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Giving birth in a foreign land: Maternal health-care experiences among Zimbabwean migrant women living in Johannesburg, South Africa

"They should not give services according to nationality, but just serve everyone as a patient not as South African, Zimbabwean or Mozambican." Maria



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601805

A research project submitted to the African Centre for Migration and Society
In partial Fulfilment of the Requirements for the Degree of
MASTER OF ARTS IN FORCED MIGRATION

Supervised by Dr Jo Vearey

Declaration

I declare that this thesis is my own unaided work. It is submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, for the Masters of Arts in Forced Migration. At no other University or Institution has it been submitted as a requirement for a degree or any other qualification.

17 March 2014

Tackson Makandwa

Abstract

The republic of South Africa has a "health for all" policy, regardless of nationality and residence status. However, challenges still exist for non-nationals and little is known regarding migrants' maternal healthcare experiences. This study explores the maternal healthcare experiences of migrant Zimbabwean women living in Johannesburg, South Africa. It focuses on the lived experiences of women aged 18years and above, who engaged with the public healthcare system in Johannesburg during pregnancy and childbirth. A desk review of the literature was undertaken. The theoretical framework in this study draws from three concepts (1) the Social determinants of health framework (WHO 2010), (2) the Access to healthcare framework (McIntyre, Thiede and Brich 2009) and (3) the "three-delays (Nour 2008). Primary data was collected through the use of open-ended semi-structured interviews with a sample of 15 migrant Zimbabwean women who have been in Johannesburg for a minimum of 2 years, and have attended and given birth or are currently attending antenatal care in inner city Johannesburg. Thematic content analysis was used to analyse data since it helps to extract descriptive information concerning the experiences of Zimbabwean women in Johannesburg and to construct meaning in order to understand their perceptions and opinions about the healthcare system in the city. Although the findings indicate that documentation status is not a key issue affecting access to healthcare during pregnancy and delivery, a range of other healthcare barriers were found to dominate, including the nature of their employment, power relations, language, and discrimination(generally) among others. Language was singled out as the major challenge that runs throughout the other barriers. More interestingly the participants raised their desire of returning home or changing facilities within the Public sector or to private institutions in case of any further pregnancy. This study concludes that the bone of contention is on belongingness, deservingness and not being able to speak any local language, that runs through the public health care institutions and this impact on professionalism and discharge of duties.

Key Words: Migration, Maternal healthcare, Healthcare system, Pregnancy, Childbirth, Antenatal care, Zimbabwean, Inner city Johannesburg, South Africa

Dedication

To my wife Bliss Masimba, son Trussel and Daughter Nicole-Tanaka Makandwa, this is for you.

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Like many of life's journeys, this thesis would not have been completed without the efforts and patience of a number of individuals. Firstly I would like to thank my supervisor Dr Jo Vearey for her tireless efforts, encouragement and patience as she took her time to guide me throughout the writing process. I am also greatly indebted to the migrant women who gave their time to participate in this study. Through tears and laughter they told me their stories in ways that have had a significant effect in shaping both the outcome of this thesis and my academic life. More so I am also grateful to the German Academic Exchange Service (DAAD) Scholarship for granting me financial support to study towards the Master program and a research grant that enabled me to write this research report. The list will not be complete without mentioning my fellow comrades Patience Sekesai Makore, Wellington Mvundura, Peter O'kefer and Eveline Mwadina Shinana, it was worthy to have you guys around during this battle. Special mention also goes to my family for the patience and the great push to embark on this project. Lastly I want to thank the almighty God for the guidance throughout the period.

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List of abbreviations

ANC	Antenatal Care
CESCR	UN Committee on Economic, Social and Cultural Rights
CSDH	Commission on the Social Determinants of Health
HRW	Human Rights Watch
IOM	International Organisation for Migration
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
NHA	National Health Act
PHAA	Public Health Association of Australia
SDH	Social Determinants of Health
UN	United Nations
UNHRC	United Nations Human Rights Committee
WHO	World Health Organisation

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1.0: Chapter 1: Background

This thesis seeks to explore the nexus between migration and access to health, more specifically exploring the maternal healthcare experiences of migrant Zimbabwean women during pregnancy and delivery in inner city Johannesburg. This is done with the understanding that in the host society – in this case Johannesburg - migrants are exposed to different social determinants to health than back home and them having specific healthcare needs brings the public healthcare system in the host community under the spotlight. This section discusses key contexts of the study – with a focus on access to health, the public healthcare system, migration, and women in South Africa, which will continue in the literature review. It will also state the research question, research objectives and the rationale of the study which will pave way for other sections.

South Africa has been a migrant-receiving country for many decades. The majority of these migrants were, and are, from neighbouring countries within the Southern African region and a significant number are undocumented (Crush and Williams 2005). This lack of documentation means they encounter many obstacles, drawbacks and thresholds to negotiate when they try to access social services and resources. Crush and Williams (2005) and Pophiwa (2009) point out that cross border labour migration between South Africa and its neighbouring countries dates back to the mid-19th century, when the South African diamond and gold mining industries were founded and the country began its trek towards a modern industrial economy. Crush and Williams (2005) further note that South Africa has continued to receive migrants from neighbouring countries, but in progressively greater numbers. Migrant streams have also become far more diverse. Moreover Vearey (2008) observes that South Africa has been faced with a high movement of people from across Africa and a vital proportion of these migrants are refugees and asylum-seekers.

More specifically, Pophiwa (2009) argues that there is a long history of migration between Zimbabwe and South Africa dating from the pre-colonial times. For instance, the African Centre for Migration & Society estimates that about 1 to 1.5 million Zimbabwean migrants were living in South African in 2010 (Polzer, 2010). It is beyond doubt that these migration patterns have been produced, influenced and shaped by different events throughout history

from the time of *Mfecane* - *a* series of Zulu wars and other Nguni tribes causing a period of disruption and population mobility of the second and third decades of the 19th century that changed the demographic, social and political configuration of Southern Africa, through to the advent of colonialism and the present post-colonial dispensation (Richner 2005). From the 1840s onwards, Zimbabweans were among some of the Africans from Southern Africa coming to work on the cane fields of Natal and the diamond mines of Kimberley. Maphosa (2009) notes that at independence in 1980, the government of Zimbabwe discontinued the contract labour system with South Africa as a protest against apartheid. Despite the discontinuation of the contract labour system, Zimbabwe has continued to be a major source of migrant labour to South Africa, although labour migration has become more informal, unregulated and illegal, because of the restrictive nature of the South African Immigration Act of 2002. The main forms of gaining illegal immigrant status into South Africa are border jumping and entering legally through official entry points and then overstaying. More over Crush (2003) found that 23% of the Zimbabwean adult population have been to South Africa, 24% have parents who have been to South Africa and another 23% have grand-parents who have been to South Africa.

An interesting dimension to the history of labour migration to South Africa is that of the health impacts of migration. According to Vearey (2011), historically migrants within the southern African region have been at increased risk of a range of negative health outcomes, largely due to their inability to access positive determinants of health, defined as the full set of social conditions in which people live and work in. Vearey (2011) further argues that despite progressive changes in legislation since the end of apartheid that upholds the right to access healthcare for all in South Africa, both internal and cross-border migrants continue to experience challenges in accessing public healthcare. Moreover international migrants continue to be portrayed as diseased people who place burdens on the public healthcare system in South Africa (Vearey 2011). Furthermore Dias et al (2010) argue that female migrants have been recognized as an important challenge for public health as increasing evidence points out that migration can adversely affect the health of migrant women as they are likely to be of reproductive age and with specific health demands. Dias et al (2010) note that when arriving in a new country, migrants often face a different social, structural and cultural context which frequently exposes them to risk factors which negatively impact on

their health status. Thus maternal health as part of the reproductive health of migrant women might be compromised when they face exclusion and have to negotiate for access to healthcare in a foreign land mainly because of their nationality and documentation status. However, more interesting is the fact that in South Africa the National Health Act 61 of 2003 section 4 gives in general terms the ways in which people are able to gain access to health care services in the public healthcare system and clearly states that pregnant and lactating women and children below the age of six are eligible for free treatment in public health care facilities (National Health Act 2003).

1.1: Research Question

The research is aimed at answering the following question:

- What are the experiences of documented and undocumented migrant Zimbabwean women accessing public healthcare services during pregnancy and child birth in inner-city Johannesburg South Africa?

1.2: Research Objectives

In responding to the above main research question, the study will address the following objectives:

- To establish if documentation status has a bearing on pregnancy and childbirth experiences of migrant Zimbabwean women accessing public healthcare services in inner-city Johannesburg South Africa.
- To examine the role of social support during pregnancy and delivery among the migrant Zimbabwean community in inner-city Johannesburg.
- To determine whether migrant Zimbabwean women who are considering a further pregnancy have future plans of attending antenatal care and giving birth in South Africa.

1.3: Rationale

The motivation for this research stems from the concern that although knowledge has been developing continuously for over a century within the field of maternal health, and sound knowledge now exists on how to prevent the majority of maternal deaths, there remains an extremely high prevalence of maternal mortality in many countries, all of which are developing countries (Human Rights Watch 2011). More importantly Burton (2013) reveals that although South Africa lacks verifiable means of counting maternal deaths, estimates of overall maternal mortality for 2007/2008 have ranged from 310 to more than 700 per 100 000 live births. Thus although it is a fact that maternal health outcomes are poor and need to be improved, through exploring experiences of pregnancy and delivery of documented and undocumented Zimbabwean women in inner-city Johannesburg this study will provide insights into what is working and not working for an often overlooked population. More so the fact that maternal mortality still remains a risk factor for women in many parts of the world reflects that efforts have clearly not been to utilise the wealth of knowledge to improve maternal health in these countries. This can essentially be seen as a violation of several human rights, such as the right to life, the right to the highest attainable physical and mental health, and the special protection of mothers during a reasonable period before and after childbirth that should be accorded (WHO 2012). Thus, women's health is under-prioritised in developing countries, making poor women unnecessarily vulnerable to suffering from the necessary and natural process of life in which humanity relies upon. It is highly unethical to let the situation continue, as it also greatly hinders poor countries in developing, as women play an important role in both the well-being of their families as well as their communities.

Zimbabweans have increased rapidly in numbers among the migrant population in South Africa during 2008 (Pophiwa 2009), and large numbers of female migrants are of reproductive age (Dias et al 2010). Thus the increase in female migrants has also increased the need for scholarly, policy and clinical attention to pregnancy, birth and postpartum period gynaecological health as well as infant and child care. It is interesting to explore their utilisation of public health care facilities especially the hospitals for emergency, maternity healthcare as little is known about migrant women's access to healthcare and experiences of antenatal care, pregnancy and delivery in the public healthcare sector in inner-city Johannesburg, South Africa. This research will therefore add to the body of available

literature on maternal healthcare experiences among migrant women which is currently more biased towards the experiences in Western countries.

1.4: Report Layout

The report is divided into five chapters. A review of the literature around migration and access to health follows this introductory chapter. The report provides the details on the methodology, including the research design, analysis and ethical considerations that guided the study. Following this section are the findings and discussion of the results. Finally the report concludes with the summary of the key findings and recommendations. More importantly the study also includes extracts from the women's stories so that their words about their experiences stand side - by – side with my words about them:
In this study I worked with 15 women. Who provided me with detailed lived experiences, during their interaction with Public healthcare Institution, with the findings indicating documentation status as not a key issue affecting access to health, as Tomara revealed,
"No they do not ask for documents, I had them but they did not ask for them." (Tomara)

With Fatima arguing that:

"Language is really a major problem; they just want you to speak in their language". (Fatima)

2.0: Chapter 2: Literature Review

This section will draw on some of the literature which has a clear linkage with this thesis and towards migration studies. More specifically the study situates itself within the broad concept of access to healthcare, as it seeks to relate maternal healthcare experiences among Zimbabwean migrants living in Johannesburg to the availability, affordability and acceptability of healthcare - important dimensions of access to maternal healthcare services (Silal 2012).

The literature review will focus on various topics organised into different themes including: maternal health overview, immigrant women's health, South Africa's healthcare policy, healthcare and international human rights framework, immigrants' healthcare challenges, and the South African maternal healthcare system. Finally, the chapter will focus on the theoretical framework applied, which draws on three concepts: (1) the social determinants of health framework (WHO 2010); (2) and the access to healthcare framework (McIntyre, Thiede and Birch 2009); and (3) the "three-delays" (Nour 2008). These will be merged into a conceptual framework that will be used to guide the study and assist in analysing and presenting the data.

There is a large body of literature dealing with access to health among migrants and a growing body of literature on migrant's access to maternal healthcare is found to focus on western (developed) countries. Carolan et al (2008) looked at antenatal care perceptions of pregnant African women attending maternity services in Melbourne, Australia; Mitu (2009) looked at immigrant Bangladeshi women's childbirth experiences in United States of America; and Bulman and McCourt (2010) looked at Somali refugee women's experiences of maternity care in west London. These studies are tightly connected to the direction of this study although having perspectives from developed countries.

2.1: Migration: the South African context and Johannesburg

Kihato (2009) argues that a significant number of those moving to cities are women – a phenomenon to which contemporary policy and scholarly attention are being drawn. In her argument she notes that until recently little attention was paid to women migrants to cities

both internationally and in Sub-Saharan Africa, due to biased and flawed arguments that emphasized male migration. Lurie and Williams (2014) argue that migration has deep historical roots in South and Southern Africa and to this day continues to be highly prevalent and a major factor shaping South African society and health. Lurie and Williams (2014) further point out that migration has become one of the important determinants of global health and social development, as people are moving in greater numbers and over larger distances than ever before. Fundamentally, Mechanic (1992) acknowledges health as a product of culture and social structure and of importance is the implications migration has for those who migrate as they are exposed to different social determinants of health throughout the migration cycle, which is at the place of origin, during the journey, at the host destination and upon return (Vearey and Nunez 2010), hence this study will follow Mechanic (1992) stance. More fundamentally Ahmad et al (2010) and Schuler (2013) argue that the city of Johannesburg as one of South Africa's metropolitan municipalities, it remains as the prime economic hub of Sub-Saharan Africa and the destination of choice for both skilled and unskilled migrant workers from beyond provincial borders of Gauteng and national frontiers. Stas SA (2012) reveals that the South African census found that nearly half of Gauteng's population was born outside the province and approximately 1.1 million of Gauteng's 5.8 million residents were born in African countries. Johannesburg is a place of stark contrast, hosting extremes of poverty and wealth, sprawling low density suburbia and high density formal and informal settlements, formal and informal trade (Ahmad et al 2010); this reveals a wider array of social determinants of health within the inner city Johannesburg. The focus of this study on the inner city provides investigation into populations that are often ignored in research and in interventions.

As migrants are exposed to different social determinants of health in inner city Johannesburg as compared to their home context, which include the administrative suburbs of Hillbrow and Braamfontein, they can be more vulnerable to negative influences to their health. Kihato (2009) in her study portrayed Johannesburg as a divided space and one of transition and argues, "to be in the city is to encounter multiple legal, socially constructed and imagined frontiers" (Kihato 2009 pg. 18). According to Landau (2005), within the South African urban zones - particularly in Johannesburg - there is the prominence of the nativist discourse oriented towards those from neighbouring countries by both residents and government

officials, claiming Johannesburg to be for citizens and othering non-nationals. This barrier of inclusion is raised against poor African migrants who are seen as economic and physical threats (Landau 2005). Furthermore Landau (2005) argues that the near universal assumption of non-nationals' criminality and threat to jobs and health have generated a series of extra-legal and often unconstitutional practices oriented towards their control and eventual removal. A cocktail of inadequate documentation, ignorance and outright discrimination ensures that non-nationals are denied access to critical social services (Landau 2005). More interestingly, Landau (2005) noted that while denying migrants access to other services like education may have delayed effects, denying migrants access to health care services - particularly emergency care - has both immediate and long term consequences.

According to Ahmad et al (2010) inner city Johannesburg, has a number of administrative districts including Hillbrow, Braamfontein, Central Business district, Doorfontein, Berea, Yeoville, Jeppestown among others. More critically Ahmad et al (2010) argue that inner city Johannesburg remains the core and historical business node since the eradication of apartheid and specifically the dismantling of its legal framework, which precluded non-whites occupying the inner city. Since then central districts such as Hillbrow and Berea have become a favoured home and destination for predominantly black job seekers from within and outside of South Africa (Ahmad 2010). More interestingly Ahmad (2010) notes that the proximity to social amenities such as hospitals, clinics, schools and social networks are additional attributes that makes inner city Johannesburg an attractive location for both locals and cross border migrants, providing a fertile ground for this study. However the comparatively high unemployment rate and low skills base of many of the migrant job seekers and residents has altered the socioeconomic dynamics of the inner city as competition for resources exposes non-nationals due to the prominence of the nativist discourse (landau 2005).

Another important aspect of the patterns of migration in South Africa pointed by Lurie and Williams (2014) citing Posel (2006), is the change of these migration patterns following the abolishing of apartheid and the first democratic elections in 1994. These changes are characterised by both an increase in the prevalence of female migration and an increasing frequency in which migrants are able to return home. However in a more insightful study Kihato (2009) argues that although migrant women who find themselves in inner city Johannesburg speak of seeking freedom from social oppression, they do not necessarily

escape oppression in South Africa. She speaks to issues on their longing to return home and - at the same time - having fears and shame of doing so without anything to show from their time in Johannesburg. More interestingly these women usually point to the harshness of the South African society, its hostility to foreigners and their inability to participate in the economy (Kihato 2009). Thus in this study, this literature will be relevant as this study seeks to explore access to health care among migrant Zimbabwean women during the maternal period in South Africa.

2.2: Maternal Health Overview

Maternal health has been an issue of concern globally and improving maternal health was set as one of the Millennium Development Goals (MDGs) - a set of anti-poverty goals agreed by 189 countries in the year 2000, with the target of achieving universal access to reproductive health by 2015 as the target for the MDG number 5 (the Human Rights Watch Report 2011). More interestingly Vandemoortele (2012) in the Post-2015 Agenda, argues that the MDGs contain three health-related goals i.e Child mortality, Maternal health and Communicable diseases which can be collapsed into one overall health goal. Hence making space for including other areas of concern of the universal agenda post-2015, which include migration, urbanization and human rights among others and this is also central in this study. The HRW (2011) further pointed out that while the United Nations (UN) agencies estimated in 2010 that maternal deaths had dropped by 34% between 1990 and 2008 with approximately 358,000 maternal deaths in 2008, still too many women die from pregnancy-related causes annually which are preventable and treatable (HRW 2011). Nour (2008) reveals that almost all (99%) of these maternal deaths occur in developing nations. With the target of reducing the Maternal Mortality Ratio (MMR) worldwide by 75% by year the 2015, this target is the least likely in Sub-Saharan Africa where nearly three-fifths of global maternal deaths occurred between 1990 and 2008, although the MMR declined by 26% in that period with 640 deaths per 100, 000 live births it remains higher than in any other region (HRW 2011). In South Africa although it lacks verifiable means of counting maternal deaths, Burton (2013) points that estimates of overall maternal mortality for 2007/2008 have ranged from 310 to more than 700 per 100 000 live births which are worrying despite higher percentages (91,5%) of women having experienced trained personnel during birth (Silal et al 2012).

While motherhood is a positive and fulfilling experience for many women, it can in many cases be associated with suffering, ill-health and even death (World Health Organization 2012). Most of the maternal suffering and mortality in resource poor countries has been attributed to three "Delays" (Nour 2008), these are presented below

(1) *Delay in deciding to seek healthcare* – which on the part of the mother, family and community not recognizing a life threatening condition resulting in most births happening at home.

(2) *Delay in reaching healthcare facility in time* –which might be due to road condition, lack of transportation or location, resulting in most women with life threatening conditions not making it to the health care facility in time.

(3) *Delay in receiving adequate treatment* – this happens at the healthcare facility upon arrival; women may not receive adequate care or ineffective treatment.

According to the HRW (2011) several women in South Africa are experiencing and witnessing significant delays after being admitted into healthcare facilities, in some cases with grave consequences. For example, the HRW (2011) notes a case of a woman who gave a narration of delays involved in getting an ambulance for her pregnant daughter, and how it took considerable time for her to be attended to at a community healthcare centre and public hospital in Port Elizabeth.

2.3: Migrant women's health

Sargent and Larchanche (2011) argue that increasing population flows, an important feature of globalisation, affects health in complex ways as migrants move not only across geographical borders but also across, between and among medical systems, both bio-medical and traditional. This is mainly because as migrants arrive in the host community they will be exposed to an environment that is different from where they have originated. As a result, significant changes in risk to health and therapeutic options which include both biomedical and traditional healthcare accompany migrants but they vary in relation to features of a migrant population such as gender, class and legal status. These authors further lament that studies of immigrant health reveal the importance of the social, political and economic

production of distress and diseases as well as the structures and dynamics that produce particular patterns of access to health services and the quality of those services. More so they note the fact that immigrants' reproductive health is a pressing issue from a public health perspective because many migrants are of reproductive age, thus the increase in female migrants has also increased the need for scholarly, policy and clinical attention to pregnancy, birth and postpartum period gynaecological health as well as infant and child care.

Sargent and Larchanche (2011 pg 349) also explore the idea that immigrants may find reproductive health decisions deeply contested in the narrative of the nation state where they alluded to the concept of "demographic theft" in Germany. This is a scenario where high fertility among foreigners has generated popular anxiety concerning the future of the state with the Germany citizenship model based on "right of blood" (Sargent and Larchanche 2011 pg 349) rather than territory. In the South African context Landau (2006) argues that South Africans heighten nativist idioms, claiming inner-city Johannesburg to be for citizens and othering non-nationals, hence labeling newly arrived migrants as having no place in the system. To this end, this problematizes pregnancy among immigrant women, especially those who are undocumented. Similarly, Sargent and Larchanche (2011) noted that Latina women in the United States of America are perceived in the popular imaginary as a high fertility population, threatening the dominant society with cultural displacement.

Vearey (2011) (drawing from Macpherson and Gushulak, 2001; and Anarfi, 2005) argues that migration is a central determinant of health requiring appropriate policy and program responses. For her, migration itself must be managed in a healthy way. Thus, population mobility must be recognised as a central public health imperative. She alludes to the fact that historically migrants within the Southern African region have been at increased risk of negative health outcomes, largely because of their inability to access positive determinants of health. Vearey (2011) further states that maternal and child health is affected when the migrant populations are excluded from the public healthcare system.

Davies et al (2010) argue that migrants' health is also to a large extent determined by the availability, accessibility, acceptability and quality of health care services in the host community or country. More importantly Davies et al (2010) point out that structural

inequalities experienced by many migrants have a significant impact on their overall health and well-being, thus migrant health goes beyond the traditional management of diseases among mobile populations, but also involves access to maternal healthcare services which is the focus of this study. It is intrinsically linked with the broader social determinants of health and unequal distribution of such determinants (International Organization for Migration 2013; Blaauw and Penn-Kekana in the South African Health Report 2010; Davies et al 2010). According to Davies et al (2010) even migrants with legal documents and in more comfortable socio-economic positions in society may experience challenges and limits in accessing health care services, mainly due to language and cultural differences as well as institutional and structural obstacles within the host community.

