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Experiences and perceptions of Zimbabwean migrant women accessing antenatal and infant/child immunisation in public healthcare services in Gauteng South Africa (2015-2017)

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Title: **Experiences and perceptions of Zimbabwean migrant women accessing antenatal and infant/child immunisation in public healthcare services in Gauteng, South Africa (2015-2017).**



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A research project submitted to the School of Public Health in partial fulfilment of the requirement for the Degree of Master of Public Health, in the field of Social and Behaviour Change Communication.

Supervised by: **Dr Jo Vearey**

Janine Simon-Meyer

Date: **June 2017**

DECLARATION

I, **Susan Saburi,** declare that this research work on: **'Experiences and perceptions of Zimbabwean migrant women accessing antenatal and infant/child immunisation public health services in Gauteng, South Africa.'** is my own original work**.** Any other work done by other people quoted herein has been properly acknowledged in the report.

The report is being submitted in partial fulfilment of the requirements for the degree of Master of Public Health, in the field of Social and Behaviour Change Communication, with The University of the Witwatersrand, Johannesburg. It has not been submitted for any other degree or examination in the aforementioned institution or any other university.

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Signature:.....

Date: 15.06.2017 .

DEDICATION

To my husband Farai, and daughters Shiloh and Shemariah Saburi.

ACKNOWLEDGEMENTS

Firstly, I would like to thank God for affording me the potency, knowledge and drive to accomplish this study. Through Him, this study was successful.

I also give my sincere gratitude to my supervisors; Dr Jo Vearey and Janine Simon-Meyer, for their unstinting patience, encouragement and efforts to guide me to the accomplishment of this study. Your contribution is deeply treasured.

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Finally, yet importantly, I wish to express my appreciation to Tackson Makandwa and Babbot Muchanyerei; it was worthwhile to have you throughout this journey. To all 2014 MPH Students, you were a magnificent team!

ABSTRACT

Globally, access to maternal and child healthcare remains a fundamental human right for all, regardless of an individual's migration status (1). People migrate for a variety of reasons, and this mobility brings forth implications for health provision, health care experiences and human rights, both for the migrants and their host population (2, 3). An increasing number of cross-border or international migrant women globally report difficulties in access to and use of healthcare services, including maternal and child health (4, 5). Little evidence in South Africa on these issues proposes that there is a need for deeper knowledge in this regard. South Africa is a signatory to a range of international commitments that place emphasis on the non-discriminatory provision of health services and a progressive health policy assuring health for all, including free access to antenatal care (ANC) (1). Despite this, South Africa's maternal and child health outcomes continue to be poor - including that of migrants (6, 7). The increased number of migrants from neighbouring countries is perceived to have placed a burden on the South African healthcare system (4). The aim of this study was to explore the experiences and perceptions of Zimbabwean cross-border migrant mothers in accessing routine antenatal care, obstetric care and infant/child immunisation in public healthcare facilities in, Gauteng, South Africa (2015-2016). Through a qualitative study design, the researcher gathered data by means of 13 face-to-face interviews with a purposive and snowball sample of participants.

Few participants gave positive reports on the quality of ANC and immunization services they had received. It is therefore important to ensure that this positive care is maintained across all public health facilities in order to instill confidence among health recipients. However, most of the study participants experienced barriers in accessing quality routine ANC and infant immunisation in the country's public health facilities. These challenges include language barriers, discrimination and poor nurse-patient relationships. Based on these findings and conclusions, the researcher recommends that the South African National Department of Health addresses some of the challenges affecting cross-border migrant

women in accessing maternal health care in public facilities nationally through the formulation, implementation and follow-up of policies. Furthermore, health care providers need to be continuously educated and motivated to respect the rights of all patients, regardless of an individual's migration status, in order to instil positive attitudes and quality care. There is also a need to conduct further research in other provinces of the country, preferably with cross-border migrant women from other countries, and draw comparisons with South African women in order to take appropriate steps to address the challenges.

KEYWORDS: Documented and undocumented migrant women, access, antenatal care, child immunisation, South Africa healthcare system, migration and Zimbabwean women, Johannesburg inner-city, Tembisa and South Africa.

LIST OF ABBREVIATIONS

ANC	Antenatal Care
DOH	Department of Health
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
MHRC	Medical Health Research Committee
PMTCT	Prevention of Mother-to-child Transmission of HIV
HRW	Human Rights Watch
SA	South Africa
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
SBCC	Social and Behavioural Change Communication
UNFPA	United Nations Funding Population Activities
WHO	World Health Organisation

GLOSSARY OF TERMS

Access to health	Refers to the use of individual health services characterised by affordability, availability, accessibility, accommodation and acceptability, to achieve the best health outcome (8)
Cross-border migration	A mix of circular, permanent and transit migration that involves crossing a national border (9).
Internal migration	Movement within one geopolitical entity, mostly a national state (10)
Migration	Process of population movement/mobility, whether within a country or across an international border (4, 10).
Migrant	Any individual who resides temporarily or permanently in a country or community where he or she was not born and has obtained some form of significant social ties to this country (4).
Health	The complete status of mental, social and physical well-being, and not simply the absence of disease or infirmity(4).
Health migration	Refers to the migration process that permits access to helpful social determinants of health for the population that move, host population and the population that remain in the household of origin (4)
Migration Health	Refers to the health of migrants, mobile inhabitants, their families and communities affected by migration (11).
Refugee	Refers to individuals who are living outside their country of birth because of fear of persecution as a result of race,

	religion, nationality or for political reasons, and are unwilling to avail themselves of the protection of that country (4, 10).
Asylum seekers	Individuals who seek to be permitted into a country as refugees and are awaiting an outcome on their application for refugee status under applicable international and national instruction (4, 10).
Documented migrant	Any individual who has the necessary documentation which authorises him/her to legally move in and stay in a country temporarily or permanently (10).
Undocumented migrant	Refers to foreign-born individuals who lack the right to be in a country of destination, having either crossed the borders without inspection, not having subsequently obtained any right to remain, or who will have stayed beyond the expiration date of a visa or other status (4, 12).
Antenatal care	Refers to the routine health control of presumed healthy pregnant women without symptoms (screening), so as to diagnose diseases or complicating obstetric conditions without symptoms and to provide information about lifestyle, pregnancy and delivery (13)
Child Immunisation	Refers to the vaccinations given to children that make them immune or resistant to infectious disease (14).

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CHAPTER ONE: INTRODUCTION, BACKGROUND INFORMATION AND LITERATURE REVIEW

1.1. Introduction

The South African public healthcare system is argued to serve the majority of the country's population and migrants, primarily those who are unemployed/informally employed and those who do not have medical aid (15). However, a 2009 paper by Coovadia et al., shows that South Africa's health care system and health service delivery has been shaped by its history, which was characterised by racial and gender prejudice, violence and inequality (16). The aim of this study was to explore the experiences and perceptions of documented and undocumented Zimbabwean cross-border migrant mothers in accessing routine antenatal care and infant/child immunisation services in South Africa's public health care facilities.

This chapter will first outline the background information on migration and definitions of migration, and will explain the feminisation of migration and the impact of migration on maternal and child health, which are the essential aspects of this study. The chapter will further outline the literature reviewed for the intentions against which the study was carried out, and gives a related background to the subject under discussion. An overview of the problem statement, the rationale of the study, and the objectives will be outlined.

1.2. Study background

Migration is the process of population mobility, either within a country or across an international border (4, 10). It is a universal phenomenon involving millions of people, with major socio-political and economic effects on communities within sending and host countries. For example, large-scale migration and increased numbers of migrants are believed to cause increased public expenditure related to the care and maintenance of the diverse population, slum growth, social and ethnic conflict, and social service delivery protests (17-22).

On the other hand, migration has been a significant survival strategy for many groups (both poor and non-poor) worldwide, and its benefits should not be overlooked (19, 23, 24). In Africa and Asia, for example, population mobility has proved to be a necessary condition for sustainable development as well as poverty alleviation (19, 23). Internal migration, for instance, is significant in terms of its potential to reduce poverty (19, 23, 25). Therefore migration should be managed in a healthy way in order to be recognised as a potential benefit to receiving nations or communities, and for the betterment of the host country, the migrants, and other countries (19, 24, 26).

In 2015, about 244 million people (about 3.3% of the world's population) were estimated to be living outside their country of birth (27). Cross-border or international migration takes place for a variety of reasons, including conflict, instability, poverty, the pursuit of education and enhanced livelihood opportunities (19, 24). This study focused on the international or cross-border migration of Zimbabwean women into South Africa.

Cross-border migration is defined as a mix of circular, permanent and transit migration that involves crossing a national border (9). There are different categories of cross-border or international migrants. Refugees refer to individuals who are living outside their country of birth because of fear of persecution either as a result of "race, religion, nationality, political reasons and are unwilling to avail themselves of the protection of that country" (4, 10). Asylum seekers are individuals who wish to be permitted into a country as refugees and are awaiting an outcome on "their application for refugee status under relevant international and national instruction" (4, 10). Circular migrants are individuals who move regularly between their country of origin and destination; for example, seasonal farm workers, job seekers, students and visitors. International or cross-border migrants can be documented or undocumented (4). Undocumented migrants refer to foreign-born individuals who lack the right to be in a country of destination, having either crossed the borders without inspection, not having subsequently obtained any right to remain, or who will have stayed beyond the expiration date of a visa or other status (12). Internal migrants are individuals who move

within one geopolitical entity, mostly a national state (10). However, although this category of migrants (internal) is important, it is rarely acknowledged in South Africa (28, 29).

A 2015 UNFPA update report on migration and other studies shows that there has been a significant change in migration patterns in the last century, as more women are migrating than before (19, 30, 31). It is estimated that women currently comprise almost half the international migrant population in South Africa, and in other countries as much as 70 or 80 percent (19). Growing evidence shows that migration can positively and negatively impact the well-being of migrant women, particularly those of childbearing age and with specific health needs (19, 32-35). Migration may also expose some women and their children to greater vulnerability, as they will encounter a diverse social, structural and cultural context which commonly exposes them to risk factors with effects on their health status (19, 36, 37). Generally, undocumented migrant women are argued to experience more challenges associated with, for example, exploitation and abuse, difficult working and living conditions, pregnancy, discrimination, social isolation, and unfamiliarity with laws and rights “when they reach foreign soil and lack of access to basic social services, including healthcare” than their documented counterparts (19, p. 75-76, 38).

In a 2009 paper in Ethiopia by Kiros, and a 2011 paper in Thailand by Canavati et al., it was revealed that children of undocumented migrant mothers had lower immunisation coverage than those of non-migrant women. This difference was attributed to the observation that migrant mothers do not use health services because of fear of arrest on the way to the clinic or at the clinic (39-41). Vaccine-preventable diseases are responsible for severe rates of morbidity and mortality in Africa because these diseases are highly infectious. Therefore immunisation is important for all children in the country (40, 41).

1.3. Literature review

1.3.1. Overview of the structure of the South African healthcare system

In a 2009 paper by Coovadia et al. on health and the healthcare system of South Africa, it is documented that South Africa's history has had a pronounced impact on the well-being of its citizens and current existing health policy and services (16). During the apartheid era, the South African public Health Amendment Act of 1897 racially segregated the healthcare facilities, and curative and preventive services were also separated (16). At that time, "the political, economic, and land restriction policies organised society according to race, gender and age-based hierarchies, which significantly shaped the structuring of social life, access to basic resources for health, and health services" (16. p , 817). A noticeable attribute of the history of healthcare services in South Africa is argued to have been fragmentation, both within the public health sector as well as between the public and private sectors (16). Before 1994, the private health insurance organisations (medical schemes) were established strictly to cater for the health needs of the white population.

The South African healthcare system has been transforming over the past decades. It is made up of a large public sector and a smaller but rapidly developing private sector, and the two health systems exist in parallel in the present day (42). Healthcare varies from basic primary health care, accessible free under the state, to highly specialised, technological health services offered in both the public and private sectors (42). The public sector is overburdened and inadequately resourced in some areas, yet the vast majority of the country's population, including migrants, relies on it (42). It is believed to deliver services to about 80% of the country's population (42). South Africa's public health sector uses about 11% of the state's total budget, and this is distributed mostly to nine provincial departments (42). High levels of poverty, unemployment and both citizens and migrants who are not members of medical schemes mean that healthcare remains mostly the burden of the state, with the DOH holding overall responsibility for health care, with a specific responsibility for the public sector (42). Regardless of this high expenditure, health outcomes are poor in

contrast with other comparable middle-income countries, reflecting an inequity in healthcare in the country (42).

On the other hand, the private sector is governed largely on commercial lines, serves middle and high-income recipients who tend to be associates of medical schemes, and it entices most of the country's health professionals (42). The transformation of South Africa's health care system to date is still faced by the past state-generated inequalities, insufficient funding of the public healthcare system, the continuation of a two-tiered health care system, human resources gaps, inadequate quality of healthcare and a high burden of diseases, with high prevalence and incidence of communicable diseases and maternal and child health problems. (16, 42-44)

1.3.2. Maternal health overview: South African National Department of Health Protocol on Antenatal Care (ANC) and Infant Immunisation

Maternal and child health has been a public health concern globally, and improving maternal health was set as one of the Sustainable Development Goals (SDGs) (45, 46). The SDGs are set for all countries to ensure healthy lives and promote well-being for all ages, therefore, they are not limited (45, 47). Therefore, the provision of early ANC is regarded as the cornerstone for improving maternal and perinatal outcomes, and it includes improving women's knowledge on ANC and child immunisation services (48, 49). South Africa is one of the countries set to reduce maternal and neonatal mortality by the year 2030, according to the SDGs (47). Hence the National Department of Health identifies maternal and child health care as one of the priority areas requiring urgent attention in the country (48). The Department also recognises the urgent need to improve the status of women and children in society, paying particular attention to education, reproductive choice, employment and the prevention of abuse (48). By addressing these issues, maternal and child health care will be positively influenced (50-52). South Africa's maternal health care system can be categorised into three major phases, namely: access to ANC, delivery in public health facilities, and infant immunisation (48) These three phases form the core of the South African basic

antenatal care (BANC) and Infant Immunisation (48). The phases emphasise issues such as preconception care, antenatal care, relationships with private caregivers, the first antenatal visit occurring in the first 12 weeks, physical examination, and prevention of mother to child transmission (PMTCT) (48).

Women should, therefore, be familiar with these important issues throughout the phases, which are also in line with the United Nations' SDGs (52). A 2008 study by Gatsinzi and Maharaj about women's experiences of maternal and child health in KwaZulu-Natal (KZN) revealed that most women lacked knowledge, for example, on the recommended number of ANC visits, and also commenced antenatal care late (53). A 2000-2004 report on saving mothers also shows that 18,1% of women who died did not have ANC, and 26,8 % delayed seeking care (DOH, 2007). In a 2003 study done by Myer & Harrison in KZN, it was shown that the majority of women did not see important health threats during pregnancy. Instead, they perceived more than one ANC visit as unnecessary (54). In the same study by Myer & Harrison women viewed labour and delivery as the time of significant health risks, needing biomedical care (54). Regardless of free access to health care services and the WHO recommendation of a minimum of four routine antenatal care visits, very few women in South Africa, including migrants, attend clinics during their first trimester of pregnancy (55). This, therefore, calls for the need to continue emphasising the issue of educating women so that they can make informed reproductive choices (48).

1.3.3. South Africa's healthcare policy

The rights relating to access to health care service are stipulated in three segments of the South African Constitution (1996), and legislation. Table 1, below, shows various health-related legal frameworks in South Africa which outline a patient's rights in accessing healthcare services in public healthcare facilities.

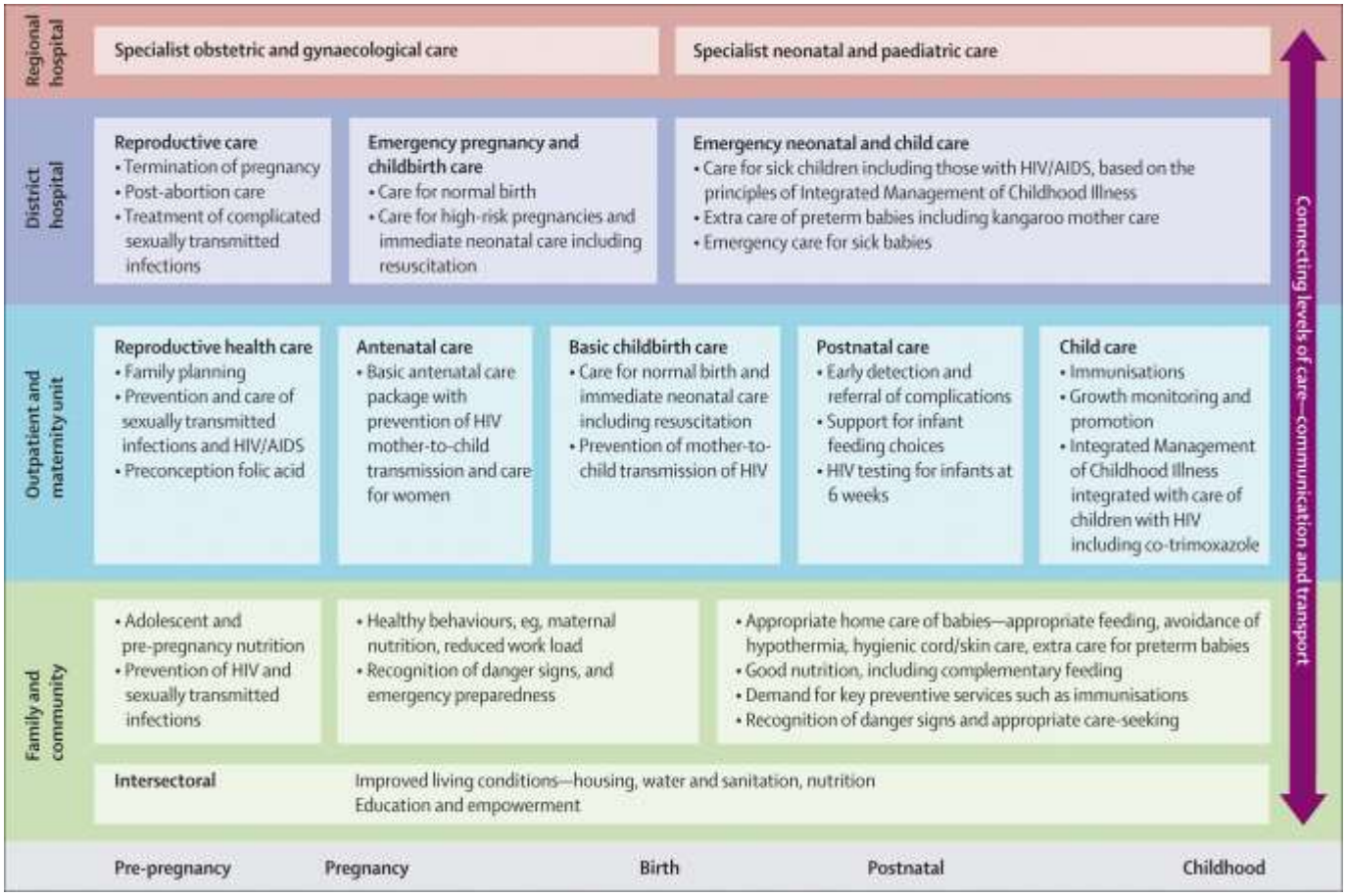
Table 1: South Africa's healthcare policies

Constitution of South Africa Chapter II, Section 27	Everyone has the right to access healthcare services including reproductive healthcare, (1)
National Health Act 2003	Healthcare professionals or the health establishment may not deny a person emergency medical treatment (1)
Patient Rights Charter	Must be obeyed by every hospital and clinic (56)
Constitution of South Africa Section 28 (1) (c)	Provides for basic health care to all children (1)

1.3.4. Levels of entry in the public health system in South Africa

The basis of South Africa's public health system structure has five layers of primary healthcare, namely: clinics, district hospitals, regional hospitals, tertiary hospitals and central hospitals (57), as shown in Table 2 below. Three distinct approaches are described as follows: primary health care clinics are the first level of access for individuals requiring health care services, and services are offered free of charge (57). The outpatient and outreach level of services comprises population-orientated services which are delivered either through static clinics, for example, routine antenatal or postnatal care; or through mobile services like immunisation campaigns or child health wellness (57). The second is the three tiers of hospitals, district, regional and tertiary, to which patients are transferred/referred from primary healthcare clinics once they require more complicated treatment (57). At the third level (also known as the tertiary level) are academic hospitals or clinics, where complex diagnostic procedures and treatments are offered (57). These also serve as training institutions for healthcare providers. This level is comprised of a person-oriented case management of mothers, infants, and children with sickness or complications, and is usually offered through facility-based care at primary and referral sites (57). Table 2 (below) summarises the different types of public healthcare facilities levels or places women will engage for ANC, delivery and immunisation (57).

Table 2. South Africa healthcare entry levels



Sources www.thelancet.com (57, 58)

1.3.5. Feminisation of migration and maternal health

There has been a fundamental change in migration patterns in terms of gender, as more women are migrating to seek employment (19, 23, 59). This autonomous female migration has been increased by a greater demand for female labour in certain services such as domestic work, as well as growing social acceptance of women's economic independence and mobility (19, 23, 59). A 2012 report by Caritas Internationalis on female migration indicates that in Africa, extensive poverty, disease and high male unemployment precipitated women to provide for family needs, resulting in a faster rate of female migration than the global average (59). Most Southern African female migrants are argued to migrate within the region, although some also move to Europe (59, 60). Evidence indicates that, in 2005, 47.4% of the 17 million migrants in Africa were women (60), and in 2010 in South Africa,

42.7% of the total cross-border migration were women (9, 61). Studies have shown that female migration can offer women important opportunities to improve health, lifestyle and self-esteem (36, 60).

According to a 2003 study by Iglesias, Robertson, Johansson et al., migrant women often initiate the migration process during their reproductive age, regardless of the reasons for leaving their countries of birth (35). It is further argued that due to the process of cross-border migration, women often experience poor biological and psychosocial health determinants when faced with new circumstances, atmospheres and lifestyles that tend to intensify conditions of social vulnerability (35, 36). Evidence shows that mental illness - for example, depression, schizophrenia and post-traumatic stress - is frequently experienced by migrants of childbearing age (36, 62). Maternal health, as part of the reproductive health of migrant women, might be further compromised when they have to negotiate access to health care in their host country and face exclusion as a result of their documentation status or other reasons like anti-foreigner sentiments and poor treatment by health care providers (36, 63). Studies conducted in the UK, Belgium, Germany and Spain show that babies of migrant mothers (especially from Africa) tend to have lower birth weight, are preterm delivered, delivered as still birth babies and higher postneonatal mortality rates (34, 64, 65) due to exposure to stressors associated with migration; for example, lack of knowledge about health services in the new social context, discrimination and social isolation (66). Addressing migration-associated health risks or threats will thus be more effectively accomplished if approached from the perspective of a population-based public health practice (4, 67).

1.3.6. Migrant women accessing health care and the Health Belief Model (HBM)

In 1983, Mooney perceived access to health care as a mutual operation of supply and demand (68). Therefore access to health care is determined by supply factors such as ”an individual’s legal status, by location, availability, accessibility, acceptability cost and appropriateness and quality of services”, along with demand factors, like the “structural, burden of disease and knowledge, attitudes and skills and self-care practices” (22, 68-70).

In-facility experiences by South African citizens may not be different from those of migrant women, but may at times contribute to the late initiation of ANC and infant immunisation by non-South African nationals (53). Previous studies have shown that a language barrier is a major challenge for many migrant patients (50, 51, 63, 71). For instance, in a 2014 study by Small et al., migrant women were found to be less happy than their non-immigrant counterparts in terms of accessing maternal care, as they felt excluded in issues such as support and decision-making due to the language barrier (50). In another 2014 study, Makandwa identified language as a major challenge for migrant mothers in accessing health care services in public health facilities (63). In a 2011 study by Vearey, it is argued that cross-border migrants may at times face challenges in communicating with healthcare staff due to a lack of available interpreters (72). There is still much resentment among local health care providers regarding the use of English by black Africans, which makes it difficult for many migrant mothers to communicate with the health staff (72).

Other barriers that hinder migrant populations' access to and use of health systems, as reported in several studies, are economic difficulties, legal status, fear of arrest and deportation, and cultural differences (73, 74). Other related challenges include long hours waiting to be seen, lack of attention from healthcare workers, being publicly shamed whilst waiting to be attended to, and being denied access (74). A study by Woodward in 2014 further indicates that healthcare workers' attitudes towards migrant mothers with young children has adverse effects such as low service satisfaction, resulting in non-compliance with children's immunisation and monitoring progress and reduced utilisation of services (73). According to Vearey's 2010 paper, the behaviour and attitude of health care workers are of concern to undocumented cross-border migrants in South Africa (4). Researchers argue that migrants often experience verbal abuse and discrimination by midwives and healthcare professionals (4, 74). This kind of treatment by some health care staff does not promote the vision and mission of international dictates (75) as well as national health policies (10, 51).

Studies have indicated that most of the maternal illnesses and deaths in developing countries have been attributed to three delays:

(i) Making the decision to search for appropriate care: when families do not recognise a life-threatening condition, resulting in birth taking place at home;

(ii) Entrance to a suitable facility: this could be due to poor infrastructure, resulting in the women with a life-threatening condition not arriving in time to the healthcare facility; and

(iii) Proper care after arriving at a health facility: this takes place at the facility when a patient does not get immediate treatment upon arrival (76, 77). The Human Rights Watch (HRW) (2011) report indicates that the majority of women in South Africa, including cross-border migrants, face delays after being admitted to public health care facilities (47).

Research examining the decision-making process for individuals around health behaviour has focused on examining the factors that contribute to their final decision, the thought process of individuals exhibiting this behaviour, and predicting health behaviours (78). The HBM has been the most widely applied to explore a range of health behaviour decisions, as the outcome of weighing perceived risks including vaccination practices and contraception practice, sexual risk behaviours and prevention of HIV (PMTCT) (79). It describes why individuals fail to exercise proposed desired health behaviour, and clarifies how behavioural determinants affect the ways people behave around problems affecting their well-being (79). The Model describes that the possibility that an individual will exhibit a certain undesired health behaviour is linked to one's belief (value) about the seriousness or severity of the potential illness (79). It combines psychological theories of goal-setting, decision-making and social learning, and hypothesises that health-practising or -seeking behaviour is motivated by an individual's insight of a threat presented by a sickness, and the belief linked with behaviours aimed at decreasing the threat (79). HBM is based on three assumptions (79). It

presumes that an individual will undertake a health-related action, for example, accessing or using ANC services timeously when that individual:

- feels that a bad health state can be prevented, i.e., HIV transmission to her baby can be prevented;
- has an optimistic anticipation that undertaking a proposed action will prevent a bad health condition; i.e., accessing or using ANC services timeously for a specific health benefit i.e PMTCT; and
- is confident that she can certainly undertake a proposed health action (i.e. an HIV positive diagnosed mother can take ARV prophylaxis with confidence to avoid HIV infection to her baby and have healthy children (79).

HBM is conveyed through several constructs signifying the perceived threat and net benefits. These include perceived susceptibility, perceived severity, perceived benefits and perceived barriers, cues to action and self-efficacy (79, 80).

1.3.7. Rights relating to healthcare and the International Human Rights Framework

The 2011 Human Rights Watch (HRW) report indicates that South Africa ratified and signed the international treaties which require it to satisfy the rights to optimal health on a non-discriminatory basis (47). Several treaties and authoritative clarifications note that decreasing maternal mortality rate and bettering maternal health services should be regarded as rights to health priorities (47). According to the UN Committee on Economic, Social and Cultural Rights (CESCR), asylum seekers and undocumented migrants must have similar rights to health as citizens (47). The International Convention on the Protection of the Rights of All Migrants Workers and Members of Their Families (Art 28) specifies that "all migrants and their families have the right to emergency medical care for the preservation of their life or the avoidance of irreparable harm to their health" (75,p.18). The convention further protects migrants irrespective of any irregularity in their stay or employment (75, 81).

1.3.8. Documentation status

Studies show that documentation status plays a significant part in shaping the patterns of the use of health services (74, 82). Several studies in both developed and developing countries indicate that undocumented migrant women are likely to face challenges in accessing or using health services. As a result, their children are less likely to receive immunisations compared to documented migrants, mainly due to the fear of being asked for official documentation and thus deportation (74, 82, 83). Confirming Kiros' findings in his 2004 study in Ethiopia, Smith-Greenaway and Madhavan, in their 2010 study in Benin, revealed that migrant mothers have lower immunisation rates due to the disruptive nature of the migration process, which interferes with women and their children's health-seeking behaviour (83). Studies done in the USA, Thailand and South Africa indicate that although migrants are eligible for health-care irrespective of their legal status, undocumented migrants still face challenges in accessing health services (74, 82, 84). According to a 2010 paper by Duponchel et al., in South Africa there are multiple reasons for being undocumented, including a restrictive Immigration Act, and corrupt police officers and dysfunctional Department of Home Affairs officials (85). Previous research by Campbell (2014) and Canavati (2011) also shows that undocumented migrants are often uninformed of their health rights and frequently fear that professionals will report them to authorities, eventually resulting in deportation (74, 82). In a 2011 paper by Vearey it is also argued that some healthcare facilities create their own guidelines that go against the national legislation (72). An example is when health care staff request South African identification and refuse access to migrants who do not have this (72). Thus undocumented migrant status hinders access to health services among the undocumented (hidden) population (86).

1.4. Problem statement

Globally, access to maternal and child health care remains a fundamental human right, regardless of an individual's residence status (1, 63, 87). South Africa is a signatory to a range of international commitments; for example, the United Nations Sustainable

Development Goals (SDGs), which strive to address universal health including maternal and child health (88, 89). Furthermore, the South African Constitution gives the right to free basic health care in all public healthcare facilities to those living in the country, regardless of legal status or documentation, and the National Department of Health (DOH) has issued directives to reinforce this general right of access.

Nonetheless, in South Africa, the maternal and child health outcomes continue to be poor, including those of migrants (1, 63, 89-91). In 1999 and 2005 studies conducted by Crush and Williams and Crush et al., respectively indicate that South Africa has been a host country for migrants for many decades (92, 93). The majority of these migrants, including women of reproductive age and children, are from the Southern African region (31). Existing evidence indicates that non-nationals face challenges in accessing health care in public healthcare facilities for several reasons, including lacking documentation required to be in the country legally (9, 25, 63, 93-95). Hence it is likely that, despite an enabling legislative environment and that the South African constitution guarantees the right to access to health for all (meaning that regardless of nationality or residence status, no-one may be denied emergency medical treatment), cross-border migrants, including women of reproductive age, face challenges in accessing public health services (1). The process is hampered by insecurity resulting in many being treated unfairly when seeking health care and also fear of being questioned for legitimate documents and deportation hence exposing a large gap between policy directive and application on the ground (1, 4, 63, 96).

Some studies, both in developed and developing countries, indicate that undocumented migrant women do not access or use health services; as a result, fewer children of undocumented migrants receive immunisations compared to documented migrants because of the fear of being asked for official documentation and deportation (74, 82, 83). In their 2010 study in Benin, Smith-Greenaway and Madhavan revealed that undocumented migrant mothers have lower immunisation rates than documented migrant mothers due to the

disruptive nature of the migration process, which interferes with women and their children's health-seeking behaviour (83).

1.5. Justification of the study

A growing proportion of migrant women internationally have cited obstacles in access to and utilisation of health care services, including maternal and child health, ANC, and immunisation services (5, 32). The little evidence on these issues in South Africa suggests that deeper knowledge is needed. Despite comprehensive evidence on how to avert maternal and infant mortality (63, 81), there remains a high prevalence of this in many countries – mainly in developing countries (47). Evidence indicates that annually more than 580,000 women of childbearing age die from pregnancy- and childbirth-related problems worldwide (97). The majority of these avoidable deaths occur in sub-Saharan Africa, where poverty and other socio-economic factors impact the accessibility of maternal health services (37, 98). In South Africa, for example, statistics indicate that the maternal mortality rate has been reduced from 189,5 per 100 000 births in 2009 to 132,9 per 100 000 in 2012/13 (99). However, the country failed to achieve the MDGs 3 and 5 target of reducing the maternal and child mortality ratio before 2015 (99). The MGD 3 has now been replaced by the SDG goal 3 that aims to guarantee healthy lives and encourages well-being for all people at all ages (88, 100, 101). The SDG report indicates that Goal 3 on health is linked to other goals as either a contribution or an outcome of activity in other goals. Goals 9 ,10 and 16 refer to the "need for resilient hospitals/health facilities, health improvement, and the promotion of peaceful and inclusive society and institutions" respectively (100, 102, p . 25-29) Examples of other goals with a clear link to health are:

> "Goals 1- 1.4: targets to ensure that all…, women, the underprivileged and the vulnerable, have equal rights to resources, as well as access to basic services…; Goal 5- 5.1: it targets to end all forms of discrimination against all women and girls everywhere; 5.2: eliminate all forms of violence against all women in public and private spheres…and to ensure universal access to reproductive health and

reproductive rights; and Goal 16- 16.9: which targets to provide legal identity for all; and 16.10.b: to promote and enforce non-discriminatory laws and policies" (102, p . 23-29).

This is worrying in South Africa for the reason that all pregnant, lactating women and children under the age of six are mandated to have free access to healthcare (1).

Furthermore, immunisation at birth and during the first year is a priority mediation to safeguard infants/children against vaccine-preventable diseases, and to help prevent the spread of communicable diseases within South Africa and other regions (58, 103). Statistics from 2012 indicate that the national full immunisation coverage rate for children under the age of 1 was 94%, which exceeded the planned target of 90%. The measles second dose coverage at 18 months was 82.7%, slightly below the target of 90% (104). However, it is not clear whether immunisation rates among migrant populations are at these levels. Literature indicates that an intensive multi-sectorial effort is required to improve and scale up services of immunisation country-wide and reduce maternal mortality (104).

Thus, it is imperative to explore the perceptions and experiences of migrant women, both documented and undocumented, to understand better the challenges they face, and to share information about their accessing and using routine antenatal and infant/child immunisation health care services at public health facilities in South Africa. In so doing, this study will offer insights into what works and what does not work for an often overlooked and under-prioritised population. There are gaps in comprehending how the consequences of poor access to health care and other risks faced by undocumented migrants may affect their attitude towards accessing ANC and immunisation health care services. Even though several studies conducted in developed countries continue to show that migration and mobility are dominant determinants of health and key concerns for public health programming, research on migration and health is insufficient in the Southern African Development Community (SADC) region (63, 105). There has been little focus on the experiences and perceptions of Zimbabwean migrant women, in particular, regarding

antenatal care and immunisation services in South Africa's public health facilities, something that this study seeks to address. Available data indicate that migrants residing in South Africa still face difficulties in accessing and utilising antenatal and infant/child immunisation health services (4, 81, 106).

In a similar study by Makandwa (2014), the researcher concluded that more empirical evidence is still needed in order to have a well-informed understanding of the numerous challenges that Zimbabwean migrant mothers encounter in South Africa's public health facilities (63). The motivation for this research stems partly from this observation. This research will, therefore, contribute to the existing literature on maternal health care experiences among migrant women in South Africa. It will also help inform health system responses and the development of improved migration and health programmes.

1.6. Research Question

The following is the study's research question:

What do Zimbabwean cross-border migrant women, documented and undocumented, experience in accessing routine antenatal care and infant/child immunisation in public healthcare facilities in Johannesburg, South Africa?

1.7. Study Aim and Objectives

This study aimed to explore and compare the experiences and perceptions of documented and undocumented Zimbabwean cross-border migrant mothers with children under the age of two on access to routine antenatal care and infant/child immunisation in public healthcare facilities in the Johannesburg inner city and Tembisa informal settlement, Gauteng, South Africa (2015-2016).

The following specific objectives were formulated:

1. To explore the experiences of accessing routine antenatal care and infant/child immunisation by documented and undocumented cross-border Zimbabwean migrant mothers with children under the age of two in the public healthcare facilities in Tembisa informal settlement and the Johannesburg inner-city in 2015-2016.

2. To explore perceptions of barriers to and facilitators of accessing routine antenatal care and infant/child immunisation of documented and undocumented cross-border Zimbabwean migrant mothers of children under the age of two in the public healthcare sectors in Tembisa informal settlement and the Johannesburg inner-city in 2015-2016.
3. To compare, by their documentation status, the experiences and perceptions of documented and undocumented cross-border Zimbabwean migrant mothers of children under the age of two and pregnant women on access to and use of routine antenatal care services and infant/child immunisation in the public healthcare sectors in Tembisa informal settlement and the Johannesburg inner-city in 2015-2016.

CHAPTER TWO: RESEARCH METHODOLOGY

2.1. Introduction

This chapter clarifies the research process and the steps followed throughout the study. It discusses methods used for data gathering and analysis, the study area, the participants involved, and ethical considerations.

2.2. Study Design

This study adopted a qualitative research approach, which is an extensive approach in social sciences grounded upon the need to comprehend human and social interaction from the viewpoints of participants in the interaction. Qualitative techniques enable the researcher to be engaged in the research process, and are particularly good at addressing the 'why', 'how' and 'what' questions (77). This approach was, therefore, appropriate and specifically chosen for this study, because it allowed the researcher to capture and explore in-depth the experiences and perspectives of Zimbabwean migrant women accessing antenatal and infant/child immunisation in public health services in Gauteng, South Africa. According to a 2011 paper by Polkinghorne, qualitative study is aimed at studying the experiential life of people (107). Its main drive is to explain and simplify experiences of people in the natural world, acquiring the sense of what individuals make of their surroundings, and how their sense motivates their behaviour, exploring people in social interaction and in context and reporting the results of research in the everyday language of the participant (107-110). Thus a qualitative methodology gave the researcher the opportunity to gain a detailed understanding of cross-border mothers' personal experiences and views on accessing and using routine antenatal care services and infant/child immunisation in public health care sectors.

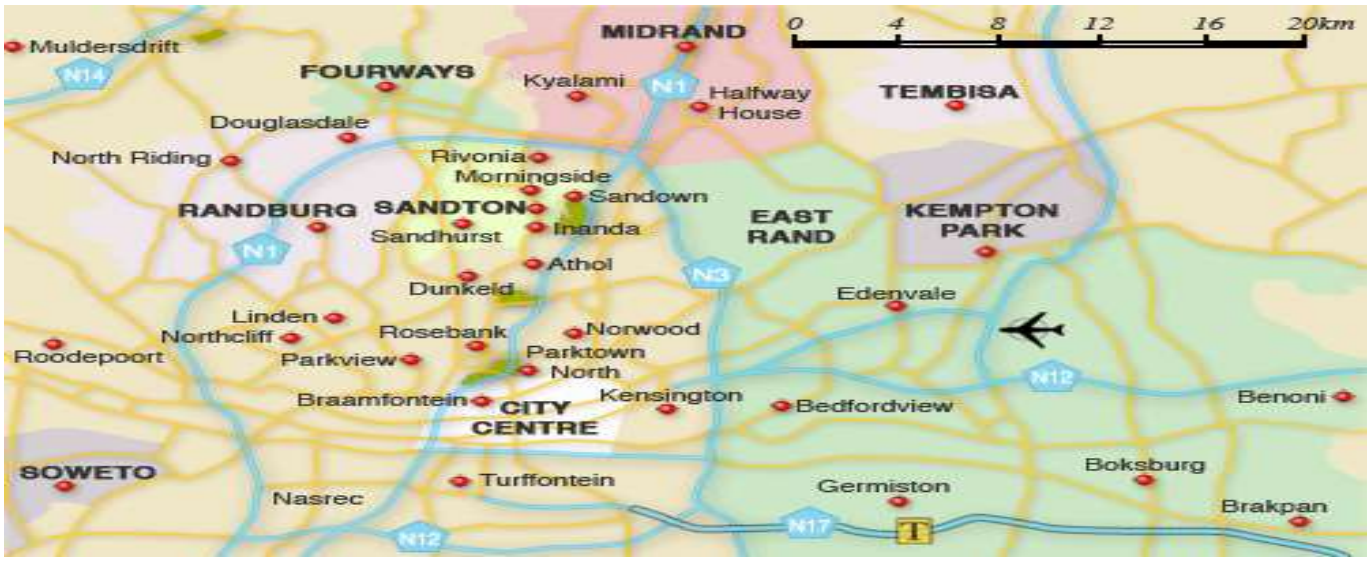
2.3. Study Site

The study was conducted in two sub-districts in Gauteng, namely: the inner-city Johannesburg suburbs of Hillbrow and Braamfontein, and Tembisa informal settlement in

Ekurhuleni North (refer to figure 1 below). Johannesburg is South Africa's largest city, located in the country's most populated province, Gauteng (25). Census 2011 results indicated that the percentage of the provincial population born of non-South African citizens is highest in Gauteng, at 7.1% (111, 112). In addition, Census 2011 revealed that nearly half of southern African migrants had migrated to Gauteng from Zimbabwe, 22% from Mozambique and 13% from Malawi, with all SADC countries represented in the population of the province (112). Individuals who are non-South Africans and are living in South Africa are called cross-border migrants (10, 112).

This study centred on migrant women's perception and experiences of access to health care in public health facilities for a particular population group (documented and undocumented Zimbabwean migrant women). The Johannesburg inner-city and Tembisa informal settlements were deemed suitable for the research to be conducted in, as research shows that the migrant population's movements in Gauteng are usually directed to and concentrated in the inner-city urban areas and also the informal settlements (25). Johannesburg's inner-city suburbs, especially Hillbrow, are densely populated with a migrant population from all over Africa; hence it was easy to identify participants (25). Although internal migrant flows among the poor and unskilled are argued to be concentrated in the informal settlements, of late the cross-border unskilled and poor migrant population have been similarly flowing into informal settlements, where life is perceived to be cheaper in terms of rentals (25, 113).

Figure 1: **Map of Johannesburg inner-city, and Tembisa, South Africa**



Source: http://www.roomsforafrica.com/dest/south-africa/gauteng/johannesburg.jsp?tab=3 *(114)*

2.4. Study Population

The study population comprised cross-border documented and undocumented Zimbabwean migrant mothers aged 18 years and older, with children under the age of two, who had been living in South Africa for the past two years. The participants were individuals who had delivered their babies, and/or accessed routine antenatal care and immunisation services in the Johannesburg inner city and Tembisa's public health care facilities. The women would be accessing postnatal/immunisation services, and since they would still be attending the relevant facilities, recall bias would be catered for, as they would be in a position to remember events that they experienced during ANC services and might still be experiencing with postnatal and immunisation services. For these reasons, the targeted population was found fitting for this study.

2.5. Sampling Strategy

Sampling is the process used to select a portion of the population for study (115). In selecting the participants for this study, the researcher applied two sampling techniques, namely purposive sampling and snowballing. According to Babbie, purposive sampling is

defined as a type of non-probability sampling in which participants are selected based on the researcher's judgment about which participants will be the most useful representatives (116). Through purposive sampling, the researcher selected participants who were relevant to the aims of the study and knowledgeable about the situation or experiences that were being explored. The sampling technique allowed the researcher to get necessary information from necessary people (115). Purposive sampling and snowballing are recommended to be used in the cases of pilot studies and studies of hidden populations (undocumented), allowing the researcher to target the intended group of participants and giving room to exploit networks among them (117).

The researcher utilised snowball sampling, whereby the initial sample was small and increased based on links to the initial participants. The researcher utilised her private and social networks with Zimbabwean social groups and families to find the first five participants. Eight participants were then snowball-sampled through referrals by the purposively selected participants. The researcher participated in some social gatherings, primarily church services, and also made the most of personal relationships that she had created with Zimbabweans who were applying for Zimbabwean Special Dispensation Permit Visas (ZSP) at the Department of Home Affairs. The goal of the ZSP was to establish a record of Zimbabwean migrants who had been residing illegally and using fraudulent South African identity documents in South Africa (26, 118). Schutt in his 2012 paper, highlights that snowballing is excellent for cases in which the participants are relatively unknown to the researcher (119), and this was an appropriate technique as it helped in securing relevant participants for this study.

2.6. Data Collection

Primary data was gathered from November 2015 to January 2016 through in-depth semi-structured face-to-face interviews. De Vos et al., observed that interviewing is a popular method of data collection in qualitative research, whereby there is a direct interchange with individuals considered to possess the required knowledge (82). Semi-structured interviews

were chosen for this study because they have more flexibility to both the researcher and the participant, allowing the researcher to incorporate more open-ended questions, to probe, seek clarity and allow the participants to openly share their views (82).

An interview guide was used during the interviews that assisted the researcher in resolving some of the common shortcomings of unstructured interviews, such as becoming diverted from the interview (120). The interview guide had themes to which the researcher constantly referred during the interviews. The main topics included personal history; key questions on use of public healthcare facilities; and experiences of antenatal care visits, delivery and infant/child immunisation services.

The interview guide was piloted once in Midrand, an area in Gauteng, with two cross-border Zimbabwean migrant women. The pilot provided the opportunity to refine the data collection instrument and for the researcher to get comfortable with the interview process. The pilot study also gave insight to the researcher that the interview schedule should not be too structured, but instead needed to give room to the women to tell their own story without emphasising specific factors.

The researcher completed interviews with thirteen Zimbabwean Shona-speaking migrant women, as this was the point of saturation when responses became repetitive or predictable. Interviews were carried out at the participants' places of residence, workplace or at churches. The interviews lasted between 30 minutes and 1 hour. All the study interviews were conducted in English, with the participants' consent. The researcher also made field notes and observations during all the interviews regarding where participants placed emphasis whilst expressing certain issues. The observation method is argued to provide the researcher with ways to check for non-verbal expression of feeling and incidents that respondents may be sensitive to, and therefore unwilling to share (121). The audiotaped data was transcribed verbatim in English for detailed analysis.

2.7. Data analysis

This study adopted Creswell's 'step-wise format' for qualitative data analysis (122). Data in this research study were first organised into a series of experiences and the participants' documentation status, and then analysed using manual coding. Initial data analysis was done concurrently with data collection to identify potential themes to explore. Data were analysed qualitatively using themes and sub-themes. Emerging themes were drawn from both the field notes and audiotaped interviews. Major themes were picked from both the interview transcripts and the field notes, sub-themes were then identified and lastly, some representative quotations were selected per category. The major themes and sub-themes were related to the research objectives. The themes that were frequently repeated in responses during the interview sessions were explored within the context and objectives of the research, as well as within the discourse on migration and health.

2.8. Ethical Considerations

Ethical clearance for this study was requested and issued by the University of the Witwatersrand Medical Human Research Ethical Committee (MHREC); Clearance number (M150908) (Appendix 6). The researcher was mindful of several ethical issues.

In this study, the researcher explained all the aspects, processes and procedures of the study to participants so that they were fully informed before giving consent. This was done as part of the obligation to protect participants from both physical and emotional harm. The researcher made sure that participation in this study was voluntary for all participants. To enable this process, the researcher requested every participant to sign the informed consent form. The participants were informed about their right to withdraw at any point of the process without any negative consequences. Participants were also informed about their right to not respond to questions that they were uncomfortable with. In all the interviews, both consent forms for the verbal interview (Appendix 1) and audio recording of the interview (Appendix 2) were signed to guarantee secured informed consent acceptance by the participants.

Arrangements had been made to help participants by means of free counselling with a qualified counsellor in case of emotional distress emanating from the study. The participants were given a contact list of organisations that offer psychological counselling and the researcher's contact details. However, none of the participants contacted the researcher for follow-up support or referral. At the end of each interview, the researcher gave participants a few minutes to express their feelings and ask any further questions about the interview and study in general, as part of debriefing.

Participants were further informed that recorded and transcribed material and information would be kept in a locked cabinet for two years following any publication, of the study, or for six years if no publication emanates from it.

Adherence to privacy, anonymity and confidentiality entail guarding the participants' interests, identity and well-being, especially if disclosing them would prejudice or injure them (123). Anonymity was guaranteed by ensuring that neither the researcher nor the readers of the research findings could identify a given response with a given participant (116). Confidentiality, on the other hand, entails handling information in a confidential manner. The researcher explained to participants that their identities would be protected during the data analysis and reporting process, using pseudonyms.

5.9. Study Limitations

Although the study reached its aims, there were some limitations worth-mentioning. The study sample was relatively small hence the experiences and perceptions of the participants might not represent those of all Zimbabwean women and other foreign women in Gauteng and other provinces of the country. Also, the study did not make a comparison with South African women accessing the same health care services in public facilities. Although this was beyond the scope of this study, the experiences and perceptions of South African women regarding the issue under study might be different from those of foreign nationals. Finally, since the researcher is also from Zimbabwe, this might have made the participants manipulate the information and say it in a particular way in order to please the researcher.

However, the researcher probed more in the interviews in order to identify discrepancies within the information shared.

CHAPTER THREE: RESULTS

3.1. Introduction

This chapter presents the results of the study. The presentation of the participants' personal history will be outlined first in Table 3, and then the introduction of the main themes that arose in the interview session follows in Table 4. This section focuses on the themes and subthemes that emerged during data analysis, as presented in Table 4, below. The discussion of these themes and subthemes is supported by direct quotes from the participants. The themes and sub-themes will be organised and presented by the phases from antenatal care to infant/child immunisation, namely access to ANC services (phase 1); delivery in public health facilities (phase 2); and immunisation and child health (phase 3). Some of the sub-themes cut across the different phases, and they are presented as such.

3.2. Socio-Demographic characteristics of participants

All the participants in this study were Zimbabwean Shona-speaking cross-border migrant women residing in Johannesburg's inner-city and Tembisa informal settlement, Gauteng province, South Africa as summarised in Table 3 below. The researcher assigned pseudonyms to protect the identity of participants. The age range of the participants was 23-39 years old. Of the 13 participants, nine were living with the fathers of their children and four were single parents. The participants' educational level range was Ordinary level (i.e. grade 10 in SA), Advanced level (i.e. matric in SA) or Tertiary education. The majority of the participants resided in Hillbrow. The duration of residence in South Africa ranged from four to fifteen years. All the participants interviewed confirmed that they had had at least one child born in public health facilities in South Africa, and had visited a public health facility several times in order to access ANC and immunisation services. There were both documented and undocumented participants. Most of the undocumented participants had passports but no permits allowing them to reside in the country, whilst the documented had work permits and asylum-seeker documents.

Table 3. Participants overview

Participant's name (pseudonym)	Age and marital status	Educational Area	Residential Area (Johannesburg inner-city (CBD) and Tembisa)	Duration of living in South Africa (SA), Gauteng	Number of children born in SA public hospitals	Citizenship status	
Janet	33 (married)	Advanced level	Braamfontein	7 yrs	2	Temporary residence permit	Documented
Regi	38 (married)	Tertiary level	Hillbrow	8 yrs	1	Work permit	
Kwago	27	Tertiary level	Braamfontein	6 yrs Moved facilities after delivery	1	Work permit	
Gugu	32 Single and never married	Ordinary level	Hillbrow	12 yrs	2	Work permit	
Marth	30 Single and never married	Ordinary level	Hillbrow	5yrs	1	Work permit	
Pretty	30 Not married but lives with her partner	Ordinary level	Hillbrow	7yrs	3	Work permit	
Joyce	38 Married	Ordinary level	Hillbrow	13yrs	3	Asylum seeker permit	Documented with Asylum- seeker permit
Ano	33 Married	Ordinary level	Hillbrow	15yrs	2	Asylum-seeker permit	
Lee	29 Married	Ordinary level	Hillbrow	6yrs	2	Passport without a permit	Documented but without permit to reside in SA (Undocumented)
Bee	29 Single and never married	Ordinary level	Hillbrow	5 yrs Moved facilities after delivery	1	Passport without a permit	
Memo	30 Married	Ordinary level	Hillbrow	7yrs	1	Passport without a permit	
Helen	29 Married	Ordinary level	Hillbrow	8yrs	2	Passport without a permit	
Musa	23 Married	Ordinary level	Tembisa	4yrs	1	Passport without a permit	

Table 4. Themes and sub-themes from the interviews

Phases of ANC Care and child immunisation	Main Themes	Sub-themes
1. Access to ANC Services	1. Motivation/Decision about booking	1 A. The need to have a history/record for ANC check-ups in order to get a bed in a labour ward 1 B. Concerns over personal health and health of the baby
	2. Late initiation of ANC	2 A. Work commitments 2 B. Hesitance and fear about which healthcare facility to access 2 C. Language barrier 2 D. Long waiting time at the clinic 2 E. Initially attending at a private GP and gynaecologist 2 F. Attitude/Procrastination
	3. In-facility experiences	3 A. Discrimination and poor nurse-patient relationships and verbal abuse 3 B. Good treatment by healthcare workers
	4. Perception of value of ANC	4 A and B. Positive quality of care and information gaining 4 B. PTMCT
2. Delivery in public health facilities	1. Experiences	1 A. Delay in attending to admitted patients 1 B. Verbal abuse and poor communication by nurses 1 C. Discrimination by some staff professionals 1 D. Language barrier 1 E. Strict requirement of valid documentation to access delivery services 1 F. Negative quality of care 1 G. Good treatment by healthcare workers
3. Immunisation and Child Health	1. Motivation to immunise	1 A. Knowledge of diseases prevented through immunisation 1 B. Knowledge of immunisation schedule 1 C. Positive attitude and perceptions of immunisation 1 D. Perceived benefits of immunisation to other children
	2. Experiences of immunisation services	2 A. Difficulties in immunising child due to non-documentation of child and parents 2 B. Language barrier 2 C. Poor nurse-patient relationships 2 D. Good treatment by healthcare workers

3.2.1. Phase 1. Access to ANC services

Theme 1: Motivation/Decision about booking

The participants indicated that they were motivated by a variety of factors to decide about registering their pregnancy for the first time or for ANC initiation. These factors include the need to have a history/ record for ANC check-ups in order to get a bed in the labour ward. Participants were also driven by concerns over personal health, as well as the health of the unborn child.

Sub-theme 1 A: The need to have a history/record for ANC check-ups in order to get a bed in labour ward

Several participants attributed the need to have a record for ANC check-ups as one of their motivations for visiting the hospital. This record or card would help them secure a bed in a labour ward. Below is what one of the participants said to support the above theme:

"…you have to have an ANC card to deliver at a hospital, so when I went for check-ups, I just wanted a record that I went for check-ups, otherwise I wouldn't go there…" (Pretty, documented migrant mother).

Sub-theme: 1 B. Concerns over personal health and health of the baby

The majority of the participants highlighted that they initiate ANC services in order to ascertain whether their personal health, as well as that of their unborn child, was good. One woman said:

"ANC is important to monitor to see if the mother is having a healthy pregnancy, to detect any abnormalities, any challenges or to prevent the maternal and infant death even …" (Lee, undocumented migrant mother).

Theme 2: Late initiation of ANC

Several participants attributed late initiation of ANC to several factors, among them work commitments; hesitance and fear; language barrier; long waiting time at the clinic; initially attending at a private GP and gynaecologist and personal attitude. These factors will be developed further next as sub-themes.

Sub-theme 2 A. Work commitments

Some participants pointed out that they could not attend ANC at an early stage due to work commitments. The participants put it as follows:

"I register my pregnancy in my first trimester I think, I think I was 16 weeks. The reason why it was so late was that I didn't have time because of work commitments…" (Kwago, documented migrant mother).

Another said:

"…I went there when I was 7 months. I was working, so I didn't have time to go to the clinic. It was because of work, so it wasn't my will not to go there…" (Ano, asylum-seeker migrant mother).

Sub-theme 2 B. Hesitance and fear about which healthcare facility to access

Hesitance and fear around the quality of care and migrant status were some of the factors that participants indicated as contributing to the late initiation of ANC. Participants said that they had to put several issues into consideration before choosing a health care centre to go to, based on information from their networks who had had bad/good experiences in using public health facilities:

"I register at 6 months. I was just thinking of which hospital to use for me to give birth to my child because some of the hospitals, people say they are not safe to give birth at… had experienced difficulties in giving birth. So it was out of fear that I registered at a late stage." (Pretty, documented migrant mother).

Another one said:

"… *I register at five-month; …because you are not in your country, you feel like I don't have papers or I don't have something so you are scared, maybe you are asking yourself if they ask me about papers, what will I tell them, …, but for me I was scared to go. I was thinking if I go they will say go back to your country."* (Bee, undocumented migrant mother).

Sub-theme 2 C. Language barrier

The majority of participants felt that language was also a major barrier leading to their late initiation of ANC. One participant had this to say in this regard:

"…I went to register at 26 weeks, which is about 6 months… due to the language barrier, with the nurses who will be giving you service…" (Janet, documented migrant mother).

Sub-theme 2 D. Long waiting time at the clinic

In addition to the issues highlighted above, participants complained about the long waiting time before being served at clinics. Participants reported that overly long waiting times often led to late initiation of ANC and scepticism among many expectant mothers. This can be captured in the following voices from some of the participants:

"…at times you wait for a long time to get help…it's time-consuming, so that's what delayed me to go to register for my second baby … just imagine you get to the clinic at 6:30 and the first person will be attended at 9:00, that's a long time to wait …" (Janet, documented migrant mother).

Another one said:

"… the clinics are always flooded, there are long lines and, I didn't think I was really up to queuing and registering and coming for monthly checks as early as possible, so I made a precious decision that I will go around 5 months…" (Lee, undocumented migrant mother).

Sub-theme 2 E. Initially attending at a private GP and gynaecologist

A few participants highlighted that they attended private clinics before shifting to public health institutions, leading to the late registration at the public clinics. One of the participants said:

"Before I went to a public clinic I first went to… a private clinic, that was when I discovered that my medical aid could not cover the delivery expenses, so my gyno advised me that I could only go to him for check-ups but for delivery, I should go to a public institution, that's the reason why I registered late." (Regi, documented migrant mother).

Sub-theme 2 F. Attitude/Procrastination

Some participants attributed their personal attitude in late initiation of ANC. They noted that they kept on postponing. These are some of the participants' responses regarding the issue:

"It was 16 weeks. I was just lazy to go so would just tell myself that I will go, I will go." (Helen, undocumented migrant mother).

"It's because the experience which I got there the first time, the information that I was given, it wasn't very important, I felt like I shouldn't have gone there because like some of the things I knew already because I am a mother of three already, so that information that they were giving me I already knew, so I was expecting to learn more from them." (Pretty, documented migrant mother).

Theme 3: In-facility experiences

Another important theme which emerged during data analysis, in the access of ANC services phase, pertains to experiences by participants when they entered the health facilities. Some of the factors mentioned to by the participants include being sent away by healthcare staff; poor nurse-patient relationships; verbal abuse; and good treatment by health care workers. The following sub-themes explain these factors.

Sub-theme 3 A. Poor nurse-patient relationships and Verbal abuse

A number of participants complained about the poor relationship between nurses and patients in some public health facilities, which they blamed mainly on the nurses' attitude. They also stated that they suffered verbal abuse at the hands of some health care staff, mainly because of being a migrant. This can be supported by the following response from one participant:

"During check-up Like the nurses would say we are tired of these people, why can't they go back to their country, they come here and give birth, lots of them who are coming here to give birth, they must go back… they must go back to their country, we are tired." (Gugu, documented migrant mother).

Sub-theme 3 B. Good treatment by healthcare workers

On the other hand, some participants reported that they had had a positive experience with healthcare workers who treated them with dignity and respect. Some of the participants had this to say:

*"…but before they checked me, they spoke to me nicely, they didn't just force me or do something, if I didn't want they didn't force me, so they were no like challenges that made me unhappy…, they were just talking to me nicely to understand, if I didn't understand they will ask if I understood, yes or no, then I will ask if I want to ask …." (*Bee, undocumented migrant mother).

"Okay honestly speaking, when I went for check-ups, the care I would get there, I would describe it as good, coz when we went there in the morning we would do exercises…" (Regi, documented migrant mother).

Theme 4. Perception of value of ANC

A key theme that emerged was the participants' perception of the value of ANC. Participants mentioned issues regarding positive quality of care; information-gaining and benefit of ANC on personal health and the health of the baby; and PMTCT. These are discussed below as sub-themes.

Sub-theme 4 A and B. Positive quality of care and information-gaining

The majority of the participants were of the view that ANC services are important in improving pregnant women's healthy behaviours, gaining information about dangerous signs, quality of care during both pregnancy and post-natal periods, improving their home care of babies and self, and the demand for child preventative services. This includes supplements, information about stages of pregnancy, self-care and physical checks. Below are some of the responses from the participants:

"They are important like if you are a first-time mother everything is new to you,… cause some of the things that will be happening you won't be knowing, should this happen, is this

normal that this is happening. So if you are given such kind of lessons, or if you are given such kind of literature to read at home, it would help in a scenario whereby like your other issues that are happening, whereby you will have to go to the hospital, not just go to the clinic …" (Janet, documented migrant mother).

"*They are very important that we can learn how to take care of the pregnancy, and after pregnancy how to take care of your child."* (Joyce, asylum-seeker migrant mother).

Sub-theme 4 B. PMTCT

ANC services were also positively received by the majority of the participants in terms of PMTCT. As one of the women expressed it thus:

"ANC is important to monitor if the mother is having a healthy pregnancy, you have to know your status…especially like on the HIV and AIDS cross infection, like these days they give treatment to the pregnant mother and so that the baby is born healthy. They are important in that way just to monitor." (Lee, undocumented migrant mother).

3.2.2. Phase 2. Delivery in public health facilities

The second phase involves the participants' experiences and perceptions of delivery in public health facilities.

Theme 1. Experiences

Just as in the access to ANC services phase, participants also pointed out that they had different experiences in different public hospitals during delivery. Whilst some of the experiences were positive, the majority of the participants noted that they had unfavourable experiences. These are explained below as sub-themes.

Sub-theme 1 A. Delay in attending to admitted patients

Some of the participants complained about delays by health care staff to attend to admitted patients. Others noted that they had heard negative stories about delivering in public hospitals; they were therefore unwilling to spend a long time waiting in the facility during their labour. As a result, they tried to stay at home until they reached advanced labour stages:

"I had to stay in the hospital admitted because I was overdue,…went there and I had to spend the whole day on the benches, and they were not attending to me because they said they were attending to emergencies, …. I spent the whole night sitting on the bench, it was on a Tuesday and I was admitted Wednesday evening that is when I was given a bed. So it was almost 24 hours sitting on a bench and waiting to be admitted…" (Regi, documented migrant mother).

Another woman said:

"My labour had actually started in the morning and I had spent the day at home because I didn't want those hassles especially from the stories that I had heard from people, so I had said to myself I will go when I think I am close to giving birth, so that I will just go and have my baby.'' (Lee, undocumented migrant mother).

Sub-theme 1 B. Verbal abuse and poor communication by nurses

The majority of the participants reported that the nurses "scolded" patients, mostly in attempts to remedy aspects of patients' behaviour which the nursing staff noticed as unexpected. One participant said:

" …*then after delivery, they were even joking telling me that you are not in a 5-star hotel you have to move from the theatre bed to a ward bed alone… and the moment that they even discovered that I was speaking English, they said why are you speaking in English are you a white person…"* (Regi, documented migrant mother).

Sub-theme 1 C. Discrimination by some staff professionals

Most of the participants expressed how they were discriminated against because they were foreigners. Below are some quotes to support this:

"You know, I am not crying for food, but you find that when you have given birth, you see some people they are eating porridge, they are dishing for them, you go there they ask you where do you come from, you tell them you come from Zimbabwe they say no, you guys you don't have papers, they say this is food for people of South Africa, not foreigners, you must

bring your own food, tell your own people to bring your food. Like they say we are tired of these people, why can't they go back to their country, they come here and give birth, lots of them who are coming here to give birth, they must go back, and you can see some people during labour times you find them sitting there on the floor, and they will ask them they must go back to their country, we are tired." (Gugu, documented migrant mother).

Another woman said:

"…nursing staff the way they treat us. They always complain that you guys you come all the way from Zimbabwe, you come and give birth here because here it's for mahala, … they said you people you will be pregnant there in your country and if you see that your pregnancy is due you come here in South Africa to give birth…they say it's our government that is paying for all these expenses" (Memo, undocumented migrant mother).

Sub-theme 1 D. Language barrier

Some participants narrated their experiences of abuse, poor treatment and discrimination because of a language barrier between them and the health staff:

*"There was another nurse who was older she said to me, she was speaking to me with another language and I couldn't hear her, so I tried to explain to her to say can you speak in Zulu or other languages which I can hear, then she started shouting at me saying you think you are special you can speak English, then she started shouting at me with her language, I don't know what she was saying." (*Precious, undocumented migrant mother).

Sub-theme 1 E. Strict requirement of valid documentation to access delivery services

It was clear from the participants' narratives that valid documentation was important and required in order to access delivery services. Some of the participants stated that it was difficult for them to be assisted at the health centres when they could not produce any valid documents:

"They called an ambulance for me to take me to Johannesburg, so when I got there, they said I must open a file, so when I was going to open a file I didn't have a passport with me,

but I did have a passport with permit at home, so they said they cannot help me, if I don't have…correct papers, then I told them, I have got my passport but I wasn't carrying it, so they said they will just do it but they are not going to give me the baby until I bring my passport with permit, then I said I will ask someone to bring it, so they wrote the file for me, then I went to deliver." (Gugu, documented migrant mother).

"But the problem there in Johannesburg Hospital, my asylum had expired and again my passport didn't have a working permit so they wanted R5000.00, so I thought there it is cheaper. Then when I come back home I found out that I don't have that type of money. To go to South Rand, it is R8000.00 whether it is C-section or normal birth it's R8 000.00. …other people, they were not even attended to because they wanted money, whether you are Zimbabwean or as long as you are not from here they want money, strictly money. Thus how they do it." (Memo, undocumented migrant mother)

Sub-theme 1 F. Negative quality of care

Some participants disclosed circumstances where they were disregarded when they asked questions or asked for help. Also, most of the women reported being examined on arrival but complained that no further examinations were done thereafter up until delivery, and these participants seemed dissatisfied with their clinical care. The majority of the women also described most of the healthcare providers that assisted them with deliveries as "rude" and not supportive, especially when it became clear that they were non-South African nationals, and all were generally displeased with their care. Many participants described informing the midwives when they developed the urge to push during labour and being ignored to the point of being fully dilated or having the baby's head visible, at which point they continued to push the baby out. At Hillbrow clinic, Isangweni Clinic, South Rand Hospital and Tembisa Hospital the midwives in each case neither responded to the women when they stated these feelings nor took measures to prepare for birth. The participants complained of being shouted at and left unattended until they gave birth. This is what some of the participants had to say:

"…having seen that I was not from here…one of the nurses checked me once and I went back sat down, and now the contractions …they were strong and … I wanted to push, … I went to another junior, she could not even like finish checking, I am sure when she opened she saw the head, she went out running to prepare for delivery, she was actually shouting like come to this side, come to this side, and within 2 minutes I was holding my baby." (Lee, undocumented migrant mother).

Another woman said:

"…one nurse who was on duty that time, … in the delivery room, …said to me, she was speaking to me with another language and I couldn't hear her, so I tried to explain to her to say can you speak in Zulu or other languages which I can hear as I am not from here, then she started shouting at me saying you think you are special you can speak English, then she started shouting at me with her language... And she even refused to help me and she went to help other people and she left me there. …until I pushed the baby by myself and the baby came out and the bed was like broken, so there was a lot of blood and water so I had to lift my baby with my hands …" (Precious, undocumented migrant mother).

Sub-theme 1 G. Good treatment by healthcare workers

Whilst most participants complained about the treatment they received, a few reported the good treatment they received in terms of the nurses being attentive and quick to their needs, listening to them as they asked certain things. Below is what one of the participants said:

"When I started attending at the hospital, the nurses were more attentive and would allow me to ask questions, and give me time. And the good thing about the Rahima Moosa hospital was that they would allocate us doctors. I was not only helped by a midwife, but I could also see a gyno." (Kwago, documented migrant mother).

3.2.3. Phase 3. Immunisation and child health

This phase involves immunisation of children. Just as in other phases, this phase also explores the experiences and perceptions of participants regarding immunisation services in public health facilities.

Theme 1. Motivation to immunise

The main theme that emerged under immunisation and child health was about participants' motivation to immunise their children. The following sub-themes emerged as drivers for immunisation among the participants: knowledge of diseases prevented through immunisation, knowledge of the immunisation schedule, positive attitude and perceptions of immunisation, PMTCT/PCR and the benefits of immunisation to other children. These are discussed below as sub-themes.

Sub-theme 1 A. Knowledge of diseases prevented through immunisation

Most of the participants, documented and undocumented, showed knowledge regarding diseases preventable through immunisation**.** The highest knowledge of participants on the importance of immunisation was on the prevention of diseases such as polio and measles. Below are the responses of the participants with regard to this issue:

*"Babies they need to be immunised for the measles, hepatitis, tetanus, polio," (*Janet, documented migrant mother).

*"Immunisation also is important because it prevents a baby from the five killer diseases." (*Precious, undocumented migrant mother).

Sub-theme 1 B. Knowledge of immunisation schedule

A small number of participants had knowledge of the immunisation schedule:

*"I am sure according to the baby's card, a child gets injection up to one year six months, but after that, they normally get the drops, for the vitamins," (*Janet, documented migrant mother).

"It's after 3 days, and 6 weeks, 10 weeks, 14 weeks, 6 months, 9 months, 12 months, 18 months, and 24 months" (Marth, documented migrant mother).

Sub-theme 1 C. Positive attitude and perceptions of immunisation

The attitude towards immunisation in this study was positive. The majority of participants said that child immunisation is important as it protects children from five killer diseases. Below are some of the voices from the participants:

"I think it prevents my child from getting sick, so my child will be protected like against jontis(sic) and all the other things." (Regi, documented migrant mother).

"Immunisation is important because they say if the baby doesn't get immunised she will get sick … because when they inject the baby, they are protecting the baby" (Bee, undocumented migrant mother).

Sub-theme 1 D. Perceived benefits of immunisation to other children

Some of the participants also mentioned points indicating that they were mindful of other children's health:

*"…reduces the risks of putting other children at risk of the five killer diseases" (*Kwago, documented migrant mother).

*"…reduces the chances of endangering other children around" (*Lee, undocumented migrant mother).

Theme 2. Experiences of immunisation services

Most participants were discontented with the type of services they received when they visited the health care facilities for immunisation services. Issues raised included the problem of documentation of children due to the lack of parents' documentation, language barrier and poor nurse-patient relationships. However, a few were happy with the services they received and mentioned good treatment by health care workers, and a positive understanding of delay in receiving services.

Sub-theme 2 A. Difficulties in immunising child due to non-documentation of child and parents

Some participants had difficulties immunising their children because they did not have the child's birth certificate/documentation:

"…having a challenge of whereby you don't have enough documents, or you are not enough documented as a person, as a mother without a permit, it's not easy to register your baby, I am sure we missed, but we had to follow up after that same day because the child was not getting immunised." (Janet, documented migrant mother).

"…But that thing of a birth certificate they were always asking about it and sometimes you know you will go to the clinic and go back because you don't have a birth certificate. Depending with the nurse who is there, if the nurse is like cold-hearted person you can't immunise your child, but if there is this other nurse there at the local clinic in Rosettenville, that nurse she has got a nice heart, with that nurse you can go and immunise your child…." (Memo, undocumented migrant mother)

Sub-theme 2 B. Language barrier

Some participants complained about the treatment they received from the nurses because of the language barrier. One participant responded as follows:

*"Actually there is this thing when I took my child for immunisation, if you can't speak Sepedi, and you find that those receptionists or some sisters there they speak Sepedi and they hear you speaking Sepedi they take you, take your child, even if you are Malas (foreigner) and hear you speak Sepedi, they will take that person and put her first, how can I put it, especially if you don't know how to speak Sepedi, or if they hear that you are a foreigner actually, or maybe you are from Malawi or from Zimbabwe, the treatment is not the same. Yah, especially if the person speaking Sepedi, problem" (*Gugu, documented migrant mother)

Sub-theme 2 C. Poor nurse-patient relationships

Some participants mentioned that they were not happy with the nurse-patient relationship experienced at the health centres, which made it hard for them to communicate with the healthcare providers, and many hesitated to express their feelings and concerns. Participants noted the lack of time and the opportunity to ask questions and get necessary information. One participant had this to say regarding the issue:

*"The challenge is like they wouldn't give like more health information on what they are giving our kids cause it's just getting into the room, you weigh, give an injection and don't even know what your child is being protected against, it's not all of us who can interpret on the injections on the road to health card. I was not happy, cause you don't know what is being given, even if you were, there is no way you can compare like what is on the health card and what you have been given and at times when you ask they get impatient, cause now you are wasting their time, like they can't give 5 minutes to somebody when the queue is that long, so you just get in, you get your vaccinations, and of which now I feel like sisters they are human, so what if they make a mistake. Maybe I am going for 18 months and they are giving my kid injections for 14 months how do I know because there is no communication, nothing, just weigh your child you sit there chu chu, you are given injections and you are out, next. Whenever she is giving the second or third one on the thigh, she is calling in for the next one. There is no room to ask or to do anything cause the next patient is already coming in, maybe I have a problem with my kid, maybe I want to ask something concerning their growth or something, but already the next one is already coming in." (*Lee, undocumented migrant mother).

Sub-theme 2 D. Good treatment by healthcare workers

Some of the participants were happy with the treatment they received from the health care workers. This is evidenced by the following voice from one of the participants:

"*Those areas they are really doing well with the kids. I was helped well. I didn't have any challenges."* (Precious, undocumented migrant mother)

CHAPTER FOUR: DISCUSSION

4.1. Introduction

This chapter discusses the key themes and sub-themes for each phase presented in the previous chapter. These main themes and sub-themes are blended with relevant literature where necessary. Since some of the issues raised by participants in different phases are similar, they will not be discussed separately.

4.2. Women expect health services that are 'QUICK'

It is important to begin by making a comparison between findings of this study and the ones by Small et al. (2014) of immigrant and non-immigrant women's experiences of maternity care in five countries in Europe, America and Australia. The authors summarised what women want from their maternity care with the acronym 'QUICK' (50). Women, according to these authors, want:

- Quality care that promotes well-being for mothers and their babies;
- Unrushed health care staff with enough time to give information, explanations and support;
- Involvement in decision-making about care and procedures;
- Continuity of care with health care staff who understand women's individual needs and thus communicate effectively and;
- Kindness and respect.

Thus pregnant women's perceptions and constructions of 'friendly' and 'unfriendly' health care staff or service providers were based on the availability or lack of one or more of these factors. Women, whether migrant or non-migrant, want maternity care which is comfortable, supportive and non-discriminatory (50).

4.3. Phase 1: Access to ANC services

The findings show that the participants' decision to initiate ANC services was influenced largely by the need to have an ANC card or record. This is in line with South Africa's

National Department of Health Protocol on Antenatal Care (ANC) and Infant Immunisation, which makes it mandatory for “all pregnant women that present to a health care facility, public or private, to have or receive an antenatal card to be completed at each antenatal clinic visit and returned to the mother until delivery” (51, 124, p. 19). This card or record, according to the participants, was essential mainly for one to get a bed during delivery. As a result, the emphasis placed on the need to have an ANC record motivates mothers to access ANC services. This in turn, wittingly or unwittingly, promotes the United Nations Sustainable Development Goal (SDG 3) to ensure healthy lives and promote well-being for all at all ages (52). It is important, however, to note that these findings are not only specific to migrant mothers but to all pregnant women who anticipate delivering at any of the hospitals, regardless of nationality (48).

Notwithstanding the motivation to access ANC services, the majority of the participants highlighted that they initiated ANC services late. This is despite WHO’s recommendation that women should have four routine antenatal care visits and that the first visit should be before four months (55). These findings regarding late initiation of ANC are in line with the findings of Gatsinzi and Maharaj in their 2008 study about women’s experiences of maternal and child health in KwaZulu-Natal (53). These researchers indicated that almost all the women who participated in their study commenced antenatal care late. However, reasons given by participants in the said study were not exactly the same as the ones highlighted in this research.

Participants in this study attributed late ANC initiation to numerous factors, namely: work commitment, hesitance and fear, language barrier, long waiting time at the clinic, initially attending at a private GP, and an attitude of procrastination The issue of work commitment emerged as no surprise, as the majority of Zimbabwean migrants in South Africa seek to improve their livelihoods due to the socio-political and economic challenges currently prevailing in their country of birth (51, 63, 71). Also, mothers often face the dual burden of being productive and reproductive - which might also directly or indirectly impact on their

health (32, 35). Thus despite their knowledge of the importance and willingness to initiate ANC at an early or recommended stage, some participants could not do so as they had to work in order to support their families in South Africa and back home (63). These findings are not unique to migrant mothers, as South African women also have to work for their families, which might also contribute to the late initiation of ANC services as found in Gatsanzi's study (53).

A considerable number of participants were hesitant and afraid of attending public health clinics and/or hospitals because of their personal experiences and reports they had received regarding the treatment of foreigners by the public health care staff. This, in turn, contributed towards late initiation of ANC.

The reasons for late initiation of ANC given by some participants were also related to their in-facility experiences. The majority of participants attributed late initiation of ANC to the treatment that they had received in public health care facilities, which was largely unpleasant. Some of the participants' concerns included long waiting time at the clinic, poor nurse-patient relationship, language barrier and verbal abuse by the health care staff. Although a few participants understood the issue of long waiting time at clinics, the majority were of the view that health care providers were deliberately undermining and frustrating patients by keeping them in long queues before attending to them. The different views among participants, nonetheless, indicate that the issue of long waiting time is not unique to migrant patients, but to all women regardless of nationality, as found in Gatsanzi's 2008 study (53). This is so because none of the participants mentioned that they were told to wait for longer periods in the queue because they were from another country. This, therefore, supports Small et al.'s (2014) assertion that all women, whether immigrant or non-immigrant, want maternity care which is comfortable, supportive and non-discriminatory (50).

The language barrier finding in this study is also consistent with several other studies as a major challenge among many migrant patients when it comes to accessing healthcare, as they felt excluded in issues such as support and decision-making due to the language barrier

(50, 51, 63, 71, 72, 105). There is still much resentment among local health care providers regarding the use of English by black Africans, which makes it difficult for many migrant mothers to communicate with the health staff since, in most cases, there are no interpreters available (72, 105). Findings from the said studies are consistent with what participants of this study noted. The majority of the participants described the issue of a language barrier as one of the reasons for their delay in visiting public health facilities for both ANC and immunisation services.

The nurse-patient relationship was generally described as poor by most of the participants. Participants indicated that most nurses were unfriendly, impatient and impolite. Patients suffer verbal abuse and insults, among other unpleasant attitudes and behaviours. This finding is similar to other studies done on migrants in South Africa and other developed countries on migrant women's access to healthcare (4, 125). It is, however, not unique to migrant women but to all women regardless of nationality (53). The situation of migrant women is, nevertheless, worsened by the language barrier, as most immigrant mothers who were interviewed were not good at using indigenous languages for communication, and this finding is similar to other studies (4, 63).

This treatment by health care staff is in sharp contrast with both international dictates (75) as well as national health policies (1, 51). It may also be viewed as a social construct of power, whereby nurses want to show patients that they are in control (63). In this regard, some of the participants noted that they would prefer to receive maternity care from private health facilities where the treatment is generally pleasant. However, as evidenced by the narrative from some of the participants of this study, women continue visiting public health facilities since they cannot afford private care. This finding is consistent with literature, in that the South African public health service serves the majority of the country's population, including migrants and those who cannot afford medical aid (42).

Despite all the challenges cited above, most participants had positive perceptions about the values of ANC. Migrant mothers were aware of the benefits of ANC services to both the

mother and unborn child. They cited the positive quality of care, benefit to personal health and the health of the unborn child, as well as PMTCT as some of the major drivers for migrant mothers in the study to access ANC services. Interestingly, some of the participants acknowledged and valued the crucial role played by some public health care providers through information dissemination and education to migrant mothers in the study. The acknowledgement of information, education dissemination, quality of care needed by pregnant women and mothers in accessing health care services is consistent with the findings of other studies, the HBM and WHO recommendations regarding improving maternal and child health, health promotion practice and women's positive health behaviour (50, 55, 58, 80, 126).

4.4. Phase 2: Delivery in public health facilities

There were many similarities between Phases 1 and 2. Most of the information gathered and processed during data analysis and described under Phase 1 was almost identical to the information in Phase 2. This relates to issues regarding in-facility experiences by migrant women/mothers, nurse-patient relationships as well as challenges faced by migrant mothers. Just as in Phase 1, the majority of participants described their experiences during delivery as unfavourable, with delays in being attended to when admitted in the hospital and experiencing a negative quality of care. These findings are similar to other studies conducted in other developing countries (39, 77). For example, a 2011 HRW report indicated that the majority of women in South Africa (including cross-border migrants) face delays after being admitted to public health care facilities (47). The fact that there were a few participants who noted that they had received good treatment from the health care staff shows that not all public health facilities and staff members are unfriendly to migrant mothers; these findings are similar to other studies (50).

4.4.1. Documented versus undocumented migrants' experiences and perceptions of delivery in public health care facilities

Concerning the participants' perceptions about delivery in public health facilities, undocumented mothers appeared to experience more difficulties than did their documented counterparts. Participants highlighted that there was a strict requirement to produce valid documentation for one to access delivery services. Findings of this study are consistent with the majority of studies carried out in this field, with information on the challenges faced by undocumented mothers in accessing health care (50, 51, 63). Ramirez (2014), for instance, narrated how undocumented migrants were hesitant to seek health care due to a lack of personal identification and permanent address, as well as a request for full payment (51). A 2004 study by Makandwa also reported the discrimination of largely undocumented immigrants by health care staff in Johannesburg (63). In this study, participants reported the same in instances whereby some of them were requested to return home and bring valid documentation, or asked to pay for the health services. Consequently, this places undocumented migrant mothers at a greater disadvantage than documented migrant women.

It should, however, be noted that valid documents also assist public health care providers with relevant information during history taking. Consequently, health service providers might be attempting to fulfil health policy requirements. This, however, may be interpreted as infringing the right to optimal health on a non-discriminatory basis (1, 127), thus depriving some people their right to free or affordable health (1). This finding is consistent with a 2010 study by Vearey, which indicated that some healthcare facilities create their own guidelines that go against the national legislation. An example is when some health care staff request South African identification and refuse access to migrants who do not have it (72). In most instances, the undocumented migrants are caught in this dilemma.

4.5. Phase 3: Immunisation and child health

Information obtained in the ANC phases is also similar to the findings in the immunisation and child health phase. Participants revealed that they were motivated by several factors to immunise their children. They also highlighted their experiences and perceptions of immunisation services. This finding is consistent with other studies, in that knowledge about the importance of immunisation is essential as it leads to a positive attitude toward vaccine uptake (51). The majority of participant mothers were aware of the various diseases prevented through immunisation. The highest knowledge was of polio, measles and tuberculosis, unlike in other studies whereby a few mothers did not perceive immunisation as a necessary practice for their children (52). Participants of this study agreed that immunisation was necessary for preventing diseases to their children and others, thus reducing child mortality. This is similar to several studies on child vaccination as an important prevention intervention to infant death and spreading of communicable diseases (39). This, however, should not undermine migrant mothers' concerns about their negative experiences and perceptions regarding immunisation services in public health facilities.

Noteworthy is that these mothers' experiences and perceptions of the rendering of immunisation services were mostly negative. As in the ANC and delivery phases, participants mentioned numerous barriers such as language, poor nurse-patient treatment and communication, and long waiting time. However, some of these barriers might not be unique to migrant mothers, also affecting South African women who are reliant on the public health system (50) Undocumented mothers had a further challenge in immunising their children due to non-documentation of the parents. This shows that regardless of understanding the benefits of immunisation, migrant mothers still face many difficulties in accessing the services (70, 71, 72). In this regard, refusal to provide child vaccination can be a big public health challenge, not only to the migrant population, but also to the host population should there be spread of non-communicable diseases like measles (128).

It should be noted that there were a few migrant mothers who reported positively about their treatment by the health personnel. These were the same mothers who also understood the reasons behind delays and long waiting time at public health facilities.

4.6. Conclusion

All the participants interviewed confirmed that they had had at least one child born in South Africa and had visited a public health facility several times in order to access ANC and immunisation services. These findings are consistent with findings from other studies that migrant women often initiate the migration process at their reproductive age, regardless of the reason for leaving their countries of birth (35).

Most participants further mentioned that the attitudes of the healthcare providers towards them, the friendliness and the degree to which the clinic staff met their perceived needs, were important in ascertaining their judgment of their time in the clinic and its usefulness to them. Communication between healthcare providers and patients and the related question of continuity of care (or lack of it), in turn, were important in influencing these perceptions. This was shown in the participants' constructions of 'nice' healthcare workers, evident in their narratives, of people who were sensitive to their needs, treated them in a friendly manner and provided them with information (50).

Overall, the participants' voices indicate that they still experience a number of challenges in their pursuit to access health services (antenatal care and immunisation services) in public health facilities within the country. Most of these challenges were similar among the participants, regardless of their documentation status (work permit, asylum-seeker permit or undocumented). This is despite the country's 'health for all' policy, an individual's nationality or residence status.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

This chapter provides an overall conclusion as well as the study's recommendations. The aim of this study was to explore the experiences and perceptions of documented and undocumented Zimbabwean cross-border migrant women with children under the age of two on access to routine antenatal care and infant/child immunisation in public healthcare facilities in the Johannesburg inner city and Tembisa informal settlement, Gauteng, South Africa (2015-2016).

5.2. Conclusions

This study has highlighted Zimbabwean migrant mothers' experiences and perceptions on accessing ANC and immunisation services in public health care facilities in Johannesburg's inner-city and Tembisa informal settlements areas. This was done according to the different phases in maternal and child health care. It is evident that issues raised by participants were similar across the phases. Moreover, most of these issues seemed to affect the majority of the participants, regardless of documentation status. Importantly, however, undocumented migrant mothers appeared to be at a greater disadvantage due to their status. It can be argued that migration is a social determinant of health (5). More so, although some of the participants reported positively about their treatment in public health facilities, the majority were unhappy with the services they received. Interestingly, though, the majority of participants still valued the importance of visiting public health facilities for ANC and immunisation services. Many migrant mothers might attribute this to the affordability of public healthcare services. This shows that the country' health care system is still highly regarded by many, regardless of some flaws already mentioned. It can be argued that healthcare use is shaped by multi-layered aspects which are often intertwined, and may range from an individual level to broader system-level factors (129). Finally, it should be emphasised that the public health system of the country is still tarnished by several challenges, as it is viewed as 'less friendly' by migrant mothers. It is against this setting that all concerned parties,

government, health personnel, and patients themselves (among others) should invest their efforts in working towards the provision of health for all, paying particular attention to accessibility, affordability, non-discrimination and respect to all people residing in the country for the betterment of all (68).

5.4. Recommendations

In light of the findings of this study, the following recommendations are proposed for SBCC interventions, Migration programs and other relevant authorities to improve migrant women's access and use of ANC services in public health facilities.

5.4.1. Addressing challenges experienced by migrant mothers and barriers to accessing routine ANC and child immunisation services.

It is evident from the findings that migrant mothers still face many challenges in striving to access routine ANC and child immunisation services in public health facilities. The obligation to address these challenges and barriers rests largely on the relevant authorities, such as the government, through formulation, implementation and follow-up of policies that protect migrant mothers from discrimination and abuse in spite of their residence and documentation status. These policies should also stipulate appropriate measures against offenders. Some knowledge and attitudinal barriers may be easily addressed through SBCC communication strategies; however more serious systemic barriers may prove more challenging to resolve. The 'QUICK' acronym can be a guideline for policy-makers to understand what health users want and expect. It is also recommended that the Department of Home Affairs should link with DOH about the documentation of pregnant women and children under the age of six. The findings of this study can help in the design and implementation of the SBCC programs for healthcare worker, further research is desired to evaluate the actual impact of SBCC programs for healthcare worker in overcoming these barriers.

5.4.2. Education of health care providers on the rights of patients

Health care providers, especially public healthcare facility staff, need to be continuously educated and motivated to respect the rights of patients despite one's residence status, in

order to inculcate positive attitudes and quality care. This is because the majority of the participants in this study perceived the care that they receive in public health facilities as mainly unfriendly and poor. This can be done by regularly involving health care providers in relevant workshops on patients' rights, as well as debriefing sessions, or stress management courses which might aid alleviate tensions expressed towards patients seeking health services. Educating of healthcare providers ought to also comprise components that aid healthcare providers to challenge and overcome exisiting stigmas towards certain population like migrant women, as well as training on how to provide services to these populations in a manner that is sensitive to their particular needs.

5.4.3. Developing partcipants' positive perceptions and experiences

It is important to develop lessons from migrant mothers' positive experiences in accessing public health care. These positive experiences by some of the participants show that it is not all negative in South Africa's public health facilities. Since some participants indicated positive quality care, such as good treatment by some public health care staff, government and policymakers should explore and use these positive reports as guidelines for improving services in public health institutions. SBCC approaches ought to be used in programs to detect existing beliefs, cultural norms and values that may affect migrant mothers and health care provider behaviour, and evaluate the prospective to target these beliefs; in order to develop migrant mothers' positive perceptions and experiences in accessing and using ANC services in Public health facilities.

5.4.3. Conducting of further research

There is a need to conduct further research, particularly on undocumented migrant mothers' experiences, as they appear to be at a greater disadvantage than their documented counterparts. Future studies should also focus on other provinces and foreign nationals in order to draw similarities and differences in different provinces, in order to come up with a well-informed conclusion on the topic. In addition, these studies should use both qualitative

and quantitative methodologies in order to generate results that are more balanced. The findings can help as a foundation for further analysis of sources and channels of information and communication about ANC, childhood vaccination services and for interventions to improve the access to health care for migrant mothers and their children.

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Appendices

Appendix A: Plagiarism declaration





PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I **Susan Saburi** (Student number: **833593**) am a student

registered for the degree of **Masters in Public Health (SBCC)** in the academic year 2017.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

Signature: _____ Date: 15/06/2017

Appendix B: Informed consent form

Informed Consent Form

Title: Experiences and perceptions of Zimbabwean migrant women accessing antenatal, and infant/child immunisation public health services in Gauteng, South Africa.

I the researcher will read through this carefully with the participant:

I hereby confirm that the person seeking my informed consent to participate in this study has given me information to my satisfaction. She explained to me the purpose, procedures involved, risks and benefits and my rights as a participant in the study and I understand that my participation is entirely voluntary.

I have received the information leaflet for the study and have had enough time to read it on my own and ask questions. I feel that my questions regarding participation in the study have been answered to my satisfaction.

I have been told that the information I give to the study will, together with other information gathered from other people, be anonymously processed into a research report and scientific publications. I understand that my personal details will be used in aggregate form only so that I will not be personally identifiable.

I am aware that it is my right to withdraw my consent in this study without any prejudice. I hereby, freely and voluntarily give my consent to participate in the study.

Participant's name…….. (Please print)

Participant's signature……Date……

Researcher's name…….. (Please print)

Researcher's signature……..Date……

Appendix C: Informed consent form-Tape recording

Informed Consent Form -Tape-Recording

The title of research project: Experiences and perceptions of Zimbabwean migrant women accessing antenatal, and infant/child immunisation public health services in Gauteng, South Africa.

I hereby confirm that the person seeking my informed consent to participate in this study has given me information to my satisfaction. She explained to me the purpose, procedures involved, risks and benefits and my rights as a participant in the study.
I am aware that my voice will be recorded. I have been told that only the research team will hear the audio recordings. I have been told that the audio recordings will be destroyed after five years.

I am aware that it is my right to withdraw my consent in this study without any prejudice.
I hereby freely and voluntarily give my consent to be audio-taped in the study.

Participant's name……. (Please print)

Participant's signature……Date……

Researcher's name……. (Please print)

Researcher's signature……..Date……

Appendix D: Information sheet

Information Sheet for migrant women participants

Title: Experiences and perceptions of Zimbabwean migrant women accessing antenatal, and infant/child immunisation public health services in Gauteng, South Africa.

This information sheet and consent form will be translated into Shona. During the recruitment phase (November 2015 –December 2015), the researcher will identify the potential participants and will read and explain this information sheet and consent form to them individually and to answer questions they may want to raise. Those agreeing in principle to participate will be given a copy of the information sheet in their preferred language and give them enough time to reflect on its contents and their implications before being asked to sign the information consent form.

This study aims to explore and compare experiences and perceptions of documented and undocumented Zimbabwean cross-border migrants who are mothers with children under the age of two years on access to routine antenatal care and infant/child immunisation in public healthcare facilities in the Johannesburg inner city and Tembisa informal settlement, Gauteng, South Africa (2015-2017).

Introduction

Hello and thank you for coming. My name is Susan Saburi and I am an MPH student at the School of Public Health at the University of the Witwatersrand. I am carrying out a study to learn about the different experiences that migrant women have in the health services in South Africa when they go for checkups in pregnancy, when they give birth and when they take their children to be vaccinated. This includes establishing if nationality and documentation status have an impact Zimbabwean women during is critical period and how future accessing of accessing routine antenatal care and

infant/child immunisation services during pregnancy and childbirth plans and perceptions are shaped by these experiences. Thus this study will help to understand what changes may be necessary to ensure migrant women and able to claim their rights to health care and to make recommendations on how to approach migrant population. So that in the long term health for all can be improved.

Invitation to participate: I am inviting you to participate in this research study because I am Zimbabwean mother of a child under two and I am hoping to understand more of what you and others in my position experience on accessing antenatal and infant/child immunisation and child service delivery. You should only agree if they understand and is comfortable as they will be entirely voluntary.

What this study entails

 The study involves one-on-one interviews that will be conducted in a private space agreeable to you and me. In this interview, I will ask you for some basic information about yourself. I will also ask questions about your experiences and perceptions on accessing antenatal care and infant/child immunisation service use in public health care facilities.

 I will also ask you if there are other women from Zimbabwe who have been here for at least 2 years, and have had experience of pregnancy and delivery and raising young children in South Africa, who will be willing to participate in this study and help me learn more about what it is like to get health care in South Africa. I am looking to interview 12 women in total. I will include any women who are currently pregnant and who fit the description.

 If you give permission, I would like to audio record the interview so that I record what you say.

 I will use this device to record.

 The once off face to face interview will take about 60 minutes.

Risks:

This study has minimum risks but you might experience distress and trauma after talking to me about your experiences during pregnancy and delivery and child raising. If necessary after this interview I will give you contact details of a counsellor or some organisations for counselling which will help you to cope with the stress. I will not give the counsellor or organisation your name or any details about you.

Confidentiality will be upheld at all stages, with consent form being preserved by the researcher in a lockable drawer away from the other data that can be used to make a link between the consent and interview data. Audio records will be saved in a password protected computer and be destroyed five years after the publication of the study. The researcher will also act with honesty at all stages by being truthful and gathering accurate data. Participants' anonymity will be sustained and safeguarded at all stages of the study, including by using pseudonyms in the interviews. No identification information and no real names recorded will be collected as data.

A referral list of local support services, names and contact details of counsellors available to receive referrals are as follows:

Name of counsellors:

1. Ms Johanna Kistner (Clinical Psychologist), SophiaTown Community Psychological Services, 4 Lancaster Road, Westdene 2092, Tel: 011 482 8530, or 20 Derby Rd, Bertrams, Johannesburg, 2094 E-mail: **johanna@sophiatowncounselling.co.za**

2. Ms Tracy (counsellor), Family Life Centre (FAMSA), 118 Commissioner street, Johannesburg, Tel: 011 833 2057/ 011 788 4784, E-mail**:** **counseling@familylife.co.za ,**

3. Jennie Williams. Johannesburg Parent and Child Counselling Centre (JPCCC), Jennie Williams, 32 Honey Street Berea, Tel: 011 484 1734/6, E-mail: **info@jpcc.or.za**

4. Ms Priscilla (adviser/counsellor), People Opposing Women Abuse (POWA), Head Office: 64 Mitchell Street, Berea, Tel: 011 642 4345/6; 011 933 2333/2310; 011 860 2858, E-mail: priscilla@powa.co.za

5. Ms Itumelenge, POWA Tembisa, 270 Sivana Section, Tembisa Tel: 084 843 2644/ 011 924 2642/011 905 2211, Email itumeleng@powa.co.za

Benefits:

You will not benefits directly for participating in this study. However, the information gathered from this study may help us improve maternal healthcare service delivery among the migrant population and also improving the reproductive health of women and children in general.

Costs

There is no cost to you for participating in this study.

Compensation

You will be given R50 to compensate you for transport.

Participation is entirely voluntary.

 You are welcome to withdraw from this research at any time. There is no cost to you and nothing bad will happens.

 The information that will be collected is purely for academic and research purposes and to learn more about the stories of migrant women during pregnancy and childbirth in Johannesburg inner-city and Tembisa informal settlement South Africa.

Ethical Approval

Medical Ethics Committee at the University of Witwatersrand, South Africa No. M150908

Information and contact person

If you have any questions about the research you may contact:

I, the researcher can be contacted by e-mail at ruvimbomandi@gmail.com or can phone at +27768971821.

The supervisors	The supervisor	HREC (Medical)
Dr Joanna Vearey,	Janine Simon-Meyer	Prof P Cleaton Jones
Email:jovearey@gmail.com	janine@meshmedia.co.za	peter.cleaton-jones1@wits.ac.za
Phone: 27 (0). 011 717 4033	+27 82 893 0051	+27 11 717 2301

Appendix E: Data collection tool

Interview guide for the respondents

Opening questions

1) Would you tell me about yourself, where you come from, when you came here in South Africa, what you do?
2) What led you to come to South Africa?
3) How do you see life here?
   i) Why do you say that? (probe)
4) How many children do you have?
5) How many children have you given birth to here in South African?
6) When and where these babies/this baby born?

Key questions on Documentation status

7) Did the healthcare provider/staff asked for your passport or documentation like a work permit? (probe)

Key questions on service use, experiences and use

8) Which health care services did you use?
   i) How did you find out where to go?
   ii) How did you get there?
   iii) Did anyone help you or went with you?
   iv) Where there any challenges you faced to get there
9) Did you go for check-ups/ANC classes when you were pregnant? (probe)
   i) How many you have attended (probe)
   ii) Which facility you have been going to (probe)
   iii) Did you receive any health talks by healthcare staff from the facilities?
10) Did you give birth in a MOU/clinic/hospital?
   i) Which facility you gave birth at?
   ii) How long you have been there for birth
   iii) Did you "book in" for your delivery?
11) Are there any other sources where you have tried to find healthcare assistance beside the public healthcare facilities (clinic, MOU or hospital) and why?
12) Has your child been immunised?
   i) Would you tell me which vaccination has he/she received? (probe)
   ii) At what ages? (probe)
   iii) Was he/she was immunised at birth? (probe)
13) Does your child have an South Africa Road to Health Card?
   Where did you get this card?
14) What was the care like when you went for check-up/give birth/immunisation? (probing for challenges)
15) When you went for immunisation did they have stock of medicines or vaccinations
   i) Were you helped in the way that you were happy with?
16) In what way do you think ANC and immunisation services are important?
   i) What changes would you suggest to improve the services for women who have come to South Africa from other countries?

Last question

17) Is there anything else that you would like to say?
18) Is there anything you think is of importance that we should have discussed?

Appendix F: Human Research ethics committee (medical) clearance

R14/49 Mrs Susan Saburi

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M150908

NAME: (Principal Investigator)	Mrs Susan Saburi
DEPARTMENT:	Public Health Johannesburg Inner-city and Tembisa Informal Settlement
PROJECT TITLE:	Experiences and Percepctions of Zimbabwean Women Migrants Accessing Antenatal, Obsteric and Infant/Child Immunization Public Health Services in Gauteng, South Africa
DATE CONSIDERED:	02/10/2015
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Janine Simon-Meyer
APPROVED BY:	Professor P Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	02/11/2015

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.
I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES