

EXPERIENCES OF ACCESS AND CHOICES OF CONTRACEPTIVES FOR DRC REFUGEE WOMEN LIVING IN ETHEKWINI METROPOLITAN AREA

by

Bazola Luvisa Bibiche

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School of Social Sciences

College of Humanities, University of KwaZulu-Natal

Supervisor: Professor Thenjiwe Meyiwa

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DECLARATION

I, Luvisa Bibiche Bazola, declare that this dissertation entitled 'Experiences of access and choices of contraceptives for DRC refugee women living in EThekweni metropolitan area' is my own original research work. I confirm that an external editor was used and my supervisor, Prof Meyiwa, was aware of the identity and qualifications of my editor. This dissertation is being submitted for the degree of Masters of Arts in the Gender Studies Programme in the School of Social Sciences, College of Humanities, University of KwaZulu-Natal, South Africa.

None of the present work has been submitted previously for any degree or examination in any other university, and is being re-submitted in accordance with the requirements of the co-ordinating report based on the original examiner's reports. All sources of information that I have used have been indicated and acknowledged by means of complete reference.

Luvisa Bibiche Bazola

Candidate's signature



Date

18 March 2012

Supervisor's signature



Date

18 March 2012

Editor's signature

Date

Dedication

I dedicate this study to my family, especially my wonderful husband Maurice Ntemo for his encouragement, patience and assistance, my daughters Samantha and Carole, my mother and my siblings for their support and faith in me.

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ABSTRACT

This study documents the experiences of DRC Durban-based refugee women; i.e. their access to and choice of contraceptives. When the decisions that concern a person are made by her, that individual is able to make the best choices for herself and to take responsibility for her life. Being able to make the decisions regarding the issues of one's reproductive health, the control of one's fertility in particular is most definitely basic to the empowerment of the individual and central to the emancipation of that individual. Reproductive health consists of a wide range of issues that have to do with the reproductive capacities and health of women. For the purpose of this study, however, reproductive health is seen in the light of contraception and its uses and access. For this study, the term contraceptives refers to a form of birth control which could be a regimen of one or more actions, devices, or medications used with the intention to purposefully prevent or reduce the likelihood of pregnancy or childbirth.

A qualitative methodology appeared to be appropriate in order to better understand DRC refugee women's choices that arise from varied experiences in accessing contraceptives. The findings of this study show that the access and choice of contraceptive methods among DRC refugee women in Durban is gendered and is a product of society. Changes therefore are necessary in order to eliminate all negative attitudes towards contraceptive access and choices.

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DEFINITION OF TERMS AND GLOSSARY

Amakwerekwere

Derogatory term used by black South Africans to describe non-South African blacks (Wikipedia, 2010).

Amenorrhoea

This refers to the absence or stopping of the menstrual periods. It is normal for the periods to be absent before puberty, during pregnancy, during milk secretion, and after the end of the reproductive period.

Antibiotic

This is a substance produced by or derived from a micro-organism that destroys or inhibits the growth of other micro-organisms. Antibiotics are used to treat infections caused by organisms that are sensitive to them (usually bacteria or fungi).

Antifungal (antimycotic)

This describes a drug that kills or inactivates fungi and is used to treat fungal (including yeast) infections. Antifungal drugs include amphotericin, griseofulvine, the imidazoles, nystatin, terbinafine and tolnaftate.

Cholesterol

This is a fatlike material (a sterol) present in the blood and most tissue, especially nervous tissue. Cholesterol and its esters are important constituents of cell membranes and are precursors of many steroid hormones and bile salts. The body uses cholesterol to make vitamin D and various hormones, such as oestrogen, testosterone and cortisol.

Coitus interruptus

Also known as the withdrawal or pull-out method, is a method of birth-control in which a man, during intercourse withdraws his penis from a woman's vagina prior to ejaculation. The man must then attempt to direct his ejaculate (semen) away from his partner's vagina in an effort to avoid insemination (Wikipedia, 2010).

Contraception

Contraception is prevention of the fertilization of an egg by a sperm (conception) or the attachment of the fertilized egg to the lining of the uterus (implantation) (Beers, 2003)

Depoprovera

Depoprovera is the commercial name for Depot medroxyprogesterone acetate (DMPA). It is a synthetic female sex hormone used to treat menstrual disorders, including amenorrhoea, to prevent miscarriage, and (in combination with an oestrogen) is used in oral contraceptives (Oxford concise medical dictionary, 1996).

Family planning

Family planning involves using various methods to control the number and timing of pregnancies. A couple may use contraception to avoid pregnancy temporarily or sterilization to avoid pregnancy permanently. Abortion may be used to end an unwanted pregnancy when contraception has failed or not been used.

Gallstone

This is a hard mass composed of bile pigments, cholesterol, and calcium salts, in varying proportions, that can form like little stones in the gall bladder. The formation of gallstones (cholelithiasis) occurs when the physical characteristics of bile alter so that cholesterol is less soluble. Chronic inflammation of the gall bladder may also be a contributory factor. Gallstones may exist for many years, without causing symptoms, however, they may cause severe pain or they may pass into the common bile duct and cause obstructive jaundice or cholangitis. Gallstones containing calcium may be seen on a plain X-ray (opaque stone), but if their calcium content is low they can be seen only by cholecystography. Cholelithiasis is usually treated by surgical removal of the gall bladder or by removing the stones themselves. The stones can be either dissolved using bile salts given by mouth or shattered

by ultrasound waves. There is no need for treatment if the stones are not causing symptoms.

Interahamwe

Interahamwe (Kinyarwanda, meaning 'those who stand/work/fight/attack together') is a Hutu paramilitary organization. The militia enjoyed the backing of the Hutu-led government leading up to, during, and after the Rwandan genocide. Since the genocide, they have been forced out of Rwanda and have sought asylum in Congo. They are currently a terrorist group hiding in the Democratic Republic of Congo and the Ugandan forest (Wikipedia, 2010)

Mucopurulent cervicitis

This is inflammation of the neck (cervix) of the uterus which presents as a pus like vaginal discharge. The infection is usually caused by bacteria that enter the vagina, most commonly, during sexual intercourse.

Nonsteroidal anti-inflammatory drugs

These include any one of a large group of drugs used for pain relief, particularly in rheumatic disease. Nonsteroidal anti-inflammatory drugs act by inhibiting the enzymes responsible for the formation of prostaglandins; they are important mediators of inflammation. They include aspirin, azapropazone, diflunisal, ibuprofen, ketoprofen, and naproxen. Adverse effects include gastric bleeding and ulceration.

Oophoritis (Ovaritis)

This is inflammation of an ovary, either on the surface or within the organ. Oophoritis may be associated with an infection of the fallopian tubes or the lower part of the abdominal cavity. A bacterial infection usually responds to antibiotics.

Oestrogen

This is one of a group of steroid hormones that control female sexual development, promoting the growth and function of the female sex organs and female secondary sexual characteristics (such as breast development). Oestrogens are synthesized mainly by the ovary; small amounts are also produced by the adrenal cortex, testes and placenta.

Osteoporosis

This refers to loss of bony tissue, resulting in bones that are brittle and liable to fracture, infection, injury, and synovitis can cause localized osteoporosis of adjacent bone. Generalised osteoporosis is common in the elderly, and in women, often follows menopause. Bones contain minerals, such as calcium and phosphorus, which make them hard and dense. To maintain bone density, the body requires an adequate supply of calcium and other minerals and must produce the proper amounts of several hormones, such as the parathyroid hormone, growth hormone, calcitonin, oestrogen and testosterone. An adequate supply of vitamin D is also needed to absorb calcium from food and incorporate it into bones.

Ovary

This is the main female reproductive organ, which produces ova (egg cells) and steroid hormones in a regular cycle in response to hormones from the anterior pituitary gland. There are two ovaries, situated in the lower abdomen, one on each side of the **uterus**. Each ovary contains numerous follicles, within which the ova develop, but only a small proportion of them reach maturity. The follicles secrete oestrogen and small amounts of **androgen**. After ovulation a corpus luteum forms at the site of the ruptured follicle and secretes progesterone. Oestrogen and progesterone regulate the changes in the uterus throughout the menstrual cycle and pregnancy.

Papanicolaou test

This involves a specimen of cellular material scraped from the neck (cervix) of the uterus that is stained and examined under a microscope in order to detect cell changes **indicating** the presence of cancer. Routine cervical smears are taken to detect precancerous and early cancerous changes. It is usually referred to as a Pap smear.

Pelvic inflammatory disease

This is an acute or chronic condition in which the uterus, fallopian tubes and ovaries are infected. The inflammation is the result of infection spreading from an adjacent infected

organ (such as the appendix) or ascending from the vagina; it may also result from blood-borne infection, such as tuberculosis. The main feature is lower abdominal pain that may, at times, be severe. An acute infection may respond to treatment with antibiotics, but in a chronic state, when pelvic adhesions have developed, surgical removal of the diseased tissue may be necessary. Blocking of the fallopian tubes is a common result of pelvic inflammatory disease.

Progesterone

This is a steroid hormone secreted by the corpus luteum of the ovary, the placenta, and also (in small amounts) by the adrenal cortex and testes. It is responsible for preparing the inner lining (endometrium) of the uterus for pregnancy. If fertilization occurs it maintains the uterus through-out pregnancy and prevents the further release of eggs from the ovary.

Progestin

This is one of a group of naturally-occurring or synthetic steroid hormones, including progesterone, that maintain the normal course of pregnancy. Progestins are used to treat premenstrual tension, amenorrhoea, and abnormal bleeding from the uterus. Because they prevent ovulation, progestins are a major constituent of oral contraceptives and other forms of hormonal contraception. Synthetic progestins may be taken by mouth but the naturally-occurring hormone must be given by intramuscular injection or subcutaneous implant, as it is rapidly broken down in the liver.

Refugee

The United Nations 1951 convention relating to the Status of refugees defines a refugee as a person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his or her nationality, and is unable to or, owing to such fear, is unwilling to avail herself or himself of the protection of that country.

In 1969, the Organization of African Unity (OAU), seeking to establish common standards for the treatment of refugees, endorsed and adopted the 1951 Convention and agreed that: the term 'refugee' apply to every person who, owing to external aggression, occupation, foreign

domination or events seriously disturbing public order in either part of or the whole of her country of origin or nationality, is compelled to leave her place of habitual residence in order to seek refuge in another place outside his country of origin or nationality.

Salpingitis

This is inflammation of a tube, most commonly applied to inflammation of one or both of the fallopian tubes. It is caused by bacterial infection spreading from the vagina or uterus or carried in the blood. In acute salpingitis there is a sharp pain in the lower abdomen, which may be mistaken for appendicitis; the infection may spread to the membrane lining of the abdominal cavity. In severe cases the tubes may become blocked with scar tissue and the patient will be unable to conceive. The condition is treated with antibiotics, and later, if necessary, by the surgical removal of the diseased tube(s).

Sedative

This is a drug that has a calming effect, relieving anxiety and tension. Sedatives are hypnotic drugs administered at lower doses than those needed for sleep. Drowsiness is a common side effect.

STI

This acronym stands for sexually transmitted infections, also commonly referred to as sexually transmitted disease (Beers, 2003)

CHAPTER 1: INTRODUCTION

1 .BACKGROUND OF THE STUDY

The Democratic Republic of Congo's six year war that went largely unnoticed outside the immediate region claimed over four million lives and sent more than 400,000 Congolese people into exile (McKinsey, 2006). McKinsey states that the pursuit of natural resources has become life threatening to humankind in this part of the world. Armed conflict and systematic warfare purposely displaced hundreds of thousands of innocent people, the majority of whom were defenseless people including women, children and the elderly. The proliferation of different rebel movements both inside and outside the country, resistance movements operating during and after the four- year Laurent Kabila era from 1997 to 2001 resulted in the death of more than four million innocent people; the rape of women and girls; and the spread of HIV/AIDS.

The war that prevailed in the Democratic Republic of Congo after 1996, was partly the result of the mass killing that happened in its neighbouring country (Rwanda) after the genocide that saw about eight-hundred thousands people, mostly from the Tutsi minority, killed in a period of seven months. After the plane that was carrying president Habyarimana was shot and the president himself killed, millions of Hutus crossed the border, some to Tanzania, Uganda, Burundi and millions of them entered the Kivu in the East region of DRC. Amongst them were militias called *interahamwe* and the regular former Rwandan army. These troops were accused of killing civilians and raping thousands of women and girls. Their presence on Congolese soil gave the new leadership in Rwanda and its army (RDF) reason to enter Congolese territory in order to prevent and stop any other tentative incursion into Rwanda and any further genocide. This situation destabilized a region that experiences tension between local communities even more (Gbanda, 1998, 2004).

Although the war officially ended in 2002, its effects in the form of conflict and political instability continues to be felt within and outside the DRC. According to Gbanda, today more

than ever, the Democratic Republic of Congo has become a symbol of armed conflicts, lack of good leadership values (including economic mismanagement) and corruption; cults around certain personalities exist and there is lack of vision (Gbanda, 2004). The lack of these ethical and rational values are among some of characteristics that lead to a collapsing nation and failed states.

It is necessary to provide this short and brief background in order to understand the reproductive habits of a people who have fled the violence and destruction of war. Their reaction to contraception and access to it in the host country of South Africa is influenced by their war experiences and the fact that many Congolese lost family members; some lost their entire families. Explaining the root causes of displacement is essential for understanding the origin, identity and composition of various displaced populations, their basic needs and the ways in which they can be assisted.

Today, South Africa is home to hundreds of thousands of asylum seekers from different African countries including the DRC. In South Africa, the majority of refugees are urban-based (Amisi, 2005), living within local host communities where they fend for themselves, and experience various degrees of xenophobia and reproductive health challenges as they try to integrate into local communities. Refugees are subject to diverse forms of exploitative practices. Key officials and the voluntary sector play different roles at different times. Social exclusion and xenophobic attitudes from some key officials and ordinary people worsen the already precarious situation of the refugee communities (Amisi, 2005). Most refugees are not aware that their status as refugees entitles them to certain rights and benefits enshrined in a number of international and national statutes to which South Africa is a signatory.

Within refugee populations, women and children are the most vulnerable. Women's reproductive health and choices are of great importance to women as individuals but it is also of global importance. For feminists, the issue of reproductive control as a form of improving women's situation dates back to the late 19th and early 20th century birth-control campaigns led by Emma Goldman and Margaret Sanger (Gordon, 1982 and Hardon, 1994) amongst others. Furthermore, the state of women's reproductive health affects the world's population,

maternal and child mortality rates and even the spread of sexually-transmitted infections (STI's) including the much dreaded HIV/AIDS (Ashford cited by Oyedeji, 2003). DRC refugee women are not spared from these conditions. Although the majority of refugees worldwide are women (Mckinsey, 2006), their reproductive health needs and experiences have rarely been addressed in a comprehensive manner. It is to this end that this study documents the experiences of DRC Durban-based refugee women; meaning their access to and choice of contraceptives. When the decisions that concern a person are made by her, that individual is able to make the best choices for herself and she can take responsibility for her life. Being able to make the decisions regarding the issues of one's reproductive health is important; the control of one's fertility, in particular, is most definitely basic to the empowerment of the individual and central to the emancipation of that individual.

2 .DELIMITATION AND LIMITATION OF THE STUDY

This study documents the experiences of DRC Durban-based refugee women in relation to their access to and choice of contraceptives. Reproductive health consists of a wide range of issues that has to do with the reproductive capacities and health of women. For the purpose of this study however, reproductive health is seen in the light of contraception and its use and access. It does not specifically involve other issues such as maternal and infant mortality, sexually transmitted infections, fertility issues, women's health etc except when otherwise stated. While discussing contraception, the condom will be discussed but mainly as a method of preventing pregnancy and not as a method of preventing sexually-transmitted diseases, unless otherwise stated.

For this study, contraceptives refers to forms of birth control which could be a regimen of one or more actions, devices, or medications used with the intention to purposefully prevent or reduce the likelihood of pregnancy or childbirth.

One of the limitations or obstacles experienced during this study was the reticence or refusal of the DRC refugee women to disclose certain information they judged personal and which could

lead people among DRC refugee community to recognize them. Also, due to time and financial constraints, this study does not apply to all DRC refugee women based in the greater Durban area. The research is limited to the women living in the CBD area as they were easily accessible.

3 .RESEARCH AIMS AND OBJECTIVES

People working with refugee women often excuse their lack of sensitivity towards the personal health care and wellbeing of these women by asserting that food and shelter have precedence over contraceptives. Even though resources for survival, security and resettlement in a safe country are of primary concern to all refugees, lack of access to comprehensive reproductive health care, insecurity, xenophobia, gender roles and economic dependency on men, precludes refugee women's full participation in asserting and promoting their rights, hence this study's broad issues. The first research objective is to document the experiences among DRC refugee women in accessing contraceptives. A second objective is to document any barriers that they may encounter when obtaining contraceptives. The third objective is subsequently to document the contraception choices they make given the limitations they have. The study's subsidiary objectives are:

- To investigate the accessibility of contraceptives among DRC refugee women living in eThekweni metropolitan area (Durban).
- To find out about the kinds of contraceptives that DRC refugee women use. This covers their choices.
- To question and examine the barriers to contraceptive access.
- To investigate if there is a relationship between the social expectations/limitations (e.g. domestic gender roles, cultural and religious values and wider community discriminatory attitudes) and the access to contraceptives/reproductive health services.

4. RESEARCH QUESTIONS

The study posed the questions bearing in mind the difficulty and stress of refugee situations which may create barriers or intensify existing barriers to accessing contraceptives

- Do DRC refugee women have access to contraceptives?
- If no, what are the challenges?
- If yes, at which level?
- What contraceptive/ family planning choices are available for DRC refugee women?
- How do DRC refugee women view a link (if they affirm it exists) between their choices and access, or lack of access, to contraceptives and ultimately the number of births within families?
- To what extent do cultural and religious values relate to the access to contraceptives?

5. PROBLEM STATEMENT

The problem statement for this research was initially based on, and formulated around the anecdotal reports that I had established as an insider from preliminary/pilot interviews of 10 women from my church community. It appears that some DRC Durban-based refugee women need greater access to contraception. This is supported by the average number of births each of them have had since they came to Durban or South Africa; i.e. 3-6 children, with most women having between 7 and 9 children. This high fertility rate is in stark contrast to the current DRC births per woman back home. Although there have only been two national censuses conducted in the country (mid 1950 and 1984), a workshop on the 'Prospects for fertility decline in high fertility countries' which was hosted by the UN's Department of Economics and Social Affairs in New York in 2001 noted that the DRC total fertility rate is about 5.5 and the country has probably embarked on a fertility transition that is emerging across much of sub-Saharan Africa (see Shapiro & Tambashe, 2001). This assertion is also supported by world respected scholars like Deborah Potts and Shula Marks where they note that, 'over the

past twenty to thirty years, a silent revolution has occurred, and is occurring, in human fertility across the region of southern Africa there is hard evidence of real significant declines in fertility' (Potts and Marks, 2001:189). Reporting on Cambodian refugees' contraceptive needs, Morrison (2000:198) rightly notes that 'fleeing from war and settling in a refugee [space] are extreme and unstable circumstances that place women at an increased risk for unwanted pregnancy, obstetric complications and rape'.

Subsequently the hypothesis of this study is: Lack of or limited access to contraceptives contributes to the high number of births within the DRC Durban refugee community.

6. SIGNIFICANCE OF THE STUDY

Aside from the difficulties in locating and obtaining access to health services and repeated calls from the United Nations High Commissioner for Refugees to South Africa to pay attention to the needs of refugees, their environments are difficult because of constant movement and fear of a possibility of xenophobic attacks (Wabungu,2003). Although this *status quo* may interfere with data collection, nonetheless, documentation of family planning needs, choices, as well as experiences, among refugee women is greatly needed; hence the importance of the study.

For the refugee women, knowing about and being educated on contraceptive issues is important. Even more important is the link between their knowledge, the ability to make a choice and the options available to them. Being able to access contraceptives and make use of them makes a big difference in a woman's life, thereby, contributing to her emancipation as an individual, empowering her to be in control of her own life and in sustaining the wellbeing of her family.

It is believed this study will provide an insight into the views and experiences of DRC refugee women in a host country and how their access and choice of contraceptives affects them in all aspects of their lives. It is hoped that this study will contribute to existing knowledge on refugees and will open up new areas for pro-active, constructive thought to improving access

and choice of contraceptive not only to the DRC refugee women, but to the entire group of refugee women living in Durban.

CHAPTER 2: LITERATURE REVIEW

2.1. INTRODUCTION

Although a number of studies have been conducted in the field of access to health care services by immigrants and refugees, most of them refer to locations outside the SADC region. There is a great deal of literature on women's reproductive health covering all parts of the world, however, the literature that is available largely ignores SADC refugees, in particular those of DRC ancestry. I discuss literature following specific themes.

Pottie et al. (2000) noted that immigration is dramatically increasing the diversity of Canadian urban populations, with immigrants from developing countries emerging as a growing and economically-important segment of the Canadian population. Whereas immigrants benefit from positive health-related behaviours, genetic factors, medical screening and considerable health disparities are emerging in sub-groups of immigrants with various social, cultural, ethnic, demographic or economic vulnerabilities.

Accessing quality health care is a challenge for immigrants and refugees. Barriers to preventive services occur at the system level (i.e., current shortage of family physicians accepting new patients), provider level (i.e., lack of practical prevention guide), and patient level (i.e., language barriers and lack of appreciation of the benefit of prevention). Some of the emerging health disparities within the sub-groups stem from these barriers to access and utilization of preventive health services. Men and women often have different preventive care needs and face different access to care barriers: for example, men often resist seeking professional health services while women, particularly women refugees, are at greater health risk because of issues around childbearing and sexual health. Furthermore, as immigration status, gender and socio-economic status intersect, women are also more vulnerable to poor health outcomes related to poverty. Pottie et al. (2000) note that the Canadian task force recognizes these gender-specific risks and has therefore built their preventive guidelines accordingly and they will also consider

specifically addressing gender-related health issues in their prevention guide. Disparities in immigrant and refugee populations are compounded by the fact that immigrants, refugees, health care providers, and community leaders face knowledge and delivery obstacles: the immigrant/refugee patient trying to communicate his or her health needs, the multicultural health mediator trying to find a supportive physician for their client, the health practitioner trying to communicate and deliver care across cultural interpreters, the community pharmacist trying to both identify foreign drugs and negotiate the Interim Federal Health Program drug benefit plan. The result, for the immigrant and refugee, is often a number of obstacles and inconsistent answers that can leave them disengaged and wary of a “foreign” primary and preventive care services (Pottie et al., 2000).

Between 2003 and 2005, the U.S. Refugee Program (USRP) resettled more than 8,000 Liberian refugees in the United States (Schmidts, 2009). Schmidts reports that the Liberian refugees coming to the U.S. now generally come from a more rural background and have experienced war, flight and refugee camp life. Social service providers should consider these experiences as well as cultural differences between Liberia and the United States when working with Liberian refugees. Liberian refugees who have experienced prolonged periods of flight and refugee camp life have typically lacked good primary health care. Since medical services have been scarce, the notion of preventive healthcare such as immunizations, prenatal care or regular dental care may be a foreign concept. This can result in a variety of treatable ailments that become more serious due to lack of medical care. The Liberian civil war has been notably damaging to civilians and the general fabric of society. Those coming out of the refugee camps have most likely witnessed or experienced violence of some kind. Those who have had to flee a place of refuge more than once may be more ‘cautious’ and may need more time to develop trust. Refugees may feel a constant sense of anxiety and guilt about relatives and friends who were left behind or whose whereabouts are unknown. Children may have become used to the language, brutality and arms of warfare, incorporating this into their play, artwork, speech and interactions with others children. Some resettlement workers report that symptoms of post-traumatic stress disorder (PTSD) begin to emerge at about 8-12 months after arrival. This is likely as refugees begin to feel comfortable enough to deal with the traumas they have

experienced. Some Liberians stress the importance of faith, houses of worship and Liberian religious leaders in dealing with the individual and collective trauma resulting from the civil war (Schmidt, 2009). According to this MA research, some DRC women based in Durban also stress the importance of religious leaders, even in their personal lives. The religious leaders have an influence in the choice and access to contraceptive use made by their fellow members. Religious leaders' opinions and views have a great impact in their fellow members' lives.

Refugees experience a number of difficulties as a result of national security concerns and weakness in the asylum systems of host countries (Wabungu, 2003). Women refugees as a group share the problems experienced by all refugees, including the need for protection against forced return to their countries of origin, and security against armed attacks and other forms of violence. Further, they need legal status that give them adequate protection of their social and economic rights and access to basic items such as food, shelter and clothing.

Wabungu (2003) states that an increase in the flow of refugees has both positive and negative economic, social, and cultural consequences for both the host population(s) and for the refugees themselves. Refugees usually bring with them skills which may be useful to the host population, however, a massive influx of refugees may also a burden the already strained economy of a host country.

According to the provisions of the South African Refugees Act (1998), a person who has been granted refugee status in South Africa needs to have proven that s/he has chosen to leave his/her country of origin because of the threat of persecution or events that have seriously disrupted the public order. The majority of refugees who have been granted asylum in South Africa have fled civil war or unrest at home (Wilondja, 2001). In South Africa, the majority of refugees are urban-based (Amisi, 2005), living within local host communities and struggling to fend for themselves. However, despite their legal status, the refugees are called "*amakwerekwere*" and experience social exclusion and xenophobic attitudes from some key officials and ordinary people.

The hostility towards foreigners living in South Africa has translated into extreme acts of xenophobic violence. In 2000, 2001 and 2008, Amnesty International's annual online reports on South Africa singled out attacks and ill treatment of asylum seekers and suspected illegal immigrants as a major source of concern. The South African media often explains xenophobia as the result of competition for scarce resources. This explanation would appear to be supported by the commonly-evoked stereotypes of an influx of African immigrants depriving South Africans of jobs (Warner, 2003).

Refugees often are marginalized and mainly experience a lack of or limited access to health services due to fear (Wulf, 1994 and Warner, 2003), lack of local language skills (Magwaza and Khumalo, 2003), insufficient information on available resources (Mckinsey, 2006), financial constraints (Caraballo et al. , 1996 and UNHCR Reports, 1998 & 2002), and attitudes of health workers (Wood and Jewkes, 2006). They are often turned away by health workers when seeking help for themselves or for family members (Magwaza and Khumalo 2003; Wambugu 2003; Warner 2003).

2.2. CONTRACEPTION

Contraception can be defined as, 'the voluntary and artificial prevention of conception or impregnation' (Blackwell cited in Oyedeji, 2003). Contraception can also be referred to as the regulation of reproduction. This study documents the experiences of DRC Durban-based refugee women in the access and choice of contraceptives. I adopt these two definitions of the word contraception because of the responses elicited from interviews. The choice depends on one person to another and some refugees are not aware that they are entitled to certain rights and benefits. Being able to choose and to access contraceptives is among their benefits and rights.

In this section, I discuss the history and methods of contraception. The impact of contraceptive on DRC Durban-based refugee women is also explored.

2.2.1 EVOLUTION OF CONTRACEPTION AND ASSOCIATED CHALLENGES

Margaret Sanger fought for the right and the freedom of women to use contraceptives in order to avoid unwanted pregnancies. Her mother gave birth to eleven living children and died prematurely at the age of forty-eight. In her work as a public health nurse, Sanger witnessed first-hand the disastrous economic and physical effects on poor women and their families of uncontrolled fertility. It became her life's mission to give to every woman the right 'to control her own body' (Sanger, 1996:326).

In Europe, Sanger studied the history of birth control and visited clinics in Holland, where doctors and nurses had been dispensing contraceptives since 1881. On her return to the United States of America in 1915, she launched a massive campaign to break down legal barriers to dissemination of contraceptive information and devices by physicians. Birth control, to Sanger, was a part – and the most important – of the struggle to liberate women. As she expressed it, the right to voluntary motherhood was a woman's 'key to the temple of liberty'.

Marie Stopes, Britain's foremost proponent of sexual techniques and birth control, was born on 15 October 1880 in Edinburgh and died on 2 October 1958. In her own personal life, she experienced sexual and emotional misfortune. This was the beginning of her career, which made her, 'the central figure in that social revolution by which men, but more particularly women, were freed from the miseries of sexual ignorance and haphazard reproduction' (Hall cited in Oyedepi, 2003:18). She fought for the liberation of women from the constraints and restraints of unwanted pregnancies and sexually transmitted diseases, by promoting contraception. She sought to make contraceptives accessible to lower class women as contraceptives were hitherto limited to the bourgeoisie. She stressed the need for clinics supported by the government and directed by trained personnel to educate the public in contraceptive use (McLaren cited in Oyedepi, 2003).

Attempts at reproduction regulation began as far back as the 16th century:

'In the late sixteenth century, Pope Benedict condemned those who violated nature or employed unnatural acts so that their wives could not conceive' (McLaren cited in Odeyeji, 2003:20).

Even though the methods of contraception might have been somewhat crude, that implies that reproduction regulation methods existed long before Margaret Sanger or Marie Stopes began their campaign for the acceptance and legalization of contraception.

According to Sanger, religion violated the right to voluntary motherhood and limited contraception through the teaching of continence as one contraceptive method allowed by the church: 'Thousands of well-intentioned people, who agree that there are times and conditions under which it is a woman's highest duty to avoid having children, advocate continence as the one permissible means of birth control. Loathing, disgust or indifference to the sex relationship nearly always lies behind the advocacy to continence. Much of the responsibility for this feeling upon the part of many thousands of women must be laid to two thousand years of Christian teaching that all sex expression is unclean. Part of it, too, must be laid to the dominant male's habit of violating the love rights of his mate '(Sanger, 1996: 326).

Birth control methods were not publicly authorized before and during the era of Sanger and Stopes. Although they were in different countries and continents, the reaction was the same. McLaren (cited in Oyedeji, 2003) states that women have had to submit themselves to discomfort in order to avoid getting pregnant. One major reason for this is the absence of proper well-formulated methods of birth control, as *coitus interruptus* was the main form of contraception employed. Governments and the various religious sects of various communities responded with different levels of resistance to the use of contraception. McLaren (cited in Oyedeji, 2003) notes that in England, as late as the 1970s, the medical defense union advised practitioners not to fit an intra-uterine device for a woman without the consent of her husband. Oyedeji (2003) states that in recent times, family planning initiatives in many southern countries had to confront religious, military and nationalist resistances. However, now,

contraceptive use and safe sex methods have been widely accepted throughout the world by governments and by the public, to the extent that contraception and safe sex methods have come to the fore in science and medicine. The need for the prevention of sexually transmitted disease has made the legalization of safe sex methods compulsory. Another factor that has also necessitated safe and effective methods of contraception is the high rate of unwanted or unplanned pregnancies that lead to abortion and that has also led to the endangering of the mother's life, and high rates of maternal and infant mortality. Gready et al. (1997) emphasized that contraceptive services should help people to take control of their lives as well as their fertility; services that are centred around keeping women satisfied with and using a method in order to keep the fertility rate down can easily overlook people's needs and human rights. Services need to make a range of contraceptive methods available to allow for the fact that a woman (and a couple) have different needs at different times and should have access to a range of methods, if need be, until the woman finds one that is best for her health, her specific needs and her fertility priorities

In the 2008 State of the Province address, the premier of KwaZulu-Natal, South Africa, Sibusiso Ndebele, in support of the distribution of condoms in schools, pointed out that over 5000 pupils fall pregnant every year and are vulnerable to abortion. He found it difficult to believe that some people were against the supplying of condoms to schools. Alongside the high pregnancy rates, abortions among teenage girls and young women are reported to have increased since abortion was decriminalized in South Africa. This further emphasizes the importance of contraceptive measures and the need for it to be accepted, variable and accessible in communities.

Contraception is of importance as it affects the world population and other aspects of human lives. Power to influence fertility and reproduction, usually found within the older generation, parents, church leaders and government needs to be deconstructed in order to avoid societal and cultural pressure in the access to, and the use, of birth control measures.

According to Bertrand et al. (1995), access to family planning, quality of care and medical barriers are key factors in the adoption of contraceptive use. Access helps determine whether

the individual makes contact with the family planning provider, while quality of care greatly affects the client's decision to accept a method and the motivation to continue using it. Medical barriers are scientifically unjustifiable policies or practices, based at least in part on a medical rationale, that inappropriately prevent clients from receiving the contraceptive method of their choice, or imposes unnecessary process barriers to access to family planning (Bertrand et al., 1995).

In a Vietnamese study by Thang and Anh (2002), we learn that although family planning services were available to the majority of women, not all contraceptive methods were equally available. Condoms, oral contraceptives and IUDs were generally easier to obtain than were other methods. Urban-rural differentials in access to family planning services were sizable for almost all contraceptive methods, with access being substantially greater among urban women than among rural women for the pill, the condom, the injectable contraceptive, the IUD and female sterilization. Thang and Anh (2002) argue that because contraceptive access in Vietnam varies sizably by region and because one method (the IUD) predominate in Vietnam's contraceptive method mix, a better understanding of accessibility of family planning services in the country could help program planners increase use.

Heard et al. (2004) found that in a multivariate logistic regression analysis, after controlling for background variables traditionally associated with use of modern contraception, access could not be shown to explain use of modern contraception in Malawi.

Hardon (1994) found that over the past three decades, contraceptive technologies have been the subject of increasing criticism from health advocates. Critics have said that the way contraceptives are designed, developed and distributed has the effect of controlling women's fertility and harming their health, rather than meeting their reproductive needs. A specific criticism is that too many of the technologies depend on medical professionals for administration and removal. This means that women are not in control of their contraception, with a resulting potential for abuse. It must be noted that there have been some improvements in this regard. Other studies on contraceptives, as for example in Oyedemi (2003), have looked at the gendered contraceptive use among students at the University of Natal (Pietermaritzburg

campus). She wanted to establish the influence of patriarchy on contraceptive use among female students. Monakali's (1995) study was undertaken to ascertain the attitudes of first year tertiary education students of both genders towards general contraceptive usage and condom usage and, to assess what impact these attitudes had on heterosexual behavior. Mairiga et al. (2010) have described and documented the socio-cultural factors affecting decisions related to fertility among the Kanuri of Nigeria and found that reasons for child-spacing were related to child welfare and maternal well-being. These methods included prolonged breastfeeding, ornaments in various forms and shapes, spiritual invocations and dried herbs. Few Kanuri women practiced modern methods of family planning. In a South African study by Gready et al. (1997), access to contraception, for all the women, was not a primary determinant to contraceptive usage. Instead, apartheid impacted on contraceptive services – most noticeably in the differences between the public and the private sector services – in relation to privacy and respect, as well as a broader range of reproductive and sexual health care. Many women who attended the public sector clinics were subjected to health worker hostility and to sterilization procedures without their full knowledge and/or consent. Concerns about the financial motivations as the primary reason for providing a more comprehensive service in the private sector cannot, however, be ignored either. Gready et al. (2000) emphasized that contraceptive providers sometimes erect barriers based on people's age, marital status, or other inappropriate criteria. They often have their own preferences and preconceived ideas about what contraceptive method is best for the women.

Refugee women have the same health needs as other women in the world. Many refugee women face unwanted, unplanned, and poorly spaced pregnancies, due to a lack of access to contraceptive services and supplies, overburdened providers with little time to educate or counsel clients, pressure from husbands or other family members to rebuild the population, and increases in rape and prostitution (Creel, 2002). Frost (2008) noted that access to clinic facilities also restricts the use of contraceptives. Sometimes women have to travel far to reach a clinic, and often the queues are long and service is slow. It could take a woman as long as a day to get contraceptives.

In past centuries and nowadays, the use of contraception is always linked to specific difficulties, for example:

1) Religious factors

In a study by Preston-White and Zondi (cited in Monakali, 1995), it was reported that most pregnancies occurred because the church was against the use of contraceptives. Catholicism implies that contraception is immoral and unnatural and that it interferes with natural processes by an outside human agency. Abdool Karim et al (cited in Monakali, 1995) commented on the religious customs against the use of condoms because of the disposal of the spermatozoa. The religions mentioned were Roman Catholic and Jehovah's Witnesses. Marsh et al. (2010) stated that for many women, condom usage was forbidden by religious beliefs thus putting them in a motivational dilemma when asked to use condom.

2) Barriers to fertility control

Accessibility of fertility control services has a significant effect on contraceptive behaviour.

a) Access barriers to contraceptive services:

According to Monakali (1995), as most contraceptives are offered free of charge in the public health sector (government hospitals and clinics), the direct cost of contraceptives should not be a deterrent. Gule (cited in Monakali, 1995) argues that the cost, e.g transport, may still be too high in terms of time and effort required to get to the supply source. This includes the time spent at the service point in order to maintain the method. Furthermore, the side effects of the method and the partner's adverse reaction may lead to client inertia whereby the cost of usage outweighs the benefits of contraceptives. Petros-Nustas et al. (2002) noted among barriers to contraceptive access some resistance by men to using male contraceptives, as well as, some deficits concerning modern methods of contraception, and their side effects in particular.

Gready et al. (2000) found that a number of obstacles often stand in the way of good client-provider communication these include unnecessary medical barriers. For example sometimes programs and providers prevent women from receiving the contraceptive method of their choice by adhering to scientifically unjustifiable policies or practices, based at least in part on a medical rationale. Outdated contra-indications also sometimes remain in a program's official guidelines or providers' informal screening routine.

b) informational barriers to, and misconceptions about, contraception:

According to Melchert and Burnett (cited in Monakali, 1995), knowledge alone has no clear association with the reliable usage of fertility control. However, education may assist in reducing misconceptions and contribute to more positive attitudes and thus to better contraceptive usage. Frost (2008) noted that a woman's attitude toward pregnancy, her satisfaction with her method and her experiences with providers of contraception plays a far bigger role in a woman's risk of pregnancy than other major risks, such as poor education and poverty.

Misconceptions may include belief in lack of individual susceptibility to pregnancy and sexually transmitted infections with unprotected sex (Monakali, 1995). Fertility control methods, such as oral contraceptives and injectables, may be falsely associated with medical problems and sterility (Preston-White and Zondi cited in Monakali, 1995). Furthermore, ignorance of how the contraceptive methods work may lead to unreliable contraceptors. In a study by Castle (2003) the social consequences of side effects of hormonal contraceptives were perceived to be more important than their biological manifestations, and together with the fear of sterility, resulted in a preference for the condom.

c) Poor quality of family planning service:

Monakali (1995) states that most clinics and hospitals are overcrowded and understaffed and because nurses are overburdened with work, they tend to give high priority to the sick and therefore there is no proper counseling of clients. Lack of privacy contributes to this problem. Negative attitudes by service providers towards contraception in general and towards certain methods, also contribute to defective contraception usage. In some services there are insufficient supplies and sometimes shortages of certain contraceptive methods (Abdool K, Preston – White & Zondi, Gule cited in Monakali, 1995).

d) Attitudes of clinic staff:

Negative attitudes from health care providers as well as lack of interest by some nurses can constitute a barrier to the access and use of contraceptives. Morrison (2000) noted that the availability of providers with whom women are comfortable is critical to expanding both awareness of and access to family planning. Palitza (2008) noted that refugees do not have adequate access to health care services in South Africa, and they have not been given correct treatment at clinics due to the display of xenophobic attitudes by health workers. Gready et al. (1997) argued that the primary factor which undermines the quality of care of contraceptive services in South Africa is not the lack of resources which plagues many countries world-wide, but rather the ubiquitous assumption by health workers that they should make decisions on behalf of clients, without providing information, contraceptive method choice or an environment in which women are encouraged to take charge of their fertility.

3) Partner disapproval

In a study by Gule (cited in Monakali, 1995), the partner's disapproval was found to play a significant role as a constraint to contraceptive use. He also found that disapproval is usually due to ignorance about the contraceptive methods or associated with

misconceptions. It is often the male partner who is perceived as disapproving and education ought to focus more on contraceptive and sexual health education for males (Byrne and Fisher cited in Monakali, 1995). Poots & Marks (2001:203) reveal that 'men in the (SADC) region frequently argue that contraception allows women to be promiscuous' and Maharaj (2001:257) states that 'men have an instrumental role to play in reproductive decision-making'. This means that, even though the issue concerns woman, the male partner has an influence on women's access to contraceptives.

Petros-Nustas et al. (2002) found that there was a consensus among all men about the link between the concept of birth-spacing/family planning and the concept of better health for the mother and the child. Yet, the practice of contraception was influenced by some religious and cultural beliefs which come when the child is born. Most men in their study indicated that spousal communication takes place on issues related to family planning, but the final decision is, in most cases, left to the husband alone as the head of the family. The demand for an increasing number of male children and the resistance of males to the use of condoms were among the most prevalent unexpected phenomena noticed in their study (Petros-Nustas et al., 2002)

2.2.2 GENDER AND CONTRACEPTION

In society, women are assigned subordinate roles and female gender is thought of mostly in relation to the biological function of reproduction, which is considered to be a woman's natural, biological role. Most of the time the woman's role is constructed around her reproductive functions. The roles associated with the female gender are 'feminine' roles of submission, dependency, gentleness, nurturance, passivity, emotion etc as opposed to "masculine" roles of reasonability, dominance, independence, aggression, toughness etc that are associated and attributed to members of the male sex (Figes, Millet, and Tong cited by Oyediji, 2003). Gender roles are dictated by society and the role dictated for each gender becomes the norm for individuals who are categorized under that gender. Sanger (1996) is of the opinion that

woman's acceptance of her inferior status is the more real because it is unconscious. For generations women have, through their maternal role, bound themselves to their "subservient" role in society. This role being to produce children for their male partners and the society at large. A patriarchal type society has been perpetuated where men have made the important decisions and women have merely swelled the population numbers. Women have been overwhelmingly occupied by their reproductive function to the exclusion of any other role which should be performed by the feminine element of our society and which is necessary for any individual to be a well rounded and broadly experienced individual (Sanger, 1996).

In her study, Sanger (1996) states that women who have knowledge of contraceptives are not compelled to make the choice between a maternal experience and a married love life; they are not forced to balance motherhood against social and spiritual activities. Motherhood is for them to choose, as it should be for every woman to choose. Sanger concludes that choosing to become mothers, women do not thereby shut themselves away from thorough companionship with their husbands, from friends, from culture, from all those manifold experiences which are necessary to the completeness and the joy of life.

Even though women are now offered freedom with the advent of birth control, the consequences of a historically submissive past have to be dealt with and slowly changed. It is now their responsibility to remove the shackles they have inherited from their mothers and grandmothers. Habits and practices have slowly to be altered and adapted to engender a more balanced society in terms of roles played by both men and women. A society in which men and women perform more equal roles in respect of family duties, parental roles and also in their relationship as a couple, must be strived for. There are obstacles to this change and these include womens' lack of education in respect of their rights and even the law perpetuates (Sanger, 1996)

Goldman (1996) echoes the concern that motherhood must be a choice. She states that the institution of marriage makes a parasite of woman, an absolute dependent. It incapacitates her for life's struggle, annihilates her social consciousness, paralyzes her imagination, and then imposes its gracious protection, which is in reality is a trap. Furthermore, she stated that if

motherhood is the highest fulfillment of woman's nature, what other protection does it need except love and freedom? Marriage but defiles, outrages, and corrupts her fulfillment.

Patriarchal constructions of society considered contraception both as a form of reproductive technology and, most importantly, as a means through which the men gain and exercise control over women's fertility. In other words, the male gender attempts to control women's bodies and fertility by controlling their choice, use and access to contraception. Often, the use of contraception brings about or reveals the already existing power struggle between members of the male and female genders. There is a need for everyone, regardless of his/her gender, to gain control of his/her life and to be able to stand for what he or she believes. This form of patriarchy is represented world-wide by government laws and policies that restrict production and availability of adequate forms of contraception to the users. We must understand the need for a fair and equal world. Gender does not deal with sex but concerns the way human society deals with human bodies and the many consequences of that dealing in our personal lives and our future together as human beings. In other words, gender usually refers to the social attributes and opportunities associated with being male and female. It also defines power relations in society and determines what is expected, allowed and valued in a woman or a man in a given context. Gender roles are not necessarily discussed but often affect the way providers and clients interact and the decisions that clients make. Gready et al. (2000) found that when clients are women, providers are less likely to answer questions, provide technical information, offer alternatives for treatment, and diagnose and treat certain diseases. They are also more likely to attribute women's complaints to psychosomatic factors. Reproductive rights are human rights which are inalienable and inseparable from basic rights such as the right to food, shelter, health, security, livelihood, education and political empowerment (Correa cited in Oyedeyi, 2003). Reproductive rights include the right to reproductive health care and the right to reproductive self-determination. Preventing contraceptive choices or making access difficult, means denying women the right to choose when to become a mother. This denial makes motherhood not a choice but a burden.

Women living in a refugee situation may have a serious need for family planning services, yet may face obstacles (both cultural and logistical) to practicing contraception due to their gender. Understanding the reproductive health needs of women in these difficult circumstances is critical to devising comprehensive programs (Morrison, 2000).

2.2.3 METHODS OF CONTRACEPTION

The stress of refugee situations may intensify existing barriers to the use of contraceptives. Concerted efforts at education must be made to dispel misperceptions about safety and increase awareness that services are available. The importance of this section is to provide the correct information in order to avoid misunderstanding and misconceptions as seen by many DRC Durban-based refugee women. This section is vital because it is an educational and motivational tool to increase the access and use of contraceptive among refugee women. Although I continue to discuss related literature, in this section I equally reflect and provide information that I found necessary to include due to the level of awareness expressed by the respondents of the study. It is important and vital that contraceptive users are well aware of what is required of them and the possible implications of their choice when choosing which contraceptive to use. Responsible decision making is dependent upon knowledge and information. There are several methods of contraception, none is completely effective, but some methods are far more reliable than others. Each contraceptive method has advantages and disadvantages. Choice of method depends on a person's lifestyle and preferences and on the degree of reliability needed (Beers et al, 2003).

1. HORMONAL METHODS

The hormones used to prevent conception include estrogen and progestins (drugs similar to the hormone progesterone). Hormonal methods prevent pregnancy mainly by stopping the ovaries from releasing eggs or by keeping the mucus in the cervix thick so that sperm cannot pass

through the cervix into the uterus. Thus, hormonal methods prevent the egg from being fertilized.

a) Oral Contraceptives

Oral contraceptives, commonly known as the pill, contain hormones – either a combination of a progestin and estrogen or a progestin alone.

Beers et al. (2003) state that combination tablets are typically taken once a day for 3 weeks, not taken for a week (allowing the menstrual period to occur), then started again. Inactive tablets may be included for the week when combination tablets are not taken to establish a routine of taking one tablet a day. Less than 0.2% of women who take combination tablets as instructed become pregnant during the first year of use. However the chances of becoming pregnant increase if a woman skips or forgets to take a tablet, especially the first ones in a monthly cycle.

The dose of estrogen in combination tablets varies. Usually, combination tablets with a low dose of estrogen (20 to 35 micrograms) are used because they have fewer serious side effects than those with a high dose (50 micrograms). Healthy women who do not smoke can take low-dose estrogen combination contraceptives without interruption until menopause. According to Sellers (cited in Monakali, 1995), the low dose combined oral contraceptive pill is the recommended method for young women having regular coitus, provided they take the pill regularly. They are extremely effective contraceptives.

According to Beers et al. (2003), Progestin-only tablets are taken every day of the month. They often cause irregular bleeding. About 0.5 to 5% of women who take these tablets become pregnant. Progestin-only tablets which are usually prescribed only when taking estrogen may be harmful. For example, these tablets may be prescribed for women who are breastfeeding because estrogen reduces the amount and quality of breast milk produced. Progestin-only tablets do not affect breast milk production.

Before starting oral contraceptives, a woman should have a physical examination, including measurement of blood pressure, to make sure she has no health problems that would make

taking the contraceptives risky for her. If she or a close relative has had diabetes or heart disease, a blood test is usually performed to measure levels of cholesterol, other fat (lipids), and sugar (glucose). If the cholesterol or sugar level is high or other lipid levels are abnormal, doctors may still prescribe a low-dose estrogen combination contraceptive, however, they periodically perform blood tests to monitor the woman's lipid and sugar levels. Three months after starting oral contraceptives, the woman should have another examination to be sure her blood pressure has not changed. After that, she should have an examination at least once a year (Beers et al. 2003).

Before starting oral contraceptives, a woman should discuss, with the health professional, the advantages and disadvantages of oral contraceptives for her situation.

Advantages:

The main advantage is reliable, continuous contraception if oral contraceptives are taken as instructed. Also, taking oral contraceptives reduces the occurrence of menstrual cramps, premenstrual syndrome, irregular bleeding, anemia, breast cysts, mislocated (ectopic) pregnancies (almost always in the fallopian tubes), and infections of the fallopian tubes. Also, women who have taken oral contraceptives are less likely to develop rheumatoid arthritis or osteoporosis.

Taking oral contraceptives reduces the risk of developing several types of cancer such as ovarian, colon, and rectal cancers. The risk is reduced for many years after the contraceptives are discontinued.

Oral contraceptives taken early in a pregnancy do not harm the fetus, however, they should be discontinued as soon as the woman realizes she is pregnant. Oral contraceptives do not have any long-term effects on fertility, although a woman may not release an egg (ovulate) for a few months after discontinuing the drugs.

Disadvantages:

The disadvantages of oral contraceptives may include bothersome side-effects. Irregular bleeding is common during the first few months of oral contraceptive use but usually stops as the body adjusts to the hormones. Also, taking oral contraceptives every day, without any breaks for several months, can reduce the number of bleeding episodes.

Some side effects are related to the estrogen in the tablet. They may include nausea, bloating, fluids retention, an increase in blood pressure, breast tenderness, and migraine headaches. Others are related mostly to the type or dose of the progestin. They may include mood disorders, weight gain, acne and nervousness. Some women who take oral contraceptives gain 3 to 5 kg because of fluid retention. They may gain even more because appetite also increases. Some women have headaches and difficulty sleeping. Many of these side effects are uncommon with the low-dose tablets. Taking oral contraceptives increases the risk of developing some disorders. The risk of developing blood clots in the veins is higher for women who take combination oral contraceptives than for those who do not (Beers et al., 2003). Many DRC refugee women taking the pills complained of weight gain, irregular bleeding and headaches.

Use of oral contraceptives, particularly for more than 5 years, may increase the risk of developing cervical cancer. Women who are taking oral contraceptives should have a Papanicolaou (Pap) test at least once a year. Such tests can detect precancerous changes in the cervix early – before they lead to cancer. The likelihood of developing gallstones increases during the first few years of oral contraceptive use; then it decreases.

For women in certain situations, the risk of developing certain disorders is substantially increased if they take oral contraceptives. For example, women who are older than 35 and who smoke should not use oral contraceptives because the risk of heart attack is increased. For women who have certain other disorders, risks are increased if they take oral contraceptive. But if closely monitored by a health care practitioner, such women may be able to take oral contraceptives.

Some sedatives, antibiotics, and antifungals can reduce the effectiveness of oral contraceptives. Women taking oral contraceptive may become pregnant if they simultaneously take one of these drugs.

b) Contraceptive injections

Two contraceptive formulations are available as injections. Each is injected by a health care practitioner into a muscle of the arm or buttocks, and each is very effective as a contraceptive.

Medroxyprogesterone acetate, a progestin, is injected once every 3 months, making it a relatively convenient and low-cost form of birth control. Medroxyprogesterone acetate can completely disrupt the cycle. About one third of women using this contraceptive have no menstrual bleeding during the 3 months after the first injection, and another third have irregular bleeding and spotting for more than 11 days each month. After this contraceptive is used for a while, irregular bleeding occurs less often. When the injections are discontinued, a regular menstrual cycle resumes in about half of the women within 6 months and in about three quarter within one year. Fertility may not return for up to a year after injections are discontinued. This was unfortunately a subject of misconception among DRC refugee women who accused the injection as a cause of sterility.

The other formulation is a once-every-two-month injection. It contains estrogen and a much smaller amount of medroxyprogesterone acetate than the injections given every 3 months, consequently bleeding usually occurs regularly about 2 weeks after each injection is given, and bone density does not decrease. Because the dose of medroxyprogesterone acetate is lower, fertility returns much more rapidly after the injections are discontinued.

In a study by Sellers (cited in Monakali, 1995), it is stated although "Depo-provera" is longer lasting, "Nur-Isterate" appears to be more acceptable to women. This is because 'Depo-provera' contributes to weight gain and increased appetite, as well as headaches. Those two side effects were noted by DRC refugee women.

c) Contraceptive implants

Contraceptive implants are plastic capsules or rods containing a progestin. Intervention of a health care practitioner is needed to place the implants under the skin of the inner arm above the elbow. The health care professional makes a small incision or uses a needle to place the implants. No stitches are necessary. The implants release the progestin slowly into the bloodstream. The effectiveness of the implant is 3 years and after this period, it must be removed through an incision. Removal is more difficult than insertion and may result in a minor scar (Beers et al., 2003)

The most common side effects are irregular or no menstrual periods during the first year of use. Headaches and weight gain may occur. As soon as the implants are removed, the ovaries return to their normal functioning, and the woman becomes fertile again.

Roux (cited in Oyedeji, 2003) states that this method is advised for women who have passed their reproductive years or who have decided to put a stop to childbirth.

d) Skin patches and vaginal rings

Skin patches and vaginal rings that contain estrogen and a progestin are used for 3 of 4 weeks. In the fourth week, no contraception is used to allow the menstrual period to occur.

A contraceptive skin patch is placed on the skin once a week for 3 weeks. The patch is left in place for 1 week, then removed, and a new one is placed on a different area of the skin. Exercise and use of saunas or hot tubs do not displace the patches.

A vaginal ring is a small plastic device that is placed in the vagina and left there for 3 weeks. A woman can place and remove the vaginal ring herself. The ring comes in one size and can be placed anywhere in the vagina. A new ring is used each month.

Beers et al. (2003) state that with either method, a woman has regular menstrual periods. Spotting or bleeding between periods (breakthrough bleeding) is uncommon. Side effects and restrictions on use are similar to those of combination oral contraceptives.

e) Emergency contraception

Cooper & Smith (cited in Oyediji, 2003) state that this pill serves as a form of corrective measure. The so-called morning-after pill involves the use of hormones within 72 hours after one act of unprotected sexual intercourse or after one occasion when a contraceptive method fails (for example, if a condom breaks). Two regimens of emergency contraception are available. The more effective regimen consists of one dose of levonorgestrel, a progestin, followed by another dose 12 hours later. With this regimen, about 1% of women become pregnant, and fewer side effects occur than with the other regimen. Alternatively, two tablets of a combination oral contraceptive are taken within 72 hours of the unprotected intercourse. Then two more tablets are taken 12 hours later. With this regimen, about 2% of women fall pregnant, and 50% have nausea and 20% vomit. Ebuehi et al. (2006) study reveals that many health care providers although they had heard of emergency contraceptive, many of them lacked specific knowledge about the method thus the necessity for health care provider's education about emergency contraception. Training should target the types of providers who are less knowledgeable about the method.

2) BARRIER CONTRACEPTIVES

Barrier contraceptives physically block the sperm's access to a woman's uterus. They include the condom (male or female), diaphragm, and cervical cap.

a) Condom

Condoms made of latex are the only contraceptives that can protect both men and women from sexually transmitted diseases. A male condom is a thin sheath, usually made out of latex, which is rolled onto an erect penis before sexual contact. It must be used correctly to be effective. A female condom is held in the vagina by a ring. It resembles a male condom but is larger and not as effective (Beers et al, 2003). None of our respondents ever saw a female condom.

Abdool Karim et al. (cited in Monakali, 1995) noted that some men, however, perceive condoms as a major barrier to sexual pleasure. In a study by Grimley (cited in Monakali, 1995), condoms are commonly used by adolescents and young adults who do not have a settled heterosexual partner. In a study by Mash (2010) the use of condoms was associated with a perceived lack of 'real' love, intimacy and trust; a key term that emerged included unequal power in sexual decision making, with men dominating and women being disempowered. Women may want to please their partner, who might believe that condoms will reduce sexual pleasure. This feeling of decreasing sexual pleasure was cited by our respondents.

b) Diaphragm

It is a dome-shaped rubber cup with a flexible rim, is inserted into the vagina and positioned over the cervix. The diaphragm acts as a barrier to sperm to prevent pregnancy but this doesn't protect against most sexually transmitted infections. The diaphragm comes in various sizes and must be fitted by a health care practitioner who also teaches woman how to insert it. A contraceptive cream or jelly should always be used with a diaphragm in case the diaphragm is displaced during intercourse. The diaphragm is inserted before intercourse and should remain in place for at least 8 hours but no more than 24 hours afterwards.

c) Cervical cap

Roux (cited in Oyedeji, 2003) states that cervical caps are complicated to use and are not readily available in South Africa. This cap resembles the diaphragm but is smaller and more rigid. It fits snugly over the cervix. Cervical caps must be fitted by a health care practitioner. A contraceptive cream or jelly should always be used with a cervical cap. The cap is inserted before intercourse and left in place for at least 8 hours after intercourse.

3) SPERMICIDES

Spermicides are preparations that kill sperm on contact. They are available as vaginal foams, creams, gels and suppositories and are placed in the vagina before sexual intercourse. They are best used in combination with a barrier contraceptive. Szarewski (cited in Oyedeji, 2003) noted that the rates of pregnancy are unacceptably high with the solitary use of spermicides.

4) INTRAUTERINE DEVICES

According to Tucker (cited in Monakali, 1995), the effectiveness of this method can be compared with that of sterilization. Intrauterine devices (IUDs) are small, flexible plastic devices that are inserted into the uterus. An IUD is left in place for 5 or 10 years, depending on the type or until the woman wants the device removed. IUDs must be inserted and removed by a doctor or other health care practitioner. IUDs kill or immobilize sperm and prevent fertilization of the egg.

Two types of IUDs are available. One type, which releases progestin, is effective for 5 years. The other, which releases copper, is effective for at least 10 years. One year after the removal of an IUD, 80% to 90% of women who try to conceive do so.

An IUD inserted up to 1 week after unprotected sexual intercourse is an almost 100% effective a method of emergency contraceptive.

The main advantage of an IUD is that, once fitted, and as long as the IUD remains in place, it can be left for 5 to 10 years. IUDs are about 99% effective. There are, however, some disadvantages. Copper IUDs can make a woman's periods heavier, longer or more painful. There's a small chance of getting an infection during the first 20 days after the IUD is fitted. Rarely, an IUD might go through (perforate) the womb or cervix when it's fitted. There is also an increased risk of pelvic infection from sexually transmitted infections (STIs). If pregnancy occurs while using IUD, there is a small risk of an ectopic pregnancy (Beers et al, 2003)

5) TIMING METHODS

Some contraceptive methods depend on timing rather than on drugs or devices.

a) Natural family planning methods

Natural family planning (rhythm) methods depend on abstinence from sexual intercourse during the woman's fertility time of the month. In most women, the ovary releases an egg about 14 days before the start of a menstrual period. Although the unfertilized egg survives only about 24 hours, sperm can survive for as long as 7 days after intercourse. Consequently, fertilization can result from intercourse that occurred up to 7 days before the release of the egg (Roux, cited in Oyedeji, 2003). Classified under natural methods of contraception are methods such as abstinence, the rhythm method, the lactation and withdrawal methods. Hall (cited in Oyedeji, 2003) states that the withdrawal method is also referred to as coitus interruptus.

The calendar method is the least effective natural family planning method, even for women who have regular menstrual cycles. Other, more effective natural family planning methods include the temperature, mucus, and symptothermal methods.

For the temperature method, a woman determines the temperature of the body at rest (basal body temperature) by taking her temperature each morning before she gets out of bed. This temperature decreases before the egg is released and increases slightly after the egg is released.

For the mucus method, the woman's fertile period is established by observing cervical mucus, which is usually secreted in larger amounts and becomes more watery shortly before the egg is released.

The symptothermal method involves observing changes in both cervical mucus and basal body temperature as well as other symptoms that may be associated with the release of the egg, such as slight cramping pain. Of the natural planning methods, this one is the most reliable.

Many DRC refugee women preferred the natural method because they believed it to be safe.

b) Withdrawal before ejaculation

To prevent sperm from entering the vagina, a man can withdraw the penis from the vagina before ejaculation (when sperm is released during orgasm). This method is also called coitus interruptus and is not reliable because sperm may be released before orgasm. It also requires that the man have a high degree of self-control and precise timing.

6) STERILIZATION

Sterilization involves making a person incapable of reproduction. In a study by Szarewsky et al. (cited in Oyedeji, 2003), clients are warned not to consider the operation as reversible although there is possibility of reversal of the procedure.

Vasectomy is performed to sterilize men. It involves cutting and sealing the vasa deferentia (the tubes that carry sperm from the testes). A man who has had a vasectomy should continue

contraception for a while because usually he does not become sterile until about 15 to 20 ejaculations after the operation. The reason is that many sperm are stored in the seminal vesicles. Complications of a vasectomy include bleeding, an inflammatory response to sperm leakage, and spontaneous reopening (in less than 1% of cases and usually shortly after the procedure).

Tubal ligation is used to sterilize women. It involves cutting and tying or blocking the fallopian tubes which carry the egg from the ovaries to the uterus (Beers et al, 2003). More complicated than vasectomy, tubal ligation requires an abdominal incision and a general or regional anesthetic. After laparoscopy, up to 6% of women have minor complications (skin infection at the incision site and/or constipation). Less than 1% has major complications (bleeding or punctures of the bladder or intestine).

CHAPTER 3: THEORETICAL FRAMEWORK

3.1. INTRODUCTION

A liberal feminist approach using Sanger's analysis around reproductive health provides the main framework with which to consider contraceptive access and choices. Liberal feminism is centrally concerned with equal rights. Liberals also believe that all human beings have the capacity to think and act rationally. It is this capacity for reason which gives rise to the idea that human beings have innate rights. Liberals support the right of individuals to seek fulfillment and pursue their own interests, providing that, in so doing, they respect the rights of others. The argument that women are 'by nature' different from men has been frequently used to justify different and usually unequal treatment for women. Rights were frequently denied to women on the ground that they were 'irrational' creatures and so less than fully human. Feminists found liberalism useful in challenging patriarchal authority justified by religious dogma (Steans, 1998: 16). For Sanger, 'No woman can call herself free who does not own and control her body. No woman can call herself free until she can choose consciously whether she will or not be a mother'. Women who have knowledge of contraceptives are not compelled to make the choice between a maternal experience and a married love life; they are not forced to balance motherhood against social and spiritual activities. Motherhood is for them to choose, as it should be for every woman to choose (Sanger, 1996: 329). In addition and more importantly, informed by precepts arrived at during a workshop that Potts and Marks (2001) makes reference to – the study hopes to provide an impetus for future studies that may be interested in understanding the interplay between fertility, the adoption of contraceptives, education, income and gendered socio-economic factors.

The social constructionist approach is to be used as a framework for analysis. This approach has argued that the gender system which constructs two different sexes is a system that works to concentrate power in the hands of patriarchs. All humans are shaped by socialization, which includes the communication of a variety of beliefs limiting acceptable behaviour. But oppressed

groups may have, or be subjected to, additional beliefs that support and reinforce their oppression. Women are often stereotyped as inferior in intelligence or character. Such stereotypes are then taken to justify social arrangements (which may be contained in cultural and religious values) that simply reinforce the stereotypes. This in turn, tends to transform the stereotypes into self-fulfilling prophecies by creating barriers against which members of the relevant groups must struggle (Purdy, 1996: 163).

This research therefore reflects women's choices drawing on their interpretations of their own experiences, relating them to the way in which the DRC community, their male partners, South African society in which we live and cultural or religious values have constructed them and therefore contributed to their access of contraceptives.

3.2. LIBERAL FEMINIST THEORY

Liberal feminism asserts the equality of men and women through political and legal reform. It is an individualistic form of feminism and theory, which focuses on women's ability to show and maintain their equality through their own actions and choices. Liberal feminism looks at the personal interactions of men and women as the starting ground from which to transform society into a more gender-equitable place. Liberal feminism seeks no special privileges for women and simply demands that everyone receive equal consideration without discrimination on the basis of sex (Baehr, 2008).

Being an African refugee woman is a double dilemma for the person in this situation. In order to understand that dilemma, we must look first at some of the criteria of a good woman according to patriarchal perspective. A good woman is the one who cooks, does laundry, cleans the house and takes good care of her family. She does not complain about bad treatment from her husband in public, shows and gives her salary to the husband, and sees it as her husband's right to make major family decisions. She may not argue with him, nor want access to the kind of benefits or pleasures he does. The husband is the one who decides for her on all important matters. She must ask permission from her husband to go out to visit friends or family, while he

is not obliged to inform her of his whereabouts. African culture considers woman as a minor who needs a perpetual guardian. The first guardians (Goldman, 1996) are her parents and when she gets married, she passes from her father's authority to her husband's. The husband always has a say in whatever she wants to do. She must dress according to her husband's desire and do everything in order to please him. Churches also have a part in this, through preaching on the virtuous woman. Women are seen as brainless or without capacity to take major decisions on their own. These women's roles are accepted and learned through socialization which works by encouraging wanted and discouraging unwanted behavior (Baehr, 2008).

Liberal feminists in the eighteenth and nineteenth centuries argued that as a result of different processes of socialization and discriminatory social and cultural practices women were afforded fewer opportunities than men to realize their full potential as human beings (Steans, 1998: 17). It is true that, because of the patriarchal system, most girl children were denied the right to education, and therefore, had little opportunity to exercise their intellectual faculty as human beings. Historically, women have been confined to the home and to the domestic service of their husbands and children. Therefore, they have had little opportunity to develop skills other than those deemed necessary for the performance of domestic duties. Over the years, liberal feminists have consistently advocated equal rights and equal opportunities for women. Many contemporary women's groups such as the National Organizations for Women in the United States of America, continue actively to campaign around issues of rights and equal opportunities (Steans, 1998:17).

The right to voluntary motherhood is a right denied to women by African tradition. Being the head of the family, the man has the chief say in all the matters regarding his family. How can a woman be free if she is denied the simple right to decide the number of children she will produce and when she will produce them as well as the reason for her to motherhood? Sanger stated that millions of women are asserting their right to voluntary motherhood. They are determined to decide for themselves whether they shall become mothers, under what conditions and when (Sanger, 1996). The society, through some rules and churches, gave men the power to interfere even in the choice and access of women to contraceptives. Women are

not the ones to decide about their body, the authority and the ability to decide on their own body seems to be denied in favor of their male partner. Birth control is the means by which women attains basic freedom. That freedom is only possible if women can access and use contraceptive. Accurate information about birth control is a tool for the freedom movement. According to Sanger (1996), most women who belong to the workers' families have no accurate or reliable knowledge of contraceptives, and are, therefore, bringing children into the world so rapidly that they, their families and their class are overwhelmed with numbers. With this comes a series of challenges to a society. In the family unit firstly there is a burden on the sole income of the man and with that comes financial strain, deterioration of living conditions, malnutrition and ill health. This in turn becomes a societal issue. In time what often happens is that the woman is then forced to seek employment to swell the sole family income and this in turn leads to the children being neglected and to the mother being even more burdened with her duties.

With each additional pregnancy the chance of the mother returning to good health decreases as does the rate of survival of each subsequent child.

When women have knowledge of contraceptives they are not forced into bondage but can choose to have both the maternal experience and the marital love life without the threat of pregnancy. They can choose to limit the size of the family and by so doing motherhood and its roles do not dominate their lives. They can have a satisfying marital relationship and they can also nurture their spiritual life and their social life outside of the home. All of these things are important for a well rounded, satisfying life.

Women must use the power contraceptives give them to limit the family size. They must take this responsibility upon themselves and break the pattern of bondage. Limiting family size affords better financial status and also enables the mother to be healthy both emotionally and physically. They "free" themselves to be more nurturing to themselves, their partners and their children (Sanger, 1996).

The other side of the dilemma facing the DRC refugee woman is her status. Actually, the fear of foreigners has reached a new level in South Africa (Amisi, 2005; Muzumbukilwa, 2007). South

Africa finds itself facing an increase in xenophobia although it promotes democracy and human rights. Refugee women are often in a situation of dependency (Kabidu, 2009). They depend on their husbands or on a social support system. Their social support system can be friends, family, churches or non-governmental organizations (NGOs). Refugees bring with them skills and intellectual faculties but sadly many of them cannot use their skills in the host country. Thus, without the support from the government, they have to fend for themselves. Amisi's study (2005) underlines the importance of social networks as a form of social capital among refugees. Social networks form the cornerstone of DRC refugees' source of income through vital information sharing, financial, material and psychological support. These networks constitute a social net for refugees and provide important support during random events such as unemployment, illness and death. However, access to the benefit of these networks is often subject to class, gender and age differentials which can have negative effects on both members and non-members. Amisi (2005) states that DRC refugees take whatever opportunities they can to establish their livelihoods and increase their resilience to shocks and uncertainty in Durban. Thus their incomes originate from different economic activities such as hair-dressing or working as a security guard. Incomes also come from social support including remittance from other countries and other provinces of South Africa, ethnic-based NGOs, political parties and churches, and manipulation from South African NGOs for individual's benefit. Yet, mistrust and social exclusion both among the DRC refugee groups themselves, and between this community and South Africans negatively affect their livelihoods.

Liberal feminist theory is used in this study by questioning the rights of the DRC refugee women, meaning their right to freely choose a contraceptive method, their right to have a say in all decisions concerning their body, their right to express their concerns about family planning issues and above all the right to voluntary motherhood.

3.3. SOCIAL CONSTRUCTIONIST THEORY

Social constructionist theory focuses upon both the public and private spheres of a woman's life and argues that liberation can only be achieved by working to end both the economic and cultural sources of women's oppression represented by patriarchy (Liebrucks, 2001). Patriarchy is a social system in which the role of the male as the primary authority figure is central to social organization, and where fathers hold authority over women, children, and property. It implies the institutions of male rule and privilege, and is dependent on female subordination (Liebrucks, 2001). The family is the significant site of power and heterosexuality is the central institution that perpetuates the gender system. Women could therefore be viewed as a social class. Where workers were thought to be oppressed by their relation to the mode of production, women are oppressed by their relation to the mode of reproduction – or reproductive heterosexuality. Liberation required the transformation of these material relations (Delphy cited in Squire, 2000). Squire (2000) refers to patriarchy as the systematic subordination of women. All humans are shaped by socialization, which includes the communication of a variety of beliefs limiting acceptable behavior. But oppressed groups, like a refugee group, may have, or be subjected to, additional beliefs which support and reinforce their oppression. Women are often stereotyped as inferior in intelligence or character. Such stereotypes are then taken to justify social arrangement (which may be contained in cultural and religious values) that simply reinforce the stereotypes. That tends to transform the stereotypes into self-fulfilling prophecies by creating barriers against which members of the relevant groups must struggle (Purdy, 1996:163). Historically, the term patriarchy was used to refer to autocratic rule by the male head of family. However, in modern times, it more generally refers to social systems in which power is primarily held by adult men, and in which men oppress, exploit and dominate women. Hooks (1986) states that we live in a world in crisis – a world governed by politics of domination, one in which the belief in a nation of superior and inferior, and its concomitant ideology – that the superior should rule over the inferior, affects the lives of all people everywhere, whether poor or privileged, literate or illiterate. Clearly,

differentiation between strong and weak, powerful and powerless, has been a central defining aspect of gender globally, carrying with it the assumption that men should have greater authority than women, and should rule over them. As significant and important as this fact is, it should not obscure the reality that women can and do participate in politics of domination, as perpetrators as well as victims. Women do practice oppression to other women or to men. According to Liebrucks (2001), oppression refers to the subordination of a given group or societal category by unjust use of force, authority, or societal norms in order to achieve the effects noted above. Oppression is also when oppressed people start to believe and act according to the oppressor's opinions. Government, church, male partner and health care practitioners can be considered as patriarchal because of the authority and power they hold against DRC refugee women. Refugee women are accepting their oppression because they don't have the resource power (money) but also the power and influence that society gives to men.

Socialization of African men is one source of conflict between women's opening out, freely expressing her opinion and individual interests on the one hand and cultural expectations on the other. Allocation of different tasks to girls and boys is an example in which socialization has created problems for the women. It is common that tasks like cleaning a house or cooking are given to girls. In the past, when all households had cattle, boys were supposed to take care of them. Time has changed, the number of household with animal stock is few, and boys do not seem to have much to do at home, yet. Girls are still regarded as responsible for households duties. The differentiated socialization of girls and boys in African families limits equality of opportunities for girls, even when they become women. As adults, women's time has to be tightly divided between work and home, yet at work woman have to compete with men, who do less at home. This unequal division of roles also cripples initiatives such as affirmative action because it does not give the same support to women as it does to men. According to standard sociological theory, patriarchy is the result of sociological constructions that are passed down from generation to generation. These constructions are most pronounced in societies with traditional cultures and less economic development. Even in modern developed societies,

however, gender messages conveyed by family, mass media, and other institutions largely favor males having a dominant status (Liebrucks, 2001).

I used social constructionist theory in the analysis of my research data by putting on the line the influence of the partner, church, people in power, regarding women's decision on contraceptive choice and access. In other words, social constructionist theory is used by demonstrating the influence of patriarchy on the decisions and choices made by the DRC refugee women.

CHAPTER 4: METHODOLOGY

4.1 INTRODUCTION

In order to better understand DRC refugee women's choices that arise from varied experiences in accessing contraceptives, qualitative methodology appeared to be appropriate. In order to collect information on the contraceptive access and choices among DRC refugee women living in the Durban metropolitan area (CBD), some of these women were approached and the purpose of this study was explained. Contact was made with the director of the congolaise de Durban and churches attended by most DRC refugees in order to gain access to DRC refugee women. I also contacted DRC refugee women in the point area. I have chosen to study this group of DRC refugee women because I myself belong within this category. This serves as an advantage as I am able to identify with the research population. I am also aware of the fact that there are limitations to studies where the researcher is an insider. Cognizant of this limitation, I followed the advice of Jousse (2000) and Stoller (1996). These scholars point out that it is crucial that researchers of such studies, first acknowledge and are upfront about their identity and are continuously reflective when collecting and analyzing data.

This chapter describes the research design, population and sampling, data collection, pilot study, ethical aspects, difficulties, and conclusion drawn from the empirical processes and the challenges thereof.

4.2. RESEARCH DESIGN

The chosen design of this study is a largely qualitative in nature, and employs feminist and reflexive research principles. However, to limited extent, I use some quantitative data collection

elements, such as the number of children per woman. Research design is described by some writers as the way in which the researcher plans and structures his/her research process. The design acts as a guide to enable the study to be conducted in a structured manner. The research design also includes the steps the researcher takes to minimize biases (Polit and Hungler cited in Monakali, 1995). Cognisant of my status as an insider (sometimes referred to as 'outsider-within'), I was cautious of this fact.

A design is determined by specific procedures that will be employed. These procedures, which are at the heart of the design chosen by the researcher, include convenient sampling, purposive sampling, an interview schedule, focus group discussions as well as data analytic procedures (Lentin, 1993).

Qualitative research is described as being consistent with the assumptions of a qualitative paradigm. Taking cues from Creswell's work, this research is defined as an inquiry process of understanding a social or human problem, based on building a complex, holistic picture formed with words by reporting detailed views of informants and conducted in a natural setting (Creswell, 1994).

4.2.1 Feminist Paradigm

According to Lentin (1994) feminist research propagates the inclusion of the researcher in all stages of data collection and data production. Feminist research maintains that we are what we study: the reflection upon and the acknowledgement of one's own objectives and biases therefore become part of the research findings (Lentin, 1994). Through reciprocal sharing of knowing between the researcher and researched, those researched become collaborators in the research project. Through reflexivity a double-edged knowledge is generated. Reflexivity is both a 'native' act and an analytic one: the act of recording (the narrator's life) and the act of self-interpretation (by the researcher) are parallel because both are the product of persons reflecting one another and thereby influencing and changing one another (Lentin, 1994). These are the principles that informed this research. The experience of oppression due to sexism and xenophobia, to which both I as a researcher and the research study's participants are subject,

create a unique type of insight and an ability to decipher "official" explanations (Fonow and Cook, 1991:1). These insights teach us not only about gender relations, but also about society as a whole and were taken as part of the practice in this research. Harding (1991) states that according to black American sociologist Patricia Hill Collins, bringing marginal groups, such as others who share an 'outsider-within' status vis-à-vis sociological study, into the centre of the analysis, may reveal views of reality obscured by more orthodox approaches (Harding, 1991). The importance of a feminist and reflexive research is seen in Lentin's assumption. Lentin (1994) states that traditional research may be seen as recreating a power relationship between researchers and 'research objects', who, it is sometimes forgotten, are subjects in their own right. Shulamit Reinharz describes conventional research as 'rape', a description which often antagonizes: in this context she defines the research as a situation where the researchers take, hit and run. She decries the fact that such researchers intrude on their subjects' privacy, disrupt their perceptions, utilize false pretences, manipulate the relationship, and give little or nothing in return. When the needs of the researchers are satisfied, they break off contact with the researched (Reinharz cited in Lentin, 1994). Not only is the research process constructed in terms of a power relations but the researcher is also the ultimate authority in terms of producing the final written report and deciding its uses and goals. This dilemma of unequal power is not easily resolved even if the researcher is a feminist; however, a feminist commitment to the empowerment of women and the researcher's reflexive account of her part in the relationship may help in equalizing power, particularly if she is honest about how her text 'constructs' as well 'reconstructs' her narrators' accounts and the inevitable ultimate appropriation of 'power' to produce her written research text. Hammersley (cited in Lentin, 1994) writes about privileging experience in research by feminists as a product of 'sustained observation' and 'listening to' the accounts of 'others', as opposed to 'method' which he defines as 'making public the means of doing research'. Anne Williams (cited in Lentin, 1994) posits another perspective to privileging experience, that is, the determination to practice personal reflexivity. She claims that this particular understanding of what is meant by reflexivity (although a term neither coined nor exclusively used by feminists) has largely been shaped by feminists doing ethnography. Radical ethnographers have discussed how writing a text

constructs realities, how 'in textual construction of "the field" or of "other" there is also a construction of "a self" or "selves". Reflexivity, then, seems the central element of feminist research methodologies. Feminist researchers do not view feminist research methodologies as unitary or hegemonic: instead of feminist methodology, there are feminist methodologies and instead of a feminist standpoint, there are feminist standpoints. Feminist researchers view feminist research methodologies not simply as another perspective, but as a separate paradigm. It is to this end that hereunder I discuss essential elements in feminist research.

4.2.2. Self definition

Whilst most feminist researchers discourage the use of the word 'subject' to refer to a study's respondents, I use it in this discussion as a research reference term rather than out of disrespect for interviewees.

Lentin (1994) states that if the research problem is of interest to the researched, they will be more likely to invest the time and energy in collaborating. In Reinharz's experiential analysis (quoted in Lentin, 1994), the researched are not chosen at random, but from established groups and communities in order to help establish the trustworthiness of the researcher in the eyes of the researched. She reconceptualises the 'subject role', allowing the researched to interview, scrutinize and question the researcher even after they have agreed to collaborate. What can be deduced from this stance is the importance of the fact that meaningful research builds on finding out what is meaningful to oneself and one's research collaborators. This stance further holds that having subject input also minimizes researcher bias since it includes diverse points of view.

The reasons which led DRC refugee women to participate in this study were the importance they attach to the choice and access to contraceptives and its impact in their lives.

4.2.3. Trustworthiness

On the subject of trust, according to Lincoln and Guba for any study to be trustworthy, it should adequately address the following questions:

- How can one establish confidence in the “truth” of the findings of an inquiry for the participants with which and the context in which the inquiry was carried out?
- How can one determine the degree to which the finding of an inquiry may have applicability in other contexts or with other respondents?
- How can one determine, whether the findings of an inquiry would be consistently repeated if the inquiry were replicated with the same or similar respondents in the same or similar context?
- How can one establish the degree to which the findings of an inquiry stem from the characteristics of the respondents and the context, and not from the biases, motivations, interests, and perspectives of the inquirer?

These scholars further state that it is important to note that although these questions are appropriate, i.e. whether the study is qualitative or quantitative in nature, the criteria for trustworthiness established by the mechanistic researchers may be inappropriate when applied to a qualitative research paradigm. Such criteria would include internal validity, external validity, reliability and objectivity. For this study I found that my attempts to use these principles was challenging – this was due to the fact that despite the fact that the study was largely qualitative in design, as an ‘outsider-within’, facial gestures of some respondents led me to believe that they found it hard to fully disclose their stories. Some of the difficulties Lincoln and Guba point out are related to a researcher battling to ensure trustworthiness, particularly when:

‘The results do not correspond with the reality the researcher claims to describe, and when reality becomes characterized by multiple and intangible factors, then the study is not carried

out under conditions of probability sampling, the results are not stable and replicable and there is no instrumentation interposed between the inquirer and the objects of an inquiry.' (Lincoln and Guba, 1985, p.218)

It is therefore clear that unless appropriate criteria for a qualitative research perspective are developed, the criteria established by a conventional perspective will remain irrelevant when researchers investigate complex human phenomena. As Guba (cited in Lincoln and Guba, 1985) points out, relevant criteria for a qualitative paradigm include credibility, which replaces internal validity, transferability instead of external validity, dependability instead of reliability and confirmability instead of objectivity.

To enhance the trustworthiness, I limited my study to the experiences of the DRC refugee women in their daily experiences of contraceptives access and choices, thus avoiding going into in-depth analysis of what they could have told me about other realities that happen in their lives. That enabled me to avoid influencing their stories with data that may have tampered with the main focus of the study.

4.2.4. Dependability

Dependability refers to the consistency of the research findings. Due to the subjective nature of the present study, reliability as one of the most important criteria for establishing trustworthiness seems inappropriate. This is well illustrated by Sandelowski (cited in Lincoln and Guba, 1985) when she states that:

“Qualitative research emphasizes the uniqueness of human situations and the importance of experiences that are not necessarily accessible to validation through the senses. Variations in an experience, rather than identical repetition, are sought.”

In order to achieve dependability, I ensured good recording quality and improved the quality of transcriptions. A good recording and transcription allows one to immediately have reliable information collected from the respondents.

4.2.5. Collaboration

Shields and Derbin (cited in Lentin, 1994) challenge the universal unwritten tenet of feminist research that the more we collaborate with the researched, the better, more accurate and less exploitative the results. They claim that because the collaborative methods of research rely so heavily on human relationships, the researched are actually at greater risk from the researcher, particularly when factors other than gender (i.e. race, ethnicity and class) are not taken into consideration. In this case there was an atmosphere of trust and safety between myself and the respondents since we share not only the same gender but also the same citizenship and refugee status. Their ages were considered in order to avoid unnecessary areas of sensitivity.

4.2.6. Validity

I ensured validity by using the qualitative research method that leans more towards being critically reflective to collect data thus gaining what I am convinced was valid. In order to acquire the data presented in the study and maximise its validity, the proposed and necessary target population, DRC refugee child-bearing women aged between 18 and 50 years, living in the eThekweni Metropolitan area (Durban Central Business District) were subjects of the research. The interview schedule was checked by the research supervisor. Ten DRC refugee women were interviewed as a pilot study in order to test if the information received was valid. I am confident that such a concentrated selection of respondents, which was concomitant with the focus and objectives of the study, contributed to enhancing the validity of the study.

4.2.7. Reliability

My insider status and the fact that I am fluent in the language of the respondents was helpful and contributed towards ensuring that the questions during the interviews were understood

and interpreted accurately and as intended. Information gained from the pilot test was all consistent and relevant. Given the same population, it may then safely be asserted that if the research were to be repeated the results derived would be consistent and the researcher would thus draw the same conclusions (Neuman, 2000).

4.3. POPULATION AND SAMPLING

The target population for this study consists of DRC refugee women between the ages of 18 and 50 years, single or married, living in the eThekweni Metropolitan area (Durban Central Business District). I took into consideration the level of education, the socio-economic context and the religion of the respondents because of the implications these elements can have in the ability to access contraceptives. I have chosen to study this group of DRC refugees in order to restrict the research to a certain citizenship/culture thereby giving the study the necessary focus. The second reason for choosing this population is also because I myself belong within this category. As a DRC refugee woman I wanted to study this particular population, and it served as an advantage, as I was able to identify with the research population. Personal involvement is therefore deemed by feminist researchers necessary because the researcher must identify with the women she is researching. Inevitable – because she is part of what is being researched – she is involved. This means reflexivity is essential – the researcher must constantly be aware of how her values, attitudes and perceptions are influencing the research process, from the formation of the research questions, through to the data collection stage, to the ways in which the data are analyzed and theoretically explained (Lentin, 1994).

The sample population of this study consists of a total of fifty DRC refugee women. They were selected through the use of convenience sampling followed by snowballing as an attempt of minimize some biases. The sample included only women who were willing to avail themselves for interviewing. Contact had been made with the director of the Congolese Organization (La Congolaise de Durban) and some refugee churches who agreed to facilitate the establishment of contacts with the respondents. Snowball sampling is a non – probability sampling technique,

most commonly used in qualitative field research. Snowball sampling is appropriate when the members of a special population are difficult to locate. It refers to the process of accumulation as each located subject suggests other subjects (Creswell, 1994).

Due to the stringent Department of Health's requirements for researchers who access their health services; informal interviews with health officials from local hospitals or clinics were conducted.

Convenience sampling in selecting health professionals was used. The first health professional was a known person. She introduced me to one of her colleagues who did the same by putting me in contact with another one. I asked my respondents to introduce me to everyone willing to participate in the study. The respondents consisted of one registered nurse working in a private hospital, four clinic-registered nurses and two registered nurses working in a public hospital (all were working in Durban).

4.4. DATA COLLECTION INSTRUMENTS

4.4.1. Process of data collection

In order to gain entry into the area of operation, contact was made with the director of the Congolese Organization and some refugee churches where I explained the purpose and the objectives of the study. They helped in identifying respondents. It was explained where and how the interviews would take place. The aim of this approach is to ensure that the sampling is inclusive and the result is representative of the focus of the study because different people in different settings face specific challenges.

4.4.2. Qualitative method

The qualitative method was used as this method was found to be more relevant for to respond to the questions and objectives of the study and as it allows more open discussion and respondents are able to express themselves more freely and accurately (Bell, cited in Oyedemi 2003).

4.4.2.1. Qualitative data collection

The instrument for the qualitative data collection process was the interview schedule. Semi-structured interviews were audio taped to capture all the responses of the participants with minimal interruption. The interviews were conducted in French and/or *Lingala*, a DRC indigenous language. The interview data was translated into English to allow for easier categorization into analytical themes. Interviews took place at the homes or churches of the participants.

I conducted individual interviews as well as focus group discussions with women who had been identified as being less sensitive to talk about the subject. Focus group discussions have proved to be worthwhile in studies on private and culturally taboo- related subjects.

Over a period of four months, I did tape-recorded interviews with 50 Congolese refugee women. Since the interviews were not in-depth, it was possible for me to reach this number. Unstructured individual interviews were initially conducted. Four focus groups were conducted after the interviews. Each group, consisting of 3 to 4 women, was organised according to where they lived. This process helped the researcher to know what individuals say in private and what they say when they are in the presence of others (Neuman, 2000). It also helped in developing rapport between the researcher and participants. Focus groups are far more appropriate for exploration and discovery, particularly when one has to learn about either topics or groups of people that are poorly understood. Because of context and depth associated with focus group discussions, it was easy to understand the background behind the people's thoughts and

experiences. Participants were encouraged to investigate the ways that their experiences in the contraceptive choices and access were both similar to, and different from, each other.

Like other qualitative methods, focus groups serve the purpose of better interpretation, that is, they enable the development of an insight as to why things are the way they are and how they got to be that way (Neuman, 2000).

Respect between me and the participants was positively related to the quality of focus group results of the inquiry. The belief in participants' input was demonstrated, irrespective of their level of education, experience or background. Krueger (1998) notes that lack of respect quickly telegraphs to participants and essentially shuts down meaningful communication.

I ensured that my role would be to guide the discussion and listen to messages being conveyed by participants instead of participating, sharing views, engaging in discussions or shaping the outcome of the group interview. I also ensured that my personal views on the topic of inquiry were suspended. As a moderator, I introduced issues and ensured that there was minimal dominance of any single individual. Neuman (2000) states that the moderator, who introduces issues and ensures that not a single individual is allowed to dominate, needs to be flexible, keep people on the topic, and encourage discussion. It was ensured that participants were homogenous enough to reduce misunderstanding and conflict.

One general question was asked. Detailed probe questions were then asked depending on how informants responded to the first general question. Data was collected regarding the women refugees' knowledge of access and choice to contraceptive. Information was gathered regarding their experience about the contraceptive access and choices.

Unlike in the case of DRC refugee women, only unstructured individual interviews were conducted with health care professionals. Similar to DRC refugee women, the interviews were audio taped; however, the data was collected in English. I interviewed registered nurses using an interview schedule.

Unstructured individual interviews and focus groups with DRC refugee women, conducted earlier during the data collection process, reinforced the need for a workshop. With the help of a DRC-registered gynecologist working at King Edward Hospital and attending the same church as I do, the workshop took place.

4.5. PILOT STUDY

The pilot study was done in preparation for the main study using participants who had similar characteristics to those required for the final study (Polit and Hungler, cited in Monakali, 1995). The objectives were used to assist the researcher to correct and modify the instrument which had been developed.

The pilot study was undertaken using 10 DRC refugee women from Faith Ministry Church. The interview took place on the church premises located at 157 Pine Street, Durban. All the women had more than 3 children.

After analyzing the responses, there was no major problem with clarity, however, some questions needed to be modified or discarded because of their personal character. For example, what contraceptive method do you use? How did you access it and what do you know about it? That question was reformulated because participants' responses appeared to be designed to please me or hide the truth.

4.6. ETHICAL CONSIDERATIONS

Prior to conducting the study, I obtained informed consent from the research participants to indicate their willingness to participate in the study. Informed consent, as Neuman (2000) states, means informing the research participants about the overall purpose of the investigation and the main features of design, including any possible risks and benefits from participation in the research project.

Written consent was received from participants. Permission was asked and consent was also given by each participant before tape-recording the interviews. Informed consent involves getting voluntary participation of the subject with his or her right to withdraw from the study at any time. I also ensured confidentiality, which, according to Neuman (2000), means that private information identifying the subjects will not be reported. Where I saw the need, individual participants were again reassured of confidentiality. Findings are reported in aggregate form. In an investigation which involves publishing information potentially recognizable to others, the subjects needed to agree on the provision of unidentifiable information.

4.7. DIFFICULTIES

The nature of the study, being one that investigates individual contraceptive use, choice and access by refugee women, places the study in a private space. This means that since the investigation requires participants to speak about their sexual lives, the researcher has to conduct the study based on what the participants have told her, and this may not be entirely true. The disclosure of contraceptive use being a private matter, the researched can say what she thinks will please the researcher. I also noted that because of the sexual character of the study, some participants were reluctant to talk openly about their sexual behavior or knowledge of contraceptive methods. Some single women were reluctant to admit that they engaged in sex. I therefore planned to conduct focus group interviews with women who had been identified as being less sensitive about talking about the subject.

There was a need to assure participants that their confidentiality and anonymity were guaranteed. This was done by giving pseudonyms to participants. The use of a tape recorder also resulted in some participants being uncomfortable, even with the researcher's reassurance of privacy and anonymity. Some participants were satisfied with this, while others insisted on the withdrawal of the tape-recorder during the interview. In that situation, I was obliged to take notes.

Another difficulty was that since the interviews took place in the respondents' homes or workplace (in the case of health care providers), I had to keep to the participants' schedules. Thus, the data collection process was slow, tedious and initially frustrating. To avoid that frustration, I started calling them every week and going to their areas, hoping to secure their availability. That action bore fruit as most of them responded in favour of my research.

4.8. CONCLUSION

The above discussion has focused on the research design used in this study. Qualitative data was collected from both DRC refugee women and health care providers, using unstructured interviews and focus group discussions. The interviews with DRC refugee women were conducted in French and/or *Lingala*, a DRC indigenous language and, the information was translated into English to allow for easier categorization into analytical themes. This discussion has noted that, despite my status as a DRC refugee woman myself, and thus an insider/outsider-within researcher I made efforts to fulfill ethical requirements and ensured trustworthiness and the reliability of the study.

CHAPTER 5: DATA COLLECTION PROCESSES AND ANALYSIS

5.1. INTRODUCTION

This chapter is a presentation of data collected for the study. It includes data collection processes and analysis wherein, there is a presenting of major themes deduced from data collected from DRC refugee women and health professionals' interviews. I also include questions posed to the respondents, how they responded and the manner in which I engaged with them following their responses – which was a form of equally availing reproductive health and /or clinical information to them. None of the information given was intended to influence them nor was used to alter their responses.

5.2. INTERACTIVE QUESTIONS

As alluded in Chapter 4 above, an interview schedule was developed for the qualitative data collection. The interview sessions allowed the respondents' voices and thoughts to be heard. Four major questions were posed to the DRC refugee women and six major questions to the health professionals.

Questions directed to DRC refugee women

The first question that was asked is: (1). Do you use contraceptives? Please explain what you know about contraceptives.

This question was asked in order to understand the meaning of the term contraceptive according to DRC refugee women. I sought to record all methods or actions, medications,

devices used with the intention of purposefully preventing or reducing the likelihood of pregnancy or childbirth.

The second question: (2) In your view, do you think that DRC refugee women have access to reproductive health services in Durban? The meaning of reproductive health was explained. They said it includes safe motherhood, family planning or contraceptive methods, prevention of sexually -transmitted infections, including HIV/AIDS, safe abortion and gender-based violence (domestic violence). I had informed the respondents that for the purpose of this study, reproductive health means contraceptive or family planning methods. The second question had two sub-questions. The sub-questions that were included in this second question were: (2a) If no, what are the barriers? (2b) If yes, are you happy with the service?

The second question and the two sub-questions sought to answer the three first research questions: Do DRC refugee women have access to contraceptives? If no, what are the challenges? If yes, at which level? I had explained to the respondents that by the level, the question implied the hospital or clinic, government or private sector, and the satisfaction with the service. The objective of the second question was to investigate the accessibility of contraceptives among DRC refugee women living in the eThekweni metropolitan area (Durban) and to question and examine the barriers to contraceptive access. This question helped also to explore the relationship between the social expectations/limitations (e.g. domestic gender roles, cultural and religious values and wider community discriminatory attitudes) and the access to contraceptives/reproductive health services.

The third question: (3) In your view as a refugee, what contraceptive or family planning choices are available for DRC refugee women? The question was designed to find out about the kinds of contraceptive and choices DRC refugee women use.

The fourth question: (4) In what way do you think choices of contraceptives you make can improve your life? The objective of this question was to investigate how DRC refugee women viewed a link (if they affirm it exists) between their choices and access or lack of access to contraceptives and ultimately the number of births within families. It was also to investigate

whether DRC refugee women considered contraceptive use as an empowering agent, an agent with potential, and to understand what benefit DRC refugee women can take from the use of the contraceptives.

Questions directed to health professionals

The interview schedule with health professionals consisted of six questions, the questions were: (1) Which contraceptives are generally/ideally available in hospitals or clinics? (2) Are any of the listed contraceptives available at your work place? (3) What are the requirements for a patient to have access to contraceptives? (4) Do refugees have the right to access the listed contraceptives? (5) Can you list any advantages and/or disadvantages of the contraceptives you have listed? (6) What role does a health worker (if any) play in contraceptive education?

How these interview questions were answered, and how the interview questions in turn answered my questions will be unfolded in the rest of this chapter.

In conclusion, the above questions were generated and have been structured in order to examine and to acquire information on the above questions, which form the basis for this research study. The next section is a presentation of data, collected following the use of the above question. It is a discussion and analysis that is informed by questions listed in this section. I categorise the data into themes generated from responses of the two main groups of the study.

5.3. MAJOR THEMES FROM HEALTH PROFESSIONALS' INTERVIEWS

In order to conduct a discrete analysis of the results of the interviews with the health professionals to whom I had access, data collected were regrouped into categories and different themes was found to be recurring in the given responses. These include:

1. Recognition of refugee health rights

2. Limitation in the availability of contraceptives
3. Knowledge on contraceptive methods
4. Role of the health worker in contraceptive education
5. Requirements in the access to contraceptives

The voices I use in this section are excerpts from the interviews to exemplify issues raised by respondents.

5.3.1. Recognition of refugee health rights

Most refugees are not aware that their status as refugees entitles them to certain rights and benefits enshrined in a number of international and national statutes to which South Africa is a signatory (Palitza,2008). A person is recognized as a refugee in the Republic of South Africa in terms of section 24 (3) (a) of the Refugees Act 1998. This recognition entitles the refugee to socio-economic rights as provided for in Chapter 2 of the Constitution including work and study in the Republic of South Africa. In addition, refugees have a right to access health services. Health professionals are informed of these rights. For instance, a registered nurse stated the following, an indication of awareness of this right:

Refugees have the right to access the health system. There is no limit for them. In fact, they have the same rights as South African citizens. They need only to provide proof that they are recognized as refugees by the Republic of South Africa. We only need the certification or the Identity document issued by the Department of Home Affairs and the proof of address to register a person. It is important to note that even the asylum seeker also has the same right to health. By presenting the document required, the refugee is assured to have all the care, free of charge in all clinics. A charge of R20 is required in the hospital.

5.3.2. Limitation in the availability of contraceptives

Although there is a huge range of contraceptives being produced in the world, it is very sad to realise that in the government hospitals or clinics, women are limited in the choices they can

make regarding contraceptives. Informal interviews with health professionals were conducted at Lancers clinic, Addington Hospital, King Edward VIII Hospital and Wentworth Hospital. At the public clinic or hospital, contraceptive services are available and offered to all clients regardless of whether they are South African citizen or not. Contraceptive services are provided free of charge. Methods of contraception available at the clinics can be categorized into three forms: the barrier method, injectables and oral contraceptives; under which fall the condom, Depo-Provera and Nur-Isterate; every day pills (commonly known as “the pill”) and the morning-after pill. These are available at the clinic together with consultation. Only male condoms are available at the clinic without consultation. They are placed in dispensers and are free of charge as anyone can just walk into the clinic and pick them up without having to pass through consultation first. Other methods (intra-uterine devices and female condoms) are available in selected clinics or hospitals and only on request.

For the question related to the availability of the contraceptives listed in their work-place, the answer was positive for all the respondents.

Except for the nurse from a private hospital, all the respondents from government clinics or hospital seemed to exclude condoms in the list of contraceptives. Possibly because of their easy access (placed inside a dispenser and obtained without permission or consultation) and the non implication of the health professionals in the administration of the method, health professionals apparently exclude condoms among contraceptive methods. When asked the question, ‘Which contraceptives are generally/ideally available in hospitals or clinics?’ Four respondents said, *“Petogen and Nur-Isterate”*; two respondents answered *“Petogen, Nur-Isterate, Triphasil, ovrail, and microval”* and one respondent answered *“injectables, pills, intra-uterine contraceptive device and condoms.”*

From the above response, one can gather that hormonal contraceptive methods (oral contraceptive usually called pills and injectables) are most commonly known and offered as contraceptive methods.

It should be noted that health professionals did mention that they offered counseling prior to the prescription of contraceptives, in spite of the limited choice. By limiting the choice and availability of contraceptives, the government acts to support patriarchal 'relations' between the government and women. By doing so, the 'patriarch' has the power to control and interfere in the women's reproductive lives. Offering widespread access to as many contraceptive methods as possible is a key to helping people make informed contraceptive choices. As more methods become available, and as an access to these methods increases, more women can find the methods they want. Offering a large range of methods also ensures that at least some methods will always be available, even where shortages occur because the supply chain is erratic (Oyedemi, 2003).

5.3.3. Knowledge of contraceptive methods

In terms of knowledge of contraceptive methods, not all health professionals were able to explain in-depth the advantage and disadvantages of each method she or he had listed. This is reflected when Ntombi, a midwife stated that:

The advantage of Petogen or Nur-Isterate is being ninety-nine percent safe, and the disadvantage is only infertility. This kind of response can make people feel unsafe if they planned in the future to have children. Health professionals are supposed to give accurate information to their clients in order for them to make an appropriate decision. Clients must be treated with respect and given the full information in simple words that they can understand and assimilate. By doing that, a health professional shows his or her consideration and care for the client. It is important to state that the respondent, when she realized there were gaps in her knowledge of contraceptive methods, started to become nervous and rushed through the interview.

It was not all respondents who showed ignorance or avoided the question. Most of the health professionals showed accuracy and sincerity during the interviews.

To the question “can you list any advantages and/or disadvantages of the contraceptives you have listed?” Vangi, a senior staff nurse, answered:

All medicine or medical procedures have advantages and disadvantages. The injectable methods (Depoprovera or Nur Isterate) have the advantage of being injected once in three or two months. Amongst their disadvantages, if you want to fall pregnant, you have to wait out that period until the medication is no longer in your system. Sometimes it stays longer in the system or even blocks the uterine tubes. Pills (Micro-novums, Triphasil) have the advantage of being taken on a daily basis, so it is a short-term method. It does not stay longer in the system. As disadvantages we can say that due to the fact that you take it daily, the tendency is to forget. If you have diarrhea, you pass it quickly before it is even absorbed. The intra uterine contraceptive device (loop) is a foreign object therefore it does not interfere with your system. Once inserted, you only go to the clinic or hospital for a check up, however intra uterine contraceptive devices can cause excessive bleeding (menstruation). Condoms have the advantage of being found easily. You get them anywhere or you can buy them from a chemist or shop. You do not really need to go to the clinic, where they are usually free of charge, and you do not need a doctor’s prescription to get them. Condoms do not prevent unwanted pregnancy only, but they also prevent sexually-transmitted diseases. Sometimes a condom breaks, sometimes it slips inside a woman’s vagina. A new one must be used every time you have sex. That method requires planning and forethought – a condom must be available whenever you decide to have sex. Female condoms must be inserted long before you have sex.

Another respondent stated that:

Injectable contraceptive methods are safe and require little patient involvement, they enhance lactation, effective, private, independent of coitus, reliable and reversible. Among their disadvantages we can name the delay in fertility, weight gain, amenorrhea (may be favourable or unfavourable to some), the risks of arterial disease, headaches, dizziness, mood swings, and break through bleeding.

All the respondents agreed that injectable contraceptives methods have the disadvantage of delaying a return to fertility.

5.3.4. Role of the health worker in contraceptive education

The need for interventions by health professionals in contraceptive education was expressed when one of the registered nurses made the following remarks:

*Actually I think that health professionals have a role to play in contraceptive education. **Their** role is very important as they introduce different methods, explain advantages, disadvantages and side effects to clients. They also answer any questions and allay fears that the clients **may** have.*

Another registered nurse at the hospital believed that the involvement of health professionals in terms of contraceptive education, to a certain extent, alleviated the great impact of abortion and teenage or unwanted pregnancy. She further maintained that:

Health workers have a big role to play in contraceptive education. Many unplanned pregnancies among teenage and even adults would be avoided if active contraceptive education has been implemented. Most teenagers who fall pregnant cannot handle all the responsibilities and problems attached to motherhood. It does not matter whether it was her choice, or the result of an unplanned pregnancy, the responsibilities and problems are the same in both cases. Having a baby will affect you for the rest of your life. It is something that you need to know about, think about and plan carefully. Most abortions could be avoided if people were well-educated and familiar with contraceptive matters. It is very unfortunate that teenage pregnancy is getting worse. Each year, more and more South African teenage girls fall pregnant, and these girls are also becoming pregnant at a younger and younger age. Health workers have a duty to educate clients, teenager or adult, about all contraceptive methods. They must teach the clients how to handle condoms and when to insert them. They must encourage clients to always check the expiry date and encourage them to use them consistently as it also protects users from sexually-transmitted diseases. Health professionals must educate the clients to take pills daily and not to

skip when taking them. Clients must report any untoward effect like bleeding. Clients must be reminded to come back exactly on the due date written to their card.

Another respondent stated that:

Clients must be encouraged to come to the clinic where they can find accurate information. There is no single method that works best for everybody. Clients need to learn about the advantages and disadvantages of each method, and then make their own decision, thus the need to attend the local health clinic and discuss contraception and contraceptives with the health worker. This is free of charge.

5.3.5. Requirements in the access to contraceptives

Registered nurses pointed out that one of the most important requirements for a woman to access contraceptives is to have a negative pregnancy test.

A health professional mentioned that:

Any woman of childbearing age can have access to contraceptives. When having injections for the first time, a woman must be menstruating.

It is very clear that a person needs to be between puberty and menopause **to access** contraceptives from the health system. Some medical examinations like the measurement of blood pressure and the level of sugar and lipids, are also needed if the client **chooses** the hormonal method. With the guidance of the health professional and without any pressure, women are supposed to make their own choice on the contraceptives available.

When asked if teenagers and married women needed permission either from their parents, guardians or husband before they could access contraceptives from the health system, a professional health worker said:

Neither teenage girls nor married women need consent from their parents or husband to access contraceptives from the health system. The responsibility lies on the client's own shoulders.

Generally, a child lacks the capacity to give consent independently of a parent or adult caregiver. In South Africa, according to the Child Care Act 74 of 1983, children under the age of 14 years cannot give consent without the permission of parents, guardians or caregivers. Where contraception is concerned, the consenting patient should be older than 14 years. Prescription of contraception to girls under the age of 14 years is an ethical decision which depends on the context of the specific case.

In brief, five major themes were retained during the interviews with the health professionals which were the recognition of refugee health rights, the limitation in the availability of contraceptives, the knowledge of contraceptive methods by the health professionals and the requirements in the access to contraceptives.

5.4. MAJOR THEMES FROM INTERVIEWS BY DRC REFUGEE WOMEN

DRC refugee women living in the eThekweni Metropolitan area were interviewed with the aim of examining access to contraceptives and the contraception choices they made, and then recording their experiences. In order to process a discrete analysis of the results of assessment of reproductive health for DRC refugee women, data collected was grouped into categories, based on prominent or recurrent themes that were found. These included:

1. Language barrier
2. Xenophobic attitudes
3. Knowledge of contraceptive methods
4. Misconceptions
5. Issues of gender power relations
6. Issues of religion
7. Satisfaction with contraceptive service with the subsection:
 - a) Health effects of contraception on the individual
 - b) Societal and cultural attitudes towards contraception
8. Contraceptive choices

9. Lack or difficulty in persuading the partner to use a condom

10. Denying the use of any contraceptive method

5.4.1. Language barrier

Language is the vehicle through which people can communicate, express their thoughts and share some information. Language also has united, regrouped different people from different backgrounds. Speaking the same language can bring people closer and it facilitates the integration of the newcomer or the stranger (Colville, 2006).

In a foreign land, the nationals of a country are not only united under their flag but also because of their language. The disputes and misunderstandings about their ethnic group/s or their fights, such as war back home, seem to be forgotten. They become one and try their best to learn the new language in the host country in order for them to facilitate their integration (Colville, 2006). Learning a new language is not easy. Some people can learn a new language in a short period while it takes a long time for others. The apprenticeship of the language spoken in the host country is an obligation for the integration in to society.

In the Democratic Republic of Congo, the official language is French and they also have four national languages: *Lingala*, *Kikongo*, *Swahili* and *Tshiluba*. There are around three hundred ethnic groups and each ethnic group has their own dialect. The education system uses the French language; it is considered to be a lingua franca for all Congolese. When seeking refuge in the Republic of South Africa, the refugee status is obliged to learn English. Those who had attended secondary school or university in the Democratic Republic of Congo would have had a distinct advantage over those who had not completed either secondary or tertiary studies as English is taught at the high school level as well as in the first year of university studies in the Democratic Republic of Congo.

When asked the question: In your view, do you think that DRC refugee women have access to reproductive health services in Durban? If no, what are the barriers? If yes, are you happy with the service? Blandine, a thirty-five year old woman with three children answered:

I think that DRC refugee women here in Durban have access to reproductive health because we are not giving birth at home but attending clinics or hospitals and access to contraceptives is also free if you have all your documents. The main problem is the language. Sometime you feel hopeless because no one can understand you perfectly. It is better when we go to the hospital for the children than when you go for yourself when you are pregnant or just for the contraceptives. African nurses usually speak isiZulu when they see black people. Trying to express yourself in English is a big challenge, and when they complicate you with isiZulu, it becomes more than a challenge. In the clinics, before going to consultation, when you are pregnant or just for those who come just for the pills or injections, nurses usually give some advises. The problem is that they only speak in English if they see Indian or coloured women in the group. It is very frustrating because they know that foreigners do not speak isiZulu but they carry on giving all the explanations in isiZulu mixed with a little bit of English and you have to guess what they said with the English words they used.

Another respondent makes reference to the situation of dependency when you are not able to express yourself. She stated that:

Sometime, you have to depend on your husband or friend when you go to the clinic or to the hospital. They are your translator. Everybody knows that people do not translate exactly the mind of the person. This situation of dependency is a barrier. There is no direct relation with your caregiver.

One respondent explained that:

Being unable to express yourself in a foreign country is one of the barriers to access the reproductive health system. People try to limit to the minimum their contact with the clinics or hospital. Sometimes they think it is not necessary to go to the clinic in order to get contraceptives. The frequentation of clinics or hospitals is for sickness matter or where there is a life threatening situation. In this country, speaking English is a must, not an alternative for us. You cannot go to the clinic and expect the nurse to speak or understand French.

Dorcas, thirty years old and married with two children stated:

The access is easy. There is no restriction. The only problem is the language. Most of nurses use isiZulu and undermine foreigners. They do not treat us in the same way as South African citizens. They practice discrimination. But no one can say that a contraceptive is not for refugees because we know that we are entitled to health care.

Fifteen DRC refugee women answered in the affirmative about their ability and ease with which to access contraceptives at the clinic/hospital. Among them, nine emphasised that the most important thing is to be served and at least to get the health care. Refugee women must learn to overcome barriers, rise up and look forward in order to improve their lives for better integration in the host community.

5.4.2. Xenophobic attitudes

It is an open secret that foreigners and mostly refugees are considered as unwelcome in South Africa. Publications (Mawere 2008, Taylor 2008, HSRC 2008) on refugee matters in South Africa acknowledge that refugees struggle for survival and their integration in the host communities is difficult because of xenophobia. These publications report that refugees are often turned away by health workers when seeking help for themselves or for family members (Magwaza and Khumalo 2003; Wambugu 2003; Warner 2003). Refugees, in their everyday life, experience some kind of xenophobic attitude from officials or ordinary people.

When asked the question: In your view, do you think that DRC refugee women have access to reproductive health in Durban? If no, what are the barriers? If yes, are you happy with the service? Three DRC refugee women shared their experiences on xenophobic attitudes among health professionals:

The first one, Linda, a thirty -one -year- old woman stated that:

I will be lying if I say that we do not have access to contraceptives or to antenatal clinics. We do have access but experience some difficulties. Being a refugee is not easy! I am educated and have a national diploma in commerce. Because of our status as a refugee, I am working in a

salon in order to survive. I am not earning much but the R 1200 I earn completed my husband salary who works as security. Our financial situation is not good so we cannot afford to add more children. We are living in a one-bedroom flat and have to share the space with our three children. That is the main reason, despite nurse attitudes in clinics, why I am stick to my injection. I do not say that all nurses show xenophobic attitudes but most of those who showed these attitudes are black Africans like me! Sometime, when you go to the clinic, nurse shout on you like if you are a small child. They are not always friendly even with South African citizens but it worst with foreigners. It is okay when your mouth is shut, but if you just open it to ask a question using English, and after finding that you are unable to speak isiZulu even though you have a good English, they immediately put you in the 'amakwerekwere' category. Their attitude can and constituted an obstacle. Someone must do something in order for them to understand that without patient, they will be jobless. Before going to the clinic, I always prayed that God can provide and help me so that friendly nurse will attend to me.

Patriarchal power is not only just a matter of direct control of women by individual men but can be exercised between women. Hooks (1986) states that differentiation between strong and weak, powerful and powerless, has been a central defining aspects of gender globally, carrying with it the assumption that men should have greater authority than women, and should rule over them. As significant and important as this fact is, it should not obscure the reality that women can and do participate in politics of domination, as perpetrators as well as victims. By using xenophobia and oppressing DRC refugee women, nurses represent patriarchy and make use of its power.

The second respondent, Agnes, a thirty-six-year-old woman with five children explained how a nurse treated her badly when she was giving birth to her fifth child:

I was in labour pain, but it was like if the nurse did not care. She just keeps on asking me when am I going back to my country and said that she was not the one who impregnated me so I must keep quiet. I went to tell her that the baby was almost here with my poor English. She said that

she did not want me to disturb her and sent me back to the room. She shouted on me and said that: You Congolese are thinking that this is your country! You are giving birth too much! No one asked you to come here and I did not come to your home to call you, so go back to your bed and wait till I come. I wait there, no one came. The contraction was so strong that I start pushing and end up delivering my baby alone without the help of the nurse. I was crying and calling for help when an Indian medical doctor who was passing in the corridor hears me. He entered the room and find that I was alone. He called the nurse and she denied that I called her. My English is not good but I know how to say help me! The baby is coming! I want to push! Ask anyone among Congolese refugee here in Point Road, they are going to tell you about my story. I am not the only one who practically delivered herself her baby in the hospital.

When asked if she intended to have other children and what she thought about contraceptives, she responded: My last delivery was so traumatic that it took on me the desire not to get pregnant again. For now, we are using condoms. My husband is the one who go to fetch them at Addington hospital. They can be found even in the toilets. I would like to have my tubes cut. For that, I have to go to the hospital to find if it is possible.

The third one, Louise, a twenty-five years old single woman said that:

I do not care about their attitude, xenophobia or not, I do not care! All I want it is my injection. The other day I went to the clinic for my injection, everybody knows that in South Africa, it is first come, first serve. So, you have to wake up early and go to line up in the clinic before they open the door at 7:00 am. I wake up around five o'clock and around six o'clock in the morning I was in the clinic. People were already standing in the queue. They open clinic's gate at seven o'clock and we entered. At around nine o'clock, people started to get upset and one of the nurse come down to say that they were busy with the inventory. Patients were asked to come the following day. She delivered her message in isiZulu. For us, it was like someone speaking Chinese! I told her that I didn't understand what she said. She repeated it in the same language. I told her that I could not understand isiZulu. She said: 'We are in KwaZulu-Natal, you must learn isiZulu!', and then she goes back upstairs. A woman who was just next to me, translated and explained to me what the nurse was saying in isiZulu. We all know that xenophobia is something

fresh in people's mind in South Africa. It hurt when a human being like you, same colour, rejected you. But as a refugee, we must overcome some rejection and face the realities. Refugee women must stop taking xenophobia for an excuse in order to avoid going to the clinic for the contraceptives. Since I am here in South Africa, there two places I really do not like to go because of the reception you can have. It is the government hospital or clinic and the department of Home Affairs. They treated you like a no one but we are obliged to go. We do not have other choices. Attending a private hospital is unthinkable for me. I cannot afford to buy every month the pills at R50 to the chemist. So, facing xenophobic attitude is like my cross. I need the injection in order to avoid pregnancy. I am single without children and I don't want to have children out of marriage. As a human being, I have some needs. I am mature and responsible, my sexual life is not a trouble. I am stick to one man in the time and he knows that I am taking care of myself in that matter. He does not like using condom all the time, so I think he must be relieved that I can protect myself.

These negative attitudes are referred to by Magwaza and Khumalo (2003), Wabungu (2003) and Monakali (1995) in their research. They found that although clinic staffs were often efficient and welcoming, sometimes they were abrupt and not friendly. Negative attitudes from health care providers as well as lack of interest by some nurses can constitute a barrier to the access and use of contraceptives.

Colville (2006) states that the potential for racism exists in all societies. Tensions between groups – religious or political groups and above all, ethnic groups, or one that are someway “foreign” – are all too easy to arouse racist attitudes. Unfortunately, all too often, refugees are greeted with intolerance in the host country. In some countries, the connotations surrounding the words ‘asylum seeker’ and ‘refugee’ have mutated from evoking sympathy and respect to evoking distrust and scorn, and the asylum system has become a convenient target for those who wish to expound racist or xenophobic views.

Instead of confronting this problem head-on, or even acknowledging its existence, governments, the public and the media have tended to blame the victims.

5.4.3. Knowledge on contraceptives

When asked the question: Do you use contraceptives? Please explain what you know about contraceptives? DRC refugee women informed me about what form of birth control they used. Their intention was to prevent or reduce the likelihood of pregnancy or childbirth.

Dorcas, a thirty-year-old woman stated that:

Yes I use contraception. When I went to Lancers clinic at the Durban market, I explained to the nurse that I come because I do not want to get pregnant again. She proposed me to choose injection or pills. I choose injection. Contraception can be a medicament, condom, withdrawal method or whatever you use to avoid pregnancy.

Joelle, a thirty-two-year-old graphic designer, mother of two said that:

I use contraceptive. It is a way of preventing pregnancy. You have to choose which method available is the best for you. It can be pills, injections, condoms or natural method (temperature or calendar). Most of the time, natural method failed. So you have to be very careful when choosing a contraceptive suitable for yourself. Contraceptive help the woman to rest and recover before planning to get pregnant again. I am using pills and have to take it every day in the same hour.

The study found that awareness and use of contraceptives also depends on the educational background of the respondent. The more the women are exposed to education, the more accurate is their knowledge of contraceptives. Women with a degree or diploma do not think in the same way as those with or without matric. The better the education, the more she understands about the impact of contraceptives. Some practices, however effective, consist of many risks but women do not seem to realize the implications for their health. Because one of

their friends affirmed and assured them of the effectiveness of a method, some women just adopt that method and continue with the practice, possibly to the detriment of their health.

One respondent, stated that:

I always take aspirin. The label disprin in the red box is very useful and powerful. After having sex, you must take two tablets and take two more later. You have to take the tablets for two days just to make sure that all spermatozoon are killed. I have used this method for many years and I can affirm that it is very effective. I have three children and expecting my fourth. The tablets of disprin helped me to plan my pregnancy.

When asked how and where she knows about the disprin, she laughed and said:

Many women use it even for abortion back home. I knew the effectiveness of the product when I was in high school, more than twenty years ago now. You do not need to go to the university in order to learn some practical methods. I am a drop-out scholar. I just drop when I reach Grade 10.

This opinion confirmed what Melchert and Burnett (cited in Monakali, 1995) state. They found that knowledge alone has no clear association with the reliable usage of fertility control, however, education may assist in reducing misconceptions and contribute to more positive attitudes and this may apply to better contraceptive usage.

Maguy, a twenty-seven -year-old woman shared her knowledge of contraceptive and said:

Most of the time, I just do the douching after having sex. I use clean water with dettol disinfectant or just salt and clean my vagina using a rubber instrument with the shape of a pear. The same instrument people use to do the wash or injection of the stomach. Even when I am in the ovulation period, the douching is very useful. That method is the best for me because I have the full control and I am not dependant on hospital.

Douching as a contraceptive is the injection of water alone or mixed with another product inside the vagina with the purpose of cleaning and eliminating semen. Although effective, douching is not exempt from complications. Merck (2003) states that bacteria causing pelvic

inflammatory disease may also enter the vagina during douching. Pelvic inflammatory disease is an infection of the upper female reproductive organs. Pelvic inflammatory disease can affect the cervix (causing mucopurulent cervicitis), the uterus (causing endometritis), the fallopian tubes (causing salpingitis), and sometimes the ovaries (causing oophoritis). In a study by Mairiga et al. (2010) conducted in Borno State, Nigeria found that vaginal douching with lime juice and other agents has been perceived to enhance sexual excitement through sensations of vaginal dryness, tightness or warmth, as well as to prevent sexual transmitted infections and restore and tighten the vagina after delivery. Its effectiveness as a contraceptive has also been reported. However, the social and health reasons/consequences of such a practice have not been adequately documented in the communities of Borno State, Nigeria.

Aspirin (acetylsalicylic acid) a non-steroidal anti-inflammatory drug, is a widely-used drug that relieves pain and also reduces inflammation and fever. It is taken by mouth – alone or in combination with other analgesics – for the relief of the less-severe types of pain, such as headache, toothache, neuralgias, and the pain of rheumatoid arthritis. It is also taken to reduce fever in influenza and the common cold, and daily doses are used in the prevention of coronary thrombosis and strokes. Aspirin works to inhibit the production of prostaglandins (one of a group of hormone-like substances present in a wide variety of tissues and body fluids including the uterus, brain, lungs, kidney, and semen); it may irritate the lining of the stomach, causing nausea, vomiting, pain, and bleeding. High doses cause dizziness, disturbed hearing, mental confusion, and overbreathing. Aspirin has been implicated as a cause of Reye syndrome and should not be given to children below the age of twelve unless specifically indicated (Oxford concise medical dictionary, 1996:52).

Merck (2003) states that during pregnancy the use of non-steroidal anti-inflammatory drugs is not exempt of problems. When aspirin or other non-steroidal anti-inflammatory drugs are taken in large doses, there can be a delay in the start of labour, premature closing of the connection between the aorta and artery to the lungs (ductus arteriosus), jaundice, and (occasionally) brain damage in the fetus and bleeding problems in the woman during and after

delivery, and in the newborn. When the drugs are taken late in pregnancy, a reduction in the amount of fluid around the developing fetus is the major problem.

During the focus group sessions, three women admitted associating douching with the natural method of calendar and one admitted using a cocktail of pain killer and vermifuge when sexual intercourse was likely to end in pregnancy. Aspirin cannot be taken as an emergency contraceptive. When asked if they had heard about the emergency contraceptive, only five participants answered positively though they had never used it. Thus, we can say that emergency contraceptive pill is an unknown concept to Durban-based DRC refugee women.

5.4.4. Misconceptions

Throughout history, little was known about women's reproductive systems, and what some people actually believed bordered on the bizarre. Even though it is now the 21st century, it is amazing what information circulates regarding birth control and falling pregnant.

Unfortunately, women still get a great deal of misinformation from well-meaning friends, sisters, and others when it comes to contraception, and this misinformation can cause serious problems (Wulf, 1994).

Nadine, a thirty-three-year old, mother of five shared her thoughts on contraceptives: *Using contraception can lead you having so many sicknesses and contraception is also responsible for sterility. I cannot use it or recommended it to someone because of it. After the birth of her child, one of my friends had the injection. She was so stick to her injection and so proud that she could raise her child without fearing another pregnancy. I told her that these injections are very dangerous. She refuses to believe what I told her. The future gave me reason. Although she stopped with the injections, she still struggling to get pregnant.*

When asked about how long her friend had been having the injection and when the last time was that she had the injection, she said:

She took the injection for two years. She was planning to get pregnant when her first born will be two years. She was thinking that in the time she will deliver the first one will be turning three years. Unfortunately for her, everything did not work according to her plan. Her daughter is now five years. I told her that injection make your womb become dry. If you are not able to use the natural method by using the calendar, it is better to convince your man to use condom if he can not to withdraw.

Miriam, a forty-year old seller and mother of six said:

These injections and tablets are the causes of many sicknesses. Today, we have many women with high blood pressure, diabetes, and fibroma. If you try to conduct a survey, you will find that all those women take pills or injection in order to avoid pregnancy. Planning when you can have a child is a good thing but using tablets or injections is going to interfere with your system and make you sick. The big loser will be you, ending with a sickness you could avoid. I had four children back home and added two here in South Africa. My last born is five years. I have a regular menstrual period so it is easy for me to calculate my fertile period. We just take extra precaution by using a condom. It is free and you can have it at the hospital. My husband does not prefer going to collect condom so it is me who is in charge for the collection. I convinced him that it was the best solution for us. We already have six and it very difficult to find an owner willing to rent his or her two-bedroom flat to a family of eight. So, for us, we use the calendar method, the condom and the withdrawal method when he cannot use the condom.

5.4.5. Issues of gender power relations

Twenty-six respondents were of the opinion that men, the husbands or the partners constituted a barrier to contraceptive choices and access. That affirmation raised the issue of power relationships between wife and husband, and the struggle between the male and the female gender.

When asked: In your view, do you think that DRC refugee women have access to reproductive health services in Durban? If no, what are the barriers? If yes, are you happy with the service? a respondent stated:

My husband is the one who does all the calculation about my fertile period. I am clueless about all this and rely on him. He did not allow me to go to the clinic to get medication or injection. He said that he only trust the calendar method and the condom. Medication and injection make a woman become barren. I do not either trust him also in that matter because despite his calculation, I end up having three children in four years of marriage. I went to the clinic to have medication without informing my husband, a few days later he discovered the tablets in my bag and we had a fight because of it. I explained to him that I do not want more children and his calculations were false because I end up getting pregnant. He stands by his decision and threw away my tablets. You know, I just realize that it is my life, my body and with the help of my friend, I went back to the clinic, lied to the nurse that the tablets make me feel sick and asked for injection. I won't let him know that I had the injection. My friend keeps the clinic card for me and gives it back to me every time when I have to go to the clinic.

Liberal feminist approach holds that all human beings have the capacity to think and act rationally. By deciding on what contraceptive his wife must use, this man denies her the right to think and choose by herself, and thus, this woman is no less than a minor. By doing **so**, this man does not only deprive his wife of her rights but also applies patriarchal power over her. As Sanger (1996) said, motherhood must be a choice. The husband's refusal is a form of patriarchal authority. The social constructionist approach refers to the gender system which constructs two different sexes in a system that works to concentrate power in the hands of patriarchs, allows men to oppress women. Purdy (1996) notes that women are often stereotyped as inferior in intelligence or character. Such stereotypes are then taken to justify social arrangements (which may be contained in cultural and religious values) that simply reinforce the stereotypes. All humans are shaped by socialization, which includes the communication of a variety of beliefs limiting acceptable behavior. African society gives the male partner the role of protector, chief,

head of the family and allows him to have the last word on all matters concerning the family. This leads to a reign of terror, secrecy and unfaithfulness.

Another respondent underlined the pressure unwilling husbands put on their wives: *I believe that the use of contraceptive in a couple is an issue which needs to be discussed. When I told my husband about the need for a reliable contraceptive method, like the injection, he refused. I tried to convince him about the importance and the need for it. He just said that he will be careful and do not want me to take any medicine because I will end up compromising my fertility. I am educated though I did not undergo a medical course. I have some knowledge of contraceptives. I asked him to find some information about the method but he just commanded me to obey, otherwise I will be in trouble. He accused me of planning to cheat on him and said that I want to use contraceptive just to avoid getting pregnant for my so-called boyfriend. For my sake, I just decide to go and have my injection without him knowing. My first thought or choice was for the tablets but I just realize that he is going to discover that I am on contraceptives. Opting for the injection is not only a way of avoiding unwanted pregnancy but also avoiding the need to hide tablets, avoiding dispute and having a peace of mind when making love. I want a better life for my two children. I want them going far. They are born here and have better chances than us to find a good job and they are not facing xenophobia like us. Don't get me wrong, I love children but for now, I cannot add because I want the best for them. Presently, I am learning from distance at UNISA and I am a cashier at Pick n pay. It is not easy but we have to hold on to our dreams. When our financial situation is stable, I will add one more and he or she will be the last. But for now, I keep my secret safely.*

The implication of the male partner in the contraceptive decision confirms Gule's findings (cited in Monakali, 1995) that the partner's disapproval was found to play a significant role as a constraint to contraceptive use. He also finds that disapproval is usually due to ignorance about the contraceptive methods or associated with misconceptions. This implication also confirms Poots & Marks' (2001: 203) studies. They reveal that men in the SADC region frequently argue that contraception allows women to be promiscuous. The male partner implication is also confirmed by Maharaj's (2001: 257) study which states that 'men have an instrumental role to

play in reproductive decision-making'. Even though this issue concerns a woman, the male partner has influence on women's access to contraceptives.

Another respondent stated that:

There is no need to inform them about your decision. If you want to avoid pregnancy, you have to keep quiet and go to the clinic without telling them. Otherwise, they are going to discourage you or try to impose their views. They are not the one to carry the pregnancy and suffer all the pains or inconveniences of pregnancy but always want to have a say in the matter. They are all the same. It is amazing to see how their brains work. When you are just in a boyfriend and girlfriend relationship, they are happy if you can avoid pregnancy. If by mistake you become pregnant, they beg you to abort. But in marriage, they change their mind and complain when you do not want or cannot have baby!

From the respondents' answers, one can say that women sometimes try to gain their freedom in reproductive and sexual matters by challenging their partners' or husbands' authority. By keeping their choice regarding contraceptives secret, they achieve their sexual freedom and challenge their partners' domination. By acknowledging that their partners are not aware that they use contraceptives and that use is against their partners' wishes, respondents highlight the issue of the power struggle going on between them and their partners. The pattern one sees here is that the male symbol of power (domination) is reflected when the women have to be obedient.

5.4.6. Issues of religion

The issue of power relations was also mentioned when one respondent emphasised the influence of the church or religion in contraceptive matters. The influence of religion is very strong as religion has similar power to patriarchy. This can be understood by the following response of one respondent.

Helen, a thirty six-year-old mother of eight said:

Children come from God and, my religion does not allow me to use contraceptives. It is a sin. Using contraceptive is exactly the same as aborting. The only contraceptive allowed to us is the natural method. The tablets, injection and the intra uterine device do not prevent the fecundation but the implantation of the product of fecundation. It is an abortion because these products make the womb unclean to receive the pregnancy.

When asked about her occupation, how she took care of her family and if she planned to have more children, she responded: *I am doing nothing except raising my children. I left school when I was in grade 10. I do not have any qualification. Most refugee women work as hair dressers but it is very difficult for me to do it because my children still young and we do not have money to send them to the pre-school. My husband works as a security guard and our church (Jehovah's Witness) helps us a lot. Our church helps us with food, school fees and some money. As I said earlier, children come from God. If He wants me to have more, I do not have a choice.*

This respondent's view of contraceptive confirmed the views of Preston-White and Zondi (cited in Monakali, 1995). They found that most pregnancies occurred because the church was against heterosexual activity combined with the use of contraceptives. Catholicism implies that contraception is immoral and unnatural and that it interferes with a natural process; contraception is seen as an outside human agency. For Catholics, since sex is meant for procreation purposes, married couples should always be open to the possibility of a pregnancy and barrier methods of birth control along with hormonal contraceptives are thought to interfere with the act of conception. Purposely stopping the joint of an egg and sperm is thought to be a sin, therefore these forms of birth control are not accepted.

Religion, through churches, is a form of patriarchy that constructs society (O'Grady, 1999). In this case certain religions attempt to control women's bodies and fertility by controlling their choice in use and access to contraception. Liberal feminists questioned and challenged the patriarchal authority of the church which is justified by religious dogma (Steans, 1998). By imposing an opinion and by applying patriarchal power, certain churches violate the rights of women to practice voluntary motherhood. Religious dogma must not be used to oppress people and to deny them the essential right of thinking rationally.

Another respondent from a different view stated:

My religion, Catholicism, does not allow me to use condom, pills, injection or intra uterine device. But with the remaining method, my choice is very limited to those with most high rate of failure. I don't want to have so many children and be unable to give them a better education, a better life and take properly care of them. Together with my partner, we decided on what is best for us and put aside our church values. We do respect our religion but some principles must be reviewed.

One of my respondents was a pastor's wife. On the issue about the church's position regarding the use of contraceptives, she said:

In our church (Pentecost movement), it is the couple's responsibility to chose the most reliable and suitable contraceptive for them. As a church, we do not interfere with their choice and we believe that God wants us to have a better life for our children. He gave us brain and we must make use of it. We cannot accuse God for our actions.

5.4.7. Satisfaction with contraceptive service

When asked the second question: In your view, do you think that DRC refugee women have access to reproductive health services in Durban? If not, what are the barriers? If yes, are you happy with the service? Nine respondents answered in the affirmative to this question. They indicated that their satisfaction was with pregnancy prevention and not with the disadvantages of relying on the method or on some nurses' attitudes. Since their contraceptive needs were attended to, they could say that they were satisfied.

Joelle, a thirty-two-year-old graphic designer and mother of two said:

Yes, I'm happy because at least I got the care. That is the most important thing for me. By accessing contraceptives, I am able to plan when I can have a baby. That's giving me also time to improve my life.

Another respondent, however, underlined the problem of limitations regarding contraceptives.

I am happy but it will be good if we have a wide range of contraceptives to choose from. For now, we can only choose between tablets and injections. I cannot count condom because they are made for man.

Six respondents were not happy with the use of contraceptives. The reason for their unhappiness was the health effects of contraceptives for the individual, and cultural attitudes towards contraception.

5.4.7.1 Health effects of contraception on the individual: Some of the respondents were unhappy with the side effects of the contraceptives. Most of them complained about the weight gain and the impact of the contraceptive on their periods. One respondent claimed that the use of the tablets caused high blood pressure and that was the reason she changed to the injection.

Most of the women who used condoms claimed to be satisfied with the methods. They were adamant that they were not happy with other methods (pills and injections) and they had decided not to use them. The following is an example of such an opinion:

I am happy with the condom and the natural method because I don't think that the tablets and the injection are safe. If you use it, maybe not today but after a while, they are going to change and trouble all your hormones.

5.4.7.2 Societal and cultural attitudes towards contraception: The reluctance to use other contraceptive methods (pills or injections) is due to some misconception and some societal and cultural attitudes towards sexual activity. The use of contraception among young unmarried women (most of them Christian) was not normal or acceptable. This explained the reason why most unmarried women were reserved about discussing the issue.

One respondent stated that:

It is not good for a woman who never had children to use contraceptives because these products will affect her fecundity. It was a taboo to have sex before marriage but nowadays, even a twelve years old girl can do it. They take medicine to avoid pregnancy today and they will be crying tomorrow because of the effects of the contraceptives in their womb.

Another respondent said:

As a believer and unmarried, I am not allowed to make love, thus the use of contraceptive is forbidden. But I am a human being with flesh and blood. No one in my congregation knows that I am having an affair with someone. I use pills in order to avoid pregnancy and this makes me feel safe when I am making love. There is no fear about pregnancy and sometime (during my period), if he wants my boyfriend uses condom.

The above response indicates that the respondent was not happy to hide her status as a contraceptive user because of her fear of societal disapproval of her sexual life.

5.4.8. Contraceptive choice

I divided the respondents in two groups from the responses collected for the question: What contraceptive/family planning choices are available for DRC refugee women?

The first group was composed of fifteen DRC refugee women who admitted attending the clinic for the injection or pills. They affirmed that the injection and the pills were the most reliable contraceptive available for DRC women.

One respondent stated:

Contraceptives are available for refugee. You can easily get pills or injection. There is two types of pills, the one allow to breastfeeding woman and the one prohibit to her. There is also two

types of injections, the one for two months and the other one for three months. These contraceptives are available for all. Refugees are not prohibited from having them.

Another respondent added:

The choices, however limited to two types of contraceptives, are still your choice. The nurse explains to you everything before you make a choice. They won't go to force you to take something you don't want.

The second group was composed of all those who advocated the use of natural methods (temperature, calendar) and the use of the condom. According to them, pills and injections, in the long term, were disastrous to one's health, particularly regarding fertility.

This can be understood by the answer given by one respondent:

Condoms are free, do not hurt or influence your health. I think, with the use of self discipline, and the knowledge of the natural methods, they can be considered as the best family planning.

The availability of contraceptives is linked to the way the person understands the importance and the advantage of contraception, the misconceptions and the fear of xenophobia. A woman who receives a bad reception when attending the clinic or the hospitals, will propagate the view that there is discrimination for refugees when accessing contraceptives. On the contrary, one who is well received, will claim that everyone has the right to good health and that she has access to what she is entitled.

5.4.9. Lack or difficulty in persuading the partner to use condom

Many women admitted they had difficulty persuading their partner to use a condom. The use of the male condom seems to be an object of compromise.

One single respondent stated:

Before we started going out, I wasn't using any contraceptive. There was no need to do so. When we started our love affair, he had to use the condom, I think three to four times, and after that it was always a problem when I asked him to use one. Firstly he accused me of cheating on him and later admitted that he was very uncomfortable with the condom. He said that he couldn't enjoy properly when wearing a condom. So I just decide on the injection. You know it give me peace of mind and we can do it any time. You can't force a man to wear a condom against his will.

From the above, we can say that the injection acts as a safeguard for the respondent against pregnancies. The use of a condom as a contraceptive choice is no longer a priority for her.

Another respondent said:

My husband refuses to use a condom and he say that it is very uncomfortable and that it diminishes sexual feeling. He always says that shaking some one's hand while wearing a glove is not the same when the hand is free of anything. He said that he has the sensation of wearing a plastic bag when making love with a condom. I was scared of using medications as contraceptive but he was the one who convinced me to get something in order to avoid pregnancies. As he is not an adept of condom and the withdrawal method, he gave me the responsibilities for our planning family method. We went together the first time I attended the clinic for contraceptive.

Being a male appears to give the husband or the partner the prerogative of enjoying their patriarchal authority by refusing to use a condom thus oppressing his female partner. Men seem to have the right to choose or refuse a contraceptive method; the same right is denied to women.

5.4.10. Denying the use of contraceptive methods

To admit to being a contraceptive user was a problem for some refugee women. Some single women were afraid to admit to having a sexual life and other married women were shy to

speak freely about the methods they used. For some (Monakali, 1995; Wulf, 1994), the disclosure was accidental and probably unintentional. This draws attention to the fact that sometimes during research, respondents do not make true disclosures. At times respondents say what they think should be the answer or what they think the interviewer wants to hear, irrespective of what their actual situation is.

One respondent claimed that as a committed single Christian, she had never had sex and did not see the need for her to resort to contraceptive use, but as the interview progressed, and I asked her if she knew some disadvantage of contraceptives she was prompt in saying,

Yes, when I had my first injection, I started having some trouble with my period which became long. I was bleeding even before and after my real period. I also started having headaches. Hopefully for me, the nurse helps me and told me that I was having the side effect of the injection.

Her disclosure as a contraceptive user was probably unintentional. People are often afraid to disclose their status because of what the 'other' is going to think. The "other" can be society, the culture, the religion or the family. By denying their status, people want to please the 'others', in order to fit or conform to societal or cultural norms.

5.5. CONTRACEPTION AND IMPACT

According to some of the study participants, most of the time, the person was not happy or satisfied with the choice of a particular method of contraception. She might have been using the particular contraceptive because it was possibly the only option or choice she had, or the use of that particular contraceptive was guided by the need to avoid another one she may have disliked even more. In the long term, a woman who is a contraceptive user might not necessarily be making a choice, but might have to use what she finds is available, irrespective of what it might be (Correa, cited in Oyedeji, 2003). This points to the issues of access to, availability, variety and choices of contraception.

Government can have policies, make rules, decide which contraceptive can be available or not in a hospital or clinic but at the end of the day, the women who are supposed to benefit from those contraceptive methods are the ones who are going to pay the price of unwanted or unplanned pregnancies.

In spite of the social distinctions and irrespective of class, members of the female gender remain the less heard and less sexually-liberated in society, and are consequently, in greater need of sexual and reproductive liberation, hence the importance of contraception as an agent for liberation. Contraception can be compare to a weapon: a weapon through which women are oppressed by societal and patriarchal constraints, or a weapon through which women achieve their emancipation, using contraception as an empowering agent.

CHAPTER 6: CONCLUSION

In this chapter, I present a summary of the findings of the study. Findings discussed in chapter five were in line with questions found in chapter four to which the participants of the study were required to respond. Hereunder I use the six research questions by way of discussing key findings of the study accordingly.

Do you use contraceptives? Please explain what you know about contraceptives?

It was found that DRC refugee women respondents living in Durban do use contraceptives. Each one has a method preventing her purposely falling pregnant. The appropriate knowledge of contraceptives depends mostly on their education level. Misconceptions are very much present in DRC refugee women's mind. From the answers given during the interviews, it was observed that educated refugee women could easily identify various kinds of contraception and related use.

In your view, do you think that DRC refugee women have access to reproductive health services in Durban? If no, what are the barriers? If yes, are you happy with the service?

DRC refugee women said they have full access to reproductive health services. A few were aware that access to reproductive health services is amongst their rights in South Africa. However, what was revealed as a problem and in turn a barrier to that access were issues related to: language, xenophobia, misconceptions, and issues of gender power relations. Certain beliefs and attitudes towards the access and choice of contraceptive among DRC refugee women results in the propagation and the maintenance of misconceptions. Contraceptive hormonal were accused of being the source of many sicknesses and responsible for sterility. Male partners due to misconceptions and issues of power relations, were the ones

to decide on the type of contraceptive the women should use, denying them the right to think and choose by themselves. On the whole, satisfaction with the service is related not to the quality but with the idea that regardless of the unfriendly welcome from some nurses, they have access to reproductive health services.

In your view- as a refugee, what contraceptive or family planning choices are available for DRC refugee women?

The choice offered to DRC refugee women in government hospitals or clinics and in the private sector is the same for South African citizens. The government hospital and clinic have a limited choice on contraceptive methods. The use of hormonal contraceptive methods is sometimes without the awareness or approval of the male partner. Some women listed their choice as the natural contraceptive method, meaning calendar method and abstinence, -which is the family planning choice for their church.

In what way do you think access and choices of contraceptives you make can improve your life?

From the responses given, I could deduce that the benefit of contraceptives was regarded as useful both in the maintenance of good health and maximizing good life of DRC refugee women. This was a belief held by most women, except those with misconceptions and low education level.

In conclusion, the access and choice of contraceptive methods among DRC refugee women in Durban is gendered and is a product of society. Therefore, changes must be made in order to eliminate all negative attitudes towards contraceptive access and choices. The involvement of the male partner, the government and the church in contraceptive practice through educational programs, seminars, discussions and research on a large array of male contraceptive methods will have a huge impact on the patriarchal beliefs and systems in societies that relegate and confine the female gender, to the role of silence thereby, nurturing, dependency, subordination, and submission. Stereotype roles imposed by patriarchy ought to be deconstructed in order for refugee women to take responsibility for themselves, their sexual and reproductive lives.

RECOMMENDATIONS FOR FUTURE RESEARCH

While the study has presented certain aspects of contraceptive access and choices among DRC refugee women living in Durban, it also raises questions requiring further research. The study of contraceptive access and choice among DRC refugee women living in Durban and the results derived brings to mind issues and opportunities for research such as, the impact of xenophobia on the birth rate, as well as attitudes to contraceptive choice among male partners. Possible further research may look into an investigation of health workers' perspectives of access and/or choices made by refugee women. Further research and policy development may give priority to understanding the dynamics of health worker/client interactions, and to developing curricula and in-service programs which may promote the role of the health worker in fostering the rights and interests of the client. There is also a need to conduct a comparative research project among male partners on the use, access and choice of contraceptive as they have a huge influence as patriarchs in the sexual and reproductive life of their female partners.

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APPENDIX 1

WORKSHOP ON FAMILY PLANNING

INTRODUCTON

Because of the importance of contraceptives and their impact on the life of the DRC refugee women, it was important to organise a workshop where all the information regarding contraceptives would be presented in order to understand DRC refugee women's problems regarding contraceptives, and to clear up any misconceptions and fears that may prevent them from using reproductive health facilities.

Unstructured individual interviews and focus group discussions conducted earlier during the data collection process reinforced the need for the workshop. With the help of a DRC-registered gynecologist working at King Edward VIII Hospital and attending the same church as I do, the workshop took place. After explaining our intentions and motivations to our pastor, and because of the impact of the subject on the life of his believers, the pastor of Faith Ministry Church in Pine Street offered great support by giving access to the premises, donating the equipment for filming the workshop and also by distributing visual support (DVDs) to all participants who needed it. The pastor's wife not only mobilized the women in the church but also other churches. She was also concerned about the increase in the number of women who gave birth every year within the Congolese refugee community in Durban. Invitations were sent to all DRC refugee women through refugee churches, and participants came from different

churches and backgrounds. The workshop took place in French and *Lingala*, the most commonly-used DRC languages.

The choice of a DRC gynecologist was justified because of the language barriers. It was decided that it was best if the language of the workshop was a language which would not need a translator. The language choice was thus appropriate for these refugees. The duration of the workshop was three days and was attended for one and half hours per day. After introducing the topic of the day, women were allowed to ask questions.

The aim of this workshop was to enhance the promotion of contraceptive access and use among DRC citizens by giving the right information about the access, choices, advantages and disadvantages and by erasing all misconceptions and fears related to contraceptive use or access.

The gynecologist prepared notes, and clarified and summarized all the topics on the last day of the workshop. The schedule for the workshop was:

First day: Planning a family

Second day: Pregnancy and diseases

Third day: Summary and questions.

Since the workshop was held at the church premises, prayer, worship and praise were conducted before the gynecologist started his talks.

Summary of the workshop

Topic: Talk about family planning.

Family planning is important for women, men and the government. Family planning helps women to prevent pregnancies, and when all childbirth is planned, parents are better equipped to take good care of their children and provide for their education. The government profits because the abortion rate will decrease and there will be fewer street children. Knowledge of the menstrual cycle in relation to pregnancy is very important because women can be aware of signs. The use of interventions and consequences needs to be understood.

Menstrual cycle:

Menstruation is the shedding of the lining of the uterus (endometrium) accompanied by bleeding. It normally occurs in monthly cycles except during pregnancy and after menopause. Menstruation marks the reproductive years of a woman's life, from the start of menstruation (menarche) during puberty until its cessation (menopause).

By definition, the first day of bleeding is counted as the beginning of each menstrual cycle (day 1). The cycle ends just before the next menstrual period. Menstrual cycles range from about 21 to 40 days. Only 10 to 15 % of women have cycles that are exactly 28 days. The menstrual cycle is regulated by hormones: the luteinizing hormone and follicle-stimulating hormone are produced by the pituitary gland (located in the brain); estrogen and progesterone are also produced. The cycle has three phases: follicular, ovulatory, and luteal.

The follicular phase: This varies in length, averaging about 13 days of the cycle. At the beginning of the follicular phase, the lining of the uterus thickens, with fluids and nutrients designed to nourish an embryo. If no egg has been fertilized, estrogen and progesterone levels decrease, the lining of the uterus is shed, and menstrual bleeding occurs. Menstrual bleeding lasts 3 to 7 days, averaging 5 days. During the first part of the follicular phase, the pituitary gland increases its production of a follicle-stimulating hormone slightly. This hormone then stimulates the growth of 3 to 30 follicles, each containing an egg. Later in the phase, as the level of this hormone decreases, only one of these follicles continues to grow. It soon begins to produce estrogen, and the other stimulated follicles begin to degenerate.

The ovulatory phase: This starts with a surge in the levels of luteinizing hormone and, to a lesser degree, follicle stimulating hormone. The luteinizing hormone stimulates the dominant follicle to bulge from the surface of the ovary and finally rupture, releasing the egg. The ovulatory phase ends with the release of the egg, (usually 36 hours after the surge in the luteinizing hormone begins). The egg can only be fertilized during a short period (up to about 12 hours) after its release. Fertilization is more likely when sperm are present in the reproductive tract before the egg is released. Around the time of ovulation, some women feel a dull pain on one side of the lower abdomen. The pain may last for a few minutes to a few hours. The pain is felt on the same side as the ovary that released the egg. The pain may precede or follow the rupture of the follicle and may not occur in all cycles. Egg release does not alternate between the two ovaries and appears to be random. If one ovary is removed, the remaining ovary releases an egg every month.

The luteal phase follows ovulation. It lasts about 14 days, unless fertilization occurs, and ends just before a menstrual period. In the luteal phase, the ruptured follicle closes after releasing the egg and forms a structure called a corpus luteum, which produces increasing quantities of progesterone. The function of the corpus luteum is to prepare the uterus in case fertilization occurs. The progesterone produced by the corpus luteum causes the lining of the uterus to thicken, filling with fluids and nutrients in preparation for a potential fetus. Progesterone causes the mucus in the cervix to thicken, making the entry of sperm or bacteria into the uterus less likely. Progesterone also causes body temperature to increase slightly during the luteal phase and remains elevated until a menstrual period begins. If the egg is not fertilized, the corpus luteum degenerates after 14 days, and a new menstrual cycle begins. If the egg is fertilized, the cells around the developing embryo begin to produce a hormone called human chorionic gonadotropin. This hormone maintains the corpus luteum, which continues to produce progesterone, until the growing fetus can produce its own hormones. Pregnancy tests are based on detecting an increase in the human chorionic gonadotropin level.

How does pregnancy occur?

Pregnancy begins when an egg is fertilized by a sperm. After sexual intercourse, sperm move from the vagina through the cervix and uterus to the fallopian tubes where one sperm fertilizes the egg. During each normal menstrual cycle, one egg is usually released from one of the ovaries about 14 days before the next menstrual period. Release of the egg is called ovulation. The egg is swept into the funnel-shaped end of one of the fallopian tubes. At ovulation, the mucus in the cervix becomes more fluid and more elastic, allowing sperm to enter the uterus rapidly. If a sperm penetrates the egg, fertilization results.

Family planning or contraception

Mention will only be made about the commonly-used methods and those available in most clinics or hospitals.

1. The pills: There are two types of pills. They are obtainable in all government clinics or hospitals and they are free of charge.

-The combined oral contraceptive (coc) made with progesterone and estrogen: the main difficulty is that women can forget to take them. The pill must be taken on a daily basis and at the same hour. The condom must be used in addition to pills if the woman forgets to take her pills. The pills have the advantage in that they regulate the woman's menstrual cycle. They cannot be given to breastfeeding women.

Example: Ovrал

-Progesterone only pills: These are the pills for the breastfeeding women.

Example: Provera

Ovrал (or all combined oral contraceptives) are unsuitable for breastfeeding woman. Six weeks after childbirth, the woman can start taking pills (Progesterone only if breastfeeding). Fertility comes back rapidly after one to two months following the arrest of the pills.

2. Injection: This is available in all clinics or hospitals and is free of charge.

-Nur isterate is a two month injection. It is consist of progesterone only. There will be no omission.

-Depoprovera: the injection has a duration period of three month. This product has the disadvantage of weight gain.

The injection can cause amenorrhea (absence of menstrual period) or bleeding. Fertility is restored usually after 6 month of stopping the injection.

3. Condom: One does not need to go to a clinic to get them because one can buy them in shops. They are, however, free of charge in all clinics. A condom use is the only method that protects against sexually-transmitted diseases. They are made of latex and can burst. The female condom is rarely used. Usually, men don't like to use the condom because it diminishes "the feeling". Some men may be allergic to latex.
4. Tubal ligation is performed in order to sterilize women. The woman must sign a consent form before the operation. It is a non-reversible method.
5. A vasectomy is used to sterilize men. It is an easier operation than tubal ligation. A consent form must also be signed. Vasectomy is a permanent method. Usually, men don't like to undergo the sterilization.
6. Vaginal methods:
 - Diaphragm: Rare in South Africa
 - Intra uterine device: On request in some clinics or hospitals. They are made with hormone or copper and last longer (more than 5 years).
 - Implants: Now available in some hospitals. They last five years and are made of progesterone.

7. Breastfeeding: Active breastfeeding (exclusive breastfeeding in the first six months after birth) can prevent pregnancy, but if during the six first months, the menstrual period comes back, exclusive breastfeeding is no longer a reliable method for the prevention of a pregnancy.

8. Natural methods: They depend on abstinence from sexual intercourse during the woman's fertile period of the month. Generally, it is very difficult for the couple to rely on natural methods. This range includes:

-The calendar method: The first day when the menstrual period occurs is considered to be the first day of the cycle. From the fifth to the seventh (some also take the eighth) day, the woman can have sexual intercourse without fear to falling pregnant.

-The temperature method: An increase of the temperature means that ovulation will soon occur.

-The mucus method: The fertile period is established by observing the cervical mucus. If the woman experiences "wetness", she is in a fertile period. If she is "dry", it is safe for her to have sex without risk of pregnancy. She can also feel the consistency of her cervix to determine her fertile period. A soft and open cervix means a fertile period.

9. Emergency pills: These must be taken within 72 hours of unprotected sex. Woman must go to the clinic. The emergency contraceptive is also free of charge. If the woman was the pills, had forgotten to take one and had sexual intercourse, she should double the dose, that is, take two pills in the morning, two at noon and **two at the** night. The pills must be taken the following day in the same manner. This contraceptive method can only work if taken within 72 hours of unprotected sex.

Topic: Pregnancies and ailments.

The aim of this workshop was to equip DRC refugees women with knowledge so that they can avoid unwanted pregnancies; know their rights in the process of accessing a government hospital or clinic; and avoiding or minimizing the risk of diseases related to pregnancy. Women were advised to attend an antenatal clinic when pregnant.

Ailments:

1. High blood pressure and pregnancy

High blood pressure (or hypertension) is abnormally high pressure in the arteries. Women who have high blood pressure (chronic hypertension) before they become pregnant are more likely to have potentially-serious problems during pregnancy. These problems include preeclampsia (a type of high blood pressure that develops during pregnancy), worsening of high blood pressure, a fetus that does not grow as much as expected, premature detachment of the placenta from the uterus (placenta abruption) and stillbirth. For most women with moderately high blood pressure (140/90 to 150/100 millimeters of mercury [mm Hg]), treatment with antihypertensive drugs is not recommended. Such treatment does not seem to reduce the risk of preeclampsia, premature detachment of the placenta, or stillbirth, nor does it improve the growth of the fetus. Some women, however, are treated to prevent pregnancy from causing episodes of even higher blood pressure (which require hospitalization). For women whose blood pressure is higher than 150/100 mm Hg, treatment with antihypertensive drugs is recommended. Treatment can reduce the risk of a stroke and other complications that occur due to very high blood pressure. Treatment is also recommended for women who have high blood pressure and a kidney disorder because if high blood pressure is not controlled well, the kidneys may be damaged further. During pregnancy, women with high blood pressure are monitored closely to make sure blood pressure is well controlled, the kidneys are functioning normally, and the fetus is growing normally. Premature detachment of the placenta, however, cannot be prevented or anticipated. Often, a baby must be delivered early to prevent stillbirth or complications due to high blood pressure (such as stroke) in the woman.

2. Anemia and pregnancy

Most pregnant women develop some degree of anemia because they have an iron deficiency. The need for iron doubles during pregnancy because iron is needed to make red blood cells in the fetus. Anemia may also develop during pregnancy because of a folic acid deficiency. Anemia can usually be prevented or treated by taking iron and folic acid supplements during pregnancy, however, if anemia becomes severe and persists, the blood's capacity to carry oxygen is decreased. As a result, the fetus may not receive

enough oxygen, which is needed for normal growth and development, especially for the brain. Pregnant women who have severe anemia may become excessively tired, short of breath, and light-headed. The risk of pre-term labour is increased. An excessive amount of bleeding during labor and delivery can cause the anemia in these women to become dangerously severe. Women with anemia are more likely to develop infections after delivery. Also, if folic acid is deficient, the risk of having a baby with a birth defect of the brain or spinal cord, such as spina bifida, is increased.

3. Gestational diabetes

About 1% to 3% of pregnant women develop diabetes during pregnancy. This disorder is called gestational diabetes. Unrecognized and untreated, gestational diabetes can increase the risk of health problems for pregnant women and the fetus, and also the risk of death for the fetus. Gestational diabetes is more common among obese women. Most women with gestational diabetes develop it because they cannot produce enough insulin (The need for insulin increases late in pregnancy). More insulin is needed to control the increasing level of sugar (glucose) in the blood. Some women may have had diabetes before becoming pregnant, but was possibly not recognized until they become pregnant. All women are routinely screened for gestational diabetes. Treatment consists of eliminating high sugar foods from the diet, eating less to avoid excess weight gain during the pregnancy, and, if the blood sugar level is very high, taking insulin. After delivery, gestational diabetes usually disappears; however, many women who have gestational diabetes develop type 2 diabetes as they become older.

Some questions asked by DRC refugee women:

1. *You said that during pregnancy, the period stopped. But how come I had my periods until I reached the second trimester?*

Another woman confirmed that the same thing happen to her.

The reason for the bleeding is probably a problem with the patients corpus luteum (a hormonal problem).

2. *You gave us the advantages and disadvantages of contraceptive methods. In my case, after the birth of my first child, I decided to have contraceptive injection. I took it three times with three month intervals between the injections. One of my aunties told me that it was very dangerous because of the high risk of sterility and I decide to stop. It took me more than 6 years to conceive my second child. How can you explain it? It is not easy to convince someone after a bad experience with the injections.*
3. *Can you please explain to us again about the calendar method? I'm still not convinced about the hormonal methods.*

Many women were of the same opinion. They seemed to be scared of the pill or injections because they had a negative belief about the effectiveness of the hormonal contraceptive methods.

APPENDIX 2: EXCERPTS FROM INTERVIEWS WITH DRC REFUGEE WOMEN

Name: Joelle

Age: 33 years

Marital status: married

Number of children: 2

Religion: Christian

Academic level: Diploma (Graphic designer)

Occupation: secretary, graphic designer

Interviewer: Do you use contraceptives? Please explain what you know about contraceptives?

Joelle: Yes I use a contraceptive. It is a way of preventing pregnancy. You have to choose which method available is the best for you. It can be the pill, injections or the natural method (temperature or calendar). Most of the time, natural method failed. So you have to be very careful when choosing a contraceptive suitable for yourself. Contraceptives help the woman to rest and recovered before planning to get pregnant. I am using pills and have to take it everyday in the same time.

Interviewer: In your view, do you think that DRC refugee women have access to reproductive health services in Durban? If not, what are the barriers? If yes, are you happy with the service?

Before you answer, I would like to give some explanations. Reproductive health includes safe motherhood, family planning or contraceptive methods, prevention of sexually-transmitted infections, including HIV/AIDS, safe abortion and gender-based violence (domestic violence). But for the purpose of this study, reproductive health means contraceptive or family planning methods.

Joelle: Yes, DRC refugee women do have access to reproductive health here in Durban. Yes, I'm happy with the service because at least I got the care. That is the most important thing for me. By accessing contraceptives, I am able to plan when I can have a baby. That's given me time to improve my life.

Interviewer: What contraceptive or family planning choices are available for DRC refugee women?

Joelle: Pills and injections are available. Most of them use pills because they think that pills are better.

Interviewer: In what way do you think access and choices of contraceptives you make can improve your life?

Joelle: The access and choices of contraceptives I make improves my condition by giving me the time to rest. I'm not giving birth every year. I can concentrate on other things in order to improve my life.

Name: Nadine

Age: 33 years

Marital status: married

Number of children: 5

Religion affiliation: Christian

Academic level: Grade 10

Occupation: hair dresser

Interviewer: Do you use contraceptives? Please explain what you know about contraceptives?

Nadine: No I do not use it. Using contraception can lead to you having so many sicknesses and contraception is also responsible for sterility. I cannot use it or recommended it to someone because of it. After the birth of her child, one of my friends had the injection. She was so stick to her injection and so proud that she could raise her child without fearing another pregnancy. I told her that these injections are very dangerous. She refuses to believe what I told her. The future gave me reason. Although she stopped with the injections, she still is struggling to get pregnant.

Interviewer: For how long has your friend been having the injections and do you know when her last injection was?

Nadine: She took the injection for two years. She was planning to get pregnant when her first born will be two years old. She was thinking that in the time she will deliver the first one will be turning three years. Unfortunately for her, everything did not work according to her plan. Her daughter is now five years. I told her that injection makes your womb become dry. If you are not able to use the natural method by using the calendar, it is better to convince your man to use condom if he can not withdraw.

Interviewer: So for you, are the calendar method and the use of condoms not considered to be contraceptive methods? Can you please tell me what you understand by contraceptive methods?

Nadine: You cannot put the condom and the calendar in the contraceptive methods. Contraceptive methods are pills and injections that people got to the clinic to avoid pregnancies. Those products lead to sterility and are the source of many diseases.

Interviewer: In your view, do you think that DRC refugee women have access to reproductive health services in Durban? If not, what are the barriers? If yes, are you happy with the service?

Before you answer, let me give you some explanation. Reproductive health includes safe motherhood, family planning or contraceptive methods, prevention of sexually-transmitted infections, including HIV/AIDS, safe abortion and gender-based violence (domestic violence). But for the purpose of this study, reproductive health means contraceptive or family planning methods.

Nadine: All refugees can go to the clinic to get the contraceptives if they wish. But the only problem is the nurses' attitudes. Some nurses know how to express their xenophobic feeling toward refugees. When your mouth is closed, it is fine but when you start talking with your poor English the problem begins if the nurse who is attending to you has those feelings.

Interviewer: What contraceptive or family planning choices are available for DRC refugee women?

Nadine: As I said earlier, pills and injections are contraceptive methods you can have in the clinics

Interviewer: How do you think access and choices of contraceptives you make can improve your life?

Nadine: It seems like we do not understand each other. Firstly I told you that I'm not using contraceptives. I only use the calendar method and condom. How contraceptive methods can improve someone's life? I told you that those contraceptive methods lead to diseases and

sterility, and I gave you my friend's example. People must use the calendar, condom or do the withdrawal instead of pills and injections. By doing that so many diseases like high blood pressure will be avoid.

APPENDIX 3

EXCERPT FROM INTERVIEW WITH HEALTH PROFESSIONALS

Professional level: Registered nurse

Qualification: 4 years' comprehensive diploma in Nursing science (general, psychiatry, community); midwifery

Workplace: City Hospital

Interviewer: Which contraceptives are generally or ideally available in hospitals or clinics?

Sister: Injectables, pills, intra-uterine contraceptive device, condoms.

Interviewer: Are any of the listed contraceptives available at your work place?

Sister: Yes.

Interviewer: What are the requirements for a patient to have access to contraceptives?

Sister: Any woman of a childbearing age has an access to contraceptives. When taking injection for the first time, a woman must be menstruating.

Interviewer: Do refugees have a right to access the listed contraceptives?

Sister: Yes they do have the right like all South African citizens.

Interviewer: Can you list any advantages and/or disadvantages of the contraceptives you have listed?

Sister: All medicine or medical procedure has advantages and disadvantages. The injectable methods (Depoprovera or Nur Isterate) have the advantage to be injected once in three or two months. Amongst their disadvantages, if you want to fall pregnant you have to wait that period until it is no longer in your system. Sometimes it stays longer in the system or even blocks the

uterine tubes. Pills (Micro-novums, Triphasil) have the advantage to be taken on a daily basis, so it is a short term method. It does not stay longer in the system. As disadvantages we can say that due to the fact that you taking it daily, the tendency is to forget. If you are having diarrhea, you pass it quickly before it is even absorbed. Intra uterine device (loop) is a foreign object therefore it does not interfere with your system. Once inserted, you can only go to the clinic or hospital for a check-up. However intra uterine contraceptive device can cause an excessive bleeding (menstruation). Condom has the advantage to be finds and get anywhere in the clinic or hospital or buy it from chemist or shop. You do not really need to go to the clinic where they are usually free of charge and you do not need a doctor's prescription to get them. Condom does not prevent unwanted pregnancy only, but also prevents sexually-transmitted diseases. Sometimes condom breaks, sometimes it slips inside woman's vagina. A new one must be used every time you have sex. That method requires planning and forethought. A condom must be available whenever you decide to have sex. Female condom must be inserted long before you do sex.

Interviewer: What role does a health worker (if any) play in contraceptive education?

Sister: The health worker must teach the client on how to handle condom when **inserting it**, check the expiry date. The health worker must also encourage clients to use condom consistently as it is also protecting against sexually-transmitted diseases. The health worker has the duty to educate women with IUCD on a regular check-up. For those on pills or **injectable** contraceptives, the health care must educate them to take pills and not to skip when taking them. He or she must inform the women to report any untoward effect like bleeding and insist that they must come back exactly on the due date written in their cards.

Dear respondent

You are kindly requested to take part in an interview which is a fulfillment of the requirements for my Masters degree in Gender Studies.

Your responses are highly confidential and anonymous. You have the right to withdraw at any stage.

Yours co-operation is greatly appreciated.

Luvisa Bibiche BAZOLA

INFORMED CONSENT

I, Mr, Mrs, Ms.....voluntarily take part in the research project “Experiences of DRC refugee women living in eThekweni Metropolitan area with regard to access and choices of contraceptives”.¹ The researcher² is entitled to assure my anonymity and I am free to withdraw from the research at any time without any negative or undesirable consequences to myself.

Date and Signature:

¹ In case of any questions or further information, I am free to contact the researcher’s supervisor during office hours; **Contact Details:** Tel. No. 0312601114; email. magwazat1@ukzn.ac.za

² Luvisa Bibiche Bazola, **Contact Details:** Tel. No. 0312018824; Cell. No. 0762595999; email. bibibazolant@yahoo.fr

Interview schedule: Durban-based DRC Refugee Women

Age

Marital status

Number of children

Religion affiliation

Academic level

Occupation

Question 1

Do you use contraceptives? Please explain what you know about contraceptives?

Question 2

In your view, do you think that DRC refugee women have access to reproductive health in Durban?

If not, what are the barriers?

If yes, are you happy with the service?

Question 3

What contraceptive/ family planning choices are available for DRC refugee women?

Question 4

In what way do you think access and choices of contraceptives you make can improve your life?

Deroulement de l'interviewQuestion 1

Que connaissez vous sur les contraceptives?

Question 2

Selon votre point de vu, pensez vous que les refugiees congolaises de la DRC ont acces a la sante de reproduction?

Si non, quelles sont les obstacles?

Si oui, etes- vous satisfaites avec le service?

Question 3

Quels contraceptifs/ planning familial de choix sont disponibles pour les refugiees congolaises(DRC)?

Question 4

De quelle maniere pensez vous que l'utilisation du contraceptif peut ameliorer votre vie?

INTERVIEW SCHEDULE: Health Professionals

Professional level:

Qualification:

Work place:

- 1) Which contraceptives are generally/ideally available in hospitals or clinics?
- 2) Are any of the listed contraceptives available at your work place?
- 3) What are the requirements for a patient to have access to contraceptives?
- 4) Do refugees have a right to access the listed contraceptives?
- 5) Can you list any advantages and/or disadvantages of the contraceptives you have listed?
- 6) What role does a health worker (if any) play in contraceptive education?