Furthermore Van Hulst et al (2011) argue that migrant women lack social support when they resettle in a new country and this has negative health impacts. They noted that lower social support has been associated with an increased likelihood of maternal depression. They also assert that social support provides material, emotional and social resources needed to cope with life threatening stressors. Likewise, Cacciatore et al (2008) point out that social support generally is recognised as any action or relationship that has positive benefits for a person. Making some reference to Hupcey (1997), Cacciatore et al (2008) also state that evidence suggests that several factors influence social support provision, including the appraisal of need by the potential provider of social support and the ability to provide that necessary support. Fundamentally, Cacciatore et al (2008) maintain that the most important variable in social support is the perception of its existence by the recipient. Taking a cue from Lieberman (1986) they suggest that during time of need, individuals may themselves be unable to define what is supportive for them, simply they just know whether they felt supported or not. Cacciatore et al (2008) view social support during the maternal period as a significant demand that requires higher levels of coping for the mother and what protects her and the family however extends beyond the intimate family circle. It includes peripheral family and friends as well as community members particularly in situations of significant risk and in this instance the potential implications for migrant women (Cacciatore et al 2008).

2.4: Healthcare and the International Human Rights Framework

The IOM (2013) argues that human rights are universal and considered the birth right of every human being. Aimed at safeguarding the inherent dignity and equal worthy of everyone regardless of nationality, gender and colour, human rights are inalienable, interrelated and interdependent. More importantly the IOM (2013) notes that human rights are articulated as entitlements of individuals and groups, thereby creating obligation of action and non-action, particularly for states. Human rights are expressed and guaranteed by law in international instruments as well as in national constitutions and legislation. Thus states assume obligations under international law to protect, respect and fulfill human rights.

The HRW (2011) report, points out that South Africa has an obligation under international and regional legal standards to ensure that all human rights are fulfilled. These regional legal standards include the African Charter on Human and peoples' Rights on the Rights of women in Africa (The Maputo protocol) and the African Charter on the Rights and Welfare of the Child (HRW 2011). These international legal instruments also emphasise the right to health, right to life, right to be free from cruel and inhuman and degrading treatment and non-discrimination when it comes to accessing health care services. Essentially the report notes that the South African constitution requires that international law must be taken into account when interpreting the domestic legislation, such that it confirms to international standards. Thus the HRW (2011) notes that international human rights framework states that everyone has a;

Right to life – according to the HRW (2011) report the international and regional guarantees of the of the right to life requires states to take measures to protect individual from arbitrary and preventable loss of life, and have recognized the obligation to protect women's right to life in the context of pregnancy and childbirth. The report further alludes to the United Nations Human Rights Watch Committee sentiments that,

"*where there is a high maternal mortality, in order to protect the right to life, the state should "[ensure] the accessibility of health services including emergency obstetric care … ensure that its health workers receive adequate training … [and] help women avoid unwanted*

pregnancies … by strengthening its family planning and sex education programmes." (HRW 2011 pg 57*)*

Right to health – the HRW (2011) report notes that the international treaties that South Africa has ratified and signed require that it fulfills the right to the highest attainable standards of health on a non-discriminatory basis. Thus several treaties and authoritative interpretations specifically note that reducing maternal mortality rate and improving maternal health services should be considered rights to health priorities. The HRW (2011) quotes the UN Committee on Economic, Social and Cultural Rights which oversees the implementation of the right to health treaty by all state parties on this basic right, when it says,

"ensuring reproductive, maternal (pre-natal as well as post-natal) and child health care is of comparable priority to the treaty's core obligations, and calls lowering maternal mortality a "major goal" for governments" (HRW2011 pg 58)

Moreover the report pointed to the fact that when it comes to migrants the UN Committee on Economic, Social and Cultural Rights (CESCR) also states that asylum seekers and undocumented migrants should have the same privileges to health as the locals (HRW 2011). According to the IOM (2013, pg 18) and WHO (2007) making reference to the CESCR General Comment number 14, argues that the scope and content of the right to health in all its forms and at all its levels contains four interrelated and essential elements which are presented below:

(a) *Availability*: of functioning public health and health facilities, goods, services and programmes in sufficient quantity.

(b) *Accessibility*: which includes the principle of non-discrimination, and involves physical accessibility, economic accessibility (Affordability), and information accessibility.

(c) *Acceptability*: this emphasizes that health facilities, goods and services must be respectful of medical ethics and be culturally appropriate, being sensitive to age and gender aspects.

(d) *Quality*: must be scientifically and medically appropriate.

Right to be free from cruel, inhuman or degrading treatment – according to the HRW (2011) report this should ensures that no one is subject to any of these ill-treatments, including women seeking maternity care. Moreover it notes that the UN Human Rights

Committee states that this does not only apply to physical treatment, but also to conduct that cause mental suffering to the victim which is not justifiable, such as,

*"The verbal and physical abuse, denial of care, neglect and delays, and some cases of treatment without informed consent that patients experienced in Eastern Cape public health facilities, sometimes for extended periods of time (especially during the particularly vulnerable periods immediately before, during, and after childbirth when women are under the control of health facilities) can amount to cruel, inhuman, or degrading treatment "(*HRW 2011 pg 61).

2.5: South Africa's healthcare policy

IOM (2012) in reference to maternal related services in South Africa pointed out that every clinic provides services for women which include family planning, check-ups during pregnancy and help with unwanted pregnancy, testing for cancer of the uterus, HIV, TB and sexually transmitted infections. While hospitals and community health centers have maternity wards for delivering babies and services to terminate unwanted pregnancies among other whole range of services. However the provision of these services is done under strict human rights guidelines and policies (IOM 2012) see Table 1 below and the attendant elaboration.

Table 1: Outlining key Policies and Acts in South Africa

Constitution of South Africa	Section (27), "Everyone has the right to access healthcare services including reproductive healthcare" (IOM 2012)
National Health Act 2003	"A healthcare provider, health worker or health establishment may not refuse a person emergency medical treatment" (IOM 2012)
Patient Rights Charter	Must be obeyed by every hospital and clinic

According to Moyo (2010) the South African constitution has been interpreted as guaranteeing healthcare access to all and the state as obliged under section 27(2) of the

Constitution to make reasonable efforts to achieve the realisation of rights enshrined in subsection 1. Section 27 of the South Africa constitution has been interpreted to afford migrants some entitlements to certain social services including emergency healthcare in South Africa, including non-South African citizens. The South African constitution section 27 (2) binds the state to make reasonable measures towards realising these rights to accessing healthcare services and section 27(3) of the constitution clearly states that no one regardless of nationality or residence status may be refused emergency medical treatment. Moreover the Human Rights Watch report (2011) argued that the South African constitution provides for the right to access health care for "everyone" in South Africa and also provide for the right to a remedy for disputes. The report pointed to the existence of a National Health Act (NHA) of 2003 which establishes standards for handling complaints by health users, and mandates provincial health departments to establish concrete complaint procedures and Article 18 of the NHA states that all complains must be investigated.

Vearey (2011) observes that due to the lobbying of civil society groups and the UNHCR in September 2007, a financial directive from the National Department of Health confirmed that refugees with or without any asylum seeker or refugee permit granted by the Home Affairs department have the same rights as South Africans to free basic health care and access to Anti-retroviral drugs for free in the public sector. IOM (2012) notes that just as South African citizens, foreign nationals are also means tested to determine how much they should pay, either to pay a small amount or nothing at all. Moreover the National Health Act 61 of 2003 Section 4 gives in general terms the ways in which people are able to gain access to health care service and noted that pregnant and lactating women and children below the age of six are eligible for free treatment in public health care facilities. Similarly, Silal et al (2012) argue that this initiative of the first democratically elected government to remove user fees for all services for pregnant and lactating women and children under six year at public facilities reduces financial barriers to accessing delivery and other maternal and child health services. However Munyewende et al (2011) argues that despite migrant women having special health needs and the South African constitution guaranteeing the right to access to health for all, the process is mired by uncertainty and many migrants do not access health care for fear of being asked for official documents and deportation, thus revealing a huge gap between policy directive and implementation on the ground.

"Despite the offer of immunity from prosecution in South Africa, many Zimbabwean women are reportedly undocumented, facing uncertain livelihoods, learning new languages, and trying to find shelter and to integrate into a new, largely hostile, society"

(Munyewende et al 2011 pg 153).

IOM (2012) also observes that the patients' right charter must be obeyed by every hospital and clinic and prescribe that they should have a sign showing opening hours and types of services on offer. Thus it further explains the dimension of right to access healthcare services by spelling that information on available healthcare services and how best they can be utilised, should they be readily available to patients.

2.6: Immigrants' healthcare challenges

According to Vearey (2011), there have been progressive changes made since the end of the apartheid era that should help uphold the right to access healthcare for all in South Africa, but despite the changes both internal and cross border migrants continue to experience challenges in accessing public health. She further laments the persistence of the challenges faced mostly by cross-border migrants despite the policy guidelines and frameworks. International migrants often struggle to communicate with healthcare providers as interpreters are not present and some health facilities generate their own guidelines which run against the national legislation. For example, some continue demanding South African identity documents and denying access to foreigners. To this end, Vearey (2011 pg 125) says,

"Although they rarely deny healthcare outright, frontline healthcare providers acts as street level bureaucrats developing their own access system for migrants. Regional migrants experience discrimination and negative attitude from frontline healthcare workers who often vent their own frustration over working in under resourced and overstretched public HealthCare system on the other."

This can also be partly due to ignorance of forced migrants' rights to health care as Pursell (2004) observes that many South Africans wrongfully assume that all migrants are illegal

immigrants and this confusion maybe caused by the unfamiliarity with refugee identity document. It may also be a broader unwillingness to consider that refugees and migrants are entitled to health care services regardless of their status. Thus this labeling has significant implications for the ability of migrants to access healthcare and the quality of treatment (Pursell 2004).

Grove and Zwi (2006) adopted the framework of "othering" to explore how refugees as a group are constructed in the host communities and set apart from the mainstream population. The person or group being othered experiences this as a process of marginalisation, disempowerment and social exclusion and this effectively creates a separation between, "us and them" (pg 1933). Grove and Zwi (2006) further state that othering based on disability, gender, health status and ethnicity have shown to have negative consequences on the delivery of healthcare services. More so, the desire of wealthy countries to present themselves as an unattractive option to potential migrants has contributed in the reduction of available support and service to foreigners in host communities.

Willen (2012) further explores the concept of othering when she observes that South Africa's deeply rooted commitment to universal healthcare access and the right to health are impaired in today's increasingly hostile political climate in which unauthorized immigrants are constructed as socially illegitimate. She asserts that this ideologically motivated representation grounded in empirically unfounded assertions, flawed culturist assumptions and racializing stereotypes interact with other tangible and intangible barriers to exacerbate psychosocial stress and constrains immigrants to attend to their health needs. Willen (2012) argues that the harmful discourse of othering can be a significant obstacle to healthcare access, as negative portrayals of undocumented migrants can in fact influence both the disposition of biomedical practitioners towards their undocumented migrant patients and the practitioner's clinical conduct, all exposing migrants to ill treatment and abuse. In this case, pregnant immigrant women are no exception as they seek medical care.

The IOM (2013) argues that communities receiving large numbers of migrants face new challenges such as increased diversity of the population and the consequent change in the cultural profile of its patients. According to Davies et al (2010) cultural and ethnic

reproductive and sexual health practices and norms of behaviour among migrant groups such as the use of contraception, or birth practices may challenge or conflict with those of the host community. Most importantly, cultural norms may prevent women from accepting care from male practitioners (Davies et al 2010). Moreover Anderson (2004) argues that health care workers are seen as responsible for bringing undue social priorities and cultural norms into their ideally culture-free work thereby affecting professionalism. As a rule, some patients are treated with attentive kindness and respect while others are made to wait, are treated with impatience and discourtesy, given less information and accorded less time (Anderson 2004). According to the IOM (2013) the cultural barrier to healthcare service access is tightly linked with the acceptability element of the right to health, as the issues of language and being sensitive to gender and age and also acceptance of male help during delivery comes into the limelight.

In addition Davies et al (2010) argue that many migrants face various communication problems when seeking healthcare that can be caused by cultural and language differences, which prevent migrants from understanding the bureaucracies of health care systems and from expressing their needs. According to the IOM (2013) language barriers have a negative effect on access to care and prevention services, adherence to treatments and timely follow-ups. Misunderstanding, for example, when a migrant patient describes his or her symptoms, and incorrect translations may result in delayed care, clinical errors and even death. Tlebere et al (2007) in a study based on analysis of the factors that influence the utilization of maternal health care in three sites in KwaZulu Natal, Eastern Cape and Western Cape found out that the quality of health care received and provider communication were poor. They found out that the issue of distance and transport to facilities were the biggest problems.

More so Van Hulst et al (2011) also argue that migrant women, particularly among minority and recent migrants are faced with the challenge of lower levels of social support and poverty in host communities. Guided by previous studies by Battaglini et al (2000), Dunn and Dyck (2000) and Sword et al (2006) they note that the concentration of poverty and lower levels of social support is even worsened by discrimination and racism in work places within the host destination. Van Hulst (2011) observes that, social support from family networks has been found to be the most important, yet often lacking for migrant women during the period of

pregnancy in host countries. Moreover Harley and Eskenazi (2006) noted social support as a resource provided by others more generally particularly family and friends, is divided into three subtypes such as emotional, informational and instrumental support (Harley and Eskenazi 2006). Emotional support encompassing love and affection often from spouses, family members or close confidantes, with informational support related to the provision of advice, information and guidance and instrumental support being tangible assistance with concrete needs, such as lending money, helping with childcare and providing help when someone is sick (Harley and Eskenazi 2006). All this can be compromised when one is in a foreign land as most will lack established social networks.

More importantly Davies et al (2010) argue that the issue of access to health in all its dimensions (availability, accessibility, acceptability and quality of services offered) depends on a multiple influences, including legal status, as well as social, cultural, structural, linguistic, gender, financial and geographical factors. Thus the IOM (2013) observes that as societies have become increasingly multicultural and multi-ethnic, the capacity of health care systems to deliver affordable, accessible and migrant sensitive quality services has been contested and become more complex.

2.7: The South African maternal healthcare system

The HRW (2011) report points to the alarming increase in the number of women dying due to complications during pregnancy and childbirth (maternal mortality ratio) of around 625 per 100 000 in 2007, up from 150 per 100 000 live births in 1998 in South Africa, which it notes as an important reminder that despite the $748 per capita spent on health and the plans to provide universal healthcare, significant deficiencies still remain in the healthcare system. More so Burton (2013), likewise, also notes that although many countries are making progress, maternal mortality in South Africa has significantly increased as data from the 2007 community survey suggest that maternal mortality in South Africa instead of showing signs of reduction, may have quadrupled from 1998 to 2007. However Burton (2013) argues that South Africa lacks verifiable means of counting maternal deaths, but estimates of overall

maternal mortality for 2007/2008 have ranged from 310 to more than 700 per 100 000 live births.

According to Silal et al (2012) although the Maternal Mortality Rate (MMR) figures are contested, such MMR is high for a middle-income country such as South Africa considering the fact that the country has overall high level of utilisation of maternal health services with 92% of women reporting one or more antenatal care visits and 91.5% having skilled attendants at delivery. However Silal (2012) also argues that these aggregate data hide variations in use by race, urban/rural residence and socioeconomic status, for instance he noted that in 2003 skilled attendance at delivery for urban areas was 94% compared to 85% in rural areas. Blaauw and Penn-Kekana (2010) also argue that there is an equity gap in access to key maternal health interventions. They argue that national indicators suggest good coverage, but these national averages can hide significant differentials in access across the country as there is need to investigate geographical, racial and socio-economic disparities in access to key maternal health interventions. Blaauw and Penn-Kekana (2010) further note the proportion of women attending the recommended four ANC visits declined from 1998 to 2003 and more interesting there is also significant racial and socio-economic disparities in the proportion of women attending ANC early with 85% being white women compared to 44% of black women who attended their first ANC care visit before five months (Blaauw and Penn-Kekana 2010 and Wabiri et al 2013).

Blaauw and Penn-Kekana (2010) observe that in South Africa maternal mortality is due largely to an increase in maternal deaths resulting from non-obstetric (indirect) causes. Although there is limited information on community level dynamic influencing women's access to and utilisation of health care services here in South Africa which includes a host of interlinked factors:

"the community package which include women's empowerment, community education, increase in service availability, affordability and acceptability, which impact on access responsiveness (demand side of services) and directly related to outcomes of women's satisfaction with birth experiences, health providers' job satisfaction and neonatal mortality and morbidity" (Blaauw and Penn-kekana 2010 pg5).

Blaauw and Penn-kekana (2010) and Silal et al (2012) argue that patient problems contributed for 45.9% of the maternal deaths reported in the 2005-2007 period. More interestingly Silal et al (2012) noted that poor provider-patient interactions, including inattentiveness of staff to patients' condition and turning away women due to not being ready to deliver can also lead to avoidable maternal deaths. They further pointed out that the two leading patient-oriented factors are delaying in seeking medical help (26.8%) and not attending or infrequent attendance of ANC contributing 23.7% of all the maternal deaths (of which 18 % did not attended at all). Blaauw and Penn-Kekana argue that 18% who did not attend ANC at all represent a significantly higher figure in terms of the general population. More interestingly Silal et al (2012) further argue that while health care system barriers to access obstetric care have been fairly well documented in South Africa, patient-oriented barriers to access have been neglected; yet they are crucial to understanding access to maternal health care.

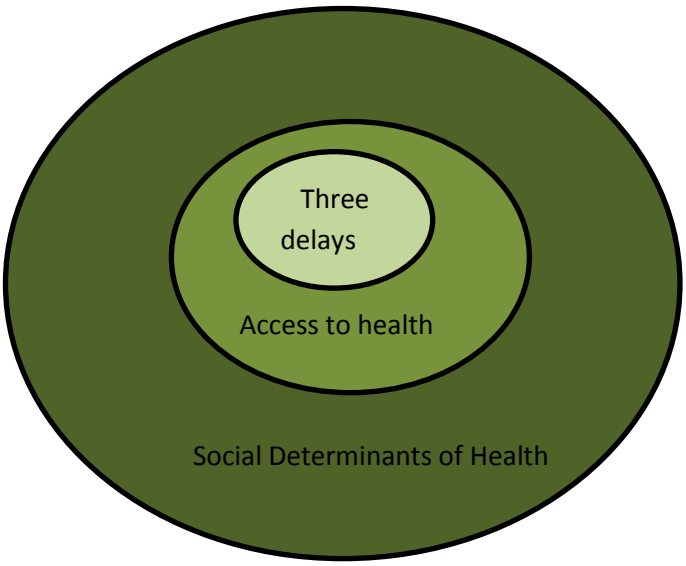
Moreover Silal et al (2012) argue that South Africa's health care system and health service delivery have been affected by its controversial past including racial and gender discrimination, violence and severe income inequalities. They note that the government that come into power in 1994 adopted several steps to address inequalities in health service and to improve access, particularly in terms of availability and affordability. For example more than 1300 primary health care centers were constructed in areas which were under-served. Furthermore Silal et al (2012) notes that another initiative of the first democratically elected government in South Africa was the removal of user fees for all services for pregnant women and children under the age of six years at public health care facilities. This they argued served to reduce the financial barriers to accessing delivery and other maternal health care services. However to quote Silal et al (2012),

"Despite the policy efforts to improve availability and affordability of health care, there have been severe problems with implementation of some of these policies, as well as with the training, distribution and motivation of health care workers"(Silal et al 2012 pg. 9)

2.8: Conceptual framework

There are several models that can be used to understand and contextualise access to health which will help understand maternal healthcare experiences of migrant women which is one branch of health as a broad concept. In inner-city Johannesburg South Africa generally the migrant population is exposed to deep socioeconomic inequalities and strong nativist idioms (Landau 2005) and these social determinants compromise the migrant population's access to resources and social services (access to health care included) as they are treated as the other and as not deserving. This study adopts the Social Determinants of Health framework (WHO 2010) as the overall frame (as illustrated in fig 1 below), thus conceptualizing the health system itself as a social determinant of health (SDH). Then the role of the health system becomes particularly relevant through the issue of access, which incorporates differences in exposure and vulnerability, and through inter-sectoral action led from within the health sector. The Access to Healthcare framework (McIntyre, Thiede and Birch 2009), will then be applied/utilised with its dimensions of availability, affordability and acceptability as they will be used to make sense of the findings. More so in this study the access framework will also be broadened to include the three Delays (Nour 2008), as they are tightly connected and these three delays are central in explaining the dimensions of access to healthcare. This is illustrated in figure I below.

Figure 1: Outline of how the three frameworks are used



2.8.1: Social Determinants of Health Framework

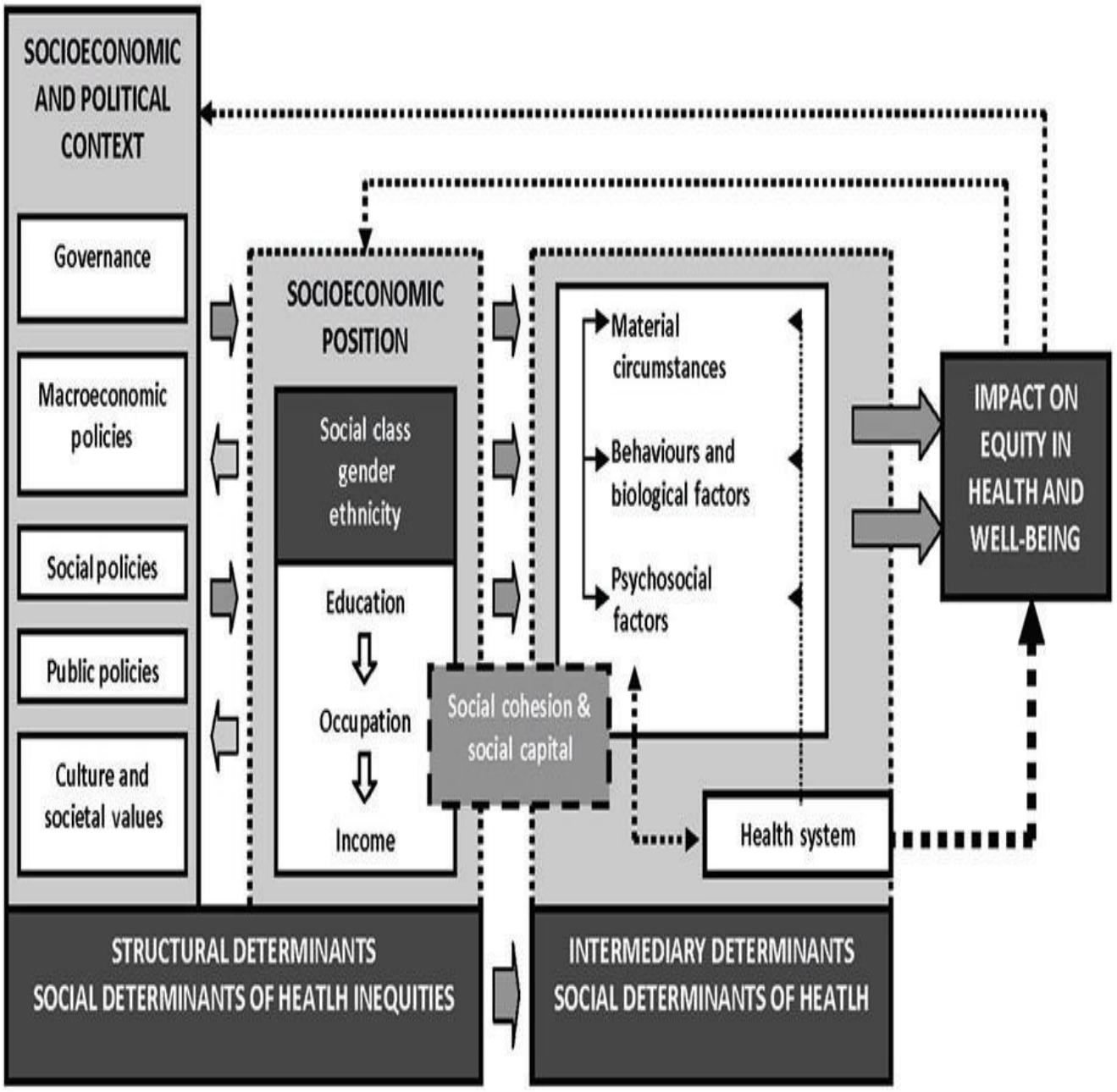
According to WHO (2010) the SDH are the conditions in which people are born, grow, live, work and age in, these circumstances are shaped by the distribution of money, power, and resources at local, national and global levels. WHO (2008) argues that the SDH are mostly responsible for health inequities, which is the unfair and avoidable differences in health status seen between and within countries (migrants included in this case). The Commission on the Social Determinants of Health (2010) argues that its vision is a world in which all people have the freedom to lead lives they have reason to value and this is a matter of social justice when the plight of migrants is closely considered in the host society. In Inner-City Johannesburg migrants are caught in between and exposed to the structural and social determinants of health as they try to integrate and seek livelihoods. Thus the CSDH (2010) illustrates that health and its determinants are an issue of human rights.

According to the CSDH (2010), the model highlighted in figure 2 draws significantly from the work done by Diderichsen et al (2001) and it places social position at the centre, with social stratification that results in differential consequences of ill health. The CSDH shows that there is duality and mutuality, as what happens in one's socioeconomic and political context determines or can be determined by one's socioeconomic position. More importantly the structural determinants are interconnected to the intermediary determinants where social cohesion and social capital are factored in and the health system features prominently in the intermediary determinants situated in the broader social determinants.

The analysis of the SDH is a valuable avenue for this study as it yields a deeper understanding of the decisions made by healthcare providers in relation to migrants accessing healthcare as a moral, human rights issue and gives an opportunity to access the routine elements of the interaction between the healthcare providers and migrant patients. Drawing on the CSDH (2010) analogy, it is plausible to argue through it that societal stratification creates advantages and disadvantages across social groups and that progressive disadvantage leads to marginalisation and disproportionate vulnerability among those excluded from societal benefits. This gives relevance to access to health dimensions of availability, acceptability, affordability by McIntyre et al (2009), together with the three delays by Nour (2008). Although for the purpose of this study these processes of disempowerment operate

only at the level of the individual, household, groups and communities, it can also operate among countries and global regions. The Public Health Association of Australia (2012) acknowledges the explicit links between the SDH and maternal mortality. PHAA (2012) argues that maternal mortality is impacted and influenced by the SDH, such as poverty, education, employment, access to health care, racial inequality and gender inequality. Below is a diagrammatic presentation of the framework (figure2).

Figure 2: Social determinants of health framework (WHO, 2010



Extracted from http://www.who.int/social_determinants/en/

2.8.2: Access to healthcare framework

McIntyre, Thiede and Birch (2009) argue that access to healthcare is the empowerment of individuals to be able to use healthcare services when needed, and it is done by means of interaction between health care systems and those individuals. In other terms the concept of access as argued by Thomas and Penchansky (1984) represents the degree of fit between the clients and the healthcare system. Thus this definition implies the availability of the opportunity and freedom to exercise this choice. Access only translates to utilisation if the individual upon sufficient reflection and of his/her own free will decides to exercise his/her freedom to use health care (Penchansky and Thomas 1981; McIntyre et al. 2009). Peters et al (2008) acknowledged that there are many definitions of the concept of access to healthcare service, with most researchers recognizing that access is related to the timely use of services according to need.

According to McIntyre et al (2009) access is based on three dimensions, which are availability, affordability and acceptability (refer to figure 3). Where availability refers to the fact that healthcare services put in the right place at the right time to meet the needs of the population. Affordability refers to those costs for accessing services, which individuals are able to pay, according to the national measurements of household budgets. More so they note that acceptability refers to the relationship between the healthcare provider and the patient in terms of attitudes and expectations, as these will influence the ability of individuals to receive care. According to Aday and Anderson (1974) in considering the factors that influence that utilization of health services, the characteristics of services and resources are not enough for use or non-use of the healthcare system, there is need to also consider the potential consumer's willingness to seek care. This according to them depends on one's attitudes towards and knowledge about healthcare and the social cultural definition of illness or condition one has learned.

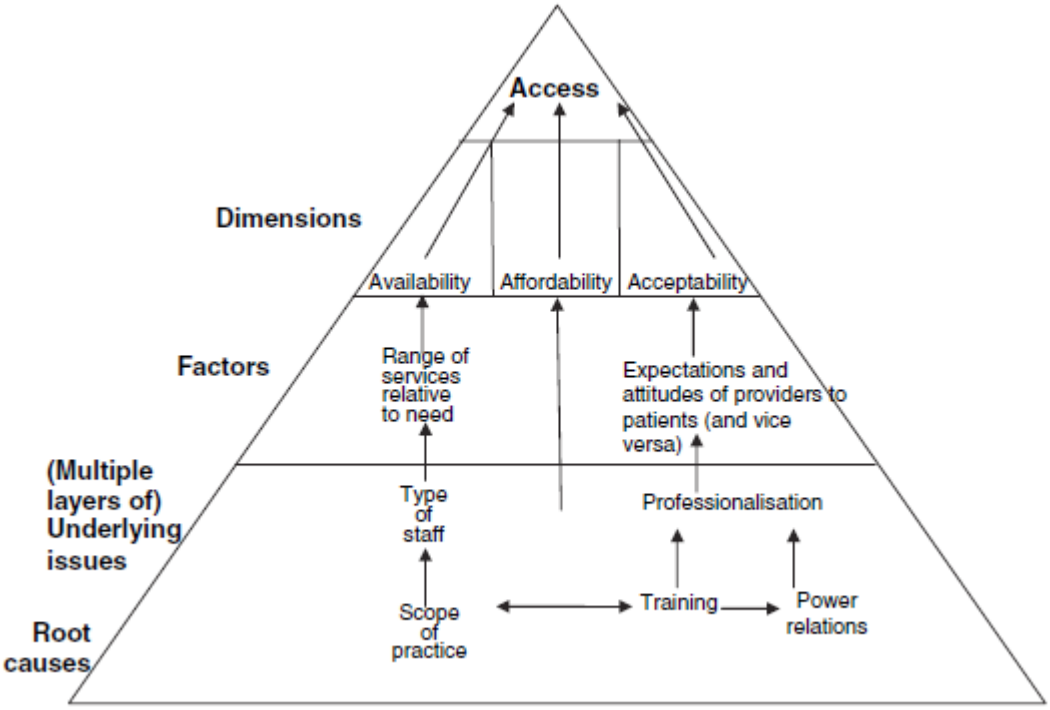
Access to health services is a key concept in this discussion and for the purposes of this study the three dimensions of access shall be at the centre of analysis. McIntyre et al (2009) argue that access is a multi-dimensional concept and further posits that although each dimension is distinct and focuses on a set of clearly distinguishable issues it is the interaction between the dimensions that determine access. In further clarifying the issue of access McIntyre et al

(2009) noted the example of the effects of improving geographic distribution of providers (availability) on individual empowerment is dependent on or influenced by whether the services of the providers are affordable (for example the travel time to provider might be less but provider's fees may have increased or might be very high to the population seeking services given their socio-economic status.) and acceptability may be because the providers may not be consistent with the cultural expectations of the population being attended to (McIntyre et al 2009). More interestingly according to Moyo (2010) acceptability or cultural access becomes more important in the South African public health system because of the presence of cross border migrants. The interaction between this segment of the population and the healthcare providers is in every way permeated by the discourse of culture and language (Moyo 2010). This is discussed in the context of certain entitlements and freedoms which are key aspects of the right to health that migrants have with respect to accessing healthcare in the public health system (IOM 2013), and accordingly, in order to comply with these entitlements and freedoms,

States must make sure that health facilities, goods and services are available, accessible, acceptable, of good quality and applicable to all sectors of the population, including migrants" (IOM 2013 pg. 18).

Drawing from McIntyre et al (2009), that access or empowerment to use health care services will only be achievable if all dimensions of access are addressed and both the healthcare system and individual perspectives are taken into account. The patients' experiences, attitudes towards and expectations of the health care system and the service provider thus become central. This captures the focus and helps in the unpacking of the interaction between migrants and healthcare providers and how this features in the broader discussion on migrant access to healthcare.

Figure 3: Access Evaluation Framework



Source: Extracted from McIntyre, Thiede and Birch (2009) pg 190.

2.8.3: The Three Delays Concept

Closely linked to the concept of access to health that explains the access dimensions is the three delays propounded by Nour (2008) and further affirmed by the Public Health Association of Australia (2012) as impacting on maternal mortality. According to Binder (2012), Nour (2008) and PHAA (2012) the three delays emphasize lack of timely and adequate care as the foundation for maternal deaths and avoiding the delays relies on overcoming both perceived and actual barriers to accessing health care services. The three delays focus on the timeframe between a women's first suspicion of an obstetric problem and its outcome, and these are presented as:

(1) Delay in deciding to seek healthcare – this according to Binder (2012) mainly result from either perceived or actual barriers that creates disincentive to act, which may be on the part of the mother, family and community, resulting in most births happening at home.

(2) Delay can result in actual barriers in reaching the healthcare facility in time, which according to Nour (2008) and Binder (2012) can be due to costs and transportation in the form of adequate ambulance and road system. This is tightly connected with the dimension of affordability, which the IOM (2013) has referred as financial accessibility.
(3)The third delay result also from actual barriers this time at the health facility – the delay in receiving adequate treatment, according to Nour (2008), Binder (2012) and PHAA (2012), this is caused by the lack of skilled birth attendants, technological equipment or simply due to not receiving adequate care or ineffective treatment.

According to the HRW (2011) several women in South Africa are experiencing and witnessing significant delays after being admitted into healthcare facilities, in some cases with grave consequences, for example the HRW (2011) note a case of a women who described delay in maternity care related to getting an ambulance for her daughter and how it takes a considerable time for her to be attended to at a community healthcare centre and public hospital in Port Elizabeth. More interestingly a close analysis of these three delays fits into the root causes and factors of the multiple layers of underlying issues on the Access Evaluation framework (refer to fig 3), were issues to do with type of staff, professionalism, training, power relations, range of services relative to need and the expectations and attitudes of providers to patients (vice versa) and the three dimensions leading to perceived and actual barriers to accessing healthcare.

Thus this conceptual framework provides theoretical reasoning in understanding access to healthcare, and is useful in understanding how various dimensions of access such as availability, acceptability and affordability impacts on maternal health outcomes of migrant women.

2.9: Conclusion

This research on the maternal healthcare experiences of migrant Zimbabwean women living in Johannesburg is central in adding to the limited body of knowledge on access to healthcare among migrants during maternal period in South Africa. While the South African Constitution guarantees healthcare access to all, regardless of nationality and residence status,

women are in more vulnerable conditions than their male counterparts where they face acculturation to the host country as well as the adoption of ideologies and practices of a new society, at the same time they retain the cultural practices and social norms of their own countries. Moreover women have specific health needs and they are more likely to be in a socially disadvantaged situation of poverty, exclusion and discrimination in the healthcare system.

This study aims to explore the experiences of Zimbabwean migrant women during pregnancy and childbirth living in Johannesburg. Hence the precarious conditions and challenges of migrant life, migrant women's health, the South African healthcare policy and maternal healthcare system become apparent. More so it is also important to turn an eye to the degree to which the international human rights framework guides the healthcare provision in South Africa. Hence providing a basis on what is working and what is not working within the healthcare system.

The analogy and understanding of the SDH (CSDH 2010) detailed in the foregoing conceptual framework is important in unpacking the issue of health as a social phenomenon and as an issue of social justice. Thus problematizing the issue of access to health (particularly maternal health) as enshrined in the broader international human rights provisions. Although the SDH framework only refers to access to health as a SDH in itself, this study infuses the understanding of the SDH framework with the focus on the Access to health evaluation framework (Mcintyre et al 2009) and the three delays reasoning (Nour 2008) in a bid to unpack the experiences and perceptions of migrant Zimbabwean women during pregnancy and delivery within the public health sector.

The coming chapter is the presentation of the methodology that has been adopted in this study. The chapter detailed the step by step procedures that led to the final selection of the 15 participants for this study. That culminates into the data collection and analysis and also the ethical considerations adhered to during the whole process.

3.0: Chapter 3: Methodology

3.1: Introduction

This chapter elaborates on the research process and the steps followed throughout the study. It discusses methods used for data collection and analysis, the study area, and the participants involved and lastly the ethical considerations are discussed that guided the researcher in this study.

3.2: Qualitative research

The research question and objectives of this study required qualitative research methods. Thus this study is based on in-depth semi-structured interviews to explore the current and past narratives of the experience of Zimbabwean women during pregnancy and childbirth in Johannesburg. Qualitative approaches focus on processes and meanings that are not rigorously examined and measured (if measured at all) in terms of quantity, amount, intensity or frequency (Joubish et al 2011). Denzin and Lincoln (2003) argue that qualitative methods help the researcher to understand the nature and meaning of reality, which is shaped by society, through the close relationship between the researcher and the subjects of the study and the environment around them. Joubish et al (2011) notes that, "qualitative research is an inquiry process of understanding a social or human problem based on building a complex holistic picture, formed with words, reporting detailed views of informants and conducted in a natural setting" (Joubish et al 2011, pg 2082). Thus in this study I used a qualitative approach in order to study individuals in their natural setting and to emphasize the researcher's role as an active learner who can tell the story from the participants' viewpoint rather than as an expert who passes judgements on participants. This approach is important in gaining insight into reality as understood and experienced by Zimbabwean migrant women during pregnancy and delivery. I utilised sampling and data collection strategies that are typically of qualitative nature, the participants were recruited by purposive and snowball sampling. I also conducted the interviews in Shona which is the most popular language in Zimbabwe and my native language and then translate into English. Furthermore this study was limited to perspectives from women only without interviewing healthcare providers, this allowed the confrontation of systematic injustice based on gender and raising awareness on

women's needs and oppression (Morse 1995). Moreover Macpherson (1983) argues that this provides the flexibility that is required to comprehend women's views and experiences and the major goal being to see the world through the 'eye of the other' for the purpose of emancipation and to see the world from the viewpoint of women being studied.

3.3: Study Area

This study was conducted in the Inner-City Johannesburg suburbs of Hillbrow and Braamfontien, South Africa (refer to figure 3 below). This study focuses on the maternal healthcare experience of a specific population group (migrant Zimbabwean women) and for this reason it's fitting for the research to be conducted in a migrant dense area making it easy to locate participants. There are also a bigger percentage of undocumented cross-border migrants living in inner-city Johannesburg who are faced with threats of deportation and mobility, circular migrants in search of improved livelihoods, and some cross-border migrants with different challenges.

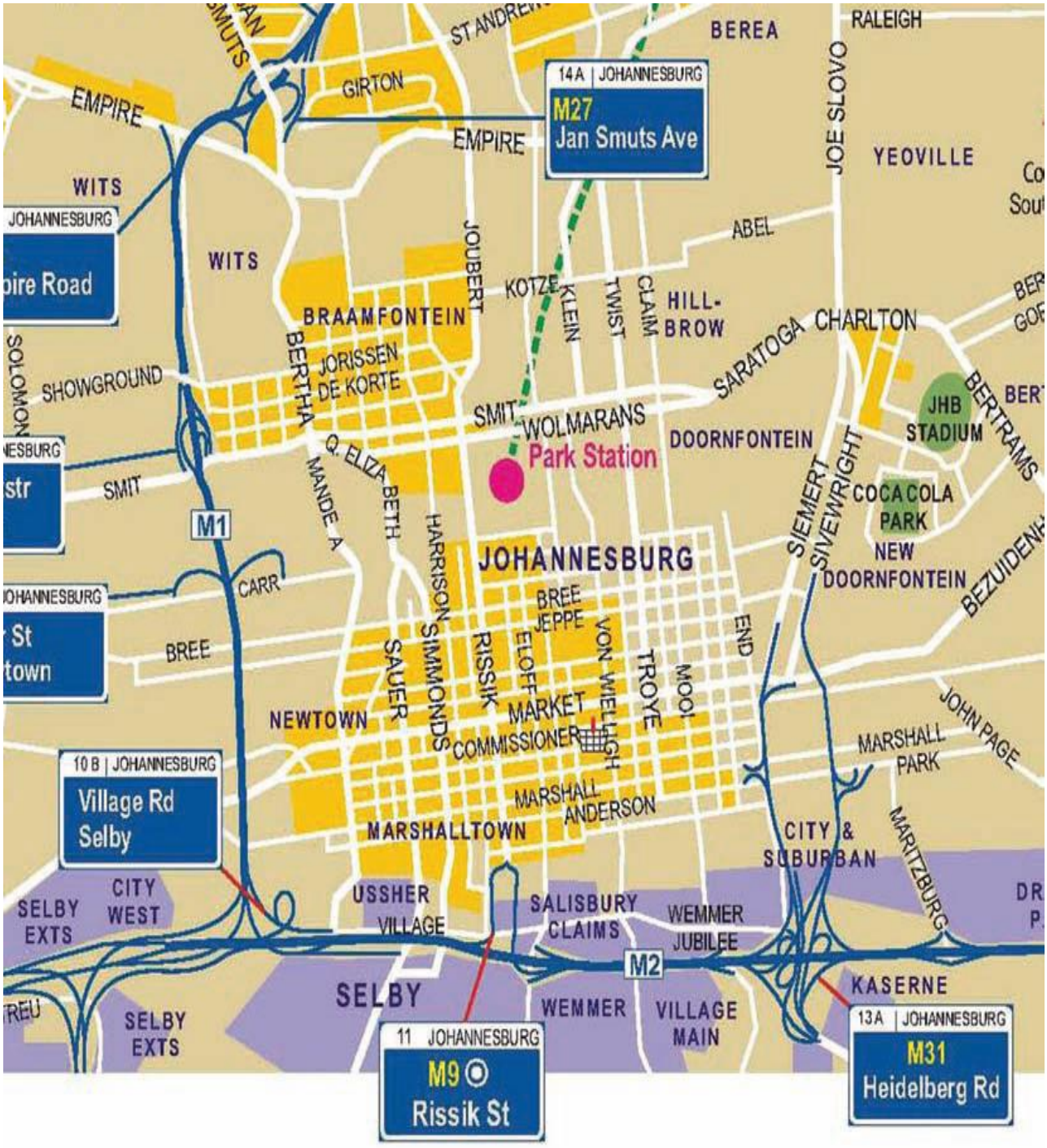


Figure 4: Map of Inner-City Johannesburg, South Africa

Extracted from http://www.broll.co.za

3.4: Summary of the Research Process

Permission to conduct the study was granted by the Non-Medical Research Ethics Committee of the University of Witwatersrand under protocol number H13/08/22. Since the research is a qualitative study and used purposive and snowballing sampling to identify research participants, the researcher used personal ties and social connections with Zimbabweans living in Johannesburg to access participants for this study. I attend social gatherings mainly church services during the weekend and I also exploited my personal relations I had managed to create with Zimbabweans at a salon I get my hair done since I started my Masters Studies in February 2013 to get participants.

The research process involved the researcher carrying out in-depth semi-structured interviews with migrant Zimbabwean women who had at least two years of stay in South Africa and had attended ANC and given birth in Inner City Johannesburg South Africa within the past five years and those who are currently pregnant but towards delivery, also attending ANC in Inner City Johannesburg South Africa. The idea of including those who are currently pregnant is the need to derive current perspectives in this regard. The field work started in in mid-October 2013 and lasted up to early December 2013. I completed a total of 15 interviews as this was the point of saturation and most issues were being repeated at this point. These interviews were mostly carried at the research participant's place of residence during weekend days when their husbands were at home, but they did not necessarily listen to the interviews. Also this was convenient as they will be doing their household chores. The interviews lasted between 30minutes to 1 hour and most of them were tape recorded with the consent of the participants, only five of the participants refused to be tape recorded.

Apart from carrying In-depth interviews I also kept a note book for field notes as backup to the tape recorded interviews and to record observations generally. Also in case of those who were not comfortable with being tape recorded, but they were comfortable with the researcher making notes during the interview and I had to quickly make extra notes after leaving the research site.

After the first two weeks of fieldwork I had a briefing with the research supervisor to reflect on the challenges, experiences and initial findings and discuss emerging themes. The

discussions were held on a regular basis to explore possible ways to elicit more data from the research process. The fieldwork was followed by the transcribing of the interviews which through funding from the supervisor I hired the services of an expert to transcribe directly in Shona and then translate into English. This was followed by the full-fledged data analysis and initial writing of the thesis.

3.5: Data Collection

Primary data was collected using in-depth semi structured interviews (see Appendix 1) and these were complimented with field notes and observations. Participants were recruited from the Zimbabwean migrant community living in Inner-City Johannesburg districts of Hillbrow and Braamfontein, using purposive sampling and snowball sampling which are discussed in greater detail below. The interview schedule sessions were divided into four different sections,

(1) Section 1 – with a set of questions eliciting background information and migrant status.

(2) Section 2 – with a set of questions on maternal healthcare experiences.

(3) Section 3 – with questions on family and social support issues.

(4) Section 4 – with questions on future plans regarding attending ANC and delivery in case of a further pregnancy.

3.6: Recruitment of Participants

The sample recruitment was initially done through purposive sampling of Zimbabwean migrants who have undergone antenatal care and given birth and those who are currently pregnant and towards delivery and are receiving antenatal care in inner-city Johannesburg's public healthcare system. According to Bernard (2006) in purposive sampling, the researchers decide the purpose of the study and locate participants to serve those purposes. Purposive sampling is usually used in the cases of a pilot studies, intensive case studies, critical case studies, and studies of hard-to-find population. Moreover according to Barbour

(2001), purposive sampling allows the researcher to be in control and thus be unconcerned about bias, thus in this study I used my social networks with Zimbabwean families to locate first participants. Since most Zimbabweans families maintain some social relationships and connections with other compatriots, I used these networks to access, invite and select participants.

I contacted my fellow Zimbabwean acquaintances living in inner-city Johannesburg and attended social gatherings especially religious gatherings to meet others. I then talked to some of the women about the research project and asked them if they were interested in participating in the study. In addition to purposive sampling, I used snowball sampling whereby I further utilised social networks among my respondents to get more participants. According to Bernard (2006) in snowball sampling researchers use key informants to locate one or two informants who can help to recommend others in the community whom the researcher might interview. Thus this sampling method allows for the inclusion of some respondents identified by asking other migrants who have received antenatal care and delivery in Johannesburg's public healthcare system. Five women were selected through Purposive sampling (Bernard 2006), and the other Ten were selected through snowball sampling, through referral from the other interviewed women to make a total of fifteen participants (Bernard 2006).

3.7: Data Collection Tools

3.7.1: In-depth Semi-Structured Interviews

This study made use of face to face in-depth semi-structured interviews as the primary data collection instrument in order to explore the perceptions and experiences of the participants. According to Bernard (2006) in-depth interviews allow the researcher to better gather information on such sensitive issues. Furthermore in-depth semi-structured interviews were based on a clear plan that one keeps constantly in mind, and were also characterized by a minimum control over the participants' responses. The idea was to get people to open up and let them express themselves in their own terms, and at their own pace (Bernard 2006). Moreover semi-structured interview format allows for deviation in the conversations, however there is enough structure to ensure that all the important topics are answered

(Nicholls 2009). Since these were one-on-one interview the women were more comfortable in sharing their experiences, as the women were part of the migrant community, and might have had issues they were not comfortable sharing in a group situation. Moreover this study aimed at understanding the experience-based perceptions of migrant women and therefore required in-depth conservations with the researcher. More importantly, although it was easier to locate participants since the researcher is a Zimbabwean nationality, however due to gender and some traditional constraints most of the women demanded to be interviewed at home during the presence of their husbands, as they required approval of their husbands first. Since snowballing sampling was also used to select participants, this assisted in gaining trust from the participants, as I was referred and even accompanied to other participants.

The women were contacted via telephone to set a time and place for the interviews to be conducted and the interview sessions were held at the convenience of the participants. The majority, about eleven interviews took place at the participants' home, while two were done at the participants' work place in Braamfontein where they work in Hair Salons, one took place at the University of Witwatersrand main campus library lawns and one took place at Essellen Witwatersrand bus station next to Essellen clinic, this was after she requested to meet there for the interview during her regular ANC visits at Essellen clinic. In the case of those interviews which were held at the participants' homes, the women would continue with their daily household chores particularly cooking and taking care of the children, while talking to the researcher. More interesting were scenarios where the participants would be relaxed at home with their husbands and families watching television. Those who were interviewed at their work place would be busy with their daily hair dressing activities, while talking to the interviewer. The interview at the Wits Library lawns, took place after the participant was done with her lectures, as she is an honours student at the University and it was also convenient for me as a researcher to meet her at school without necessarily going to her place of residence. During the interviews the order of the questions was not always followed in the same format. The order of the questions was largely dependent on when it appeared appropriate to ask them. The interview sessions by their nature were very flexible and exciting and they lasted for about forty (40) minutes to one hour ten minutes (1hr10min).

More so, almost all the interviews were carried in Shona which is the researcher's and most participants' native language, serve for only two which were carried in English, as the participants requested so. Although the participants could communicate in English, they were not fluent enough to express their personal issues in depth. Each and every session would begin with the researcher reading and explaining the verbal consent form (see Appendix III) to the participant and obtaining verbal agreement to participate in the study. The tape recording forms were also explained and given to the participants to read and sign (see Appendix IV). The participants were also provided with the participant information sheet (see Appendix V), which details the nature of the study and the contact details of both the researcher and the Supervisor of the study.

3.7.2: Field notes

"Be honest with people and keep your notepad out as much of the time as possible. Ask your informants for their permission to take notes while you are talking with them. If people don't want you to take notes, they'll tell you" (Bernard 2006 pg. 390)

During interview sessions I complimented audio-recording with field notes in form of jottings. Moreover for those who were not comfortable with the researcher tape recording them, they were comfortable with the researcher taking notes during the interview sessions. Field jottings according to Bernard (2006) in reference to what Roger Sanjek (1990) calls scratch notes, argues that the latter are what get one through the day, and that human memory is a very poor recording device, so keeping a note pad all the times and making field jottings on the spot is very crucial. This applies to both formal and informal interviews in homes and the street (Bernard 2006). More precisely Bernard's position guides the researcher on making field notes during data collection.

"Jottings will provide you with the trigger you need to recall a lot of details that you don't have time to write down while you're observing events or listening to an informant. Even a few key words will jog your memory later. Remember: If you don't write it down, it's gone" (Bernard 2006 pg. 389)

After leaving the interview site I would look for a place where I would sit and think through the jotted notes and interesting incidents during the interview session and put them into writing in the form of detailed field notes. Hence the field notes constituted data from the

formal interviews and observations during these interviews where participants would be expressing some issues and putting emphasis. This was again guided by Bernard's argument that,

"The faster you write your observations the more detail you can get down, more is better, and much more is much better."(Bernard 2006 pg. 390)

More fundamentally Moyo (2010) argues that writing field notes at the end of each session or day means that the memory of major incidents and conversations will be still fresh in the mind of the researcher and allows the documentation of the key points that inform the findings of the study. However, the major limitation with this method during the data collection was the inability to capture all the interesting points during the sessions as the main aim was to maintain the flow of the conversations and to avoid unnecessary interruptions. This was especially the case with those who declined to be tape recorded, but with those who consented to tape recording this data source was used as backup and constituted a part of the data on which later conclusions were based about maternal healthcare experiences during pregnancy and childbirth.

3.8: Data Analysis

Data was analysed through thematic content analysis. According to Anderson (2007), in thematic content analysis the researcher places the data into themes so as to provide commonality among the participants. Three steps were involved in the process of data analysis. Firstly, grouping collected data into themes, then secondly arranging the data into a display matrix and lastly considering the analysed data and assessing their relevance in accordance with the research questions. Data analysis was done concurrently with data collection to avoid accumulation of unanalysed data. The largest part of data was analysed through the review of interview transcripts and field notes. Major themes were picked from both the interview transcripts and the field notes and then subthemes identified and lastly some representative quotations were selected per category. The major themes and subthemes were related to the research objectives; moreover some were frequently repeated in responses during the interview session. The themes were examined within the context and objectives of the research as well as within the discourse of migration and health.

3.9: Ethical Considerations

According to Moyo (2010) ethical research practice refers to values and rules of conduct in research and consultation. Before carrying the fieldwork, the research was submitted for ethical approval to the Non-Medical Ethics Committee at the University of the Witwatersrand. Approval was granted on the 12th of September 2013 under protocol number H13/08/22 (see Appendix VI). Ethical clearance was a requirement of the institution in order to gain permission to carry the study. In accordance with the principles of ethical research I had to reflect on the risks that the participants could be exposed to, and safeguard the interests and safety of the participants. The Non-Medical Ethics Committee approved the data collection tools, verbal consent form, tape recording consent form and the participant information sheet.

Verbal consent was used for the participants to take part in the study, this was done to avoid participants signing a lot of papers and more importantly this was guided by the respect of various documentation status among participants hence need to protect them. This verbal consent was obtained after explaining the nature and benefits of the study that it is meant to improve the reproductive health status of women and also help to improve future maternal healthcare in public health care system in Johannesburg and South Africa in general. It was also clarified to the respondents that the study was aimed at improving the plight of migrant women during pregnancy and delivery, although it would not necessarily benefit them directly in some instances, it would somehow contribute to the improvement of healthcare provision.

I read and explained the consent script and obtained some verbal agreement to participate in the study which I tape recorded after assuring the participants that the information they would share would only be kept confidentially between them, the researcher and the research supervisor. The participants were also assured that the data would only be used for academic purposes and their real names would not be mentioned during the writing of the final report. The participants were asked to sign a tape recording consent form, and anonymity of the respondents was guaranteed by the use of pseudonyms. More so the interviews were carried at secure places where respondents were comfortable.

The entire research was carried in respect of the ethical code of conduct, guided by Biber's (2005) understanding that ethics is a matter of principled sensitivity to the "moral integrity" to ensure the research process and findings are trustworthy and valid. I informed the participants about the nature of the study (see Appendix V), and I gave them adequate time to decide whether to take part or withhold their participation. More importantly I made it clear from the onset of the interview sessions that the participants had the right to withdraw at anytime during the course of the study and they would not be forced to take part in the study hence they had to exercise their subjective choices.

3.10: Limitations and field experience

In this study the field experience included a number of challenges. After identifying the participants it was often difficult to arrange for the actual interviews to take place. This was mainly due to the participants' demanding schedules as the majority is self-employed and they are street vendors. More so, the fact that most requested to be interviewed during the presence of their husbands meant that we had to struggle to arrange for an appropriate time they would both be home. Hence it was difficult for some to schedule time for the interviews and it took numerous phone calls and negotiations to have them squeeze me in their tight schedules. However, this scenario, according to Denzin and Lincoln (2003) is not uncommon in qualitative research especially with the marginal populations who have busy family and working schedules. However, some appeared suspicious about what I was going to do with the information. In this case I took time explaining the research process and how I was going to write the final report to gain their confidence.

Furthermore those who were pregnant by the time of the interviews were suspicious of being tape recorded. They refused to be tape recorded citing mysterious events that are common on television whereby someone can pray for an individual and get healed by touching the screen. Thus, they also feared that their unborn babies could be affected if I tape-recorded them; however they were welcome and open to the researcher taking some notes during the interview sessions. More so, gaining trust among the participants was a big challenge as some participants tried to hide their identities and pretended to be South Africans. They even

quizzed the researcher using local languages, challenging him why he was interested in South Africa issues. However, due to the fact that I was referred to them by women in their social networks they would later open up.

The fact that the study focused on maternal experiences of migrant women and the researcher being a male figure posed some challenges since some respondents did not feel comfortable to open up. They felt that they needed the approval of their husbands and also demanded to be interviewed during their husbands' presence. The gender of the researcher as argued by Carling et al (2013) is a fundamental element of social identity that affects the experience of sameness or difference and this places the researcher as an outsider (Carling et al 2013). However this was minimised by the fact that some of the participants were well known to the researcher and snowball sampling helped the researcher to gain trust from the participants as I was referred by other women in their social networks.

Moreover there were some advantages of the researcher being part of the participants' culture and this placed the researcher as an 'insider'. According to Carling et al (2013) an insider researcher is a migrant or descendant of a migrant population who does research on his/her own immigrant group. This placed the researcher with the advantage of having linguistic and cultural skills that facilitated access to, and interaction with group members. Also the identity of the researcher as a student facilitated the participants' expression of solidarity and desire to help students from their home country to complete their studies.

3.11: Conclusion

Rich data was evident in interviews that were complimented by field notes and observations. More so, the inclusion of the currently pregnant women who were towards delivery and those who had recently delivered provided current dynamics in, and perspectives on the maternal health care discourse among the migrant population. Furthermore this enabled the research not only gathering rich data, but also relevant and current data. Although faced with some challenges such as the gender of this researcher being male, (which also threatened to drag the time frame of this study) the issue of nationality, (being Zimbabwean) strategically positioned the researcher as an 'insider'. Moreover, the manipulation of social networks and

snowballing sampling assisted the researcher to gain trust and support of the migrant families in Inner-City Johannesburg, South Africa.

The successive chapter below is the presentation of the research findings and their discussion. The research relied heavily on in-depth semi structured interviews, which were tape recorded and also backed by field notes with migrant Zimbabwean women who were pregnant and towards delivery attending ANC and also those who had delivered and also attended ANC in Inner-city Johannesburg public health care facilities.

4.0: Chapter 4: Findings and Discussion

4.1: Introduction

This section will begin with the presentation of the participants' background information and an introduction of the main themes that emerged in the interview sessions. The discussion is guided by the need to have a detailed understanding of access to maternal health care among migrant Zimbabwean women in Inner-City Johannesburg, by looking at their experiences during pregnancy and delivery. Thus to this end the study combines experiences and views of 15 migrant Zimbabwean women who were pregnant and towards delivery attending ANC in Inner-City Johannesburg and those who had given birth and attended ANC in Inner-City Johannesburg public health care facilities. The findings and discussions were done thematically, as five main themes were identified and divided into subthemes with representative quotations. The experiences of pregnancy and childbirth are deeply personal that are located in the larger context in society.

Table 1 below summarises the background information of the research participants, fifteen very different women who are all Zimbabwean migrants living in Inner-City Johannesburg districts of Hillbrow and Braamfontein with pregnancy and childbirth experiences in Inner-City Johannesburg public health facilities took part in this study. The age range of the participants was from 22years to 40 years (Table 1) as Dias et al (2010) notes that most migrant women are of the reproductive age. The participant women had different documentation status. Among the 15 participants, 7 participants were undocumented migrants who were having passports without permits or their passports have expired. Furthermore 4 participants were having valid permits, 3 being quota work permits and 1 having a study permit, also 2 were having permanent residence and the other 2 were having Asylum papers - a section 22 permit. However the documentation status of the migrants in this study reveals that it is not a challenge for them in accessing health care services in the public health facilities, as documents are only used for registration not for screening as to who has the valid papers. All the women maintained a heterosexual life, and in terms of marital status they were staying with their husbands serve for only one woman (Kudzai 28years) who was a widow by the time of the interviews. In terms of educational background most of the women have attained Ordinary level which is the basic standard of education in Zimbabwe, only

three participants were with tertiary level qualification Vaida with a Bachelor's degree, Tomara doing here Honours at Wits University and Doreen with her Diploma.

Table 2: Demographic Information of the Participants

Participant's name (Pseudonym)	Age And Marital Status	Education level	Duration living In South Africa (Inner-City Johannesburg)	Residential Area In Inner-City Johannesburg	Number of Children Delivered in SA	Citizenship Status
66 (Tinto)	35yrs (Married)	Ordinary Level	11yrs	Hillbrow	1	Permanent Residence
67 (Micky)	30yrs (Married)	Ordinary level	9yrs	Hillbrow	2	Passport without permit (Undocumented)
68 (Ayanda)	27yrs (Married)	Ordinary level	2yrs 4months	Hillbrow	1	Passport Without Permit (Undocumented)
69 (Vaida)	31yrs (Married)	University Bachelor's degree	5yrs	Hillbrow	2	Quota work permit
70 (Tomara)	23yrs (Married)	University Honours degree	4yrs	Braamfontein	1	Study permit
71 (Kudzai)	28yrs (Widow)	Ordinary level	9yrs	Hillbrow	1	Asylum
72 (Kundai)	40yrs (Married)	Ordinary level	17yrs	Hillbrow	3	Permanent Residence

73 (Memo)	38yrs (Married)	Ordinary level	6yrs	Braamfontein	1	Asylum
74 (Maria)	36yrs (Married)	Ordinary level	4yrs	Hillbrow	1	Expired passport (Undocumented)
75 (Fatima)	29yrs (Married)	Ordinary level	3yrs	Hillbrow	1	Passport without permit (Undocumented)
76 (Amanda)	36yrs (Married)	Ordinary level	7yrs	Hillbrow	1	Passport without permit (Undocumented)
77 (Lundi)	22yrs (Married)	Ordinary level	2yrs 8months	Braamfontein	1	Passport without permit (Undocumented)
78 (Gamuchirai)	26yrs (Married)	Ordinary level	3yrs	Hillbrow	8months pregnant	Passport without permit (Undocumented)
79 (Zora)	32yrs (Married)	Ordinary level	8yrs	Braamfontein	1	Quota work permit
80 (Doreen)	30yrs (Married)	Diploma	8yrs	Hillbrow	1 and also 7 months pregnant	Outa work permit

In this study, I primarily received help from Vaida, Tomara and Maria (Table 1) to locate other women from the community. Tomara in particular introduced me to her House Maid who linked me to other women in her social networks. Later, I also received additional contact information from participants about women in their social network, and then used the referrals from them to select other participants. More so during my regular visits to a hair salon were I get my hair done I met Doreen who had also come for her makeups she was pregnant and I introduced myself and my research topic. I requested from her if she was interested in taking part in the study, which she agreed and she requested if I could meet her the following day at Essellen clinic when she would be attending her regular ANC check-ups, she later introduced me to Lundi her friend who stays in Braamfontein. Although these

women had differing maternal health care experiences during pregnancy and childbirth the experiences reveal sentiments of powerlessness and discourse of othering mentioned in the literature earlier (Grove and Zwi 2006). More importantly the issue of health care access as affected by the broader social context in which an individual resides is tightly supported by the expressed views and experiences.

Basing on the transcribed interviews and field notes, both from the In-depth semi-structured interviews from the experiences of the fifteen participants, I identified five broad themes: (1) socioeconomic status, (2) service provider-patient interaction, (3) institutional administration, (4) social support, and (5) future plans. These broad themes and subthemes are presented in table 2 below with representative quotation from the participants on each theme provided. Although the other two themes that is social networks and future plans were directly adopted from the interview guide sections, the other three broad themes: socioeconomic status, service provider-patient interaction and institutional administration were driven from the broad interview guide sections on maternal health care experiences and migrant status. Furthermore despite coding the data into themes and coming up with a table, the analysis reveals that these themes are also fluid. Thus certain issues are cross cutting and are addressed in several sections, although they are approached from different viewpoints. During the interview sessions the issues of language, hearsay and social support were constantly raised by the participants. Language in particular was noted as the tool and entry point of how one was to be treated by the health care service providers. Tomara for example argued that South Africa is a rainbow nation hence they need to improve on language and tone.

"The language made it very difficult for me at Hillbrow so that's when I decided let me go to private since it was so uncomfortable for me. I could not ask them questions as I felt very intimidated, the ladies there at Hillbrow have very high pitched voices and it's the same as at Coronation it makes them unapproachable. So they should change tone and language" (Tomara)

This even result in some respondents seeking ANC at both public and private health care facilities as a way of compensating what they feel was half done at public facilities, Tomara, Maria and Ayanda did this while maintaining their Public health care visits. More

interestingly, although numerous issues were raised during the course of the fieldwork, hearsay also acted as a big motivator in delaying seeking health care services, this access barrier is tightly connected with Nour's (2008) and Binder's (2012) perceived barriers on the part of the mother or community in seeking health care in time.

Furthermore, although coding in thematic content analysis requires careful reviewing and comparison of both transcribed and field notes from the different participants, I however strongly believe the broad themes captured what continued to emerge throughout the in-depth interviews. Different issues were represented as more important, however on the issue of language and bureaucratic arrangement in the public health care system, women talked with the same voice and give some tactics they used to maneuverer the system, such as lying about the addresses they reside at during the registering day, for example Lundi has to use a friend's address at Windsor so as to be referred to Coronation hospital. The sentiments echoed during the in-depth interviews on the issues of access to health dig deep on the challenges faced by migrant women and these were mostly related to the acceptability component of access to health noted by McIntyre et al (2009) and Moyo (2010) and delays at the healthcare facility.

Table 3: showing themes and representative quotations

Themes and Sub-themes	Representative Quotations
Socioeconomic Status • Nature of employment • Power relations • Distance and taxi fares	*"During my pregnancy I could say I was a street person, because I spend most of my time in the street selling as I am self-employed and sometimes I go with big orders back home. Even the day I delivered, the previous day I spend it in the street selling, walking up and down" (Memo).*
Service Provider-patient interactions • Language • Discrimination • Documentation • Type of staff	*"They don't want to hear even the slightest English from a black person; they say we are not whites here. When they say that they then start to speak in Sotho or some deep Zulu which you cannot understand them, so it doesn't help at all" (Fatima).*
Institutional Administration • Bureaucracy • Time • Maternal cost	*"yeeee one has to register at a local clinic and that's where you go for all antenatal visits and they will refer you to a hospital or clinic. So when you are due for delivery you go to a health facility you are referred to" (Maria).*
Social Networks • Family Members • Hearsay	*"My sister was with me for a long time and a month before I delivered my mother in-law came and she was there until the baby was a month old" (Tomara)*
Future Plans • Going back Home • Facility change • Medical Aid	*"if I fall pregnant I would want to go and give birth in Zimbabwe because the staff there is caring, even if you call them they will come and check on you unlike here. So I will go back home unless it's an emergency I will go to Johannesburg hospital, not Hillbrow I will not go there again" (Fatima)*

This chapter will provide the in-depth analysis and discussion of the findings from the fieldwork. The chapter develops an analysis of maternal health care access that enables an appreciation of the experiences of migrant women in Inner-City Johannesburg public health care facilities. The structure of the section is based on the five themes that I have picked and the discussion is guided by the need to have a detailed understanding of the access to health care among 15 migrant Zimbabweans women during maternal period. Participants' maternal healthcare experiences were the most important part of this study and it was important to understand these experiences in the context of the migration discourse.

4.2: Socioeconomic Status

Considering the plight and living conditions migrants find themselves in the host communities, it was not surprising in this study to find out that the participants find themselves affected by the socioeconomic and political situation of the host community. The conditions the migrants live in also influence their maternal health seeking behaviours and also their attitudes towards the health care system. In this study the findings revealed that the participants living in Inner-City Johannesburg, the majority of them find themselves in the lower positions of the social strata where the search for livelihoods overrides all other facets of life. The social positions and the economic standing of these participant Zimbabwean migrant women militate against their access to health during maternal period either during their interaction with health care providers or in delaying seeking health care. More fundamentally the attendance of ANC has been an area which is greatly affected as most women interviewed either decides not to attend all ANC sessions or just not attend at all until the day of delivery. This has been due to their economic standing which affect their livelihood and keep most women at work even though they need rest. This is further exacerbated by the fact that most are working in the informal sector.

The findings from the face-to-face interviews were even strengthened by the fact that some of the participants were always on the street selling and this made making real appointments for interviews difficult and resulted in some interviews being conducted at the participants' work places. This in particular was done with Memo at Park Station Taxi rank, Kudzai who works at a Saloon in Braamfontein and Fatima who was constantly postponing the interviews because she was running around with orders to her clients around the city. More so the

participants although some being formally employed agreed to the mere fact that as migrants it puts them in disadvantaged position in the host society. This constantly raised issues during the interview sessions which revealed that during health care seeking the healthcare providers will also act as agents of power who constantly reminded and treated the participants as outsiders who do not deserve the services. All the participants expressed the issues of them not having much say and choice during health care seeking, revealing the issue of powerlessness and vulnerability at the hand of the healthcare providers. Thus the discourse of power and power relations in society being topical and giving the prominence to the issue of hierarchy and status in society as running even through state institutions.

The theme of socioeconomic status is a strong theme in the maternal health care experiences of the women who participated in this study as they also laments the fact that the issue is not only of being foreign, but being Zimbabwean which is very critical when trying to access maternal health care in public healthcare facilities.

4.2.1: Nature of Employment

Livelihood activity is an issue that was constantly raised during the interview sessions. The maternal experiences of the participants revealed the purpose why they are in South Africa, in doing this they were revealing the nature of employment activity they engage in for survival. As such these migrant women highlighted that they would work until they are due for delivery as the majority are self-employed in the informal sector. This section will expound how the nature of employment affected access to health and also how this revealed the social position of the women in inner-city Johannesburg as they are exposed to a new socioeconomic environment. This confirms WHO (2007)'s position that all societies have social hierarchies in which economic positions and social resources are distributed unequally. This in-turn affects access to healthcare among the migrant population in terms of seeking healthcare early, also managing time to attend ANC regularly and resting. Moreover this also sheds more light on how one takes and adheres to healthcare provider instructions and social networks an individual makes which will inform health seeking decisions. Although this issue of social networks will be explored further here this concept is critical as the employment arena is crucial in network formation and diffusion of information which later influence healthcare seeking decisions among the participants.

When the nature of employment is presented, aspects of work as being formal or informal takes centre stage and consequently calls in the need for the analysis of the working conditions in these two broad categories. In this study almost all the women were employed in the informal sector either as hairdressers or selling in the streets, save for Vaida who was formally employed in the insurance sector and Tomara who was a student by the time of the study. This provided a host of challenges the participants face in the host community, especially during pregnancy as they battle to make ends meet. This according to Dias et al (2010) typified the position that taking a gender perspective immigrant woman is more likely to be in a more socially disadvantaged situation of poverty rendering them vulnerable. Memo reveals how she struggled to make money for survival and at the same time trying to manage time to attend ANC regularly, she revealed during the interviews that,

"For me I don't want to lie, because of the fact that I am self-employed, I sell in the streets and sometimes I go with big orders back home, sometimes I could skip or miss ANC visits, because I also wanted money, which resulted in me attending only two ANC visits, and then the delivery day". (Memo)

This clearly reveals that the issue of access to health is greatly influenced by the nature of employment. More fundamentally maternal healthcare experiences of these migrant women shades more light on their social life in Inner-City Johannesburg, as they work tirelessly and even risk their lives because they want to make money for survival as Memo further says:

"During my pregnancy I could say I was a street person because I spend most of my time in the street selling and I did not have any complications or illness so I could walk around selling and even the day I delivered the previous day I spend it in the street selling, walking up and down". (Memo)

Sharing the same experience of working until the day of delivery is Maria, who although acknowledging the existence of social support from close relatives and friend with household chores she could not stop going to work selling in the street because for her it was the source of income for the family. She worked until she was in labour and then walked to the hospital after work; this extract from part of the interview session with Maria details how as a migrant

Zimbabwean woman she valued working. This deeply revealed how as a woman she carried the burden of providing for the family as poverty affects in a new socioeconomic environment.

"Not in so many ways just to help with household chores like cooking and laundry, my husband and sister in law used to help in that. But I would go for work because I needed the money. The thought of staying at home would remind me of how much money I would have missed in a day that I stayed away from work. Also staying at home was not a good thing as I would get bored by being idle so I worked until the very time I was due".(Maria)

Furthermore on the aspect of the nature of employment, besides impacting on women by either skipping ANC visits or working until the labour time, Kudzai's experience revealed another dimension to healthcare access among migrant women during maternal period. She was working as a hairdresser and this to her had its own drawbacks, she delayed seeking medical healthcare until she was six months pregnant, and even skipped ANC visits because her boss was not giving her time off to go to the hospital. At the same time personally she was feeling fine so she did not see any reason to attend ANC. Hence she only registered her pregnancy and then waited until the day of delivery

"I was given dates to go back, but I was working every day. I was staying alone, so I was not getting time, at work my boss did not give us time. I was not really bothered to go also because I was not sick, I was fit and I never needed medical attention. I was doing alright". (Kudzai)

The situation of Kudzai confirmed the first delay by Nour (2008) and Binder (2012), which is the delay in seeking medical care resulting from perceived and actual barriers on the part of the mother, family or community. This is further cemented by Kudzai's sentiments when further pressed if the issue of skipping ANC was solely due to not getting time off work. The issues she raised digs deeper into the issues of social networks either at work or at home. This confirms the importance of informational social support by Harley and Eskenazi (2006), which is related to the provision of advice, information and guidance by others.

"I also heard from others at work that at the clinic the nurses shout at you, so I just said let me avoid going there so that I just go once ad get shouted at once. I was scared of them

shouting at me so I withdrew from going so that I will go at delivery and they shout at me once and for all". (Kudzai)

Although those who are informally employed have challenges in accessing and balancing time at work and time attending ANC, Vaida who has formal employment as an insurance consultant has a different experience altogether as she got maternal leave early during her two pregnancies. She even confessed that her boss was more supportive and understanding beside the fact that she is Japanese and very strict:

"I had so much support from my immediate family, from the maid and even from work. From the very first time people were supporting me, they were very supportive even my boss with my first pregnancy. I started my maternity leave very early, maternity leave here is 4 months but mine was close to 5 months". (Vaida)

From this there is direct contrast were those informally employed they had challenges during maternal period especially when it comes to attending ANC as they could not balance time between work and ANC care visits. They were more on reaching more clients and making money as they know their disadvantaged economic position on the contrary being formally employed for Vaida provided here with enough support from both work and at home and also getting enough maternal leave which gives her enough rest. However the general picture justifies WHO (2012) that while motherhood is a positive and fulfilling experience for many women, it can in many cases be associated with suffering, ill-health and death. This can be deduced that as migrant Zimbabwean women in Inner-City Johannesburg most of the participants are socially and economically occupying low level jobs with little returns but requiring a lot of investment in terms of energy and time. As a result, this compromised their maternal health status as part of migrant population.

4.2.2: Power

This research found that healthcare providers although they are constitutionally obliged to serve every patient with respect and timely regardless of citizenship status, they occupy a more powerful position in their execution of duties. This is clearly exposed by the way they interacted with migrant women in this study during ANC visits and during delivery. More interestingly the sentiments expressed by some of the participants as the reasons for delaying

seeking care and skipping ANC visits are loaded with discourse of powerlessness and perceived fears, because of real past experiences, hearsay from friends and other significant people within their social networks. Specifically the perceived fears of being reprimanded and the actual fears of being shouted at and being ignored are some of the realities they raised. The images of the healthcare providers as having power affect migrant pregnant women's willingness to seek healthcare (Aday and Anderson 1974), consequently the participants sometimes feel not empowered to approach and even express what they are feeling. In some cases the healthcare providers act without the consent of the patient only to advise them on the day or time of discharge that they have injected them with birth control injections such as Depo-Provera. The concept of power has been elaborated by the majority of the participants when they reveal how they have been shouted at and also neglected during ANC and delivery, Maria in narrating her experience at the hands of the healthcare providers has this to say:

"When I was in labour I went to Hillbrow Hospital but the experience was not good at all. When I got there I was told that all beds were full, they then told me to sit on a chair although I was in pain and about to deliver. I sat on the chair until I saw that it was no longer comfortable on the chair and the baby was almost coming out, I then told the nurse and she shouted at me saying I did not bring a bed from Zimbabwe therefore I should stop being a nuisance and sit where I was told to sit. I then went to the labour ward without permission from the nurse on duty and I helped myself to the bed. The nurse never bothered to come to me and I delivered my baby on my own and I woke up and put the baby away as I feared that the blood would affect him…….. " (Maria)

Maria's experience is one of the touching stories as she had to suffer and had to deliver the hard way, in her own opinion she had no choice or option she had to endure the pain. As she was denied any resting or being consulted about how she was feeling and only to be instructed to sit on a chair, this and the experience of other women clearly bares how the actions of the healthcare providers affects access to health by affecting the degree of fit between clients and the healthcare system as noted by Thomas and Penchansky (1984). Thus in confirming access to healthcare as the empowerment of individuals to be able to use healthcare services when needed (McIntyre et al 2009), which is done through the interaction between the healthcare providers and the participant migrant women during maternal period.

This reveals how migrant women are disempowered and denied life serving care, hence critically compromising their lives and health status. This was even confirmed by the experience of Fatima who has this to say regarding her birth experiences at Hillbrow hospital:

"Whilst in that ward I could feel that the baby was already much closer to delivery and I told the nurse……all break loose and she shouted at me. She said this is not in Zimbabwe where you play all soft, here we don't do things that way, why are you being too forward. Here you only do what we tell you not you telling us what to do. The one who was shouting at me was speaking in Zulu but I could hear all she was saying, but I told the students that I could not stand up and walk on my own. So I called that nurse who was shouting at me and she said "it's up to you if you push your child in that room, you will kill your own child and I would not care. I'm telling you to wait pushing until I say so but you are not listening." (Fatima)

The sentiments expressed here, are loaded with notions of anti-foreigner and having no control towards one's body and health. This confirms Grove and Zwi (2006)'s argument when they deploy the concept of othering in health provision, that the person or group being othered experiences this as a process of marginalisation and disempowerment and social exclusion which effectively creates separation between, "us and them" (pg1933). This othering in this situation based on health status and ethnicity has negative consequences on the delivery of healthcare services. More interestingly is the fact that the qualified nurse are the once who are caught on the wrong side of discharging their duties, with the students nurses very forthcoming in assisting migrant women mainly during delivery, this I could argue might be due to the fact that they are still learning and yet to qualify hence they feel less powerful to ill-treat patients, as most participants shows an appreciations of services they get from student nurses.

Furthermore this concept of power revealed through the interaction of the participants and healthcare provider is also a critical aspect that affect the right to access health in terms of its acceptability and quality of healthcare as noted by the IOM (2013), and also the right to be free from cruel, inhuman or degrading treatment (HRW 2011) which include verbal and physical abuse, denial of care, neglect and delays and some cases of treatment without consent. Fatima has this to say as she expressed her pain of given treatment without consent and how she was in fear of asking the healthcare providers:

TM: so when you give birth there is nothing else they give to you?

Fatima: not much, they just injected me Depo-Provera (for family planning) and another pain injection to numb the pain.

TM: Depo- Provera is a family planning method right? Had you asked for it or they just injected without you requesting it?

Fatima: They did not ask me they just injected me and they inject everyone who gives birth there. They only told me on my way out that they had injected me Depo-Provera. You cannot ask those people anything, they also do not give patients a choice.

Tomara and Kudzai also pointed to the issue of shouting and having high pitched voices which made the healthcare providers unapproachable, Kudzai pointed that besides her being told disheartening word she could not do or say anything in response since she was the one being in need of services. The issue of language also acts as one of the militating factors for one to feel empowered to approach and ask for any assistance from the healthcare provider and this was worsened by the high pitched voices of the service providers, as Tomara has to decide to leave Hillbrow hospital and go for ANC visits at Netcare Parklane private Hospital, she has this to say:

TM: What of the Hillbrow clinic you said you went there the very first time?

Tomara: the language made it very difficult for me at Hillbrow so that's when I decided let me go to private since it was so uncomfortable for me. I could not ask them questions as I felt very intimidated, the ladies there at Hillbrow have very high pitched voices and it's the same as at Coronation it makes them unapproachable. So they should change tone and language. Hillbrow was actually very clean as I actually realized they had just renovated.

The image of healthcare providers as powerful and the sole decision makers in either providing or denying healthcare has serious consequences and traumatic implications on the part of the migrant pregnant women. This has been expressed by Lundi as she narrated how she was traumatised by being send home while she was already in labour and her experience reinforces the position by Silal et al (2012) that poor provider-patient interactions including

inattentiveness of staff to patients' condition and turning away women due to not being ready to deliver can lead to avoidable maternal deaths, as she says:

"It was not easy; I was faced with so much pain and being send back home when I was already in labour. I asked myself questions like why did they send me back home at that point when I was in labour, what could have happened to my child if I did not get back to hospital that quickly. So it was so difficult for me". (Lundi)

The weaker position of the migrant women is also further exposed by the bureaucratic structures within the health system which leaves them with little choice. The unwillingness of the healthcare providers to give assistance to a woman who reported at Hillbrow hospital seeking emergence healthcare as narrated by Gumuchirai, while not registered to deliver at that particular institution exposes the power dynamics. This and other experiences raised by other research participants also calls for an understanding of Anderson (2004) position that healthcare workers are seen as responsible for bringing undue social priorities and cultural norms into their ideally culture free work there-by affecting professionalism. As such some patients are treated with attentive kindness and respect while others are made to wait, are treated with discourtesy, given less information and accorded less time. From the field notes Gamuchirai who was eight months pregnant has a touching story when she was narrating how one Zimbabwean woman gave birth at Hillbrow Hospital's entrance gate because of the nurses' refusal to assist her since she was not registered to deliver there:

"One Zimbabwean women delivered at the gate at Hillbrow hospital because the nurses were refusing to assist since she was not registered to give birth there, and when they later decided to give a hand the nurses who brought a wheel chair did not even touch the women they only instructed those who were with her to assist her to the wheel chair" (Field notes, 24-10-2013)

The concept of power as deployed in this research revealed how the women are made to suffer during ANC and delivery and denied any voice when they try to access health. This has a huge impact on the acceptability and quality of the healthcare services as noted by (IOM 2013), also the views by the participants on the interaction between them and the

healthcare providers during pregnancy and delivery are permeated by the discourse of language and ethno-nationality rendering migrants to be constructed as socially illegitimate (Willen2012). More interestingly this is akin to the analogy by Vroom(2011) that the biggest challenge lies in addressing the structural violence that silently suppresses the voice of millions without access to healthcare and it is structural violence in the medical world on a large scale that often determine who falls ill who has access to healthcare. Thus exposing the central role of power as expounded through the concept of social position in the social determinants of health equities (CSDH 2012).

4.2.3: Distance and Taxi Fares

For the world of access to healthcare IOM (2013) defined accessibility as physical accessibility in terms of the geographical aspect and economic accessibility in terms of taxi fares. More so, in elaborating the access dimensions in terms of availability and affordability McIntyre et al (2009) touched on the geographical distribution of the healthcare facilities as very critical and in so doing they noted time and costs of getting to service providers. It is worth to mention here with regard to distance and taxi fares that is tightly linked to time and social support by friends which I will explore in other sections. The findings of this study are contrary to those of other studies by Silal et al (2012) and Tlebere et al (2007) on access to maternal health carried in South Africa mainly because they were carried in rural setting where distance and road conditions is a challenge. In inner-city Johannesburg the issue of distance and taxi fares is not a problem at all as most of the clinics and hospitals are well networked and within walkable distance. More so some participants even appreciated how travelling between hospitals on referral is not problematic as they are well serviced by efficient ambulances, but the challenge is when one tried to call an ambulance at home they will not respond in time. Fatima's piece in justifying why she preferred going to Albert clinic during ANC visits she says:

Fatima: The staff at Albert is better that is why I prefer going there even if I have to catch a taxi to go there.

TM: so how much is the taxi to Albert?

Fatima: It's cheap just 5rands

However during delivery since she is staying next to Hillbrow hospital she had to just walk slowly to the hospital. Although distance and taxi fares are not a challenge in accessing clinics and hospitals in Inner-City Johannesburg (availability and affordability side), the issue at stake as revealed by Fatima is on the acceptability of the services represented by her consciousness that the ambulance service department is problematic when one request it when at home

Although there are many versions on how the participant women attend ANC and delivery, their stories did reveal that access in terms of availability and affordability of public healthcare services is not a challenge from their experiences, due to the proximity of the places of residence to the facilities. Tomara who is a university student at Witwatersrand had an interesting version as she used both public and private healthcare facilities throughout her pregnancy and then Public health services (delivered at Coronation). Since she stays in Braamfontein and attending ANC at Essellen clinic in Hillbrow, for her it was a walkable distance of less than ten minutes. More interestingly when she decided to also use private healthcare facilities at Netcare Parklane hospital she would use the Wits University bus to and from as the buses passes through the place, she has this to say:

"So me being a student I decided I have got so much to do, I have got classes to attend to and at times assignments such that I didn't have much time to spend following the queue hence I decided to go to a private medical facility for my antenatal checks. I used Netcare Parklane, I would take the Wits bus and drop at Wits junction and walk to the clinic then catch the bus again back to Wits". (Tomara)

This further digs deeper to the issue of time, as not impacting access to health in terms of not only time spend travelling, thus the second delay in reaching the healthcare facility due to road condition, lack of transportation or location resulting in most women with life threatening condition not making it to the healthcare facility (Nour 2008). But is more on the actual barrier (third delay) at the healthcare facility were time is spend queuing or waiting to be served (Nour 2008 and Binder 2012). Thus time in this study will be further examined under institutional administration as an important challenge that not only migrant women

face. For the purpose of this study its greater effect is on the participants as they try to balance with the search for livelihoods.

Furthermore Tomara revealed how social network helped her when she was in labour; her friend who owns a taxi was there to assist here so she didn't face any challenges travelling to and from Coronation hospital where she delivered. Also when she had to go back after delivery for collection of the birth record to use at home affairs the friend provided with transport. This confirms Harley and Eskenazi (2006)'s sentiments on social support as a resource provided by others during pregnancy particularly family and friends. In this case of Tomara it was instrumental support, as it was tangible assistance with concrete needs. Kudzai and Lundi also reveals that the taxi fare were not that expensive, as Kudzai has to part with sixteen rands (R16) to and from the clinic per each ANC visit and distance between the hospitals was not an issue as they are well connected and serviced by ambulances as she was transferred from Hillbrow hospital to Johannesburg hospital. Lundi although she has to fork out thirty rands (R30), to her it was not that expensive as the ANC visits were done once per month. However, when she was mistakenly send home at Coronation hospital when she was already in labour, she has to quickly hire a Cab back for about two hundred and fifty rands (R250), which she rightly point was very expensive but she and her husband has no option.

4.3: Service Provider-Patient interaction

The concept of the interactions between health care providers and the participant women in this study sheds light on the access to healthcare dimension of acceptability and exposes the actual delays at the healthcare facilities in getting medical attention. More interestingly the interaction between all the access variables (McIntyre et al 2009) is elaborated from the narratives of the experiences of the participants during ANC visits and during delivery. Moreover these experiences as confirmed by the pieces of stories told during the interview sessions also informs on some migrant Zimbabwean families and women's future plans in case of an further pregnancies. The sentiments are of going back home and these sentiments some of them are full of regrets.

The subthemes I have identified situate the experiences of the participants during pregnancy and delivery within the broader social determinants of health argument. This according to the

CSDH framework (2010) allows the framing of health as a social phenomenon which emphasizes health as a topic of social justice broadly and I argue it calls for the need for the treatment of the issue of health care provision as a moral obligation. The CSDH framework (2010) notes structural mechanisms as those that generate stratification and social class division in society and define socioeconomic positions within hierarchies of power, prestige and access to resources. More fundamentally these structural mechanisms are rooted in the key institutions and processes of the socioeconomic and political context (WHO 2012).

Thus with the data I gathered from the women in this study, helps in understanding the differential treatment of patients during health seeking in public health care facilities as a function of social structures which position people in society (Framer et al 2006). Fundamentally Mechanic (1992) acknowledges health as a product of culture and social structure. Moreover Anderson (2004) and Moyo (2010) argue that differential treatment of patients by health care providers in African medical institutions is widespread and even acknowledged by patients, health workers and policy makers alike as a problem in realizing government policies of equity in health care provision. As such the issue of language, discrimination, documentation, delayed care and racial preference among patients are topical in the narrative of the participants' experiences. However, it is interesting to note that in all these sections the central concept of power and othering runs throughout the stories.

4.3.1: Language

The participants spoke about language as the major challenge in access to healthcare services in public healthcare facilities. In a migrant dominated context like Inner-City Johannesburg the issue of membership and belonging (Landau 2005) is common and it infiltrate into public institutions as Anderson (2004) argues that healthcare workers are seen as responsible for bringing undue social priorities and cultural norms into their ideally culture-free work there-by affecting professionalism. Stories emerged from the interviews pointed that language is used as an entry point to screen patients as healthcare providers wanted them to speak local languages such as Zulu and Sotho not English. The case of Maria's experience at Joubert Park clinic bares it all as she says:

"I think it was the first day I went to register. We were all taken inside, we were asked questions to do with maternity and child birth, like why babies need to be immunized against diseases like Polio. We were all mixed foreigners and locals, then a Zimbabwean woman responded in English and she was send away. They asked another question and picked on a Zimbabwean again and she responded in English and she was send out again that's when the nurse said if you know you don't understand or speak Zulu you better go, if you are Zimbabwean why do not you go for antenatal in Zimbabwe? I was only left alone because I can speak a little Zulu so that's how I survived". I registered but later own I had problems with my legs. I went back to the hospital and to explain my problem in Zulu was a problem I had to use English to be understood, that's when I was told they could not assist me I had to go to Zimbabwe".

Although English is one of the official languages there is much resentment among local healthcare provider for its use, also most participants finds difficulties in expressing themselves in these local languages and this typifies Vearey (2011) sentiments that international migrants often struggle to communicate with healthcare providers as interpreters are not present. Tomara also revealed that speaking in English however is helpful to foreigners; her argument was that South Africa as a Country is a rainbow nation in terms of its diverse migrant population. This cultural diversity suffices that not everyone could speak local languages and it also makes life difficult for foreigners to approach and express themselves. Hence creating an access barrier and also being the reason she decided to also use private healthcare facilities at the same time with public facilities, as the narratives from Tomara hints here:

"The language made it very difficult for me at Hillbrow so that's when I decided let me go to private since it was so uncomfortable for me. I could not ask them questions as I felt very intimidated, the ladies there at Hillbrow have very high pitched voices and it's the same as at Coronation it makes them unapproachable. So they should change tone and language" (Tomara)

More so, when pressed further on what should be done to improve maternal healthcare in public healthcare facilities, Tomara overemphasized the language issue, and she pointed out that at Coronation Hospital where she gave birth; the doctors tried on this regard.

Nonetheless, she was quick to point out that the challenge is when interacting with other staff members.

From the field notes, Hillbrow Hospital was picked as largely staffed with black population and this was noted as posing a great challenge to migrant patients trying to access healthcare services in general:

"What makes those nurses to be angry and shout is the failure to follow instructions properly, language is the main problem especially at Hillbrow they mostly use their local languages, maybe because there is more black nursing staff, than at Johannesburg hospital".(field notes, 19-10-2013)

In line with Moyo (2010)'s findings in his study that access acceptability becomes important in the South African public healthcare system because of the presence of cross border migrants and the interaction between this segment of the migrant population and healthcare providers is in every way permeated by the discourse of culture and language. Fatima's story is loaded with challenges she faced due to language in trying to access maternal healthcare. She however, underlined that language is the source of most of the ill-treatment in clinics and hospitals in Inner-City Johannesburg, as foreigners faces problems of expressing themselves in local languages and even English. More so, language complication also has very detrimental effects on migrants as they also witness delay in getting help from the healthcare providers when using English.

TM: you have said so much about language……. (She interrupts)

Fatima: yes because language is really a major problem, they just want you to speak in their language, if you speak in English they ignore you and pretend not to get what you will be saying. So for me I only understand Zulu but I cannot speak back and I respond in English and this other nurse shouted at me, I had to tell her that I try to learn but I just can't catch their language.

The language complication, is closely connected to the issue of discrimination and othering as although I am going to look at it separately the inter-linkage among different access variables is also exposed here as the fact that one understands and is able to speak any South

African local language as in the case of Kudzai who is Ndebele, she was not spared the suffering. Although she did not face any communication challenges she however suffered ill-treatment and exclusion because of the assent in her tone that tell that she was not South African but Zimbabwean, here in one of the script she bares her experience during delivery at Johannesburg hospital:

TM: So in short how can you describe the service you got from the hospitals?

Kudzai: The nurses that helped me especially the young lady shouted at me saying you Zimbabweans you just come here to give birth. When I gave birth I was not shouted at but in the morning when they do their morning checks that's when the shout at you and when you go to take your bath.

TM: so these morning checkups do they do them one patient at a time?

Kudzai: No they are done in a group.

TM: So how do they know that this is a Zimbabwean?

Kudzai: they know by the way we speak that this is a foreigner. Also the time I gave birth most of the people who were also there giving birth were mostly from Zimbabwe.

This situation fits nicely in the access triangle by McIntyre (2009), by the mere fact that language and cultural diversity impact attitudes of healthcare providers and vice versa. The information I gathered from the respondents reveals that they are convinced that the issues are not about being a foreigner, but being Zimbabwean. Also healthcare providers on the other hand views Zimbabwean women as giving birth too much than South Africans rather than comparing them with all other nationals in South Africa.

4.3.2: Discrimination

Being migrant patients, some of the participants often spoke about being segregated by healthcare providers during ANC visit and delivery period. The degree of this challenge reveals the commonly held attitudes and perceptions in the general South African society which assign migrant population to social positions as socially undesirable and it is a key finding which cannot be separated with that of nationality hence I combine them together.

Landau (2005) argue that in Johannesburg as locals compete for space and resources with non-nationals they resort to nativist idioms, which results in international migrants being othered and treated as not belonging hence not deserving the services. This according to Willen (2012) when exploring the concept of othering she observed that South Africa's deeply rooted commitment to universal healthcare access and right to healthcare is impaired. This harmful discourse of othering which set apart migrant patients from the mainstream population as highlighted by Grove and Zwi (2006) mostly in the case of this study based on ethnicity and nationality has negative consequences on the delivery of healthcare services. Moreover although Willen (2012) argues that this harmful discourse of othering as a significant obstacle to healthcare access, as negative portrays of unauthorised migrants also influence the attitudes of healthcare providers towards their unauthorised migrant patients and these practitioner's clinical conduct. Hence all this exposing migrants to ill-treatment, the findings of this study reveal that the issue is not confined to only unauthorised migrants but to all migrants as nationality and ethnic identity take relevance during service provision. Maria adamantly says:

"I would just say if they stop segregating it will be good, they should just treat patients equally. They should not give service according to nationality but just serve everyone as a patient not South African, Zimbabwean or Mozambican. Segregation is the most rampant challenge in the community clinics. They should love every patient and be polite and kind. They also should not ignore patients when they call for help. They should constantly check on patients". (Maria)

This aspect of discrimination which is defined either as othering, or in terms of exclusion and denial of the services because one has a migrant background is also tightly connected to the concept of power and which according to the CSDH (2010) is sometimes equated to domination in a negative sense as the stories from the respondents reveals that when it comes to access to healthcare as migrants they are powerless and vulnerable to ill-treatment, hence being disempowered to approach healthcare facilities in need of healthcare, hence elaborating the issue of empowerment by McIntyre et al (2009) and consequently affecting access acceptability. More interestingly Maria expressed that Zimbabwean nationals are viewed as a burden to the healthcare system and being a demographic threat, this was at Hillbrow during delivery. As she says:

"The other nurses appeared to be busy with other patients. The one who was meant to attend to me was sleeping on the passage way on the heater, it was in May and it was very cold. She was claiming that they were so tired of only attending to Zimbabweans, we have had a number of Zimbabweans today and you could be the 17th today. We need to rest, you Zimbabweans are giving us to much work whilst no South African is coming. So I went to the hospital but ended up giving birth on my on with no professional assistance". (Maria)

Thus nationality here is being used as the basis of being denied services at the healthcare facility. According to IOM (2013) different forms of discrimination creates obstacles for the realisation of the right to access health and other rights of migrants. Most often the state uses nationality or legal status as the basis to draw the distinction between persons who may and may not enjoy access to health-care facilities, goods and services. This scenario from the extract from Maria is in direct violation of the human rights (IOM 2013) aimed at safeguarding the inherent dignity and equal worthy of everyone regardless of nationality.

The issue of ethno-nationality cannot be separated from the concept of discrimination and othering discourse. The interesting part here is the issue of Black to black hatred as elaborated by Katsaura (2013) when digging out the concept of ethno-nationality within Inner-City Johannesburg as part of the public culture. The power of these discourses infiltrates into the health care system in South Africa and suffocates foreign nationals as revealed through the experiences of the women in this study during ANC visits and delivery period. The demand for the use of local languages results in isolation of foreign nationals. Although English is one of the official languages, the demand by black healthcare providers to use either Zulu or Sotho is rampant in the healthcare system, further exposing the black South African nationals and black migrant population stand-off situation. In this study Zimbabwean migrant women confessed their preference to being assisted by white healthcare personnel as they are more helpful hence the concept of race is viewed positively as Fatima, and Maria who openly claimed that white healthcare providers are better and more sympathetic than blacks. Kudzai in the same path of thinking has this to say:

"I was assisted by a young lady at Johannesburg hospital, that nurse shouted at me saying you Zimbabweans you just come here to give birth. She said a lot of bad things about Zimbabweans coming to South Africa but as someone who wanted help I never said anything

to her and did not take her words to heart. Then came a white nurse, she never shouted at me she just helped me in a very nice and good way, then she put me on machine and they took me to the labour ward, but still I was not in active labour".(Kudzai)

These scenarios as experienced by kudzai, Maria and the other women during pregnancy and delivery I argue affect access to health dimension of acceptability and quality of healthcare as noted by IOM (2013) and WHO (2007). This is linked to the social determinants of health in this case in Inner-City Johannesburg which position people according to ethnicity and nationality. More fundamentally, these findings justify Farmer et al (2006)'s argument on structural violence on why certain people in society are particularly at risk of unnecessary suffering. The issues of ethno-nationality as a rule of accessing health, in this case maternal health has become one of the strong reasons why most women are emphasised the need to return back home and give birth there in case of a further pregnancy and also willing to advise others to take this path.

4.3.3: Documentation

"They don't look for permits, but they ask for a passport to get your personnel details for the records". (Field notes 13/10/2013)

Generally from the experiences of women in this study living in Inner-City Johannesburg during pregnancy and delivery, documents were not a real issue. The healthcare providers only asked for documents in order to get the correct records, they are not concerned with the validity of the documents and migrant status. As IOM (2012) noted that no one can be refused medical treatment because they do not have an identity document, however it pointed that, it is advisable to carry an identity document for the first time one visit a particular hospital or clinic. According to IOM (2012) this makes it easier for the clerks for preparing personal files. This is even confirmed by the fact that of the fifteen participants, six were undocumented migrants with passports without permits and one undocumented with an expired passport. This is in line with the South African constitution section 27(2) and (3) which provide for the right to access emergency healthcare for everyone in South Africa regardless of nationality or residence status, hence confirming IOM (2012) position that the highest law cannot be ignored just because one has no proper documents. More so Moyo

(2010) in his study also comes to the same conclusion that documentation is not really a challenge as healthcare providers confided that they only ask for documents when the patient does not speak any of the local languages to get the correct names and spellings. Lundi confirmed this and went on to suggest that they ask for the permit after delivery when one needs to get a birth certificate, as this script form part of the interview session with her reveals:

TM: Do they ask about documentation at the hospital?

Lundi: Yes they ask for IDs, but if you have a passport it's still fine so I used my passport.

TM: Do they ask about validity of permits or something?

Lundi: no they do not ask about permits for treatment, but when you want to get a birth certificate the permit is required.

Documentation is interlinked with the issue of delay in seeking healthcare and hearsay, Fatima and Memo had to delay seeking healthcare because they have heard from others in their networks how at the healthcare facilities they denied services to patients without documents. They both registered when seven months and six months pregnant respectively. More interesting Fatima has to have her passport stamped out at the border and keep it without days, however their stories were loaded with perceived fear reinforced with hearsay and this was elaborated by Munyewende et al (2011) as they argue that besides the fact that the south African constitution guaranteeing the right to access to health for all, this is mired by uncertainty and many migrants do not access healthcare for fear of being asked for official documents and deportation. Kudzai confesses her fears of being asked for documentation by suggesting herself that she has an asylum without being asked for it, as this script bares it all:

TM: Let's talk about the issue of documentation, since it's one of the issues that trouble foreigners in most cases, What kind of documentation did you hold when you went to the hospital?

Kudzai: I had an asylum.

TM: Do they ask for documentation at the clinic?

Kudzai: you mean do they ask for asylum?

TM: yes

Kudzai: No they did not ask for it but I just told them that I had an asylum.

The experiences were mixed from being asked for documents for recording purposes to not asked, but the bottom line is that the documents were not used as a basis for screening. Tomara and Maria were not asked for documents and more interestingly they both used both Public and Private Facilities for ANC and then delivered at Public hospitals, Tomara giving birth at Coronation Hospital and Maria at Hillbrow Hospital, but they were never asked for any identity document. As Tomara' say:

"No they do not ask for documents, I had them but they did not ask for them. At Netcare I was using my medical aid so they also did not ask for my passport although I had it". (Tomara)

Besides most of the participants not being asked about documents, Memo's case is a rare one as she was denied healthcare services at Joubert park clinic when she wanted to register her pregnancy. Although she reported her pregnancy early the challenge for her was documentation, this case confirms Vearey (2011) findings that some healthcare facilities generates their guidelines which runs against the national legislations, as some continues demanding South African identity documents and denying access to healthcare to foreigners. However I argue that with the detailed stories there is general acceptance of the need to provide health to all, but individuals might not be willing to provide healthcare services to the migrant population, although generally access to maternal healthcare is not be affected in Gauteng province. Memo's experience affected her accessing healthcare early only to receive care when six months pregnant after she had acquired an asylum paper:

"At first I went without documents and they refused to register me, so I had to go and get proper documents in Pretoria, after getting the asylum paper when I was six months pregnant thus when I went and register my pregnancy, but I went earlier when I was three months pregnant". (Memo)

4.3.4: Type of staff

During the interview sessions some participants mentioned student nurses several times in comparison with the senior qualified nurses' reception during delivery. The interaction here also revealed a lot to do with age and race hence I identified type of staff as a more inclusive term to capture their sentiments. Although I could have made separate sections on these issues, but they were always being presented as issues being influenced by the fact that one is either a student or a qualified nurse. The fact that one is qualified or still a student created a class structure within the healthcare system with the qualified nurses having power to deny patients healthcare and even being unapproachable from the way the participant narrated their experiences, and them preferring to be assisted by either students or white healthcare providers as noted in the access to healthcare framework by McIntyre et al (2009) (see figure 3 on the access to healthcare framework pg38). Drawing from Sargent and Larchanche (2011) and the CSDH (2010), I argue that there is a production of class which produced particular patterns of access to healthcare services were student nurses and whites as the preferred personnel by the migrant women during ANC and delivery. However the preference of student nurses also speaks volumes on the quality side of the healthcare services which has been noted by the IOM (2013) as the fourth aspect of the access to health framework. During delivery Fatima, Maria, Kudzai and Memo had student nurses coming to their rescue after being ignored by the qualified nurses. However, Lundi has a different experience altogether as she was sent home whilst she was already in labour. Fatima revealed that student nurses are always helpful and sometimes they do this hideously maybe because of fear of the senior nurses. More interestingly the student nurses at Hillbrow where Fatima delivered were mixed whites and blacks, but as for the qualified they were all Blacks and the qualified nurses preferred to use their local languages which even complicated the experiences of the migrant patients as they face challenges in communicating with them.

"No it was only 1 white student and the other students were black. But the students nurses are the ones who were helpful and caring, the qualified ones were so terrible. They did not even care for patients especially if they know that you are a foreign patient they will just leave you". (Fatima)

The experiences by Fatima shades more light on the interlinkages between the themes and subthemes I identified, although here the issue is about student nurses being helpful, the stories also reveals the place of race, the creation of nativist discourses and discriminative tendencies as pervasiveness among the senior qualified staff as pointed by Landau (2005). More fundamentally the findings of this study confirms the position by Silal et al (2012) and Blaauw and Penn-Kekana (2010) that although there is a higher percentage (91.5%) reporting having skilled attendant during birth, but these aggregated data hide use by specific population categories and for this study, how migrants are doing in this end, as the stories reveals that migrant population is more likely to be assisted by inexperienced healthcare providers.

Maria adamantly in her story defended her preference for younger healthcare provider than the older personnel. This age preference however took a different complexion when further asked to clarify her position, she exposed that actually she preferred student nurses as older qualified nurses are impatient with patients and they have negative attitudes towards foreigners when it comes to healthcare service provision. She also took the opportunity to make a comparison with the healthcare system in Zimbabwe where she noted some similarity in this regard. More over Maria is also of the view that the more one has witnessed women giving birth the more they hold labelling tendencies of women as being a nuisance as this extract from the interview I did with her on the 23rd of October 2013 reveals

"If it was younger nurses I think they were going to assist patients with love and patience. For maternity care I think they should put younger women not older ladies they are so impatient and to them they have seen so many women deliver such that they think women are a nuisance". (Maria)

The type of staff as portrayed from the stories of the respondents who has experience within the healthcare system in Inner-City Johannesburg during pregnancy and delivery particularly from Maria, Fatima and Memo also run with racial preferences. To them they prefer to be assisted by white personnel whom they view as sympathetic to the foreigners. Furthermore Kudzai, and Ayanda in their future plans confessed their desire for institutional change from Hillbrow hospital to Johannesburg hospital in case of a further pregnancy and their main

reason being that at Johannesburg hospital there are a lot of white personnel, hence increasing their chances of being treated nicely. Maria has to say this:

"At Johannesburg hospital they say its better because there is so many white healthcare personnel, the whites are better. They are not bad to us foreigners, they sympathize with us. So Joburg hospital is better than Hillbrow clinic. At Hillbrow clinic there are too many Zulus and they hate Zimbabwean. Maybe if you are Mozambican they will assist you nicely". (Maria)

However, the issue of being assisted by student nurses and doctors as revealed in this study findings can also lead to some costly medical blunders which can result in loss of life and also with lasting traumatic conditions. Lundi in her story she narrated how she was send home by a student doctor when she was already in labour and up to now she don't even understand why she was send away as she almost gave birth at home. In registering her pain she lamented that it's always good for health personnel to always seek second opinion when dealing with pregnant women, although she acknowledged the nurses being helpful.

"It was at Coronation, I don't know why the doctor failed to pick that I was in active labour already without sending me back home. But they were student doctors, although still I don't know what really made him to send me home". (Lundi)

This scenario of Lundi, Fatima, Maria, and kudzai elaborates on the morality of healthcare provision as a matter of social justice as stated by the CSDH (2010) and expectations and attitudes of providers to patients and vice versa by McIntyre et al (2009).

4.4: Institutional Administration

Institutional administration, identified as one of the broad themes in this study, has greater implication on access to healthcare services among the women in this study. The sub-themes I identify plausibly elaborate on the access dimensions of affordability acceptability. The issue of time and maternal costs both digs deeper on access affordability as experienced by the migrant Zimbabwean women in this study. More interestingly bureaucratic nature and time spend queuing for services also affect the women's perceptions toward access acceptability and quality of the services received. The theme of institutional administration

also allows the women to give a comparative perspective of the different healthcare facilities they have used either in the public sector or in both public sector and private and also comparing it with the Zimbabwean healthcare system although this was not the focus of this study, but those women who had once given birth back in Zimbabwe always tempted to compare their experiences within Inner-City Johannesburg clinics and Hospitals with those back home.

4.4.1 Bureaucracy in the Public healthcare sector

All the participants during the interview sessions confirmed the bureaucratic structure within the health care system in South Africa. These migrant Zimbabwean women in narrating their experiences during pregnancy and delivery in Inner-City Johannesburg all has to undergo through the bureaucratic arrangement as they were supposed to register at the local clinic and attend ANC visits there and then they will be referred to either Hillbrow hospital, Johannesburg Hospital or Coronation Hospital. Here the participants spoke with one voice that one has to be registered at a local clinic and has to be referred from there. This arrangement elaborate the working arrangements within the Public healthcare facilities as IOM (2012) points that in South Africa, government health services is made up of clinics, community healthcare centers and hospitals. Clinics and community healthcare centers offers different kinds of services from hospital hence it is imperative to know when to use a clinic or community center and when to go to a hospital (IOM 2012). More importantly Tomara's experience Justifies the guidelines by IOM (2012) that if one goes straight to the hospital without a referral will be probably turned away at reception and sent to a clinic. Tomara who alternated between private and public healthcare facilities she has to be referred back to the local clinic to get a reference letter to deliver at Coronation hospital.

"So having calculated and seeing the financial reality that I was not going to afford the delivery cost at Netcare I then decide to give birth at Coronation hospital a government/public healthcare facility. So I went to Coronation, and I was almost due but they referred me back to the clinic that is their procedure here in S.A. So from there I went to the clinic and they said I had to come the following day early in the morning. So I went back and returned following day in the morning then they wrote me a referral letter to Coronation hospital then I finally got my May delivery". (Tomara)

The proceeding extracts illustrate that besides being open to everyone there are some rules and procedures that needs to be followed and are rigid and these are the rituals of access to healthcare services in South Africa. More so it is plausible to argue that this confirms Sargent and Larchanche (2011) position that migrants move not only across geographical borders but also across, between and among medical systems with different ways of access hierarchies. Also it is evident from Davies et al (2010) argument that even migrants with legal document and in more comfortable socio-economic positions in society may experience limits in accessing health care services, mainly due to language and cultural barriers as well as institutional and structural obstacles.

These institutional and structural barriers imposed by the bureaucratic arrangement within the public healthcare system in South Africa, give some of the respondents an opportunity to compare services at the healthcare institutions. The women would usually compare ANC service and healthcare services during delivery and also between private and public, or broadly between Zimbabwean maternal healthcare and South African maternal healthcare. Maria during the interview exchange says this:

TM: Let me take you back, I heard you say you registered at Joubert Park clinic and delivered at Hillbrow, these are two different facilities, how can you describe the service at these two clinics. Are there any similarities or differences?

Maria: Joubert Park is much better, that is where I got a sister who resolved my issue with the nurse who had turned me away. She is South African but she is caring and she spoke to me in a good way. She said it did not matter where someone comes from everyone deserves good healthcare. So I was happy that at least someone there cares for all people and does not discriminate. But at Hillbrow the nurses were so rude and rough, nothing impressed me there. All they do is shout at patients especially if they know that you are not South African.

At another point during the course of the interview she reveals that:

"At Joubet park I was impressed by the idea that the sister in charge there responds to people's complains, she does not segregate. So if you get to know the procedure there and follow it she will solve your problems at least she is someone who looks out for patients. So I

would say at Joubet park things are better than Hillbrow. At Hillbrow nobody tells you who is in charge or where to go and place your complaints……..” (Maria)

The sentiments from the two extracts, evidently reveals the depth of the ill-treatment within the public healthcare system in South Africa. However the availability of complaint channels is also a welcome development where women can seek assistance and highlight their concerns to the healthcare providers. With this availability of dispute resolution channels, it suffice to argue along McIntyre et al (2009)'s line of argument about access to healthcare as the empowerment of individuals to be able to use healthcare services when needed and this being done through the interaction between the healthcare system and those individuals in need of the services.

Although there is this bureaucratic arrangement to access maternal healthcare in the public healthcare system in South Africa which begin at the local clinic and then referred to a hospital, migrant women's experiences from Ayanda, Lundi, Fatima and Tomara revealed that they had to lie about their address so that they will be referred to a hospital of choice.

"The thing is if you are in a certain area you are restricted to go to a local clinic, and then if you are prone to complications they refer you to a hospital. But the problem is if you want to go to a place outside the area you stay you have to lie about your address, which is what I did to be referred to Coronation". (Lundi)

The more interesting aspect on the issuing of fake addresses by some migrant Zimbabwean women in this study was mainly informed by social networks and hearsay from other fellow Zimbabweans. Vaida during the interviews pointed out that she lied her address so that she could be referred to Johannesburg hospital since she heard there are many white healthcare providers who are more sympathetic to migrants. To this end it's plausible to argue that social networks are very crucial in providing informational support among the migrant population (Harley and Eskenazi 2006)

4.4.2: Time

"When I realized that I was pregnant, I just said ok and I kept on with my life. My boss did not give me off days or time to go away on the job. So I only got time when I was six months pregnant". (Kudzai)

Time as expressed by the participants was a very critical factor in determining access to health at the healthcare facilities in Inner-City Johannesburg. This aspect also exposes the interconnectedness of the access to healthcare dimensions, as the participants expressed time in different ways that ranges from delay in seeking healthcare services, delay in getting healthcare services at the institution, expressed in terms of work commitment as in the case of Kudzai, time in terms of costs and distance and lastly as a driver for some women to consider use of private healthcare and medical aid in the future as the case of Tomara. According to Peters et al (2008) noted access to healthcare as the timely use of services according to need, however the findings prove otherwise as the women faced challenges and critical delays both perceived (linked to the delay in seeking health by Nour 2008) and also actual delay in receiving healthcare at the healthcare facility. This scenario typifies and fits in Silal et al (2012) and Blaauw and Penn-Kekana(2010) findings about the two leading patient-oriented factors of maternal mortality and complication when they noted that delay in seeking medical help contribute 26.8% and not attending and infrequent attendance of ANC leading to 23.7%.

The participants revealed that they had to go to the clinics during ANC early before opening so that they join the queue to be served. There was a general consensus to this effect among the women who were using the public healthcare system for ANC visits. Hence it is plausible to argue within IOM (2012) guidelines that most public healthcare facilities do not make appointments, and they assist patients whether locals or foreigners in order that they arrive at the clinic hence it recommends that it is wiser to arrive early. The issue of time is very important in determining satisfactions with the healthcare service among the women in this study, as the following quote from Fatima illustrates this point:

Fatima: for me there is nothing really good to talk about, when I used to go for antenatal clinic I would go very early in the morning and spent close to whole day there but there is

really nothing much they do since it's a routine check. So if I fall pregnant again I would rather go back home.

TM: so are you saying they did not conduct the checkups in a proper manner?

Fatima: No they do it a proper manner but they just take too much time to serve people. They delay and the queues at the clinic are normally very long.

The preceding extract also reveals the frustration behind Fatima as she even admittedly says she will rather go back home in case of a further pregnancy. More interestingly most women have to go before six in the morning to join the queue as both Maria and Fatima has to go at 5 AM and 5:30 AM respectively and to be served around midday in most cases. Tinto with a complaining tone revealed how she used to go to Essellen clinic around 4:30 AM and 5:00 AM in the morning as she was avoiding to be turned away as she claim they sometimes turns patients and the services being slow at the sometime. The experiences highlighted by the participants here cemented the findings by the HRW (2011) that several women in South Africa are experiencing and witnessing significant delays after being delayed at the public healthcare facilities, and in some cases with grave consequences.

Tomara, who was doing her Honours degree by the time of this study narrated how it was challenging to go for ANC care at Essellen clinic early in the morning and only to be served around midday at the sometime having to attend Lectures. This complication later made her to make the decision to use private healthcare at Netcare Parklane, her argument was that with private it was flexible in terms of time for the ANC visits and can make appointments that suits her class schedules at school. More interestingly considering the delays she experienced and the language barrier she has to use private and then go back to public for toward delivery to avoid cost as she suspected some complications. She says:

"When I first discovered that I was pregnant, I went to Essellen Clinic. You have to go there very early in the morning despite of the weather is cold or not. This is because there will be very long queues at the clinic. I'm asthmatic and hence they referred me to Joburg hospital. AT Joburg the queues there are also very long and they take forever to serve patients. So me being a student I decided I have got so much to do, I have got classes to attend to and at times assignments such that I didn't have much time to spend following the queue hence I

decided to go to a private medical facility for my antenatal checks. I used Netcare Parklane, I would take the Wits bus and drop at Wits junction and walk to the clinic then catch the bus again back to Wits. At Netcare it was expensive yes, but the service was good and I would be served at a convenient time as the time slots were agreed between me and my gynecologist. I didn't have to wait for something like 5 hours for me to get service. So it really worked for me. Most of my visits were during times convenient for me and when I didn't have class". (Tomara)

This experience by Tomara also has influenced her greatly such that when I asked her about her future plans in case of a further pregnancy she jovially pointed that it would be after completing her studies and she would be probably working hence she will have a proper medical aid. Hence she will be able to totally use the private healthcare system as it is convenient. For her, she does not want a scenario where she will be called by her boss at work while standing on the queue. Thus time in this study was a cause of concern for pregnant women as queuing and persistent delays during ANC were unbearable. This I can argue along the CSDH (2010) that the socioeconomic position of migrants also determine how they will access social resources and plan for the future.

Furthermore the findings on the aspect of time did not only speak to the period during ANC visits, but also to that during delivery as most women lamented being discriminated on the grounds of language and being not able to speak an local language will results in patients being ignored and served later. More interestingly is the fact that some women pointed to the fact that they ignored phoning the Ambulance when in Labour and decided to walk to the healthcare facility, Maria and Fatima walked to Hillbrow hospital as it is near their place of residence, but this was informed by their bad past experiences with the ambulance guys. Moreover Memo who has a good past experience with the ambulance services and when she phoned them, they responded quickly. She confessed how deliberately she decided to delay going to the hospital in fear of being operated so for her time was an instrument she used to achieve this objective as she says:

"*I decided not to go there early because I heard that if you go to the hospital early they will operate you, if you stay long there that was my fear. So I delayed and phone the ambulance when I was so sure that I was to give birth". (Memo)*

Although this move by Memo worked to her advantage but it was a very dangerous way of maneuvering the healthcare system. More so this proves how dangerous relying on hearsay can be, although there is a strong belief among some of these migrant women on information from their social networks.

4.4.3: Maternal Costs

According to Silal et al (2012) the government that came into power in 1994 adopted several steps to address the inequalities in the healthcare service provision and to improve access, particularly in terms of availability and affordability. Silal et al (2012) further noted that the first initiative of this democratically elected government In South Africa was the removal of user fees for all services for pregnant women and children under the age of six years in all public healthcare facilities. More interestingly the National Health Act 61 of 2003 section 4 also gives in general terms the ways in which people are able to gain access to healthcare services and noted that pregnant and lactating women and children below the age of six are eligible for free treatment in public health care facilities. The stories from almost all migrant Zimbabwean women in this study during pregnancy and delivery in the public healthcare system confirms the removal of user fees as they all concur that the services are wholly free. However, the cost was only associated with transport to and from the healthcare facilities for some. Nonetheless some walked to the healthcare facility and this point to availability of the healthcare facilities. Those who pointed to having incurred cost were in private health care, as some opted to use both systems. Kudzai, Lundi, Amanda, Ayanda , Fatima, and Maria and the rest of the women commented that it was free in the public health care system. Kudzai among others has this to say:

TM: can you tell me about the financial costs of maternity you went through?

Kudzai: I did not pay anything.

TM: How about when you went to register and even when you were transferred to Joburg hospital?

Kudzai: I never paid anything at all at the two hospitals.

TM: so how did you travel from Hillbrow clinic to Joburg hospital?

Kudzai: I was transported by a hospital ambulance and it was still free.

This extract confirms and shows the adherence to the constitutional provision on access to health care for everyone regardless of nationality and residence status. More importantly I argue within the line of the International Human Rights Framework that free access is in line with the right to life and the state fulfilling its obligation of protecting the right of every human being under its jurisdiction according to the international laws (IOM 2013 and HRW 2011). During an interview with Fatima she also dispels the rumour that foreigners are now asked to pay at public healthcare facilities. Having given birth on the 24th of July 2013 she had a recent experience and clearly stated that she had to look for taxi fares only during maternal period. Despite not paying anything at the public health facilities, Maria had a different perspective as she later opted to use the private healthcare system as well, while maintaining her visits at public health care facilities. To her she expressed her dissatisfaction and she was quick to say the ill-treatment was mainly because it was for free as she says in this extract:

TM: was there any payment that you made to any of the two healthcare facilities you used?

Maria: No it was all for free, at times I think maybe if we were paying probably we would have been given better service. I think when you are paying people are eager to assist because they will be giving you value for money. But with the baby they were so good.

Maria's sentiments were also reiterated by Vaida in her own story as she expressed her desire for a Medical Aid and how in the private sector they give value for money and more interestingly is how she perceived costs as not only in monetary terms but also involving the emotional component and the risks likely to be encountered there, baring her desire to us private facilities in future, as she has this to say during the interview:

Vaida: *In private hospitals there is s value for money. As long as you are paying you get special treatment and money talks. Free things are expensive you know that don't you…… (She chuckles)*

TM: What do you mean by free thing are expensive?

Vaida: umm I don't mean in monetary terms, the stress that you go through, the emotional challenges and the standards you receive are not good. It's even riskier hence I say free things are expensive because they cost you in some way. The treatment you receive is not good and you will always be talking about them. I tell you what happens in public hospitals is not good. I even hear a lot of ill-treatment goes on at Joburg hospital.

In this extract there is evident dislike of foreigners in the public healthcare facilities hence here costs are not being seen in monetary terms but it is given a different perspective, associated with the emotional component and the standard of the services received hence this clearly reveals the perceptions and attitudes of some of the migrant women in this study towards the quality of services and healthcare providers in public health care facilities.

Moreover the aspect of maternal cost gives the opportunity for this study to have a comparison of both the public health care system and the private health care. Thus it is clear from this study that in the public the provision of health care services is guided by the issue of social justice hence the moral obligation takes centre stage as argued by the CSDH (2011). Thus in the public health care facilities health is treated as a social phenomenon, however in the private sector health care provision is treated as a commodity thus business principles guides the discharge of duties. Tomara has to alternate between the healthcare systems and has to lastly resort to the public health care system as the charges in the private sector were ridiculous and her realising that she was likely to deliver through creaser, she felt this:

"Most of my visits were during times convenient for me and when I didn't have class. So I did this throughout my pregnancy and when delivery was approaching, I realized the medical bill at Netcare was very huge and ridiculous. I also realized that I was likely to have complications since it was my first pregnancy and the baby was big I realized I was going to give birth via caesarian section. So having calculated and seeing the financial reality that I was not going to afford the delivery cost at Netcare I then decide to give birth at Coronation hospital a government/public healthcare facility". (Tomara)

The findings of this study revealed that in public health care facilities in South Africa maternal healthcare is for free, regardless of nationality and residence status. However this aspect of access (affordability) is compromised by the attitudes and treatment of foreigners at

the health care facilities, affecting acceptability and quality of services as witnessed by some of the participants alternating between health care systems (Public and Private).

4.5: Social Networks

It was very interesting to notice that during the interview sessions, the participants' expressed experiences during pregnancy and delivery in Inner-City Johannesburg are full of complains and regrets. The women repeatedly stated that they faced challenges during ANC visits and delivery as most were working until the beginning of labour as part of sustaining their livelihood which are rooted in the informal sector. More vividly in their memories were the challenges to do with language and segregation when they try to access health care service, however when the questions turns to the social side, they admittedly pointed to the role played by their husbands and a few very close family members especially their sisters, biological mothers and mothers in-laws. However, in their stories the aspect of distance from home impacted them in getting support from the extended families and also missing the traditional practices during pregnancy in case of first time mothers. Moreover beside the complications churches has been a ray of hope for some of the participants during pregnancy mainly as they revealed how they turned to churches for spiritual guidance and some prayers at the sometime attending to their ANC visits. These churches are mostly attended by fellow Zimbabweans hence bringing strong social bonding Capital. More fundamentally these networks were also a source of informational support as noted by Harley and Eskenazi (2006). This is instrumental in that the aspect of hearsay from friends and colleagues and fellow Zimbabweans runs through most of the stories from the participants.

4.5.1: Support from family members, friends and churches

"My sister was with me for a very long time and a month before I delivered my mother in-law came and she was there until the baby was a month old and she prepared for the baby and all. My sister stays in Pretoria but she had to come down to Joburg to take care of me and help me for a while. My mother in law also helped with the training of the maid". (Tomara)

When it comes to the role of family members and friend as the source of emotional, informational and instrumental support to women in this study during pregnancy and delivery

the views are varied. Some admitted enjoying support from relatives and friend during this period, as Tomara, Maria, lundi, Tinto and Ayanda revealed that beside receiving support from their husbands they were supported by members of the family particularly sisters and mothers in-law as in the case of Tomara, sister in laws in case of Maria, Lundi enjoyed support from her sister and mother as well. However the majority of the women have their husbands as the only source of support during this period. However although the experiences reveals the existence of social support, but since it is in a foreign land the support was minimal as compared to that one enjoys when at home. Tomara in her experience she narrated how her mother in-law was there and assisted her throughout pregnancy and the bathing of the child during the early days after birth and also encouraging her to attend her ANC visits. However she had to constantly go back to the border to have extra days on her passport as she was without a permit. More interesting she (Tomara) was a beneficiary of her father's medical cover hence she was able to use private medical care at the sometime.

TM: You were using student medical aid, is it the momentum for students?

Tomara: No my dad also works here so I'm a beneficiary on his plan but it just did not cover everything comprehensively. I don't know maybe I was not meant to fall pregnant at that time but it didn't cover all the costs.

TM: You were using your parents' medical aid not your husband's?

Tomara: Yes because it's the one I have been using since and I haven't changed surnames so I still use it and my dad pays but my husband met the cash component.

In this extract it justifies Cacciatore et al (2008) on their position that social support is something which provides positive benefits. This is further solidified by Maria's experiences as she have her sister in-law and husband helping with household chores and on the beginning of labour pains she was escorted by them and her five friends to make them eight in total, this helped here emotionally. Her situation reveals how emotional (love and affection from spouses and relatives) and instrumental support in terms of tangible support such as helping with household chores, washing and cooking is helpful during this period (Harley and Eskenazi 2006).

Although the majority of the participants have friends and relatives to support them during maternal period, the situation was different for Fatima and Kudzai who revealed lack of support during this period. For Fatima she adamantly said:

"*No I did not have anyone assisting me, I was actually going for work every day. On the day I got into labour I actually went for work. So I would go for work every day. It was only on Sundays that I took time off to go to church". (Fatima)*

The experience of Fatima and Kudzai confirms Van Hulst et al (2011) sentiments that migrant women and migrants in general are faced with the challenge of lower levels of social support and poverty in host communities. This is because of the search of livelihood and them being employed in lower levels employment (Kihato 2009). Kudzai who worked as a hairdresser in Bramfontein has only her sister but they were not staying together, at the same time her husband was in prison during her pregnancy and he later died there, this worsened her plight as the relatives of her husband rejected her as she sadly expressed:

"They did not help with anything although they knew and some of them are here in Johannesburg". (Kudzai)

Although social support from family members helped to ease the burden during maternal period it did not affect access to health directly, however support from friends and colleagues at work in terms of what Harley and Eskenazi (2006) called informational support was so critical in determining access to health, as some of the participant revealed how they acted upon advice from friends and delay registering and seeking medical help. The majority of the participants expressed how they were told by friends, that at the health care facilities documents were required; they shout at Patients and there is a danger for one to be operated if one report early when in Labour, as Memo said:

"I decided not to go there at Hillbrow early because I heard that if you go to the hospital early they will operate you, if you stay longer, that was my fear, so I delayed phoning the ambulance until I was so sure that I was about to give birth". (Memo)

The preceding quote digs deeper on the concept of hearsay and how it can be detrimental to access to health among the migrants in the host community as represented by the narratives

of Memo during pregnancy and delivery. This concept of hearsay I am going to expand as a separate section, as this shows the inter-connectedness of the issues.

Just as the central role of family and friends in providing social support, churches for some participants played a crucial role in providing emotional, informational and instrumental support to migrant women in this study during pregnancy, mostly in preparation for childbirth. This elaborates Harley and Eskenazi (2006) on the three components of social support as some participants particularly Ayanda, Maria, Kudzai and Fatima who acknowledged going to church and receiving prayers, advice and exercises during pregnancy. Although some of the women denied going to church directly for divine intervention, they viewed themselves as believers, who always go to church hence this was part of the normal church events of being prayed for, as Maria portrayed herself as someone who always go to church, but not directly for divine intervention for the pregnancy.

However Fatima and Kudzai directly revealed how they went to church to seek divine intervention, although it also includes exercises from the women they believed to have been chosen by the Holy Spirit to do that in the church, as this exchange with Fatima reveals:

TM: when you were pregnant did you ever look for help elsewhere beside the hospitals?

Fatima: I was going to church because I'm a believer.

TM: What kind of help did you get from church?

Fatima: We were given holy water and oil. So I would drink that water and make porridge from the water and put the holy oil in it.

TM: would you mind explaining in detail how things are done for pregnant women at your church?

Fatima: We are prayed for, they give us exercises to do to keep fit, together with the holy water and oil for protection.

Although in the preceding extract she presented herself as a believer, a closer analysis of her experience during pregnancy, that she suffered discrimination which affected her attitude towards public health care facilities to the extent of deciding sometimes to buy over the

counter medication if not feeling well during pregnancy and also received medical attention from student nurses as the qualified were not willing to do so. The idea might be that going to church was an alternative way of seeking medication. More interestingly being given holy oil and water to make porridge during pregnancy justifies this analysis.

Ayanda although she was not going to church here in central Johannesburg, she revealed how she used to constantly phone home to get spiritual guidance from her church. More so her mother was so supportive as sometimes she will call if some prophecy was done at church and solutions recommended, hence she will always urge her to use holy oil and Alfa and Omega holy water during bathing and preparation of food.

4.5.2: Hearsay

The concept of hearsay runs throughout most of the aspects raised and discussed so far in this study. It's strength and widespread nature is unpacked as linked to the concepts of discrimination and shouting of patients, the issue of documentation, aspect of support from friends, time and it has also been revealed to be influencing some of the participants' future plans in case of a further pregnancy mainly for those who are considering facility change. The prominence of friends and fellow Zimbabwean nationals in providing information is central in this concept. More inciting is the power that the information provided through these network channels have in accessing health care in public facilities by the migrant women who took part in this study. The findings of this study unpacks that the delays in seeking healthcare and skipping of ANC visits is tightly connected to the information received through informal channels of friends and colleagues at work.

The participant reveals during the stories that friends and colleagues were the main sources of information about the situation at public healthcare facilities. Maria in expressing her suffering at Hillbrow hospital and how she has made up her mind to go back and give birth home in future, unless in case of an emergency. She will better change facility for delivery, and rather consider going to Johannesburg hospital or Coronation hospital as a lot of her friend who has given birth there has told her about good experiences and also the fact that there are more white healthcare providers who are sympathetic to foreigners.

Intimately connected to the first delay by Nour (2008) and Binder (2012) is Fatima's story were she admitted delaying seeking healthcare during her pregnancy by registering when she was seven months pregnant because of the information she was receiving from her friends and other people, as she says:

"I was just discouraged, because everyone was saying you have to wake up very early in the morning. They also told me that they wanted a valid passport to register you. So I thought I was just going to go to a hospital to deliver, that's when I heard that you will not be taken in for delivery without a referral from a clinic or another facility showing you attended antenatal care". (Fatima)

With the sentiments in this extract, it reveals how bad these informal channel of information can be in influencing behaviour and attitudes toward the healthcare system as elaborated by McIntyre et al (2009), consequently affecting access to health particularly acceptability of the services. More fundamentally is the idea of hearsay being portrayed on the negative side and this challenges the position by Cacciatore et al (2008) referencing to Hupecy (1997) of generally viewing social support as actions or relationships with positive benefits for a person. In solidifying my position in this regard, the sentiments by Kudzai reveals that hearsay was the reason she skipped or rather decided not to attend any ANC visits. However the prominence of friends in provision of information justifies Harley and Eskenazi (2006) argument that social support is a resource provided by others during pregnancy particularly family and friends. Kudzai in her story says:

Kudzai: No I also heard from others that at the clinic the nurses shout at you, so I just said let me avoid going there so that I just go once ad get shouted at once. I was scared of them shouting at me so I withdrew from going so that I will go at delivery and they shout at me once and for all.

This preceding extract exposes that there is something bigger than simply not having time off work that influenced Kudzai's decision for delaying registering her pregnancy and skipping ANC visits, thus the biggest barrier to accessing health care in the public health sector is the aspect of hearsay from trusted people in their social networks particularly friends, with a nationality connection. Memo expressed the same sentiments, but because of the nearness of Hillbrow hospital she could not afford going to Johannesburg or Coronation hospitals

because she was not so familiar with places in Inner-City Johannesburg South Africa. This sheds more light on the widespread nature of hearsay among the migrant population; Ayanda revealed how she initially avoided the public healthcare system because of information from her networks and seek medical attention in the private sector. Vaida with the same perspective revealed how this is a strong issue not to cast a blind eye on as she says:

"The problem is all I will say about that is hearsay since I have not had first-hand experience in other public hospitals. But what I know in this area is for registration they go to the local clinic, then they go to Hillbrow and things are not easy there. If not at Hillbrow they go to Joburg and I heard it is not easy or maybe experiences differ with people. But all I hear is not good things in public hospitals". (Vaida)

This concept of hearsay in this study has been exposed as the main source of informational support among the migrant community. More interestingly is its centrality in determining access to health, as it shapes attitudes and perceptions about the health care providers and health care institutions in Inner-City Johannesburg.

4.6: Future Plans

This theme and that on social support has been directly adopted from the sections of the interview guide. The most interesting insights raised by the participants about their future plans in case of a further pregnancy alternate between considering going home, changing facility either within the public sector or seeking care in the private sector. However the sentiments and the desires speaks a lot on the acceptability of the health care services received, the expectations and attitudes developed by the women towards the healthcare system and the health care providers as elaborated McIntyre et al (2009) in the access to healthcare framework. This theme I can argue from the finding that it consolidate and provide an overall picture on the access to health care dimensions. The major reasons for the future decisions here paint a picture on the sticking issues within the public health sector in Inner-City Johannesburg and the areas of improvement.

4.6:1 Going back Home

"*The way they treated me was not good at all, so I have made a decision that you don't have to force to be cared for in a foreign land. It is better to go back home and get assistance there. In Zimbabwe it is better they treat you well with respect because you will be one of them". (Maria)*

During the interviews eight participants spoke directly about the aspect of home, either pouring out their desire of going back and giving birth in Zimbabwe or ruling out the idea of intending to receive maternal health care in Zimbabwe in case of a further pregnancy. Those who adamantly consider home as the best, were relieving the feeling of being at home as the main reason and they have previous birth experiences in Zimbabwe. The findings plausibly justify that by Kihato (2009) and Schuler (2013) on migrants always speaking of longing to go back home to their countries of origin. Hence they were comparing the health care services between the two countries, although this was not the orientation of this study. For those who ruled ever thinking of seeking maternal health care back home (Tomara,Vaida and Doreen), in case of a further pregnancy were considering solely using the private health care system as they intend to have medical Aids by then. However from them I could gather deep perceptions and attitudes towards the health care system in South Africa.

Maria who has given birth to only her last born in South Africa of her six children was strongly convinced that she will definitely go back and seek maternal health in Zimbabwe, although she was referring to giving birth. In referencing to the nature of the service she was so convinced that back home they do their best as she says:

"So I think it's much better for someone to go back home, in Zimbabwe they check your blood pressure and if you are vulnerable to possible complications they say it on time, now here its different even blood tests were done at a late stage such that if you are diseased (HIV positive) your baby can be infected. In Zimbabwe they check you from 3 months, 6 months until you are 9 months and when you deliver you never deliver alone. Here you will be all alone and they expect you to deliver at their own set time. Even if you call them they will not come, they will only come when they hear the baby cry. What then will happen to first time mothers who do not know what to expect in child birth. In Zimbabwe when giving birth for

the first time they will not leave your side. So I think its better that when someone go and deliver at home". (Maria)

The preceding extract, is informed by her experience in Inner-City Johannesburg as she was denied and received care later in her pregnancy, more so having given birth five times in Zimbabwe and having information through hearsay about the how they operate in the public health sector in South Africa she had attitudes already. This fits and justifies the inclusion of expectations and attitudes of the patients towards the health care providers and vice versa in the access to health care framework (see figure 3, chapter 2), McIntyre et al (2009). More interestingly the issue of cultural expectations and differences during birth becomes central in Maria's experiences as she noted how In South Africa they do not press the tummy in order to flush the after birth remains as done in Zimbabwe, as they were instructed to sit in a Kangaroo position, drink a lot of water and to breast feed instantly.

Furthermore Fatima, kudzai and Amanda in a comparison stance they reiterated the some sentiments with Maria and thought Home is best. Kudzai narrated how as a first time mother she was left alone bleeding without care, interestingly Fatima who has maternal experience in Inner-City Johannesburg of her last born of her five children revealed how she suffered inadequate care through significant delays at the hospital and also being assisted by untrained staff. When further pressed on where she prefers to give birth in case of a further pregnancy given a choice she could not hesitate to single out home as she says:

"If I fall pregnant again I will go to Zimbabwe, if I had not found student nurses when I went there I don't know what would have happened to me or my baby. I was so lucky to find student nurses, because the seniors don't even care about foreigners, they just wish you or the baby can just die. So it's better to go home". (Fatima)

More so although Tomara, vaida and Doreen ruled out the idea of going back and seek maternal health care back home in Zimbabwe. They were clear on their desire for the use of the private sector services even if it is in Zimbabwe. However Doreen ruled out going home completely due to her medical complication which requires special medical attention as she says:

"No I will use facilities here because I have a problem which needs special medical attention, so going back to Zimbabwe I will not because you have to pay for the service"

Thus for Doreen sticking with the public health care facilities is a desirable option as service are free of charge. However although Tomara, Vaida and Doreen expressed the issue of professionalism in terms of service delivery they were also quick to mention the aspect of language in the public health system as requiring urgent attention. More insightful is the fact that they were both socially well positioned as Tomara is a student at Wits university, Vaida and Doreen were formally employed, but they all faced communication challenges during Maternal period in the public health care facilities. This justifies Grove and Zwi (2006) and Willen (2012). On the issue of othering and separation between the nationals and non-nationals, hence deservingness being justified in terms being able or not able to speak any local languages in South African Public health care facilities is central and instrumentalised by the health care providers.

4.6.2: Facility change

This aspect is tightly connected with the desire of going back home and that of having a medical aid so that one will be able to seek medical help in the private sector. From the findings the results reveals that time is a fundamental aspect for patients, also the aspect of service provisions linked to discrimination, shouting and beating of patients informed by hearsay is critical among the migrant population. This further confirms the power of informational social support by Harley and Eskenazi (2006), on the provision of advice, information and guidance.

During the interview session Maria, Ayanda and Gamuchirai in making their intentions clear of willing to going back to Zimbabwe in case of a further pregnancy, they pointed out that they will only give birth in Inner-City Johannesburg Hospitals in case of an emergency. Maria, in her sentiments it appears that what was important was the period of delivery were there is need to go to the Hospital and as for ANC visits she can skip and delay registering as she did with her previous birth. She was prepared to change facilities during delivery and prefers using Johannesburg hospital or Coronation hospital as she had information about the two hospitals as being staffed with a lot of White personnel as she says:

Maria: I will go back home unless its an emergency I will go to Johannesburg hospital, because most people who give birth there say they were in better care same as those who give birth at Coronation. Not Hillbrow I will not go there again.

TM: so do you have some people who gave birth at Joburg Gen or Coronation hospitals?

Maria: yeeee quite a number have given birth at Joburg Hospital and Coronation and they say the service was good.

TM: what do they say happens that is different from your experience?

Maria: At Johannesburg hospital they say it better because there is so many white healthcare personnel, the whites are better. They are not bad to us foreigners, they sympathize with us. So Joburg hospital is better than Hillbrow clinic. At Hillbrow clinic there are too many Zulus and they hate Zimbabwean. Maybe if you are Mozambican they will assist you nicely.

In the preceding extract it is evident that the issues of hearsay and nationality are central in determining access to health care among the migrant population. More revealing is the fact that the health care system is being central in influencing migrant women's decisions and choices. This scenario elaborates WHO (2010) sentiments on the health care system itself as a social determinant of health and that the role of health care system becomes particularly relevant through the issue of access which incorporate differences in exposure and vulnerabilities. The respondents as migrants being segregated and separated from the local population, more so the health care providers creating access barriers, particularly at Hillbrow where there is black majority as service providers and being viewed as more hostile to foreigners as opposed to Johannesburg and Coronation Hospitals were the participants noted that there are more white personnel who are sympathetic to foreigners.

However, despite this aspect of institutional change having a dominant influence on future plans, some of the participants were comfortable and contented with their past experiences as they expressed. Lundi for example firmly confirmed how she is prepared to go back to Coronation Hospital (public facility) in case of a further pregnancy. This was further solidified by her stance on her willingness to advice friend and relatives to use Windsor clinic

for ANC visits and Coronation for delivery, more convincing was her story when she even pointed that she had already done so by recommending her friend to do so as she says:

"I would advise them to give birth here in South Africa but I would suggest for them to use Windsor clinic and Coronation as hospitals. This is because the services I got in these two facilities were good and I have no reservations against them. I have even advised a friend to give birth at Coronation and she did and was also happy with the service so it's up to someone to make their own decisions but that is what I would advise them". (Lundi)

This strongly confirmed her desire and appreciation of the services besides at one time complained about being wrongly send home whilst in labour by a student Doctor, and also put in a waiting room with other ladies who were being prepared for caesarean birth, which was traumatic to her.

However from the findings although there might be strong willingness to change facilities the aspect of Bureaucratic arrangements within the public health care system works as a barrier as one has to attend ANC visit at a local clinic in the area of residence as lamented by Tomara, and then referred to a hospital. Also worthy to note is the socioeconomic status of most migrant women as they are caught in the web of urban poverty (Ahmad et al 2010), which is a social problem that cannot be ignored.

4.6.3: Medical Aid

Apart from the desire to go home and changing facilities, having a medical aid was another aspect raised by some participants, although a few are of this idea, I felt this to be critical in that it also unpacks the barriers to access to health within the public health care system. Tomara and Vaida directly revealed the need for a medical aid, however Maria's actions of also consulting a private doctor reveals the need for medical cover, but resources were not permitting.

The most interesting fact is that although maternal health care is free in the public sector for all in South Africa, migrant women in this study generally finds it difficult to access health care service in these facilities. Thus for those participants who raised the issue of medical aid, they pointed to the aspect of language, time spend queuing for services and the lack of

flexibility, as the biggest pull and push factor in the equation. Tomara confidently revealed that in case of a further pregnancy she will be working by then and definitely on a proper medical aid as she says in this extract:

TM: If you decide on having another baby would you deliver here in South Africa or you would consider Zimbabwe?

Tomara: Going back to Zimbabwe it would be a new experience altogether. But if I do it here probably I would be working and on a proper medical aid so would find my way back at Netcare because it's convenient. I would not want a situation where by you would beg your boss to allow you to go for antenatal care. People were being called by their bosses at the clinic asking them why they are not at work yet. So public does not cater for working women.

The exchange is loaded with access to health care barriers of language which is the dominant factor raised by all participants as problematic in public health care facilities, which the private is a luxury one has to enjoy in private. More fundamentally is the aspect of balancing work and time off attending ANC were in public facilities is a big challenge, hence with a medical aid one can always make arrangements with the doctor in private facilities.

The idea of a medical aid is also tightly connected to the ideology of socioeconomic status, as I can confidently say from the majority of the participants the silence about the desire for a medical aid is directly linked to the nature of employment and the level of poverty migrant women in this study find themselves in. This according to Ahmad et al (2010) migrants' poverty is more devastating in most cities and it contrast with the wealth that Cities generate for some or most of the population.

5.0: Chapter 5: Conclusion and Recommendations

5.1: Key Findings

This section discusses the different conclusions drawn from the research findings and the study informs the broader discussion on access to maternal health and access to health care in South Africa. Basing on the research question of this study (What are the experiences of both documented and undocumented migrant Zimbabwean women accessing public healthcare services during pregnancy and child birth in inner-city Johannesburg South Africa), together with the research objectives. I identified five themes from participants' narratives including socioeconomic status, health care provider-patient interaction, institutional administration, social support and future plans. However in these themes the aspects of discrimination, language, nationality and hearsay run throughout most of the stories. The findings of this study although confirming government efforts in making access to health universal to everyone within its borders despite their nationality and residence status through its constitutional provisions and National health policies. The healthcare providers have their own perceptions and attitudes toward foreigners, which hampers the effort and consequently affecting the realisation of access to health as a basic human right.

The maternal healthcare experiences of the participants has shown that access to health care is broadly affected by and understood through the social determinants of health in the host community (CSDH 2010). Thus as migrants settle in the host community, the socioeconomic situation and the popular discourses in the host society work to their disadvantage. In this study the urban context of inner city Johannesburg and the prominent discourse of anti-foreigner and nativist stance (Landau 2005), also runs through government institution there-by affecting professionalism and discharge of duties among the health care providers. The SDH framework (figure 2) portrays the health care system as a social determinant of health in itself, as this from the findings of this study has been exposed through the ill treatment of the patients and preference by some patients to change institution in the future because of hearsay or personal experiences with the institutions. The SDH framework by the CSDH (2010) through its stance on viewing health as a social phenomenon and its provision as a matter of moral or social justice is well articulated, as the stories reveals a lot of injustices and abuse of migrant patients when accessing health care in public institutions.

More importantly the access triangle (McIntyre et al 2009) provided the valuable tools in understanding the interaction between health care providers and patients during access to health. It provides a detailed summary of the access component and a range of factors that affects availability, affordability and acceptability of the services. The base of the access triangle gives a solid base of some of the findings especially the aspect of power, type of staff and professionalism as important ingredients on access to health among the migrant population. More fundamentally these factors also play a critical role in shaping expectations and attitudes of patients toward the health care system and the providers themselves.

In this study language has been singled out as a big barrier in accessing health care among the migrant population and has been also instrumentalised by the health care providers to segregate patients or delay giving care to patients. It has been used as a denominator to access health care as all participants were complaining about this factor or recommending the healthcare providers to improve on this regard. It has been used to screen patients or in some cases delaying provision of services. However, of interest is the fact that language complication was directed towards ability to speaking local languages mainly Zulu and Sesotho as the use of English will even expose patients as foreigners. The condemnation of the use of English and the demand of use of local languages reveals deep seated notions of nativist idioms (Landau 2005), thus exposing black to black hatred and prominence of ethnicity and nationalism.

The merging of the access triangle (McIntyre et al 2009) and the three delays by Nour (2008) prove valuable in that migrant women's experiences are mushroomed by significant delays either on the part of the patient because of perceived fears from hearsay or delays at the healthcare facilities as providers has their own perceptions and held attitude towards foreigners as they are viewed as bring 'threats' and bringing pressure on the South African healthcare system, hence consequently treated as the other. This brings into the limelight the concept of deservingness and also questions the degree of 'fit', more importantly calls for the monitoring of government policies versus implementation on the ground.

Furthermore from the findings of this study, although the access triangle provided the necessary ingredients, this study also proves there is need to also include the fourth access dimension on the access framework, which was expanded by IOM (2013) to look at the

quality side of the services. Although acceptability considers satisfaction, but the fact that most of the participants were raising the aspect of being attended to by student nurses and even suffering significant delays at the institution, quality might be compromised. This also justifies what Anderson (2004) has pointed to that the locals in most cases are treated with attentive kindness, while foreigners are treated with discourtesy and accorded less time. This reveals how quality can be compromised because of discriminative tendencies in public health care facilities.

Despite all the challenges which impact on the acceptability aspect mostly, it is worth to point that in terms of access availability and affordability in inner city Johannesburg these aspects are not of major concern. As maternal health is free of charge as per constitutional provision and also the public health care facilities in terms of clinics and hospitals are within walkable distance of less than ten minute according to the stories and for those were transport is required it was affordable as well.

5.2: Recommendations

From the findings of this study and the experiences that I underwent during the course of this study a number of recommendations can be made for future researches, government considerations, NGOs, Advocacy groups, public health care institutions and migrant community to work together for a better cause.

- For future researchers focus must attempt to look on maternal healthcare experiences among the migrants in general and make comparative analysis. More importantly try to employ both qualitative particularly with the use of the diary method and quantitative methodologies.

- In order to improve the plight of the migrants during access to health, government must not only recognize the human right to access health care in South Africa, but there is need also to attempt to raise awareness of the rights of the migrants and patients among government workers. With direct interaction with migrants, patients and health care providers.

- There is also need to work with the broader community to address the SDH. Hence need to involve all stakeholders including government, NGOs, Advocacy groups, Healthcare Providers and Migrant community in workshops to educate them and raise areas of concern.

- Although it involves an extra expenditure on the part of government. I recommend for the hiring of interpreters to break the communication barriers between healthcare providers and migrant patients, as this was the main sticking point raised by all the participants with greater concern.

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Appendix I
In-depth interview guide

Title of Study: Giving birth in a foreign land: Maternal health-care experiences among Zimbabwean migrant women living in Johannesburg, South Africa

Section 1: Background information and migrant status

- How old are you?
- How long have you been in South Africa and how long have you lived in Johannesburg?
- Where else have you lived in South Africa?
- Who are you staying with?
- Do you and those you are staying with have any documentation challenges? (probe for strategies they employ to overcome those challenges)
- How many children do you have?
- I would like to confirm when did you have your last birth and how many births have you had here in Johannesburg South Africa and how many in Zimbabwe?

Section 2: Maternal healthcare experiences

- Please tell me about your experiences with antenatal care in healthcare facilities you have used here in Johannesburg starting with your oldest child (probe for when did they go there and did they use more than one healthcare system)
- What kind of services did you receive here during your pregnancy and delivery period? (probe for where did they get them)
- How did you feel about those healthcare services you received/ you are receiving here in Johannesburg? (probe if they have choices where to go to get these healthcare services)
- For each health system/facility experiences with each of your pregnancies and birth how did you feel about healthcare service providers' attitudes and environment of healthcare facility?

- Did you have any communication problems with healthcare service providers? (Probe for how they were solved)
- How did you find the cost of healthcare in the public sector and other sectors here in Johannesburg? (probe on how they managed to go about in settling the costs)
- In general how would you characterize your experiences with pregnancy and delivery here? (probe for what they like and dislike about their experiences with antenatal care here)
- Did you face any challenges during your pregnancy and delivery period? (probe for what services they seek to solve these challenges)

Section 3: family and Social support

- Did you receive support from family members and friends during your pregnancy and childbirth experiences?
- If you did would you describe the kind of help or if no what were the reasons?

Section 4: Future plans

- Would you return to public healthcare facilities with your next pregnancy here in South Africa? (probe why they will act in that manner)
- Would you recommend your friends to use healthcare facilities here in South Africa during pregnancy and delivery? (Probe for what makes them say that).
- What could have been done/should be done to improve your experiences during pregnancy and childbirth?
    - **Thank you for your time**
    - **Is there anything you would like to ask me?**

Appendix II
List of Referral Organisations

Name of Organisation	Address	Email and Telephone number	Services offered
CSVR- Centre for the Study of Violence and Reconciliation	4th Floor, Braamfontein Centre, 23 Jorissen Street, Braamfontein, Johannesburg, South Africa, P O Box 30778, Braamfontein, JHB, 2017	info@csvr.org.za +27 (11) 403-5650	**Solidarity in action and building feminist activism:** activism around cases of rape and violence; political education and consciousness raising (1in9 Campaign University) - teaching feminist theory and critique) **Feminist knowledge production and research**: research and publications (for example, *"We were never meant to survive" Violence in the Lives of HIV Positive Women in South Africa,2012*);
South African Human Rights Commission	2nd Floor, Braampark Forum 3, 33 Hoofd Street, Braamfontein	0118773750	**Advocacy for Human Rights**

Legal Resource Centre	15th and 16th Floor, Bram Fischer Towers, 20 Albert Street, Marshalltown, Johannesburg P O Box 9495, Johannesburg 2000	http://www.lrc.org.za +27 11 836 9831	**Legal services** for victims of abuse
Commission for Conciliation, Mediation and Arbitration (CCMA)		0113776650	**Legal Services** to victims of Gender Based Violence
POWA – People Opposing Women Abuse	Head Office:Berea PO Box 93416, Yeoville 2143 Johannesburg, POWA Soweto, Room 10 Nthabiseng Centre, Chris	POWA Legal Advice:- priscilla@powa.co.za 011 642 4345/6 011 933 2333/2310 0118602858	**Counselling:** Individual face to face counselling **Short term sheltering**- two shelters where women can stay for 6 months and one second stage house where women can stay one year and longer

	Hani Hospital, POWA Katlehong 667 Monise Section, Katlehong 1431		**Therapy:** Child play therapy for children residing in safety shelters with their mothers **Legal Support:** Court preparation for women due to appear as witnesses in court in cases of abuse Court support which includes accompaning women to court and helping them fill in court documents where required Maintenance and interdict assistance which entails assisting women to access the courts to provide them with the legal avenues to circumvent economic and physical vulnerability to abuse **Training Services** for women in local community projects and support of community based women initiatives.

Crayl Park- Volunteer – Formerly of Abuse in No Excuse		carleedancer@abuseisnoexcuse.co.za	**Counselling:** Caryl offers advise and counselling to abused women via email correspondence **Legal Assistance:** Depending on the case, she refers victims either to shelters, legal contacts or medical centers

Appendix III: Verbal Consent Form for In-depth interview participants

Title of research project: Giving birth in a foreign land: Maternal health-care experiences among Zimbabwean migrant women living in Johannesburg, South Africa.

Introduction: You are kindly invited to take part in a study that Tackson Makandwa is conducting for the fulfilment of the requirements for the Masters of Arts (MA) in Forced Migration Studies at the University of the Witwatersrand in Johannesburg, South Africa.

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

- I agree to participate in this research project and I understand that my participation is entirely voluntary.
- I understand that confidentiality and anonymity will be protected.
- I have read/been read this consent form and the information it contains and had the opportunity to ask questions about them.
- I agree to my responses being used for this research on condition my privacy is respected.
- I understand that my personal details will be used in aggregate form only, so that I will not be personally identifiable.
- I understand I have the right to withdraw from this project at any stage.

PARTICIPANT:

Printed Name of Participant Date

For verbal consent only (to be completed by me the researcher)

- I (*Name of Researcher*), herewith confirm that the above participant has been fully informed about the above study and has given verbal consent to participate in the study.

Printed Name Signature/Mark or Thumbprint Date

Appendix IV: Tape-Recording Consent Form

Title of research project: Giving birth in a foreign land: Maternal health-care experiences among Zimbabwean migrant women living in Johannesburg, South Africa.

Introduction: Hello**,** my name is Tackson Makandwa and I am coming from the African Centre for Migration Society (ACMS) at the University of the Witwatersrand. I am carrying out a study that is exploring the maternal health-care experiences of migrant Zimbabwean women in inner-city Johannesburg, South Africa. In this research I want to learn about the different experiences that migrant women come across during pregnancy and delivery. This includes establishing if documentation status has a bearing, and examining the different social support networks that Zimbabwean women draw on during this critical period and how future pregnancy and childbirth plans and perceptions are shaped by these experiences. Thus this study will help to improve maternal healthcare service delivery and reproductive health among the migrant community and women in general.

Can the researcher tape this interview?

- I understand that tape-recording is voluntary
- I understand that if at any point I feel uncomfortable tape-recording will be stopped.
- I understand that recorded information will be confidential and will only be accessible to the researcher.
- I understand that if at any point I want to withdraw from this study, recordings will be destroyed
- I understand that transcripts of the interviews will be made available upon request
- I agree/do not agree that my interview be tape-recorded
- I agree/ do not agree that my verbal consent be tape recorded as well.
-

Print Name (in full) _____

Signature_____ Date_____

Appendix V: Information Sheet for migrant women participants

Introduction: Hello**,** my name is Tackson Makandwa and I am coming from the African Centre for Migration Society (ACMS) at the University of the Witwatersrand. I am carrying out a study that is exploring the maternal health-care experiences of migrant Zimbabwean women in inner-city Johannesburg, South Africa. In this research I want to learn about the different experiences that migrant women come across during pregnancy and delivery. This includes establishing if documentation status has a bearing, and examining the different social support networks that Zimbabwean women draw on during this critical period and how future pregnancy and childbirth plans and perceptions are shaped by these experiences. Thus this study will help to improve maternal healthcare service delivery and reproductive health among the migrant community and women in general. My supervisor is Dr Joanna Vearey, who can be contacted at jovearey@gmail.com or by phone at +27 (0). 011 717 4033. I, the researcher can be contacted by e-mail at Tacksonmak@gmail.com or can phone at +27785031772/+27743552991

Invitation to participate: I am inviting you to participate in this research study as it will help in understanding maternal healthcare experiences and service delivery among migrant communities.

What this study entails

Your participation in this study include the following

- The study involves one-on-one interviews that will be conducted in a private space agreeable to you and me.
- If you give permission, I would like to audio record the interview. If you are not comfortable with it I will not record the conversation.
- 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 in South Africa, who will be willing to participate in this study so that I can conduct them.
- The initial interview will take about 45 minutes to 1 hour and I may ask you that we meet again for a second time to talk more about this.

- In this study I am looking to do interviews with 10 Zimbabwean women who have been in South Africa for at least 2 years and have undergone antenatal care and childbirth or are attending antenatal care here in Johannesburg and are towards delivery.

Risks: This study has minimum risks but you might experience distress and trauma after talking to me about your experiences during pregnancy and delivery. However after this interview I will refer you to a counselor or some organizations for counseling which will help you to cope with the stress. In this study confidentiality and anonymity will be guaranteed since it will be a one on one interview with the researcher and also will make use of pseudonyms so that the information you provide will not be traced back to you.

Benefits: there are no direct benefits for participating in this study; however it will help in improving maternal healthcare service delivery among the migrant community and also improving reproductive health of women in general.

Costs: there are no direct costs associated with participating in this study,

- Participation is entirely voluntary.
- You are welcome to withdraw from this research at any time without any costs for doing so.
- The information that will be collected is purely for academic and research purposes and to learn more about the narrative experiences of migrant women during pregnancy and
  childbirth in inner-city Johannesburg South Africa.

Appendix VI: Ethics Clearance Certificate

Research Office

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

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER H13/08/22**
PROJECT TITLE	Giving birth in a foreign land: Maternal health-care experiences among Zimbabwean migrant women living in Johannesburg, South Africa
INVESTIGATOR(S)	Mr M Tackson
SCHOOL/DEPARTMENT	Social Sciences/African Centre for Migration & Society
DATE CONSIDERED	16/08/2013
DECISION OF THE COMMITTEE	Approved Unconditionally
EXPIRY DATE	11/09/2015

DATE 12/09/2013 **CHAIRPERSON** _____ (Professor T Milani)

cc: Supervisor : Dr J Vearey

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10003, 10th Floor, Senate House, University.

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

_____ _____/_____/_____

Signature **Date**

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES