of origin, must also be acknowledged as active players in transnational communities.

Through the use of social media platforms and cross border transport operations, migrants continued to keep strong ties and communication with people at home. For example, the interview with Choice, who has been living in South Africa for two years, demonstrates how social media platforms have enabled herself and other women from Zimbabwe to reproduce a cultural practice called *"China chemadzimai",* in South Africa. The respondent had this to say:

"Ini ndingatoti zvakawanda zvandoziva pamusoro penyaya dzatirikutawura pano ndakazvidzidzira kuChina chemadzimai. Vanhu vanotaura zvese sezvazviri kuda nekuti vanhu vanenge vasina kutarisana pamaziso, uyezve havazivani saka hakuna kunyara kana kuti munyarikani". ***(I can say a lot of the things pertaining to what we are talking about today, I learnt about them from the China chemadzimai group. People say things as they are, maybe because there is no eye contact, they don't***

know each other and there is no fear of one being embarrassed of discussing sensitive or taboo topics usually of sexual nature with people one is traditionally or socially not supposed to discuss such topics with).

(Choice - 16.02.2020)

It is evidenced how women, through the use of new communication technologies, still continue with the traditional practices of coming together as sexually active women with husbands or sexual partners and houses to manage, to discuss SRH issues and other matters of interest to them. The membership of this WhatsApp group called "*China chemadzimai*" is exclusively women. "*China chemadzimai*" borrows from a Zimbabwean concept of setting aside Thursday as a day for different meetings by different groups like religious, community leaders or members, different clubs etc. On this day, people desist from attending other day to day businesses like going to work in the fields and doing other personal errands and meet in their respective groups or clubs. These Thursday meetings have traditionally been physical meetings, and it was interesting to note that through the use of Social media, the concept has transformed to a digital group meeting, with even a bigger coverage and not restricted by a geographical space. Choice notes that she was introduced to the group by another Zimbabwean migrant woman who comes to the market seeking for casual jobs. The group has around 100 members, and some of which are not in South Africa telling through observation of group participant's phone numbers. Choice indicated that, not all group members know each other.

Social groups like "*China chemadzimai*" are filling an important space created by the absence of family, relatives, and friends in the lives migrant women as they try to eke out a living away from home. This finding is line with available literature which indicates that some migrants feel lonely in the destination country and miss certain things at home (Portes et al., 2012). They, therefore, express agency and find ways to cope with difficulties related to being away from home. This situation is illustrated by Fatima, who is also a group participant in "*China chemadzimai"*. She shared her story of how as a young woman aged 28 years in South Africa, with no family close-by to consult on marital issues to get tips has found solace from "*China chemadzimai"*. She explained:

"Kunoku kuJoni[6] *shamwari yechokwadi unotoyishaiwa. Vanhu varibusy nemabasa avo. Haumuwane zvekumhanya asi manje negroup iri munotowana time dzekutaura zvakawanda. Ndakatonzva nemadzimai aripa group kuti nzungu dzinobatsira panyaya dzepabonde. Ipapa ndakatotakura nzungu dzangu idzi (achindiratidza) ndadzitenga pane mamwe maZimbabwean hanzi dzinobatsira kubvisa mvura nekudzora nhengo kuyitira bonde rinodiwa nevarume. Saka ndichasvika ndodziyisa mumvura dzogara ndozopota ndichimwa mvura iya".* ***(Here in South Africa, you fail to find a true friend. People are busy with their jobs and there is no time to frequently see each other. It is not easy to find a friend. However, with this group you get time to talk about many issues. I have heard from women in the group that peanuts help with sexual issues. Right now, I have my peanuts (showing them to me the researcher) that I have bought from Zimbabweans along the way. They said peanuts help drain excess arousal fluids that are produced by women during sexual intercourse and they also make the size of the vagina smaller. So, when I get home, I will soak them in water and constantly drink that water).***

(Fatima – 21.02.2020)

Having been in South Africa for five years, Fatima speaks about the loneliness that comes with the busy life in South Africa as people are busy with their jobs. She also highlights an important factor of how being a migrant takes one away from people that she trusts and confides in. They often find themselves in the mist of strangers making it difficult to find genuine friendship. Moyo (2017), also presents similar findings and states that:

"There is an increasing utilisation of social group functions in social media platforms such as WhatsApp. Family members, friends and sometimes people from the same village or town of origin in Zimbabwe, create social groups that resemble online chat

[6] Joni is a term used to refer to Johannesburg and broadly South Africa in Shona. Although it is taken from, and short for Johannesburg, Zimbabweans from the Shona ethnic group generally do not make a distinction between Johannesburg and the rest of South Africa when using the term. Among the Ndebeles the equivalent of the term is eGoli also used loosely to refer to South Africa broadly by many.

> *rooms where they share news about each other, their communities and local gossip. For example, news of deaths and other stories from villages or townships of origin quickly spread through the WhatsApp messaging platforms. The new features create co-presence where people engage in instantaneous conversation while in geographically disparate places". (Moyo, 2017, p. 173)*

The group "*China chemadzimai"* and the chat rooms made reference to by Moyo (2017) reflect a continued practice from Zimbabwe with a bit of transformation in terms of "modus operandi", from physical meetings to digital. This also indicates that migrant women have social networks which are transnational where they socialise and also get valuable information including SRH issues, as revealed by Choice and Fatima. This is consistent with Kawachi & Berkman (2014) who contend that there is a connection between social capital and health outcomes, with social networks acting as conduits for the distribution of knowledge and information. They note that heterogeneous relationships, therefore, facilitate access to external resources.

Considering the important role played by technological advancements in keeping migrants connected and receiving information from their kin, friends, cultural and religious groups; the argument made over a decade ago by Allotey et al., (2004) may not be very relevant to many migrant women nowadays. They argued that, social realities of resettling refugee and migrant women which include loss of social networks, cultural and religious factors, make the context of negotiating SRH complex for the women. Yet, in contrast to that, findings from this study show how traditional practices such as "*China chemadzimai"* have continued to evolve over time, beyond borders and how social media as a communication platform is being used to facilitate discussions on important matters like SRH, thus occupying the void of physical meetings with kinsman created by migration. However, information shared on these groups with such wide coverage might be detrimental to the health of many if it is harmful. This is because knowledge about the utility of traditional methods in improving sexual life, keeping partners happy and even on antenatal benefits is based on here-say and has not been tested scientifically. In a context where maternal mortality remains remarkably high and a significant number of women are either dying or suffering from cervical cancer with some studies attributing the cause to some women's

practices of using herbs (Hamoonga et al., 2019) and (De Abreu, 2015), this matter is of great concern.

4.2.5 Transnationalism and Health Care Economics

One of the striking findings in this study was that there is a thriving transnational economy in Pretoria and Johannesburg, specialising in trading of Zimbabwean contraceptives and traditional medicine. The continuity of practices such as the use of traditional herbs during pregnancy, use of the Zimbabwean pill and aphrodisiacs for sexual pleasure has been facilitated by some enterprising Zimbabwean migrants. It emerged that these products are sold illicitly by other Zimbabweans who smuggle them into the country using cross border transport operators and other migrants travelling into South Africa for visiting or business purposes. Batsirai, who as indicated earlier that she was expecting her second child during the time of the interviews revealed that:

> *"Inotowanikwa muno mishonga yacho yechibhoyi. Ini ndakatonotenga kuMarabastaad ndove yenzou nezvimwewo, zvayita ma R50 chimwe nechimwe".* ***(The traditional medicines are available here. I went to buy at Marabastaad. I bought the elephant dung and other things. They cost R50 rand each item).***
>
> ***(Batsirai – 16.02.2020)***

Fatima, an entrepreneur woman who is also a member of the *"China Chemadzimai"* Whatsapp elaborated on how this platform is used to spread business news among group members and this includes advertising the sale of these products imported from their country of origin. She mentioned that:

> *"Imo mugroup reChina Chemadzimai muya ndipo patinotonzva zvese, kuti izvi zvinotengeswa nani, mhunu wacho achiwanikwa kupi. Ini ndipo pandakawana ruzivo rwekuti kuMarabastaad neku Hillbrow patori nemisika yezvinhu zvekumusha zvinosanganisira iyo mishonga iyoyo nezvekudya. Ndemamwe maZimbo anototengesa".* ***(In the group "China Chemadzimai" is where we get all the***

information about where to buy these things and from who. That is where I learnt that in Marabastaad and Hillbrow there are markets where Zimbabwean products like the traditional herbs and food items are sold. It is the other Zimbabweans who sell these things).

(Fatima – 21.02.2020)

Emerging from the above accounts by Fatima, Batsirai and other participants who indicated that they have purchased Zimbabwean contraceptives and medicinal herbs in South Africa, is the diversity of migrant's transnational economic activities. This adds a dynamic contribution to the body of literature which has often focused on transnational remitting, investments, infrastructure development in the country of origin as major transnational economic activities, for example (Adugna, 2019); (Hugo, 2012) and (De Haas, 2011). This reflects the multiplicity of roles that shape the daily experiences of immigrants (Morales & Jorba, 2010), and how transnational economic activities are bidirectional. Evidently, these findings are reflective of an existing reverse remitting practice into the destination country especially in form of sending goods to serve transnational migrant communities. In view of the above, I argue that it is therefore, important to understand all the dynamics of migrant economic transnationalism. These interactions between migrants' destination and country of origin are catalysts of social change in both settings, hence understanding them is key to understanding change in general (Williams et al., 2014).

Drawing from the socio-ecological conceptualisation of health and wellbeing, a growing body of research for example Rhodes et al., (2012) and (Navarro & Muntaner, 2004) has highlighted that health is an outcome of social and structural conditions, in particular, sociocultural, economic, and political inequalities Similarly, in this study I found that Zimbabwean migrant women's contraceptive use and antenatal care practices are characterised by plethora of transnational economic considerations. Migrant women, therefore, negotiate their contraception and antenatal health care practices through a series of complex and intersecting economic factors. For example, participants reported that the choice of where they give birth is made after a consideration of the cost of pregnancy and maternal health care in both countries. Fatima recounted how she arrived

at a decision to give birth in South Africa and take her baby to Zimbabwe to be raised by her mother, six months after delivery.

> *"Isu patayive tavakuda mwana wechi two nemurume wangu, takabvumirana kuti ndinotiyita pamuviri ndozvarira hangu kuno, kana ndazopona uyezve mwana ati kurei ndonomusiya kumusha nekuti kuzvarira kuno kurinani kuzvipatara zvehurumende vanoshanda zvakanaka pasina kubhadhariswa nemastrike pane zvirikuyitika kumusha. Asi chinozodhura hazvo kuyita mhunu anozotarisa mwana nekuti vanoda ma R2500 kana iri stay in apa ini pamusika pangu pano chero tasanganisa neyemurume hayitombowanikwe mari iyoyo. Saka mwana paakayita six months ndakayenda naye ndikambonogara dizmwe two months kachijaira nekukurawo, iyezvino ava ne 10 months. Takawona zvirinani kuti titi pane iyoyo tipote tichitumira kumusha plus ndiko kwagara kune umwe mwana kuna mai vangu. Kumusha ukatumira chero R1000 mwedzi ne mwedzi uchimbokanda netugrocery pano nepaya unenge watogona".* ***(When we wanted a second child, we agreed with my husband that I can fall pregnant and deliver here. When the child is grown, I take to Zimbabwe because child birth is cheaper and safer here, as public hospitals work efficiently without strikes and you are not made to pay like what is happening in Zimbabwe. What is expensive here is child care because child minders are paid R2500 if she stays in with you. The money that I make from my vending stall combined with husband's contribution is not enough for that. So, when the baby was six months old, I went to Zimbabwe with him and I stayed for two months while he was growing and getting accustomed before, I leave him. He is now 10 months old. We decided that it was better for us that way, to subtract from that little that we make and send back home because in any case that is where our older child is. So, my mother is taking care of both children. In Zimbabwe if you send R1000 every month and groceries here and there, you would have done well).***
>
> ***(Fatima – 21.02.2020)***

Fatima's account reveals the intersectional nature of factors that are considered by migrants as they make decisions regarding pregnancy and child birth. In her scenario, the practice of giving birth in South Africa and taking the baby to Zimbabwe a few months later, to be raised there was founded on multiple, intertwined factors located in the different levels of the socio-ecological framework. For instance, as a couple, they considered the economic aspect of raising a child in South Africa, where they would need to pay a child minder because they were both unavailable to take care of the baby due to work commitments. Additionally, they considered that in Zimbabwe, her mother is available to take care of the baby for free while they provide groceries. For Fatima, while South Africa and its health system could better provide her with quality health care services during antenatal care and child birth compared to Zimbabwe due to its deteriorated health care system, the benefits which South Africa offers were not enough to meet her other needs. As a result, she considered a transnational approach as a possible solution to serve her needs. That is acquiring services of child birth and child raising in South Africa and Zimbabwe, respectively.

On a similar note, Irene, a mother of two, who reported having her second child in South Africa outlined the following:

"Zvinhu zvakacheaper kuno, unokwanisa kudya mafruits, uchiwana chikafu chinehutano chinodiwa kana unepamuviri, zvino ku Zimbabwe unofa nema vegetable nyama hayitengeki wozvara chimwana chakatsonga uyezve preparation yemwana inotengeka kuno. Ndosaka kwava nemaZimbabwean akawanda anoti kana anemimba wowuya kuzvozvarira kuno wozochidzokera hake kuZimbabwe kana wapona. Kune wandakatosangana naye kuchipatara achidaro pandandinepamuviri". ***(Things are affordable here, you can buy and eat fruits and healthy foods that are required during pregnancy whereas in Zimbabwe meat is not affordable, you will eat vegetables till you deliver a frail child, buying baby preparation is also cheaper here. This explains why many Zimbabweans are coming to South Africa when they fall***

pregnant and go back after delivery, I actually met one lady doing exactly that at the hospital when I was pregnant).

(Irene – 24.02.2020)

Like Fatima, central to Irene's chronicle of her experience pertaining to what informed her decision about where to give birth, is the issue of costs associated with the process in South Africa vs in Zimbabwe. A paucity of literature (Chikanda & Crush, 2019); (Crush & Tawodzera, 2014) and (Crush et al., 2012), documents that patients from countries neighbouring with South Africa, Zimbabwe included, engage in what is called medical tourism. This is where migrants travel to South Africa, solely for purposes of accessing health care. Although Irene made a decision that relates to health care and chose to give birth in South Africa, her experience reveals that migrant's decisions are informed by a plethora of other factors which in some instances, are not centered around the health systems in either of the countries. The discourse of medical tourism offers a simplistic explanation of why migrant women make such decisions as traveling to into other countries for accessing health care services, especially giving birth. Irene, therefore, demonstrates the complex and intertwined factors that have an effect on migrant's practices, beyond the obvious and often documented, the quality of health care. Considerations of aspects such as diet during pregnancy and buying of baby clothing in preparation are factors that are usually obscured in other discussions, yet they matter to migrants when they are considering their pregnancy and birthing options.

Evidenced in the experiences of these women who reported giving birth in South Africa is that, these migrants gave birth in South Africa, not necessarily practicing medical tourism but as people who were already resident within the country. Although migrant women noted differences in quality of care between Zimbabwean and South African health facilities, and as a result, they preferred giving birth in South Africa, they, however, did not travel from Zimbabwe, solely, for purposes of access to maternal health care. In some instances, despite the good quality of health care offered locally, they still travelled back to Zimbabwe to get other forms of support like motherly care during advanced days of pregnancy, at labour and after giving birth. These are part of antenatal services which women require, and the South African health system cannot offer them.

4.3 Nationality, Health Care Costs and Navigating the System

The subject of migration and its implications on migrants' health outcomes has widely been explored in the determinants of health studies and it has often been argued that the relationship between the two is bidirectional (Wickramage et al., 2018); (Marceca, 2017) and (WHO Commission on Social Determinants of Health & World Health Organization, 2008). In these studies, among others, it has been presented that while migration can affect migrants' health outcomes as a result of barriers in accessing health care such as documentation status, language impediments, unavailability of health insurance, attitudes of service providers at the health facilities, and unaccommodating policies; it can also lead to improved health outcomes. In this study, I found that one's nationality and migration status in particular have a profound influence on how expecting Zimbabwean women experience, access to maternal health and how they navigate the health care system. Although public health facilities might provide free pregnancy registration and routine checks up to both documented and undocumented migrants, child birth however, came at a cost for undocumented migrants. Batsirai who was pregnant during the interviews as indicated earlier on revealed the following:

Interviewer: *Semhunu aka booker kuzvarira muno, vakambotaura nyaya dzekubhadhara here?* ***(Since you booked for delivery here in South Africa, did they mention anything about payment?).***

Batsirai: *Hongu, vanotozvitaura paunowuya kuzobooker asi ini andisi kuzobhadhara nekuti ndakangoyenda ne asylum yangu iyoyo yepasi pemuti, vakatoyigamuchira.* ***(Yes, I heard that. They say it when you come to book, but I am not going to pay because I registered using my fake asylum seekers permit and they accepted it).***

(Batsirai – 16.02.2020)

Although she had not yet given birth, her booking for delivery had already been secured and she had used an unlawful way to be able to secure a booking for a free delivery. Evidently, these anti migrant policies are not just a threat to migrants' health, but also send them into engaging in

criminal activities to get documentation which will enable them to meet the criteria for free delivery services. This relationship between prohibitive, anti-migrant policies and reactive criminal activities by migrants has often been noted in literature regarding restricted immigration legislation and subsequent border jumping, human trafficking of smuggling (Machecka et al., 2015), (AVDAN, 2012) and (Vigneswaran et al., 2010). To this effect, (FitzGerald, 2020, p. 10) observes that "visa requirements often have a 'domino effect' as governments enact restrictions to prevent the entrance of unwanted migrants […]. This study therefore reveals how similar dynamics come into play with regards to access to health care. For example, how the need for documentation and the differential treatment between categories of migrants, can subsequently lead some undocumented women into resorting to the use of fake documentation.to beat the system.

Another participant named Fatima, who had interfaced with the same hospital as Batsirai, Tshwane district hospital, about 10 months before the interviews reported the following:

> *"Kunyangwe hazvo ndayifanhira kubhadhara, andina kubhadhara hangu. Vakandibatsira hangu sezvo yayiva i emergency asi chinozoyitika kuti unozosara nechikwerete. Ipapo ndinechikwerete asi vakangondi discharger zvakadaro pasina chandakabhadhara. Apa andina kana plan yekuti chikwerete ichocho ndinochibhadhara seyi, uyezwe ndinototya kuti ndikazorwara ndozoda kudzokera ikoko panozo dzokereka sei uyezve ndingabatsirikana here".* ***(I did not pay for delivery; they did help me nonetheless since it was an emergency. I was discharged and I still owe them. So, I have fears that what if I fall sick, and want to go back there, will they help me).***
>
> ***(Fatima – 24.02.2020)***

Martha, whose experience happened seven years ago, but also interfaced with Tshwane hospital explained how she got away with none-payment for labour and delivery services despite being undocumented. She had this to say:

> *"Kwakumele ngibhadale for idelivery njengoba ngangingela maphepha, so bathi bengi admitter bangisthela ukuthi bazangamkela bangibelethise kodwa abasoze*

bangiphe amaphepha omtwana nxa ngiphuma, betsho ibirth record, leyo efunakayo nxa uthatha ibirth certificate. Inhlanhla kwaba yikuthi ngaba lamacomplications ekubeletheni bangigijimisela eSteve Biko[7]*, yikho lapha engafika nga operatwa ngabelethela khona, bangi discharger ke lapho, lamaphepha omtwana ngawaphiwa, bengakhulumanga ngokubhadala. Asazi kumbe i file lami elalichaza ukuthi angibhadalanga lalisele eTshwane kumbe vele imithetho yabo iyatshiyana, mina ngibonga nje inhlanhla engaba layo".* ***(I was supposed to pay for delivery since I was undocumented at the time and when they admitted me, I was told that upon discharging me, they are going to withhold the baby's documents meaning the birth record which enables one to apply for a birth certificate. By luck I had complications at delivery, and I was quickly rushed to Steve Biko, that is where I had a caesarean delivery. At Steve Biko I was discharged and given everything, without withholding and documents or the mention of any payment. I am not sure if my file that had details about none-payment had been left behind at Tshwane or their regulations are different. I am however grateful for the sheer luck which I had).***

(Martha – 29.02.2020)

Although these reports were shared by respondents who had interfaced with Tshwane hospital in Pretoria, available literature suggests that there exist similar occurrences in Johannesburg as noted by Vanyoro (2017). He observed how at an antenatal care department in a health facility in Johannesburg, patients accessing care were requested to present their valid documentation, or they would not be admitted. Embedded in the narratives above, and also as evidenced by Vanyoro (2017), are the difficulties in accessing maternal health care which are encountered by expecting migrants who are not documented as a result of policies that offer differential treatment to categories of migrants. This reflects a glaring gap between the lived realities of migrants and multiple pieces of legislation and guidelines such as the South African Constitution and the National Health Act (2003) which state that everyone in the country, regardless of immigration status, should have access to life-saving care (Vearey, 2011). Drawing on these migrants' experiences it is evident how exclusionary legislation may be detrimental to maternal and child

[7] Steve Biko is a Provincial Academy Hospital in Pretoria. It attends to complicated cases that have been referred from the district hospitals.

health outcomes among migrant populations. Notably, unequal access to public healthcare experienced by migrant groups and denying them timely access to appropriate healthcare endangers their lives (Vearey, 2011).

Based on the findings above, I found that treating migrant women as a unitary and homogenous group, undermines the different forms of disadvantage or privilege that they face. Zimbabwean migrant women's practices surrounding access to maternal health are diverse and are influenced by multiple factors in the different levels of the socio-ecological framework. At the first level are individual factors such as documentation status and the differentiated treatment between the documented and the undocumented. At the very same level, social class further compounds the source of oppression or privilege as they cannot afford to pay the fees required from those without regular documentation. Coupled with that are structural, institutional, and societal factors under which rules, policies are located which shape experiences of migrant women based on their documentation status. As argued by Spitzer et al., (2019) that improving the health and wellbeing of migrants requires attention to their diverse circumstances, and using the intersectionality approach in this study, I managed to bring to light different voices of migrant women and their unique experiences of disadvantage or privilege in accessing the health system as a result of nationality, documentation status and policies. More importantly, I demonstrate diverse practices engaged on by women as they navigate the health care system to access maternal services.

4.4 Summary of the Chapter

In this chapter I have demonstrated how migrant transnationalism is deeply rooted in the lives of Zimbabwean women, as evidenced in their beliefs and practices surrounding contraception or antenatal. Dominant practices such as accessing contraception and traditional herbs for antenatal care purposes in Zimbabwe, demonstrate the transnational nature of their engagement with health care in South Africa. Furthermore, the continued influence by cultural and religious beliefs surrounding contraception, antenatal care and other SRH issues are also evidence of their embeddedness in their country of origin. More importantly, maintenance of strong links and communication with relatives or friends left behind in Zimbabwe, which also acts as a catalyst for their transnational activities such as trading of Zimbabwean products locally is a strong indicator

of migrant transnationalism among this study population. Evidently, Zimbabwean migrant women across different ages, varying lengths of stay in South Africa, differing socio-economic statuses, levels of education, marital and documentation statuses continue with their beliefs and practices surrounding contraception or antenatal care from their country of origin.

Notably, from the women's experiences, multiple intersecting factors located in the different levels of the socio-ecological framework such as the process of migration, their heterogeneity as individuals with varying socio-economic or documentation statuses, policies relating to nationality and health care access among other factors, which affect women differently. This demonstrates the complexity of Zimbabwean migrant women's contraception and antenatal care practices in South Africa, and the multiplicity of influencing factors. Inspite of the differences noted in how women experience and navigate access as well as utilisation of contraceptives or antenatal care, it was apparent that migrant transnationalism is a common factor among them. These findings cement the assertion by Moskal (2013, p. 159) that while "most migration and settlement experiences fit within one of the models of incorporation to the host society (assimilation, differential exclusion and multiculturalism), […] a growing group does not". Similarly, these findings are in line with what was noted by Levitt et al., (2003) and observed by Williams et al., (2014) over a decade later that:

> *"The concern about assimilation, acculturation, and incorporation of immigrants evidenced in a huge of literature* (Guarnizo et al., 2003) *implies a one way path where migrants adopt the cultural, economic, and political patterns of their host society while simultaneously shedding the patterns of their origin. This makes sense if we assume that migrants intend to stay permanently and have little contact with their origin. However, these assumptions are often not relevant today, and this has likely been the case for a long time". (Williams et al., 2014, p. 2)*

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

In this final chapter I present a summary of the key findings. I also outline the study's contributions in the fields of migration and sexual reproductive health. Additionally, I briefly reflect on the utility of the data collection methods, theories and on ethical practice. I end the chapter by presenting a summary of the contributions the study makes to policy makers, practitioners, and recommendations for future research.

5.2 Summary of Key Findings

Consistent with the assertion by WHO (2008), that migrants travel with their culture-based health philosophies, their SRH notions and practices, this study found that Zimbabwean migrant women continue to hold beliefs on, and engage in contraception or antenatal care practices they migrated with, from their country of origin. Zimbabwean migrant women's contraception and antenatal care practices are characterised by transnational health care, transnational economic activities, cultural and religious reproduction, maintaining of transnational ties, and communication. Using a combination of the socio-ecological framework and the intersectionality theory, the study identified diverse, multilevel, interactive social influences that work together and have an effect on the differentiated experiences of migrants.

For example, most Zimbabwean migrant women have a perception that Zimbabwean contraceptives are better than South African ones, because the local hormonal options cause side effects to the user. The majority of the study participants, therefore, have opted to continue using the Zimbabwean ones, particularly the pill. However, due to their differentiated social locations such as class, most women access the Zimbabwean pill at a cheaper cost form other migrant women who smuggle in into South Africa, resulting in an illicit transnational economy, whose size and workings needs another study to be fully understood. For those with relatively better financial

resources, they access an equivalent of the Zimbabwean pill from local pharmacies at a higher cost, demonstrating the heterogeneity of migrants as a social group. Contrary to the discourses that portray migrants as a burden to the South African health system, who utilise limited resources meant for nationals, the study revealed that with regards to the issue of contraceptives a number of migrants are resourceful and actually do not utilise local contraception options. Those that do, use their purchasing power to buy them from private pharmacies.

In addition, the study established that Zimbabwean migrant women have a profound belief that to alleviate labour complications, maternal, foetal and neonatal deaths, they need to take traditional medicines during their pregnancies in concurrence with receiving antenatal The belief in the efficacy of pluralistic antenatal health care is founded on fear of maternal and infant deaths which remains high in developing countries. This finding is particularly in contrast with exiting literature which suggests that the use of traditional medicine during pregnancy can lead to adverse maternal outcomes. Additionally, it is in contrast with studies propounding that this practice of using traditional medicine during pregnancy by African women is largely due to long distances they live from health facilities, the costs associated with access to biomedical health care, and unpleasant treatment by health care workers.

While other studies concluded that the use of traditional medicines is widespread in South Africa and Africa in general especially amongst indigenous population, this study made an important finding that even women who are away from their home country continue to use these remedies. The use of traditional medicine to complement biomedicine and minimise labour complications, continue to be an important part of their antenatal health care in South Africa. The border is not a barrier to them using traditional medicines, with some of which not being easily available in South Africa.

With regards to practices regarding other pregnancy and birthing related traditions such as going back home to receive care and support from one's mother, the study established that women migrants from Zimbabwe continue to practiced them in South Africa, although with variations depending on one's socio-economic status. For instance, when one can afford to invite her mother

to come to South Africa, they opt for that, whereas those who do not afford that, in most cases as a result of living in small rooms that cannot be shared between a married couple and a parent; the expecting woman prefers to go to Zimbabwe before giving birth. Migrants therefore engage in an array of transnational activities such as sourcing their traditional medicines from Zimbabwe to make their child birthing safer and some travel home to be with their mothers during this important time in a woman's life. With such practices being practiced by migrants in South Africa, the study established that these women do not fully depend on the South African health care system for their maternal needs. More importantly, discourses such as medical tourism into South Africa by Zimbabweans for child bearing purposes, may necessarily not be applicable to a number of Zimbabwean migrants, as women who reported giving birth in the country, had already been there for purposes of work.

Although migration redefines some of the women's practices, most of them remain the same. Consequently, and in line with Maphosa (2010), Zimbabwean migrant women engage in transnational activities as a survival strategy to survive in an environment characterised by alienation and a desire to continue with practices from their country of origin. For instance, access to traditional medicine in South Africa proved to be a challenge to some women with no knowledge of where to get the products, compounded by the lack of formalisation of traditional medicines and dealers, in a system that is predominantly biomedicine. As a result, migrants who fell in this predicament started taking their traditional medicine when the pregnancy is advanced, in some instances having returned back to Zimbabwe. The process of migration, coupled with factors such as awareness of sources of transnational medical remedies, a policy environment that does not acknowledge the transnational nature of migrants health care needs, and a health care system that is not pluralistic in nature to provide a range of options to individuals depending on their needs, are some of the complex, intersecting factors through which Zimbabwean migrant women navigate their antenatal health care. In this context, transnationalism is capital that is available to Zimbabwean migrants as argued by Moyo (2017), hence migrant transnational activities are a source of resiliency to the women (Merry et al., 2017).

In as much as migrant transnationalism is a survival strategy for migrants, providing them with resiliency, in some instances, it poses as a potential threat to their health care and freedom. As evidenced in the discussion of the findings, some migrants resort to hoarding contraceptives to last them up to eight months while in South Africa. Some buy from illegal channels, having been imported illicitly. Proper storage of drugs and using them while they are within the prescribed expiry dates are important factors with regards to the efficacy of the drugs and minimization of contraindications. However, migrant women purchase drugs that they do not know how and where they have been kept or stored during smuggling, also keeping drugs for an exceptionally long time before use. Furthermore, this facilitates the existence of illicit activities such as smuggling which puts these women at risk of imprisonment if caught. Added to that, the trading of transnational products, contraceptives, and traditional medicine points to an existence of a parallel and unsanctioned market which equates to breaking the law by migrants. These are some of the irregularities that characterise the lives of Zimbabwean migrant women, owing to their desire to meet personal contraception needs while they work and live in South Africa.

The above findings point to a need for strategies that address the underlying causes which make migrants engage in such intense and illegal transnational activities. This resonates with the assertion by the International Organisation for Migration (IOM) that many of the challenges related to transnational practices are a result of policies that do not think transnationally. Consequently, suggesting that "the task for policymakers is to make transnationalism work for migrants and societies through better migration management, keeping in mind the transnational dimension when designing policies. […] instead of focusing on just one country or the other, policies with a transnational outlook specifically address the linkages between countries arising from transnational activities and practices by migrants" (IOM, 2010:4).

5.3 Utility of Theoretical frameworks and Data Collection Methods

The use of both the socio-ecological framework and intersectionality theory enabled me to document migrant's contraception and antenatal care experiences in an absolute manner. This facilitated an exploration of the intersectional nature of factors that determine migrant women's health practices and locating these within the different levels of the socio-ecological framework (individual, relational, community and societal).

Using qualitative methodology in the form of one-on one in-depth interviews and observations allowed for an in-depth exploration of participant's lived experience in the best way deemed possible. The explorative and discursive interaction with the participants, afforded by the qualitative approach, enabled the women to warm up to our discussion and reveal practices that are rarely or have not been documented in existing literature. As a result of that, the study has provided much more contributions than it was envisaged to the under researched area of Zimbabwean migrant women's SRH experiences in South Africa.

5.4 Reflections on Ethics

I was obliged to protect the identity of my participants at all costs so that my study does not compromise them. I achieved this, through making sure that consent is done verbally, nowhere in the interview scripts did their names appear. I assigned them pseudo names for reference in the research write up. Using pseudo names and verbal consenting helped the participants to be at ease with discussing personal experiences even pertaining to their sexual life and illegal activities. Despite the tensions that arose in me regarding documenting these activities, I however did, after considering that there is no wat that it can be linked back to them, following the strides that I made to keep the women anonymous.

5.5 Contributions of the Study to Research, Policy Makers, Practitioners

This study makes a critical contribution to the debates revolving positionality vs bias/subjectivity. In this study, the relevant researcher's positioning includes my personal characteristics, such as gender, race, being a migrant, age, personal experiences and speaking the same languages as participants. These positionalities helped me gain access to the respondents and trust for them to openly discuss sensitive matters pertaining to their SRH. Identifying as an insider did not only help gain access but to gain in-depth knowledge and it was facilitated by speaking in same languages, making it easy for them to vividly express themselves. This reflects how the researcher's positionality actually has potential to be used in the advantage of the study, which is not necessarily bias.

This study adds on to the body of knowledge regarding the role of and interactions of multifaceted factors in shaping migrants SRH practices and experiences. As argued by Erevelles, (2011), most research studies essentialise the categories of people for example in migration studies, primacy has often been given to the category "migrant" over other key elements that influence life experiences, behavior and choices. This study, however, explores different intersecting factors that have facilitated a series of continuities and discontinuities regarding migrant's SRH practices, beyond the category of being a migrant.

5.6 Recommendations for Future Research

Drawing from the study findings, that have unraveled undocumented practices done by Zimbabwean migrants to access Zimbabwean contraceptives from Zimbabwe, I recommend that there is need to carry out bigger studies to ascertain the magnitude of these practices. As it was indicated from one of the interviews that nationals from Malawi and Mozambique also prefer the Zimbabwean pills, there is need to extent such studies even to these nationals and understand their motivations towards that. On that same note, I recommend that practitioners should consider a standardisation of drugs, as it has been advocated for HIV/AIDS treatment so as to avoid these different experiences that push migrants into illicit practices in order to get contraceptives of choice from outside South Africa.

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UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Dunjana

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H19/07/41**
PROJECT TITLE	Exploring knowlegde, perceptions and practices of migrant women regarding their sexual reproductive health: The case of Zimbabwean migrant women in Johannesburg
INVESTIGATOR(S)	Ms S Dunjana
SCHOOL/DEPARTMENT	African Centre for Migration and Society/
DATE CONSIDERED	19 July 2019
DECISION OF THE COMMITTEE	Approved
EXPIRY DATE	10 February 2022

DATE 11 February 2020 **CHAIRPERSON** (Professor J Knight)

cc: Supervisor : Dr D Ndlovu

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

_____ **Signature** _____/_____/_____ **Date**

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Annexure B: Informed Consent

Study title:

Exploring Zimbabwean Migrant Women's Beliefs and Practices Surrounding Access, Utilisation of Contraceptives and Antenatal Services in South Africa

Participant's Consent to Participate in the Interviews: My participation in this research study is voluntary. I have read and understood the information provided on the information sheet, asked any questions which I had, and I have agreed to participate.

Response to be ticked

Yes

No

Participant's Consent to be audio recorded: My consent to be audio recorded in this research study is voluntary. I have read and understood the information provided on the information sheet, asked any questions which I had, and I have agreed to be audio recorded.

Response to be ticked

Yes

No

Annexure C: Information Sheet

Study Title: Exploring Zimbabwean Migrant Women's Beliefs and Practices Surrounding Access, Utilisation Of Contraceptives and Antenatal Services in South Africa

Introduction

Good day to you Madam.

My name is SIBONGINKOSI DUNJANA. I am a student studying at the University of Witwatersrand and I am conducting a study that seeks to explore Zimbabwean female migrants' knowledge, perceptions, beliefs, attitudes and practices of migrant women regarding their sexual reproductive health as they work and live in South Africa.

Invitation to Participate: I am asking / inviting you to take part in a research study that I am conducting as part on Masters in Migration and Displacement at the University of Witwatersrand. What you should know about this study are the following:

Objective

The topic of discussion is of Migrant Women Sexual Reproductive Health focusing on contraceptive use and access to pregnancy related services. By contraceptives, I mean using methods such as pills, injection, implants, IUCD, condoms and sterilization. The purpose of this study is understanding Knowledge, Perceptions and Practices of Migrant Women Regarding their Sexual Reproductive Health: The case of Zimbabwean migrant women in Johannesburg and Pretoria.

Procedures

You have been selected because you may have something important to contribute, and I would like to hear from you. Your opinion is very important to me. There is no right or wrong answer. I will conduct an interview with you in person, where I ask you about your experiences of access,

use of contraceptives and pregnancy related services in South Africa. With your permission, I would also like to record the interview using a voice recorder, so that I can go back and listen carefully to what has been said today. That way, I can make sure that I have accurately captured all the important information that you will be sharing with me. So, immediately after the meeting, I will create a transcript from the recording. To maintain your privacy, the transcript will not include any names or information that could potentially identify anyone.

Duration of the interview: the interview is expected to take between 45 mins to 1hour.

Risks and discomforts: The major discomfort that you may experience is being asked personal questions about your sexual health. Should you need support counselling services as a result, in liaison with the counselling service providers, we will avail the services to you free of charge. Apart from that there is no major anticipated risk for participating in this study. If you have any questions pertaining to the study, you are free to ask before you agree to participate.

Benefits: Your participation in this study will mainly contribute towards knowledge generation on access and utilisation of contraceptives and pregnancy related services among migrant women. There will be no payment for participation in the study.

Confidentiality: The information that I will obtain from you will be stored confidentially and only authorised fellow researchers like my supervisor. No addresses or names will be recorded on the forms but only pseudo will be used. During the interview non-participants are not allowed to be present, this will ensure a conducive environment for you to feel free to respond to the questions.

Voluntary participation: Your participation in this study is completely voluntary and you are free to decline. Furthermore, if you decide not to participate in this study, your decision will not affect your future relations with the researcher or the University of Witwatersrand. If you choose to participate, you have the right to withdraw your consent and stop the interview at any time without negative consequences to you. You may not have to respond to any question that you feel like not

answering and may end this interview at any time without giving reasons. There are no disadvantages or penalties for not participating.

Whom to contact: For any questions you may have regarding this study, you are advised to contact the researcher's Supervisors: Dr D Ndlovu on this email address: duduzilendlovu@gmail.com, Cell Number +27795285073 and Prof Vearey on this email address: jovearey@gmail.com, Phone Number +27117174033 . Should you need to contact me as the researcher, you may do so on this email: bongiedunjana@gmail.com, Cell Number +27760701330. If you have any concern over the way the study is being conducted, please contact the HREC secretary, Shaun Schoeman on this email address: Shaun.Schoeman@wits.ac.za.

Correction made here by adding the 2nd Supervisor, my email address and the contact details for the HREC secretary.

Offer to Answer Questions: Before you agree to participate in the interview please ask any questions on any aspect of this study that is unclear to you. Do you have any questions?

Annexure D: Socio-Demographic Questionnaire

Exploring Zimbabwean Migrant Women's Beliefs and Practices Surrounding Access, Utilisation Of Contraceptives and Antenatal Services in South Africa

Date of Interview: _____ Respondent Pseudo Name_____

How old are you?	Years
What is the highest level of education you have completed?	○ Never attended school ○ Primary school ○ Secondary school ○ Technical school ○ University
What is your religious affiliation	○ Catholic ○ Protestant ○ Muslim ○ Pentecostal ○ Seventh Day Adventist ○ Other (please specify)
What is your current marital status?	○ Single, never married ○ Currently married ○ Living with someone as if married ○ Divorced ○ Widowed
How many children do you have?	
For how long have you been in South Africa?	○ Less than a year ○ 1 to 3 years ○ 4 to 9 years ○ Over 10 years
Have you ever used a family planning method?	○ Yes ○ No
Have you ever accessed pregnancy related services in South Africa?	○ Yes ○ No

Annexure E: In-depth Interview Guide

In-depth Interviews Participants

Exploring Zimbabwean Migrant Women's Beliefs and Practices Surrounding Access, Utilisation of Contraceptives and Antenatal Services in South Africa

PART 1: KNOWLEDGE AND PERCEPTIONS ON SEXUAL REPRODUCTIVE HEALTH

1. What are the ways of preventing pregnancy do you know?

   Probe:

   - How do you know them - who told you and where?
     - Sources of information e.g. media, peers, family, health providers etc.
   - What do you think about them? Why?

[**For all current and past users**]:

2. What method/s are you using, or have you used?

3. Where do you or did you used to get it from?
   - What kind of challenges if any did or do you encounter in trying to access?
   - How did or do you cope with those challenges?

4. Have you or did you experience side effects? which ones?

   Probe:

   - Did it change anything in your relationship?
   - Are there any particular things you or your partner does to relieve side effects?

[For past users only]:

5. What was the biggest reason you stopped the method?

6. Would you recommend a friend or relative to use any method of prevention?

   Probe:

   - Which method and why?

7. What things should migrants take into consideration when choosing methods of prevention to use?

8. Do you discuss issues to do with prevention of pregnancy with friends/peers?

    Probe:

    - Where? How often?
    - What triggers these discussions?
    - How would you describe your friends or peers' attitudes towards contraceptives?

9. How good are the available methods of preventing pregnancy here in South Africa?

    Probe:

    - Side effects
    - Convenience to use
    - Access including price and source,
    - method of administration,
    - Frequency of use,
    - Interference with sexual dynamics
    - Effectiveness in preventing pregnancy

PART 2: MOTIVATIONS AND BARRIERS TO CONTRACEPTIVE USE

10. What are the reasons that people use methods of preventing pregnancy?
11. What are the benefits of using methods of preventing pregnancy?

    Probe:

    - Financial reasons
    - Health
    - Relationship reasons including sexual pleasure

12. Do you know of any migrant women who do not use methods of preventing pregnancy at all and what are their reasons for not?

    Probe

    - Personal reasons
    - Attitudes, Belief and Myths

- Examples of these
- Sources of information about this
- Meaning attached to them

- Side effects
  - *Probe*: Perceptions of the meaning of these side effects for self, family and community
- Relationship factors:
  - *Probe*: relationship type, stage of relationship, sexual pleasure, partner communication, fertility aspirations, economic dependence
- Community factors –
  - Social disapproval, gender dynamics (role of women as child bearers, associations with promiscuity)
  - which types of methods are popular in your community and why?
- Institutional factors –
  - Choice of methods
  - Access e.g. location, price, waiting periods, institutional rules or requirements
  - Relationships with providers

13. What are the challenges of not using methods of preventing pregnancy?

Probe:

- Consequences of unintended pregnancy on individual
- Consequences of unintended pregnancy on relationships with partner
- Consequences of unintended pregnancy on family and society

14. How do men in your community generally perceive methods of preventing pregnancy?

Probe:

- What are their levels of participation and why?
- Does this work against or for women's desire to use methods of prevention?
- How do women who face such barriers work around them?

  Probe:
  - Do these strategies work?
  - Do they have any negative consequences?

PART 3: QUALITY OF CONTRACEPTIVE SERVICES

15. How would you describe the quality of services available for women's health regarding prevention of pregnancy services?

    Probe:

    - what kind of care is available?
    - Price
    - Requirements to access services

- Health provider's inter-personal relations
    - communication, language, attitude

PART 4: ACCESS TO PREGNANCY SERVICES

16. Have you ever fallen pregnant in South Africa and accessed pregnancy related services in South Africa?

    Probe: how long ago, was is at a public hospital/clinic or private, did you have medical aid or paid anything for the services, did they require documentation and how did go about the whole process?

17. What were the services that you received?

    Probe:

    - Antenatal, post-delivery, post-natal?

18. What would you say about the service you received?

    Probe:

    - For quality of service?
    - Treatment by health workers?
    - Processes associated with access

19. Are there any circumstances under which one should avoid falling pregnant and why?

    Probe: age, education/training, documentation status, household income, personal or spousal health, career goals, parity and sex of existing children, type and stage of relationship, living in particular region or district, other personal or familial responsibilities?