



**Experiences of Women Refugees from the African Great Lake Region
regarding Reproductive Health Services in the City of Durban, South
Africa**

By

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DECLARATION

I, Yvonne Munyaneza, hereby declare that this dissertation titled “Experiences of Women Refugees from the African Great Lake Region regarding Reproductive Health Services in the City of Durban, South Africa” is my own original work. It has never been submitted for any other degree or to any other university. Sources of information used have been acknowledged and referenced.

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Date.....

DEDICATION

I dedicate this dissertation to:

- The Almighty God for His Amazing Grace
- My husband, Mr Thomas Jean Claude Munyaneza

ACKNOWLEDGMENTS

- I am most grateful to God Almighty, the sole provider of knowledge.
- I am very grateful to my husband, Thomas Jean Claude Munyaneza, and our son, Parfait Yves Munyaneza, for their love and support. Even when things seemed almost impossible they encouraged me not to give up.
- I would like to extend my sincere gratitude to my supervisor Dr Euphemia Mbali Mhlongo, for her invaluable support, guidance and encouragement. I wouldn't have done it without her.
- To my Mum and Dad, thank you for your prayers and for teaching me the importance of education from the time I was a toddler. You will forever hold a special place in my heart.
- To the rest of my family, my brothers and sisters, thank you for having my back all the way. I am very grateful for your support.
- My special thanks go to the refugee women who participated in this study and their church leaders for their support. God bless you all.

LIST OF ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
ANC:	Antenatal clinic
CDC:	Centre for Disease Control
DHET:	Department of Higher Education and Training
DHS:	District Health System
DRC:	Democratic Republic of Congo
HIV:	Human Immunodeficiency Virus
HPCSA:	Health Professions Council of South Africa
HRW:	Human Rights Watch
ICPD:	International Conference on Population and Development
KZN:	KwaZulu-Natal
NHI:	National Health Insurance
PHC:	Primary Health Care
SAMP:	Southern African Migration Project
STI:	Sexually Transmitted Infection
UNHCR:	United Nations High Commissioner for Refugees
WHO:	World Health Organization
WISN:	Workload Indicators of Staffing Need

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ABSTRACT

Introduction

There is a sparse literature on the experiences of refugee women regarding reproductive health services. In South Africa specifically, research that documents such issues is lacking. Upon their arrival in South Africa, refugee women do not undergo any screening, and this exposes them even further to health risks making them more prone to all different types of diseases, as many of them are survivors of rape and many other acts of sexual violence. This study looked into reproductive health with a particular focus on reproductive healthcare services in Durban-based public healthcare facilities among refugee women from Rwanda, Burundi and Democratic Republic of Congo (DRC).

The aim of the study

This research study was conducted with the aim to document the day to day experiences of refugee women and uncover their challenges regarding reproductive health services in Durban-based public health facilities.

Methodology

The study was qualitative in nature and adopted a descriptive phenomenological approach. Using this study design, in-depth interviews were conducted with eight (8) refugee women aged between 24 and 48 years old. The participants originated from the Great Lake countries, namely, Burundi, Rwanda and DRC.

Results

The findings in this study revealed **negative experiences**, which included: medical xenophobia, language barrier, discrimination, unprofessionalism, lack of healthcare education and good customer-care training, failure to obtain consent from the patients and lack of confidentiality, ill-treatment, financial challenges, internalised fear, shortage of healthcare professionals and overcrowding of public health facilities, and religious and cultural hegemony. The findings also revealed some **positive experiences** including: positive care and treatment, and social support.

Conclusion

The conclusions are that refugee women who participated in this study face a number of challenges and have had negative experiences regarding reproductive healthcare services received in public healthcare facilities in the city of Durban, and that their issues have not been given attention by either government, local authorities, institutions concerned with refugees, or health policy makers.

Recommendations

Recommendations of this study included recommendations to the department of health to train healthcare workers in handling refugee issues, in customer care as well as in refugee rights to access and utilise healthcare services in South Africa. Recommendations were also made to policy makers in the health sector to consider involving refugee community leaders when formulating policies. In addition, the Department of Health should consider employing interpreters at the public facilities most visited by refugees.

Key words

Refugees

Women

Reproductive health services

Public healthcare facilities

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CHAPTER 1

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Background

The number of refugees in the world continues to grow at a fast pace. According to the United Nations High Commission for Refugee (UNHCR), there are around 46.2 million refugees worldwide and most of them are war-related (UNHCR, 2015). It documented that South Africa hosts more refugees than the rest of the sub-region. Of the 449,000 refugees in the sub-region, South Africa alone hosts 65, 226 refugees, excluding the undocumented and uncounted asylum seekers. (Zihindula, 2016). Refugees in the world are classified among the vulnerable population. In addition to facing challenges related to documentation, language barrier and negative attitudes from the citizens in the host countries, most refugees are also left unprotected and exposed to human rights violations (Mujawamariya, 2013). As vulnerable people, refugees are economically challenged as they live in conditions of poverty and insecurity. Once they find themselves in the host countries they face challenges of reconstructing their material lives and cultural identities (Kiura, 2012). Refugees are thus a population at high risk, especially women, as their reproductive healthcare needs are often not met, and this further exposes them to different types of illnesses and diseases which affect their lives in the host countries. Any population displacement introduces risks, but a mass influx of refugees always creates the immediate danger of major loss of life (Krause, Williams, Onyongo, Sami, Deodens, Giga, Stone & Tomczyk, 2015; Lema, 2012; Masterson, Usta, Gupta & Ettinger, 2014; Newbold, Cho & McKeary, 2013).

Reports from the Southern African Migration Project (SAMP) and Human Rights Watch (HRW) indicate that the African continent is experiencing a rise in political instability, war, conflict, sexual violence, and other socio-economic aspects that are forcing people to leave their countries in search of a more peaceful place to live (HRW, 2015; SAMP, 2015). Sub-Saharan Africa is the most affected region, and specifically the central Africa countries, namely, Burundi, Rwanda and the DRC. This region has been unstable since 1994 due to the war and conflicts which started in Rwanda and later affected its neighbours, and the people have been on a run since then. While many of those who flee these countries have sought refuge in Europe and America, research has shown that a considerable number have landed in the Southern African region, specifically in South Africa (HRW, 2015; Landau, 2014;

Vearey, 2014). The UNHCR (2015), reports that South Africa hosts the highest number of refugees from the three above-mentioned countries in the region. These refugees are in need of healthcare services, which are difficult for them to access. Zihindula, Meyer-Witz & Akintola (2015) suggest that the most affected refugee group is women, due to their specific needs for reproductive health services.

Upon their arrival in the host country, women are at high risk of contracting different types of illnesses (Apalata, Kibiribiri, Knight and Lutge, 2007; Zihindula et al., 2015a), most of which are related to their reproductive health. Many of those who need reproductive health services are unfortunately not accessing them for different reasons, including being a refugee or an asylum seeker (Zihindula, 2015). In South Africa specifically, there is a lack of documentation on reproductive health services and refugees. The existing limited information looks at access to healthcare services at large (Crush & Tawodzera, 2014; Nkosi, 2014; Vearey, 2014), while during this study no literature was found that focuses on refugees' reproductive health services in South Africa. This study documents the women refugees' experiences in their attempts to access and/or utilise reproductive health services in the public health sector in Durban, South Africa.

1.2 Problem statement

The number of refugee women in South Africa continues to grow as the number of refugees and foreigners entering South Africa is increasing. (Dalton-Greyling, 2008). Among them are women from the Great Lakes region, whom due to the war situation in their countries have been exposed to health risks from their home, along the way to their destination, and carried those risks into the host country. Upon their arrival in South Africa, the refugee women do not undergo any screening, yet many of them are survivors of rape and many other acts of sexual violence. During the literature search for this study, no study was found that documents the experiences of these refugee women with regard to reproductive health services in South Africa. This lack of documentation is a threat, not only to the refugee community, but also to the host, because after integration in the host community, there is inter-marriage and cohabitation between local people and refugees. Furthermore, the latter are continuously reproducing despite the socio-economic life conditions that they are living under.

This study was intended to document the day-to-day experiences of refugee women and uncover their challenges regarding reproductive health services in Durban-based public

healthcare facilities. Refugee women are not only in need of family planning services, but they also need to be protected against HIV&AIDS, STIs, cervical cancer and many other reproductive health risks. This study explored the experiences of the refugee women in relation to the above-mentioned reproductive health services in Durban South Africa.

1.3 Research aim

The overarching aim of this research study was to document the day-to-day experiences of refugee women and uncover their challenges regarding reproductive health services in Durban-based public health services.

1.4 Research objectives

The specific objectives of the study were:

1. To describe the day-to-day experiences of refugee women with reproductive health services in Durban
2. To describe the challenges faced by refugee women in utilising reproductive health services if any

1.5 Research questions

The following research questions guided the study:

1. What are the day to day experiences of refugee women regarding reproductive health services in Durban's public hospitals?
2. What challenges do refugee women face in utilizing the reproductive health services?

1.6 Significance of the study

This study is very significant and much needed, since it can contribute not only to the currently scarce literature on refugee women's accessibility to reproductive health services in South Africa and Southern Africa at large, but also that it carries other benefits, for example, its findings will influence health policy formulation and implementation. This study will also fill the gap in literature about refugee women and their reproductive health in South Africa, as indicated in the introductory section. With reference to the literature review in this study, many research studies that have been conducted have not addressed issues of refugee women and their experiences with reproductive health services in South Africa.

None of the studies has explored the refugee women's experiences with reproductive health services in public hospitals on South Africa. Any other study that alluded to refugees'

experiences of healthcare services (both general population and women) were all conducted internationally and not in South or Southern Africa. These include studies on: reproductive health services for Syrian refugees done by Krause et al (2015); reproductive health service delivery in Sub-Saharan Africa by Lema (2012); reproductive health and violence against displaced women by Masterson et al. (2014); and experiences of refugee women in Hamilton by Newbold et al. (2013).

The current study will bridge that gap with empirical data that will be generated from in-depth interviews with refugee women in Durban. Finally, this work will make a contribution to policy changes and implementation, and health system improvements, which will ultimately enhance the quality of life of refugee women living in South Africa.

1.7 Definition of terms

In this study, many terms related to the study title are defined below in order to give a clear understanding of the study. There are many definitions by different researchers and organisations, but for the purposes of this study the following definitions were used.

1.7.1 Reproductive health

Reproductive health is described as the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive, including its functions and process, at all stages of life (KZN Department of Health, 2005). In this study, reproductive health infers that people are to have a safe and satisfying sex life, and be able to reproduce as well as having the freedom of decision on how, when and how often to do so. For the purposes of this study, the definition by the International Conference on Population and Development (ICPD, 1994) will be adopted, as it describes reproductive health care in the context of primary health care to include: family planning; antenatal care, safe delivery and post-natal care; prevention and appropriate treatment of infertility; prevention of abortion and management of its consequences; treatment of reproductive tract infections; care and treatment of sexually transmitted infections (STIs) and HIV&AIDS; information, education and counselling on reproductive health; prevention and surveillance of violence against women; care for survivors of violence and other actions to eliminate traditional harmful practices; and appropriate referrals for further diagnosis and management of the above.

1.7.2 Family planning

The World Health Organization (WHO) describes family planning as a method that allows couples to anticipate and attain their desired number of children and the spacing and timing of their births (WHO, 2014). This definition suggests that the abilities of women to space and /or limit their pregnancies directly impact their health and well-being as well as each pregnancy's outcome.

1.7.3 Antenatal care

A recent World Health Organization report on antenatal care in Africa defined antenatal care as “the care that women receive from health care professionals during the course of their pregnancies” (Lincetto, Mothebesoane-Anoh, Gomez & Munjanja, 2013).

1.7.4 Safe delivery

Safe delivery involves giving birth to a healthy baby without complications. To ensure a safe delivery, health care providers including midwives and obstetricians have to do a regular check-up of the mother and her unborn baby during the antenatal period through the whole pregnancy until delivery. During labour, it is important that delivery is conducted by a skilled midwife for the well-being of both mother and her newborn. (Abera & Belachew, 2011)

1.7.5 Post-natal care

Postnatal care refers to the attention given to general care of the mother and her infant after delivery up to six weeks post-delivery. Care is directed towards prevention, early detection and treatment of complications and diseases and should include counselling, advice on breastfeeding, family planning, immunisation and maternal nutrition (Warren, Daly, Toure, Mongi, Dina Lord, Lesie, Kristina & Alicia, 2006).

1.7.6 Abortion/Termination of pregnancy

Abortion is defined as the termination of pregnancy before the foetus is viable. It is either spontaneously or artificially induced expulsion of the embryo or foetus. As used in the legal context, the term abortion is usually used to refer to induced abortion (WHO, 2015).

1.7.7 A refugee

A refugee is as a person who is forced to flee his/her home due to persecution, whether on an individual basis or as part of a mass exodus due to political, religious, military or other

problems (UNHCR cited in Zihindula et al., 2015; Lakika, 2011; and SAMP, 2014). The studies above have focused on general groups of refugees and their experiences with all aspects of healthcare services. This study focuses specifically on women refugees and their experiences with reproductive health services. This is based on existing literature suggesting that women are the most vulnerable group in healthcare settings in South Africa (Zihindula, Oppong, Meyer-Weitz & Akintola, 2016).

1.8 Organisation of the dissertation

Health-related research has shed light on the relationship between illness and migration as well as on health system challenges in countries hosting immigrants. This thesis provides empirical evidence that is supported by the findings based on a critical literature review of relevant documents on women refugees and their experiences with reproductive health services linked with developmental, economic and social livelihoods of refugee women. This research focused particularly on experiences of refugee women when seeking reproductive healthcare services in public healthcare facilities in Durban. The focus was more on refugee women from the Great Lakes countries. The dissertation is divided into five chapters:

Chapter 1: Introduction: This chapter provides an overview of the study: the background; problem statement; the aim and objectives of the study; research questions; and the significance of the study. It also includes the definition of key terms and ends with this short conclusion. In brief, this chapter introduces the entire dissertation.

Chapter 2: Research methodology. This chapter describes the study design, the target population, sample and sampling methods, data collection tools and methods of data analysis. In general this chapter presents a detailed description of the methodology utilised in this study to achieve its objectives and to answer the main question being investigated. All the sub-headings under methodology are presented here and a short conclusion is drawn.

Chapter 3: Literature review: This chapter draws on existing literature relevant to the study in question. Crucial issues are discussed in this section relating to the experiences of refugee women with reproductive health services in Durban public hospitals/clinics.

Chapter 4: Analysis of findings: This chapter presents the data analysis, and the study findings. The results from qualitative interviews with refugee women are presented and interpreted in this chapter, followed by a short conclusion.

Chapter 5: Discussion of findings, conclusions and recommendations: This chapter discusses the main findings of the study with reference to previous literature, which is used to

substantiate the researcher's findings. A short conclusion is drawn summarising all the findings in the previous chapter above. Finding-based recommendations are also made to healthcare professionals, health policy-makers, the Department of Health, and the refugee communities, as well as some recommendations for future research.

1.9 Summary of the chapter

This first chapter of the thesis presented the background to and outlined the study's research problem. It provided a short introduction to the literature alluding to refugee women's experiences with reproductive health services in public healthcare facilities in South Africa, and brief reference was made to constitutional human rights and policy requirements for equal healthcare service utilisation, with specific attention to reproductive health services for refugee women. In this chapter the researcher covered the problem statement, the aim and objectives of the study, the significance of the study, research questions and definition of terms. The researcher described the need to conduct the study about the experiences of refugee women living in the city of Durban, KwaZulu-Natal, in connection with reproductive health services. The following chapter discusses the methodology used in the study.

CHAPTER 2

METHODOLOGY

2.1 Introduction

The methodology that guided this study involved the researcher in gathering data and led her to reaching the aims and objectives for the study. The study was conducted in order to explore and understand the experiences of refugee women with regards to reproductive healthcare services in the city of Durban, South Africa. Refugees from Burundi, DRC and Rwanda living in the city of Durban came to South Africa as forced migrants escaping execution, war, violence and unstable political situations in their countries. This study investigated the experiences of refugee women regarding reproductive health services in the city of Durban, South Africa. It aimed to describe the day-to-day experiences of refugee women with reproductive health services in Durban and the challenges they face in utilising these services, and to explore their awareness and understanding of the reproductive health services available to them. The study also included the challenges faced by refugee women regarding reproductive health services. The chosen methodology and research design are explained in the sections that follow.

2.2 Research approach

In order to document in detail the challenges in accessing health care, a qualitative methodology was adopted as it allowed the gathering of in-depth information from the participants. Qualitative methods are invaluable for exploring the complexities of health care and patients' experiences in particular. Moreover, diverse qualitative methods are available that incorporate different ontological and epistemological perspectives. The methodologies are defined differently by different authors. For the purposes of this study, the researcher has considered Burns and Grove's (2001) definition of research methodology as the application of all steps, strategies and procedures for gathering and analysing data in a research investigation, in a logical and systematic way. The selection of the qualitative research methodology was the core of the research design adopted in this study. Furthermore, the qualitative methodology was used because it is the only methodology that deals with subjective data produced by the minds of the participants and thus allowed the researcher to

understand the significance participants attached to their study subject (Stainback and Stainback, 1984).

The term qualitative implies “an emphasis on an examination of processes and meanings, but not measured in terms of quantity, amount or frequency” (Labuschagne, 2003). Rather “the qualitative research method was used in this study to allow the researcher to understand how research participants perceive their situation and their role within the context” (Katzenellenbogen, Joubert & Abdool-Karim, 2002). The great strength of qualitative research is therefore that it attempts to describe the fullness of experience in a meaningful and comprehensive way (Winget, 2005). Since the main aim of this study was to document the day-to-day experiences of refugee women and uncover their challenges regarding reproductive health services, a qualitative research approach was the appropriate method to gain such insight. This research gave the participants a unique opportunity to voice their experiences with reproductive healthcare services and how this affected their lives in one way or the other, the successes and failures of their coping strategies, and what they believed should be done to address the problem of access to and utilisation of reproductive healthcare services for refugee women.

In order to provide a detailed profile of the refugees’ situation, a particular type of qualitative research, a qualitative descriptive approach, was used in this study. Sullivan-Bolyai, Bova & Harper, 2005:128) explained that “the goal of qualitative description is not theory development, but the provision of thick description, and adding interpretative meaning to an experience depicted in an easily understood language”. Thus, this qualitative method responds to the goals of the topic undertaken. A qualitative descriptive approach offered the opportunity to gather rich description about refugee women’s experiences with reproductive healthcare services in public hospitals/clinics. The focus was placed on direct communication with the research participants, eliciting rich descriptions about their experiences of access to and utilisation of reproductive health services, and offering a valuable opportunity to acquire inside knowledge about how they see their world. This was made possible by interviewing the participants at their respective churches in familiar environments, enabling them to feel more comfortable. And coming from the health field, my experience and skills as an experienced healthcare provider assisted me in conducting the interviews and made it easier for me to interact with the participants in an empathetic and understanding manner, in naturalistic and everyday settings. (Terre Blanche, Kelly & Durheim, 2006:206).

2.3 Research paradigm

This study was founded on the interpretivist paradigm which operates on the premise that knowledge and the way it is studied is dynamic, contextual, and may be dependent on the perspectives of different participants, be they researchers, policy-makers or other consumers of such knowledge (Kiura, 2012). Interpretivism, also known as the interpretivist paradigm, involves researchers in interpreting elements of the study, thus interpretivism integrates human interest into a study. Accordingly, interpretivist researchers assume that access to reality (given or socially constructed) is only through social constructions such as language, consciousness, shared meanings, and instruments (Myers, 2008:38). Interpretivism aims to discover the details of the situation and to understand the reality, or perhaps a reality, working behind them. People place different interpretations on the situation, in order to make sense of and understand the motives, actions and intentions of other people. For the purposes of this study, the researcher listened to the refugee women's description of their own experiences in connection with reproductive health services offered in public health facilities around Durban, and tried to understand the reality behind this situation.

Furthermore, interpretivism allowed for multiple realities and multiple truths in this study. Reality is socially constructed and constantly changing. It also allows the researcher and who or what is being researched to be interactively linked, and findings were thus mutually created within the context of the situation which shaped the inquiry (Sale, Lohfeld, & Brazil, 2002). Individuals were understood to perceive the world differently because of their own experiences and perceptions in different contexts. By using interpretivism the researcher was able to listen to the refugee women's "hidden voices" about the phenomenon of experiences in relation to reproductive health services in public health facilities in terms of its aspects and features, impacts, and their responses to these impacts in their lives.

2.4 Research design

This study is a phenomenological research study as described by Groenewald (2004), in that it attempted to understand the perspectives, perceptions and understandings of the refugee women and their experiences with reproductive healthcare services. The nature of the study and subject matter lend itself to a phenomenological approach. The benefits of this approach are that it allowed participants to tell their story in great depth, to provide descriptive information of their experiences, and to reflect in their own abilities and shortcomings around reproductive health services (Giorgi, 1997). The purpose of phenomenological research is to

describe people's experiences with regard to certain phenomena, as well as how they interpret their experiences or the meaning those experiences hold for them (Brink, 2006). Hence, a phenomenological approach was a good fit with participants describing the meaning of their experiences of reproductive health services and the use of a qualitative research design (Barritt, Beekman, Bleeker, & Mulderij, 1984; Beck, 1994).

For the purposes of this study, a Husserlian descriptive phenomenological approach was adopted. Edmund Husserl, the founder of the philosophical movement of phenomenology, believed that phenomenology suspended all suppositions, was related to consciousness, and was based on the meaning of the individual's experiences. Husserl referred to the experience of perception, thought, memory, imagination and emotion as intentionality, which is one's directed awareness or consciousness of an object or event. His central question was: "*What do we know as persons?*" Husserl then developed descriptive phenomenology, whereby everyday conscious experiences were described, while preconceived opinions were set aside or bracketed (Reiners, 2012). Edmund Husserl introduced the term "bracketing" into phenomenology: he suggested that researchers need to "bracket" their presuppositions and preconceptions. This process makes it possible for researchers to focus on the participants' experiences and the data are accepted uncritically as given (Crotty, 1996:19).

Moreover, a qualitative research design was used due to a need to engage in an open-ended, inductive and explorative type of research design to understand and describe the phenomenon being studied. Based on the fact that the study consisted of participants' description of their experiences with reproductive health services, a descriptive phenomenological approach was adopted, as it was considered the most appropriate method to capture the refugee women's knowledge and understanding of the phenomenon of reproductive health service utilisation. This is supported by Coyle and Faan (2004), who agreed that phenomenological research is one of discovery and description, and emphasises meaning and understanding in the study of the lived experience of individuals. This justifies using such method design, especially as little is documented about reproductive health services of refugees in South Africa (Cohen, Khan & Steeves, 2000 and Donalek, 2004). Therefore, the phenomenological approach was used in order to present personal lived experiences, as well as the transfer of the private understanding of reproductive health service experiences into the social and public area (Reinhartz, cited in Coyle & Faan, 2004; Sandelowski, 2000).

This study was qualitative in nature. This approach was suitable for the study as it enabled the researcher to develop an understanding of social life and to discover the subjective

meaning that the refugee women construct and attach to their actions (Neuman, 2011). The design provided an opportunity for “thick and rich” descriptions of the participants’ experiences of reproductive healthcare services, and offered a chance to individuals whose voices are rarely heard (Ulin, Robinson, Tolley & McNeil, 2002).

2.5 Research setting

Polit and Beck (2005) refer to a setting as the physical location and conditions in which the data collection takes place. The study was conducted in the City of Durban and did not consider participants who are located beyond the above-mentioned city’s borders. The city is also one of the three main cities that host a majority of refugees from the Great Lakes region, including the cities of Cape Town and Johannesburg (UNHCR, 2015). Durban is one of the largest South African cities and is located in the province of KwaZulu-Natal, overlooking the wonderful beaches of the Indian Ocean. It features the largest port in South Africa. Durban is perched on the round hills overlooking the spectacular Indian Ocean coast, and just nearby the magnificent peaks jagged on the Drakensburg Mountains. It covers an area of 2,292 square kilometres, making it one of the least dense cities in South Africa. The surrounding area features subtropical thickets, deep ravines littered with small creeks, as well as steep slopes and other geographical elements which are usual for the Afromontane forest typology. The municipality of Durban has recently opened the King Shaka International Airport and it is now used as the main gateway for the city and the surrounding areas. There are numerous airlines that offer both domestic flights as well as international flights to and from the city. Durban has extensive and quick bus connections with the other cities in South Africa, as well as the nearby foreign capitals, such as Maputo (Mozambique) or Mbabane (Swaziland). There are plenty of national and international carriers that cater for both the locals, as well as for tourists. Durban is famous as being an extremely welcoming city and it is a wonderful destination all-year-round because of its pleasant weather. The city has a population of approximately 3.5 million citizens and it is widely regarded as the largest city on the Indian Ocean coast of Africa. (Source: mapsofworld.com/South-africa/cities/durban-city.html)

Among other reasons is the fact that the researcher has lived in Durban for a very long time; it is an advantage for her to conduct the study in the above-mentioned city. Furthermore, Razavi (1992) and Hayano (1979) stressed that conducting fieldwork at home is a rite of passage by which the student becomes a professional anthropologist. Hence, being part of the community under study guarantees the researcher access, and the fear of facing strangers if

studying an outside community is not an issue. The trust and easy access to my own community authorises me to consider this as doing anthropology at home. Jackson (1987) considers that doing fieldwork at home is advantageous because there is freedom, which allows easy access the community. The researcher is also aware of the danger of bias through being close to the subject, but measures were taken to avoid the occurrence and nothing undocumented was included in the report.



(Source: [http:// www.cybercapetown.com/Maps/Durban](http://www.cybercapetown.com/Maps/Durban))

Figure 2.1: Map of the city of Durban

2.6 Research population

The study population included nationals from the three countries of the Great Lakes region, namely, Burundi, DRC, and Rwanda. The participants were recruited from two churches, namely, Durban Mission Church and Paran Pentecostal Church, and they are refugee women living in the City of Durban. This research targeted refugee women from three countries called Great Lakes countries as mentioned above, who are part of a group of forced migrants

(both documented and undocumented), who refer to themselves as refugees regardless of the possession or non-possession of a refugee permit or refugee status. Only a few of these community members have secured permanent residency since their stay in the country. It is from the above group that the sample was drawn, and refugee women who lived outside Durban were not considered for inclusion in the study.

Unlike refugees who settled in Johannesburg for economic and political reasons decades ago, the majority of Durban-based refugees left their countries because of different “liberation wars” and most of them came from the eastern part of the Great Lakes region. (Amisi, 2005). While many of the refugee women consider themselves refugees, their influx into the country, the time of arrival and their reasons for migration have been noted. Upon their arrival in South Africa with different expectations, many of the refugees, including women, find it hard to cope based on many issues characterising them. First, they find it hard to get employment, due to their limited ability to communicate in English and other local languages, and many of them are not qualified to compete for positions in the formal job market. It is indicated that South Africa is not familiar with the hosting of refugees and migrants and therefore these groups experiences hardships. Dalton-Greyling, 2008). Few of those who are able are employed informally or self-employed. Most of those who constituted the sample for this study had left their country following political instability, war and different types of violence.

2.7 Sampling procedure

The researcher chose a purposive sampling method because she wanted to seek out and sample only refugee women who originated from the Great Lakes region (Rwanda, Burundi and DRC), who live in Durban, KwaZulu-Natal and have sought reproductive health services in any public healthcare facilities in Durban. That is to say, purposive sampling was chosen in order to provide the researcher with the most useful data by taking a conscious decision about which individuals would best provide the desired information. In fact, purposive sampling is most commonly used in phenomenological inquiry (Speziale & Carpenter, 2007:94). Purposive sampling was used to recruit participants in this study as it allowed the researcher to select participants who are able to provide rich information about the phenomenon that is being studied (Creswell, 2009). The disadvantage of using this sampling method was, however, that it did not allow generalisation of the findings. This is to be expected in the study based on the fact that the study was conducted only in one city in South

Africa and the experiences of women refugees might not necessarily be the same in other cities of South Africa.

2.7.1 Sample size

A total of ten (10) participants were purposively sampled among women refugees who are members of Durban Mission Church and Paran Pentecostal Church, provided that they (1) are women refugees aged between 18 and 49 years, (2) originated from DRC, Burundi or Rwanda, (3) live in Durban, KwaZulu-Natal, and (4) have sought reproductive health services at one of the public hospitals in the city of Durban. The researcher decided to recruit the participants from the two mentioned religious institutions based on the fact that she wanted to single out only women refugees from the Great Lake region, and the two churches in question host the majority of refugees from the above region. In addition, even though the researcher bracketed her preconceived ideas prior to data collection, she already knew from experience that almost all foreigners were treated the same way in public healthcare institutions whether they were church goers or not. Therefore the researcher found the group of women refugees from Durban Mission and Paran Ministry churches similar to the women refugees from other religious groups. However only eight (8) participants were interviewed due to the fact that data saturation was reached and data was repeating itself

2.7.2 Inclusion criteria

Participants were included in the study if they met the inclusion criteria of being a national from one of three Great Lakes countries and living in Durban as a refugee, being a female aged between 18 and 49 years old, and having sought reproductive health services at one of the public health facilities situated in the city of Durban.

2.7.3 Exclusion criteria

Refugee women were not selected for inclusion in the study if they were only visiting the city of Durban and had not sought reproductive health services at public health facilities. Women who cannot talk or hear were not included as there was no sign language interpreter for this study. Non-citizens of the above-mentioned three countries were not considered for inclusion in this research study.

2.8 Pilot study

A pilot study was conducted four weeks prior to the actual data collection phase. This was done in order to provide an opportunity to test the data collection tool, and the participants' perceptions of the study. A total of two participants were selected for the pilot study. Kim (2010) advises that conducting a pilot study is beneficial in that it provides researchers with an opportunity to make adjustments and revisions in the main study. Further literature (Van Teijlingen & Hundley, 2002) confirms that a pilot study can help in assessing the feasibility of the proposed research process. This phase helped the researcher to estimate the amount of time to be spent with the participants. The data collected from the pilot study was not included in the study.

2.9 Data collection process

The raw data for this study was the naïve description. Natural cognition begins with experience and remains with experience. So the naïve description is the first person account of experience as it was lived and understood by the participant in his or her everyday common sense mode of understanding. (Broome, 2001:9)

The naïve descriptions provided by the participants were audio-recorded for later transcription. A mobile cell phone was used to record the interviews. The researcher then transcribed the interviews for analysis. As part of the data collection process, pseudonyms were used to protect the participants' identity.

Qualitative data for this study were collected using an interview guide. In-depth interviews were conducted with the participants. The interview guide was structured so as to allow room for probing questions. All the questions were asked in English, and clarification and reformulation of the questions was done where it was needed to assist the participants with a better understanding. The data collection tool for this study was developed by the researcher and included questions related to the study's aim and objectives. The interviews were audio-recorded and transcribed in order to capture the interviewees' answers in their own terms and also allow thorough examination of what participants said (Bryman, 2004). In addition to audio-recording, the researcher took notes during the interviews. The interviews were held at the Divine Mission Church and Paran Pentecostal Church in Durban at suitable times for each participant. A semi-structured interview guide was used for data collection (see annexure 9),

and interviews were audio-recorded using the researcher's cell phone and a laptop. Interviews were conducted in a quiet environment where there were no disturbances or noise.

According to De Vos (1998), "the most widely used methods of data collection in the social sciences and humanities are documentary sources, observation, in-depth, intensive interviews and questionnaires". For data collection, the researcher used face-to-face in-depth interviews as this was considered to be the most appropriate method for the purposes of the study. The instrument (interview guide) was taken to the field for use until the fieldwork was completed. Instruments for data collection were prepared in advance and approved by the supervisors prior to the data collection phase. In-depth interviews were conducted through which rich data were provided which revealed the meaning that refugee women attached to their situations. The interviews took from 30 to 45 minutes except for the one which lasted 26 minutes. The main guiding question of the interview was: "what are the day to day experiences of refugee women regarding reproductive health services in Durban's public health care facilities"

2.9.1 Face-to-face in-depth interviews with refugee women

A primary aim of the study was to gain an in-depth understanding into complex situations, which "usually requires semi-structured, in-depth interviewing or observational methods that, though time consuming, often result in a deeper more detailed appreciation of the complicated issues involved" (Bradshaw & Stratford, 2005:72). Therefore, face-to-face interviews were used in which the researcher attempted to obtain information, opinions and perceptions from the participants (Dunn, 2005). Interviews are an excellent method of gaining access to information about events, opinions, and experiences. Questions posed in the interviews allowed for open-ended responses as opposed to a simple yes or no.

2.10 Data analysis

Data were analysed following Husserlain descriptive phenomenological approach. Data analysis was done after each interview to allow the researcher to monitor data saturation. The in-depth interviews were transcribed verbatim. The researcher started by transcribing the recorded data at the same time paying attention to the notes taken during each interview with the participants, to ensure no information is left behind. Then the researcher read and re-read the transcribed data, highlighting, identifying and organising the main categories with similar

ideas, which she later grouped into themes and sub-themes to help her outline the analysis before the actual analysis took place. The researcher then proceeded by summarising and interpreting the findings and themes.

The descriptive Phenomenological Psychological Method is a five-step system of research that holds Husserlian Phenomenology as its philosophy foundation. The first step of the phenomenological psychological method is for the researcher to assume the phenomenological attitude which is different than natural attitude. In the phenomenological attitude, the researcher brackets his or her everyday knowledge to take a fresh look at the data. The researcher sees data as it appears in itself and in its own context without doubt or belief. So bracketing and withholding of existential positing allows the researcher to see and thus describe what was present for consciousness from the participants' first person perspective. (Broomé, 2011:11).

Bracketing is a process where the researcher sets aside his/her experiences, as much as possible, in order to take a non-biased look at the phenomenon in question. The goal of bracketing is for the researcher to set aside his/her own experiences to be in a position that is as non-biased as possible (Creswell, 2007). For the purpose of this study, the researcher completed the bracketing process by writing down her lived experiences with regards to reproductive health services in public institutions prior to beginning the interview process with the participants and hearing their lived experiences regarding the study in question.

Bracketing refers to three processes: the process of setting aside, suspending or holding in abeyance, presuppositions surrounding a specific phenomenon; the process of focusing in on the essences and the structure of the phenomenon; and the process of the setting aside of presuppositions and rendering explicit the studied phenomenon. (Gearing, 2004: 1433).

The second step in the data analysis requires that the researcher read the entire naïve description to get a sense of the whole experience. (Broomé, 2011:12). The researcher read the transcript several times to ensure the data was captured as it was given and to familiarise herself with the data. The third step in the data analysis is the demarcation of meaning units within the narrative so that the data can be dealt with in manageable portions. (Broomé, 2011:12). The researcher went through the narrative text in a subsequent readings in order for her to determine where places of meaning shift within it. In the fourth step, the researcher

transformed the meaning units into a whole sensitive descriptive expression of each of them. In the fifth step the meaning units are transformed using imaginative variation within the phenomenological attitude (Broomé, 2011:12). The researcher summarised the main themes and sub-themes, linking them to the literature and the research topic. The researcher then wrote up the analysis of the findings as seen in chapter four.

2.11 Data management

The collected data were transcribed by the researcher herself and stored under a file name known only by the researcher on her computer and the researcher made sure that no one else had access to her computer. A copy of the transcripts and audio-recordings were given to the research supervisor, which were kept in a safe lockable cupboard in her office, where only the researcher and her supervisor have access. The supervisor will keep the copies of the data for five years after completion of the study under a password-protected file in her office in the school of nursing and public health at the University of KwaZulu-Natal, and thereafter the data will be destroyed.

2.12 Trustworthiness

Trustworthiness is a very important aspect in qualitative research (Kiura, 2012). According to Lincoln & Guba (1985), the principles to examine the trustworthiness and quality of the research include credibility, dependability, conformability and transferability. The researcher has to clarify the issues during interviews, and demonstrate that the findings of the study are at least compatible with experiences of the people under study; in this case refugees women. Ultimately, trustworthiness is essential to the very nature of interviews. It can be enhanced by piloting of the research instrument and the use of member checks (participant validation), where participants are given a transcription to check if data is captured correctly (Kiura, 2012).

To ensure control quality during recording, the researcher made sure the interviews were done in a quiet environment, away from noise, in order to avoid sounds that might affect participants' voice recording. In addition, the recording instrument must be trustworthy. The researcher made sure that there was enough space in the memory of the phone and laptop used for recording. The quality of data transcription was ensured and the researcher listened carefully to the audio-recordings to avoid errors and ensured that all participants' responses are captured appropriately.

2.12.1 Credibility

Credibility evaluates quality and refers to truth in data (Polit & Beck, 2005). Lincoln and Guba (1985), define credibility as confidence in the truth of the data and the interpretations thereof. For the purposes of this study, the researcher met with participants often during the course of the study and made sure that the participants in this study did so voluntarily. After the interviews, the researcher returned the transcribed as well as the recorded information to the participants for them to confirm the accuracy of information they gave, through a process of member checking. The researcher also used multiple sources of data to triangulate the findings of the study. Then the researcher approached her research supervisor for a debriefing session, where she provided valuable guidance on data analysis and the study process in general including the field work process.

2.12.2 Dependability

Dependability refers to the stability of data overtime (Polit & Beck, 2005). The researcher ensured this by using the same interview guide for all participants during the interviews done on different dates and at different times. The researcher also ensured that the findings were consistent and could be repeated by conducting an inquiry audit, which requires someone with knowledge about research but who is not involved in the same research to examine and do an audit trail of the process and products of the research study. The purpose is to evaluate the accuracy and evaluate whether or not the findings, interpretations and conclusion are supported by the data (Holloway & Wheeler, 2010). In addition, the researcher ensured dependability by audio-recording all interviews and self-transcribing the recorded data to ensure the greatest possible accuracy of the information collected from the participants.

2.12.3 Transferability

Transferability refers to the extent to which findings can be transferred to other settings (Polit & Beck, 2008). The researcher ensured that the findings from this study can be transferred to similar situations or participants by providing sufficient information around the context of the study, and information on research participants who took part in the study. The knowledge in one context will be relevant in another, and those carrying out the same research in another context will be able to apply certain concepts originally developed by other researchers (Polit & Beck, 2005). This is a way of achieving a type of external validity by describing a phenomenon in sufficient detail that one can begin to evaluate the extent to which

conclusions drawn are transferable to other times, settings, situations and people (Holloway & Wheeler, 2010).

2.12.4 Confirmability

Confirmability depends on others agreeing with the researcher's findings and interpretations (Polit & Beck, 2005). The researcher ensured Confirmability by making sure that data are linked to their sources, for the reader to establish that the interpretations and conclusion arise directly from them. The researcher ensured this through triangulation. The process of triangulation involves using multiple data sources to produce understanding or to corroborate views and representations given by the participants. (Kiura, 2012). The researcher was aware of the possible biases due to the fact that she is a part of the community under study, but measures were taken to avoid this.

2.13 Ethical considerations

The interaction between researchers and participants can be ethically challenging. Researchers face ethical challenges in all stages of the study from designing to reporting. These include anonymity, confidentiality, and informed consent, researcher's potential impact on the participants and vice versa. (Sanjari, Bahramnezhad, Khoshnava Fomani, Shoghi, & Ali Cheraghi, 2014). Broomé, (2011), believed that, as a part of ethical consideration, it was important to maintain the participants 'voices in the research as much as possible.

Before starting the data collection process with research participants, the researcher sought and obtained their informed consent. The researcher also obtained ethical approval from the Humanities and Social Sciences Research Ethics Committee of the University of KwaZulu-Natal, as well as permission to conduct the study from the two church leaders. Participants were given an information letter to clarify that participation in the study was voluntary and that there were no monetary benefits from the study, and they were given an informed consent form to sign as a confirmation that they agreed to participate in the study before commencing the interviews. The consent for audio-recording was also obtained. Participants were informed about their right to withdraw from the study at any time should they wish to do so and that they would not be penalised or lose benefits should they refuse to participate or decide to stop at anytime. The researcher used pseudonyms to protect the identity of the participants who took part in the study and no names were mentioned during audio recording,

therefore ethical concerns in relation to confidentiality, anonymity, causing no harm, honesty and member checking were taken into consideration.

The researcher took into account the following ethical principles as described by Emmanuel, Wendler, Killen and Grady (2004)

2.13.1 Community participation

This study involved refugee women from the Great Lakes region, living in Durban KwaZulu-Natal. The researcher approached the church leaders and presented the idea of the topic in question and they agreed that it was going to be interesting for everyone involved. The researcher worked with the refugee women as well as with the church leaders. During the shaping of the topic, the researcher approached her supervisor who assisted her in putting the research topic together.

2.13.2 Social value

The data were collected during interviews with the chosen participants upon signing consent to participate in the study, and were analysed for a better understanding of experiences of refugee women regarding reproductive health services in the city of Durban, South Africa. It is believed that this study will make a contribution in policy changes and implementations, and health system improvements, which will ultimately enhance the quality of life of the refugee women living in South Africa. This study is very significant and much needed, since it will contribute not only to the currently scarce literature on refugee women accessibility to reproductive health services in South Africa and Southern Africa at large, but it also carries other benefits. The study will expand the body of knowledge and will benefit the discipline, which will produce new knowledge in this area.

2.13.3 Scientific validity

The overarching aim of this research study was to document the day-to-day experiences of refugee women and uncover their challenges regarding reproductive health services in Durban-based public hospitals. Therefore, participants were interviewed individually at their convenience time in Durban Mission and Paran Pentecostal churches. The interviews were audio-recorded and transcribed by the researcher. The electronic data was saved on the researcher's computer. The recordings and hard copies were kept in a lockable cabinet by the research supervisor in her office for five years following completion of the study at School of Nursing at the University of KwaZulu-Natal.

2.13.4 Fair selection of participants

Participants were purposively selected among members of Durban Mission Church and Paran Pentecostal Church, provided that they met the inclusion criteria. Participants were included in the study if they met the inclusion criteria of being a national from one of three Great Lakes countries and living in Durban as a refugee, being a female aged between 18 and 49 years old and having sought reproductive health services at one of the public hospitals in the city of Durban, KwaZulu-Natal.

2.13.5 Risk-benefit ratio

The findings from the proposed study should benefit and cause no harm to the participants and society. Participants were assured of being protected from any kind of harm or deception if they consented to participate in the study. Privacy, confidentiality, fidelity and veracity were maintained at all times. Protection of participants' identity was ensured during audio taping and transcription. All interviews were coded and their names were not used, thus responses will not be identifiable. The transcribed data were stored in password-protected folders to which only the researcher has access. However the details about the study may be disclosed if required by law.

2.13.6 Independent ethics review

The researcher obtained ethical approval from the Humanities and Social Sciences Research Ethics Committee of the University of KwaZulu-Natal. Also, permission to conduct the study was requested from the church leaders. Participants were given an information letter to clarify that participation in the study was voluntary and that there were no monetary benefits from the study and confidentiality was assured. Furthermore, the participants signed informed consent forms as confirmation that they agreed to participate in the study before commencing the interviews.

2.13.7 Informed consent

In order to obtain the consent of the participants, an information letter was given to them by the researcher before asking them to sign the informed consent form, as well as the consent for audio-recording of the interview.

2.13.8 Respect for recruited participants

Participants were informed in advance about their right to withdraw from the study at any time they wished to do so and that they would not be penalised or lose benefits should they refuse to participate or decide to stop at anytime. The researcher promised to give them any additional information they asked for in the course of the study. At the end of the study, each church leader will receive a copy of the final paper, and another copy will be kept by the University of KwaZulu-Natal. In addition, the research could be published in accredited professional journal once completed.

2.14 Referral mechanisms and psychosocial support

A major concern for any data collection process is that asking questions about their views, knowledge, attitudes or life experiences particularly to sensitive phenomena, may result in emotional response and this should be acknowledged by the researcher .(McCosker, Bernard& Gerber, 2001). The following measures were in place to deal with discomfort or distress due to discussing the negative experiences:

*Should the participants break during the interviews, the interview will be stopped immediately and the participants will be allowed time to cry or express their feelings/emotions. McCosker et al, (2001) cited that it is important for the researcher to comment on the strengths of the participants whilst at the same time allowing the participants to terminate the interview if too distressed.

*The researcher will show sympathy to the participants who require psycho-social support. McCosker et al, (2001) noted that if the researcher indicates the acceptance of the interviewee's emotional response, the interviewee may feel that it is safe to reveal further information which he/she may have felt was too stressful to talk about.

*Other strategies will be to refer the participants to the church prayer support where the Pastors pray at the same time counselling members who experienced stressful events. If required, the participants will be referred and assisted by the researcher to see a Psychologist in Addington hospital which is the nearest to the interview address

2.15 Summary of the chapter

This chapter discussed the methods and methodologies used in the study; the research design and research setting; sample and sampling technique; research population; data collection

procedure; data analysis; data management and data storage; as well as ethical issues. The following chapter will present a literature review.

CHAPTER 3

LITERATURE REVIEW

3.1 Introduction

The literature review chapter looked at the current situation and experiences of refugee women from the Great Lakes countries, namely, Burundi, DRC and Rwanda, in relation to their access to reproductive health services. In this study, the researcher made use of the following search engines: Jstor, Google Scholar and Ebscohost. Previous researches have been conducted in areas related to reproductive health services of refugees, and their health-seeking behaviours were documented. Durrheim & Terreblanche (1999) suggested that the literature review involves more than merely citing as many sources as possible, but highlights pertinent literature and contributes to the field by providing a novel and focused reading of current studies. A thorough and critical review of existing literature was conducted to access relevant reports, books, papers and briefs, which will be discussed in this review. In order to link this study with the research problems, aim and objectives, the literature review was structured on: global perspectives of reproductive health services, the access to reproductive health services, reproductive health needs of refugee women, and the challenges of access and utilisation of reproductive healthcare services by refugee women, as well as the current state of the use of reproductive health services by refugee women in South Africa.

3.2 Health systems in South Africa

In this study, it is difficult to study the experiences of refugee women in relation to reproductive health care services without first understanding the South African health system. This is not only because of the history of the host country, but based on the fact that the population studied seeks health services within the health system. Understanding the system's history, establishment and processes will inform the study, and specifically to understand if the reproductive health care services are being provided within the current health system.

South Africa has dual healthcare systems: the public and the private health systems. These two types are very similar to those found in developed countries (Van Rensburg, 2007). During the period from 1948 to 1994, known as the era of "apartheid", different and unequal treatment of the different race groups manifested itself in the form of unequal provision for and access to care, different availability and quality, and the disproportionate distribution of human resource services and facilities according to race (Van Rensburg, 2004:77). In the

Department of Health 2000–2004, Health Sector Strategic Framework, the above was reiterated, that, prior to 1994, the South African health system was built on apartheid ideology and characterised by racial geographical disparities, fragmentation and duplication, as well as hospi-centricism with lip service paid to the Primary Health Care (PHC) approach. The Browne Commission of Inquiry (1980) into Health Services was appointed to rationalise health services, to promote services that are more effective and to place the costs of the services on a sound basis. The 1986 report found the following shortcomings: fragmentation of control over health services; under-emphasis of preventive and PHC; over-regulation of the private sector; constraints in state psychiatric, geriatric, dental and rehabilitation services; under-development and poor co-ordination of health education; shortages of health personnel; and inadequacy of statistical information on health matters (Van Rensburg, 2004:90). These shortcomings amount to a failure to align with the WHO (2000) statement:

“Today and every day, the lives of a vast number of people lie in the hands of health systems. From the safe delivery of a healthy baby to the care with dignity of the frail elderly, health systems have a vital and continuing responsibility to people throughout the lifespan. They are crucial to the healthy development of individuals, families and societies everywhere” (WHO 2000:11).

With regard to the health system in South Africa, Shisana (2011) documented that the South Africa’s healthcare system has been evolving over the last four centuries (Shisana et al., 2003). Historically, prior to the arrival of Dutch colonialists en route to India via the Cape, the local population, i.e. the Khoisan and Africans, relied on indigenous healthcare. Even today, many continue to use this system. Jan van Riebeeck arrived in the Cape in 1652, carrying in his three ships sick, hungry and poor Dutch sailors. The Dutch East India Company, an organisation he served as an administrator, required him to establish a food station and medical care for the crew as well as other settlers. Van Riebeeck, a medical doctor turned merchant who brought white settlers to South Africa, converted his house into a hospital to care for the sick, using Dutch medically trained surgeon-merchants. This hospital was later used, not only by settlers, but also by local people. This was the beginning of western medicine in South Africa, which also made great efforts to subordinate indigenous medicine (OECD, 2011; Shisana et al., 2003; Shisana et al., 2009).

With trade between the East and Europe via the Cape growing, diseases came. One that played a pivotal role in formalising medical care in South Africa was the smallpox epidemic of 1713, which was brought by sailors who arrived from India with infected clothes to be

washed by local people, the Khoisan. The disease spread and killed a quarter of the European settlers and decimated the Khoisan workers. With increased demand for healthcare due to smallpox, health services were restricted to whites. Another smallpox outbreak that occurred in 1751 further decimated the local and European population. The 1755 smallpox epidemic brought by a ship from Ceylon (now Sri Lanka) was responsible for racial segregation in healthcare, only providing care according to one's skin colour (Shisana, 2011).

There were many events that contributed to the development of public health in all four provinces of South Africa namely: Cape, Orange Free State, Transvaal, and Natal. These included the outbreak of diseases such as leprosy, bubonic plague, tuberculosis and venereal diseases. But the biggest event that influenced the establishment of public health in South Africa was the Spanish influenza epidemic of 1911–1918, which led to the passing of the National Public Health Act in 1919. Coming after the establishment of the Union of South Africa in 1910, the Act was established by the Department of Health in South Africa and allocated functions for health at national, provincial and local government levels, leaving the latter to provide personal care services paid for by individuals, instead of state resources. Various committees advocating for state responsibility for healthcare were established between 1920 and 1935, arguing that the National Public Health Act did not extend to the provision of healthcare for all. In 1941, there was an effort to establish a national health insurance (NHI) plan for South Africa, which aimed to cover all people of all races, except those in rural areas. There was resistance from various quarters, including the medical fraternity (Shisana, 2011; Shisana et al., 2009).

Eventually, the National Department of Health, inspired by community-based care approaches, decided to establish a community-based care system that treated patients holistically, including a good understanding of their culture, and provision of health promotion services and curative services. As a result of the pressure, the state appointed the Gluckman Commission to investigate the establishment of a new public health system. Its chairman, Henry Gluckman, was probably also influenced by the British reformists, who had major challenges regarding their own health system. The recommendation of his commission, which would have seen a much more state-centralised healthcare system with integration of curative and preventive services, was excluded from the revised 1946 National Health Act. The apartheid government, which came into office in 1948, simply entrenched the racial segregation that had started in the 18th century and began segmenting the population by ethnic group and rural/urban divide, allocating resources according to different racial groups,

a move that was to contribute to disparities in health outcomes by race. Africans, largely based in rural areas in what were later called Bantustans, suffered from diseases of poverty, such as diarrhoea, tuberculosis and respiratory disorders, while the whites suffered from diseases of affluence, common in industrialised countries (Shisana et al., 2003; Shisana, 2011).

With the release of Nelson Mandela and other political prisoners, the new democratic state was formed, culminating in the historic 1994 elections that brought the African National Congress to power. The post-apartheid government started introducing major changes in the healthcare system in 1994, amalgamating the 14 health departments created by apartheid – ten for blacks who lived in Bantustans and four for population groups who lived in urban areas, namely, Whites, Coloureds, Indians and Africans. The balkanisation of South Africa into these racial and ethnic groups had enabled the apartheid government to establish a state-determined policy of allocation of resources (including health resources) to ensure that inequality was maintained (Shisana, 2011). This background provides an understanding of the current challenges facing the South African healthcare system as inherited from the pre-apartheid and apartheid regimes.

Post 1994, South Africa was one of the few countries in the world where wholesale transformation of the health system began with a clear political commitment to ensuring equity in resource allocation, restructuring the health system according to the district health system (DHS), and delivering health care according to the principles of the primary health care (PHC) approach. Yet today, regardless of all efforts by the post-1994 government, South Africa's healthcare system is still rightly called "a sickcare system" and a terminally ill one (Sboros, 2013). According to the WHO rankings of healthcare in 191 countries, South Africa is trailing at 175 (WHO, 2013). The country's Health Department has made many attempts to reform the health system but without success. According to Shisana (2011) and Van Rensburg (2004), the reform of South Africa's healthcare system is challenged by historically state-generated inequalities, inadequate financing of the public healthcare system, the existence of a two-tier healthcare system, human resource gaps, the poor quality of healthcare, and a high burden of diseases.

In addition to the above, there is yet another challenge facing the healthcare system with regard to the migrants or refugees accessing and utilising healthcare services. With the already struggling health system, it is hard for the health system to cater for the non-citizen when it is difficult to accommodate its own population, who are the legitimate beneficiaries

of the services. The challenges are even greater when female refugees are the population of concern, simply because they present with specific needs that require focused attention. This study looked at refugee women in relation to their experiences regarding reproductive healthcare services in public hospitals.

3.3 Treatment seeking, help seeking and service utilisation

The terms “treatment seeking”, “help seeking” and “service utilisation” are often used interchangeably. Much of the reliable data regarding help seeking comes from the field of health services research. These researchers often measure the use of services as an event that did or did not take place, and then describe the frequency with which it occurred (Andersen, 1995). Potential access is defined as the presence of enabling resources. Realised access is defined as the actual use of health resources (Penchansky, 1976).

Limited research has been conducted to explore the reproductive health services experiences of refugee women in sub-Saharan Africa, and specifically in South Africa. Most of these studies investigated knowledge, attitudes and practice of HIV prevention (Tanaka, Kunii, Hatano, & Wakati, 2008), others focused on refugees’ perceptions regarding HIV&AIDS and their child-bearing issues (Nkwinika et al., 2014), while a few others only explored refugees’ family planning and HIV education needs (Tompkins, Smith, Jones & Swindells, 2006). These studies suggested that refugees should be educated on HIV and that the latter should benefit from sexual and reproductive health services available. These studies were not conducted in South Africa and did not investigate the refugees’ experiences regarding the full package of reproductive healthcare. Moreover, the studies were not women-specific but included both female and male refugees. This study was conducted in order to explore the experiences of refugee women living in Durban in relation to reproductive health services in the public sector in Durban, South Africa.

3.4 Barriers to accessing healthcare services in South Africa

This section discusses some issues that are viewed as barriers to accessing healthcare services in South Africa. In most cases the commonly known barriers have failed to be addressed and instead the list keeps adding up. In this section, the review revealed that amongst the many elements hindering refugees from accessing healthcare services are language, documentation, and ignoring the human rights of every individual to quality healthcare regardless of their status are the most dominant barriers.

Refugees are not the only population group facing barriers in access to healthcare services in South Africa, and South Africa is not the only country where both refugees and nationals are facing inequity in access. Harris, Goudge, Ataguba, McIntyre, Nxumalo, Jikwana & Chersich (2011) documented that more than a billion people, mainly in low- and middle-income countries, are unable to afford needed health services. The WHO reports that in South Africa, healthcare access for all is constitutionally enshrined (WHO, 2010); yet, considerable inequities remain, largely due to distortions in resource allocation. Coovadia et al., (2009) point out that access barriers also include vast distances and high travel costs, especially in rural areas, high out-of-pocket payments for care, long queues and disempowered patients (Goudge et al., 2009; Nteta et al., 2010; Schneider et al., 2010). These barriers, created by uneven social power relationships, resonate with access obstacles experienced in low- and middle-income countries elsewhere (WHO, 2010).

Other studies have discussed different factors that influence access to healthcare in South Africa. Coovadia et al. (2010) said that South Africa's apartheid past still shapes health services, resulting in resource inequities. Racial, socio-economic and rural-urban differentials in health outcomes and between the public and private health sectors remain challenging (Gilson & McIntyre, 2007; McIntyre, Muirhead, Gilson, Govender, Mbatsha, Goudge, & Wadee, 2007; WHO, 2010). For example, in 2005, spending per private medical scheme member was nine-fold higher than public sector expenditure, and one specialist doctor served fewer than 500 people in the private sector but around 11 000 in the public sector (McIntyre et al., 2009). Large information gaps remain about health access in the general population in South Africa, especially around utilisation rates and out-of-pocket payments for health care (Ataguba & McIntyre, 2009).

There is a literature thread that can best be described as falling within the "conservative approach". In this approach the main advocates argue on the basis of traditional understanding of "citizenship". They posit that refugees are denied healthcare services in order to save resources for nationals (Rosenkranz, 2013; Schwartz, Stewart, Bolla, Simon, Bandeen- Roche, Gordon, Links, & Todd, 2001). This strand is somehow opposed to the aspect of human rights which ought to be accorded to refugees. Looking at the legal aspects of refugees in South Africa, denying refugees healthcare services, is the violation of refugee rights. The section 27 of the refugee Act indicates that refugees have the same right to basic health and primary education as the citizens of South Africa. (Dalton-Greyling, 2008).

Landau (2010) notes that, “South African citizens and politicians regularly rely on nativist discourses that make one’s rights to the city contingent on one’s national origins”. Scientifically, this approach has been criticised for taking too narrow an approach, as health problems such as infectious diseases suffered by refugees may very easily increase the incidence of diseases in the host population (Bruns & Spiegel, 2003). Conceivably, many, but not all, health practitioners associate forced migration with healthcare seeking, and some officials still regard the refugees as asylum shoppers. This statement again does not present women’s experiences opposed to those of men. However, some studies have attempted to include issues and experiences of refugee women regarding healthcare services, and only a few have focused on reproductive healthcare services.

3.5 Reproductive health services

Much of the available literature exploring access to health care investigates experiences of healthcare services in camp-based settlements. The dynamics of using healthcare services in refugee camps differ significantly from the experiences of self-settled communities like that of refugees in South Africa. Camp-based health services tend to be highly structured and designed specifically for relief or emergency situations. Thus, much of the available literature is concerned with health problems that arise out of emergency situations. Of the limited research available that looks at reproductive health care and the health needs of female forced refugees, only a few document the situation of refugee women living in the Southern African region. For the purpose of this study, the researcher looked at the statistics of refugees in South Africa. Dalton-Greyling, (2008) indicated that the number of refugees in South Africa increased notably over the years from 6619 in 1997 to almost 30000 in 2006 and estimates the number of forced migrants in the country vary from two to eight million.

The focus of this study was motivated by the recognition that being a female refugee carries with it a particular set of problems and difficulties. Reproductive Health Care provides the lens through which these issues can be studied more closely (McGinn, 2000). Moreover, the field of reproductive health care has become increasingly important in the context of sexual violence being used as an instrument of war. The atrocities perpetrated in Rwanda and the DRC have drawn attention to the risks faced by women during war, and the literature on the consequences of sexual violence on reproductive health not being available (Zihindula, 2011). However, research on the need for reproductive health care and access to reproductive health care has often included Congolese women in the sample population. According to

Heise (1994), this material has proved very useful in beginning to identify key themes and to gain a better understanding of the gender dynamics which exist in the Congolese community. The literature on reproductive health care access has not given sufficient attention to the ability of refugee women to access basic health services in the urban environment and the constraints which impede access (Masterson et al., 2014; Newbold et al., 2013). For example, the nature of self-settled refugee communities is that they become responsible for ensuring their own safety and securing their own rights, outside of the delivery of core programmes in a camp setting. Self-settled refugees have to become responsible for ensuring their own access to health care, and the extent to which they are able to meet such needs is greatly influenced by their ability to integrate with their host community. Barriers created by the structure of the health system, as well as language and culture, prevent integration of refugees with host communities. This increases potential for isolation and exclusion. Such issues of isolation and exclusion may be greater barriers to access than a situation where only very core emergency and basic health services are being delivered in camp settings (Heise, 1994; Meselle, 2000; Shreck, 2000). It can be argued therefore that both camp-based and city-based refugees face various types of barriers in accessing formal healthcare services, specifically reproductive health services for refugee women.

3.6 Refugee access to reproductive health services

Access to reproductive health services is crucial for refugee women specifically. However, it has been well documented that refugees face many challenges in their attempts to access healthcare services in general (Apalata et al., 2007; Crush & Tawodzera, 2014; Vearey, 2014; Zihindula et al., 2015a) and particularly reproductive health services (Zotti, 1997). According to the last author, urban refugees who are self-settled in developing countries are faced with challenges in accessing healthcare services which result from their vulnerability to health issues caused by financial disempowerment and poor living conditions. While research has shown that South African women have fair access to reproductive health services like family planning services (Swartz, 2009), no study has shown refugees accessing the same services fairly. On the contrary, it has been documented that refugees, particularly those from non-English speaking countries face a language barrier when using healthcare services (Zihindula et al., 2015a).

In addition to the language barrier, Facione, Dodd, Holzemer, & Meleis, (1997) cited poverty or lack of money as the main barrier to refugees' accessing and utilising reproductive

healthcare services. In support of the above, Peberdy & Majodina (2000) argued that access by some refugees and asylum seekers to reproductive healthcare services is already affected by low and unsatisfactory income, as well as unemployment. Landau & Segetti (2009) conducted a study amongst refugees in South Africa and their findings suggested that refugees and asylum seekers are vulnerable groups and may lack economic, social and political influence that could enable them to improve their status and access to specific healthcare services in the host country. Other studies indicated that lack of identity documents is another problem that hinders refugees, including women refugees, from accessing reproductive healthcare services. A study conducted by Munyewende, Rispel, Harris & Cherish (2011) revealed that most refugees are unable to access health care services simply because they are afraid to present themselves to the hospital without documentation, which could lead not only to failure to access the services, but to expulsion from the host country.

Authors like Apalata et al. (2007) and Muzumbukilwa (2007), studied social aspects of refugees, while Landau (2010, 2014) and Vearey (2012, 2014) focus on all strata of migrants and health issues, and Crush et al. (2014), HSRC (2010), HRW (2015), Mujawamaria (2013) and Randolph (2012) studied xenophobia and refugees or migrants, and how the latter affects their health, while studies by Mabidi (2013) and Zihindula et al.(2015b) explored access to healthcare services for the entire population, and for the refugees in the Southern African region respectively, while (Nkwinika, Khoza, Lebesse & Shilubane, 2014),investigated refugees' perceptions regarding HIV&AIDS in South Africa.

A decentralised, integrated healthcare system has been found to improve uptake of treatment, adherence and retention in care, and increase utilisation of healthcare services (Coetzee, Hilderbrand, Goemaere, Mtshys, & Boelaert, 2004;Legido-Quigley, Montgomery, Khan, Fakoya, Getahun, & Grantet, 2010;Wallrauch, Heller, Lessells, Kekana, Barnighausen, & Newell, 2010).Some patients may have to overcome more hurdles than others in order to utilise and sustain care. Patients express demands and expectations, such as acceptability, affordability and availability of services, which have to be met by the health system for continued uptake of treatment and retention in care. The health system should be able to satisfy the patients' demands, although it may or may not be able to immediately alter the availability or physical hurdles that patients and (refugees in this specific context) face. Supply factors should be able to address most or all of the patients' demands for patient satisfaction to be realised and this feeds back into continued expressed demand. The

challenges faced at each level/dimension of care may vary for different types of forced migrants with different health care needs. Although most forced migrants are already utilising care, understanding the barriers they face in the process of utilising care and the hurdles in utilisation is important in shedding light on the challenges faced by those in need but not accessing or utilising care, as well as pointing out the areas that policy-makers need to improve on to increase accessibility to reproductive healthcare services by refugee women (Aday, Andersen, Loevy, & Kremer, 1985; Anderson, 1995; Coetzee et al., 2004; Donebedian, 1973).

After being hosted in the country of destination, the refugees in most cases remain untreated for various reasons (Masterson et al., 2014; Newbold et al., 2013). This leads to an increased number of deaths amongst the refugee community. The literature shows that catastrophic mortality rates have been documented during large refugee emergencies. As the UNHCR (1995) report suggests: “The major causes of morbidity and mortality among refugees are measles, diarrhoea diseases, acute respiratory infections, malaria and malnutrition. These diseases consistently account for between 60 and 80 per cent of all reported causes of death among the refugee community.” While the above diseases that are killing refugees can be treated and cured, it is important to understand the reasons for failure to do so (Krause et al., 2015; Lema, 2012; Moyo, 2010; UNHCR, 2015).

3.7 Refugee women’s healthcare vulnerability

Existing literature documents that the majority of refugee women face several problems. Their problems include, but are not limited to, non-acceptance in healthcare facilities and even death due to lack of effective post-partum follow up (Apalata et al., 2007; Vearey, 2014). Counselling and antenatal education are done in isiZulu and the HIV test is performed without informed consent (Zihindula et al., 2015a). In addition, Apalata et al. (2007) note that laboratory results are given to some refugee women without clear explanations, while pregnant women are forced to have a caesarean section without their consent. This is considered to be culturally inadmissible, as their understanding from knowledge gained in their home country is that caesarean sections are only used in cases of extreme emergencies. There are limited options for a refugee woman seeking reproductive healthcare services. It is the healthcare worker’s decision to select even the family planning method to be adopted by the refugee couple and this without their consent as existing literature shows above. This increases their vulnerability because firstly, in their society they are culturally bound to make

any decision. Coming to the health care centre where one is the legitimate person to decide upon her health, but the nurse imposes the choice. When refugee women individually go through such experiences, this adds to the vulnerability already imposed on them by the health system, and results in compromised health (Crush et al, 2014; Zihindula et al., 2015; Zihindula et al., 2016). The vulnerability of women in health care varies from one case with which they present to the health care worker to another. This calls for an examination of how they experience their utilisation and access to reproductive healthcare services.

While the above is a true reflection of the situation on the ground in South Africa, only limited research has been conducted to explore the experiences of refugee women in accessing reproductive health services in South Africa at large. During the literature search for this study, I did not come across any study that has been conducted in the Southern African region documenting the above-mentioned situation of the refugee women. This research was conducted in order to find out the current experiences of refugee women, and document their stories relating to the situation they face in accessing reproductive healthcare services in the public health facilities in Durban, KwaZulu-Natal.

3.8 Reproductive health services for refugee women

It is well documented that globally refugees experience many challenges related to health, especially women. A large body of literature exists including case studies, review articles and books, that document in detail the refugees' experiences with health issues. Both refugees living in camps and those in transit have specific experiences as will be shown in this literature chapter. Existing literature points to different elements which are grouped into five types: the availability and use of health services, sex and gender-based violence, sexually transmitted infections, pregnancy and child birth, and fertility regulation (Gagnon, Merry & Robinson, 2002). Thus refugee women should be accessing reproductive health services in order to avoid most of the reproductive health related issues.

However, literature suggests that there are different views on the implications of migration on fertility and family planning (McGinn, 2010). On the one hand, forced migration is viewed as increasing fertility on the basis that refugees want to replace their deceased children as soon as they are in a healthier environment in their host countries, where there is good nutrition and improved healthcare services (Gagnon et al., 2002). On the other hand, migration is said to decrease the fertility rate of refugees due to perceived economic instability, future uncertainties and unstable marriages (McGinn, 2010). In all these circumstances, however,

refugee women are the most vulnerable and recorded to be at higher risk than other women when it comes to HIV and STIs (Gagnon et al., 2002; McGinn, 2010). It is therefore crucial for refugee women specifically to have adequate access to reproductive health services in their host country, in this case South Africa.

3.9 Cultural issues vs reproductive health services

It is widely recognized that sexual and reproductive health services are underutilized by culturally and linguistically diverse migrant communities leading to risk of poor health outcomes. Culture prohibits sex before marriage among Assyrian and Karen women refugees living in Australia. It was also discovered that cultural norms affect unmarried women's access to sexual health services, such as contraception and abortion. The authors concluded that healthcare workers need to be aware of cultural constructions of sex and sexuality, as well as the construction of gendered roles within relationships when offering sexual health services to refugees. Culture and religion was found to be an important factor influencing women's sexual self-understandings. (Ussher, Rhyder- Obid, Perz, Rae, Wong & Newman, 2012).

3.10 Summary of the chapter

In conclusion, the literature review chapter looked at studies related to the experiences of women refugees. Both local and international literature was reviewed, taking into account the study in question. Most of these studies did not address the experiences of refugee women regarding reproductive health services as a whole, and where similar studies were done, they included both males and females (women and their partners). The following chapter will look at the analysis of the findings.

CHAPTER 4

ANALYSIS OF FINDINGS

4.1 Introduction

The previous chapter presented the literature review. This chapter presents the analysis of data, the study's findings and highlights the major themes and sub-themes that emerged from the interviews with refugee women regarding reproductive health services in the public sector in the city of Durban. Audio-recorded interviews were transcribed, and the researcher then had to read and re-read the transcripts and compares them to the notes taken during the interviews. Relevant literature was also presented as a control to the research findings. Each category/theme is discussed with relevant quotations from the participants, and the relevant literature is cited as a control to the research findings. The analysis section is introduced with the demographic characteristics of the participants, and a short conclusion is drawn at the end of the chapter.

4.2 Sample realisation

The study intended to sample ten participants from the three Great Lakes countries, namely, Rwanda, Burundi and DRC. However, as the sample size was guided by data saturation, a total of eight refugee women were interviewed using a semi-structured interview guide. The participants' ages ranged between 24 and 48 years old.

Two of the participants were from Burundi, four were from Rwanda and two were DRC nationals. Of these, six were married and two were single. A total of five refugee women who participated in the study had a diploma from their home countries, one of the participants studied up to the second year of secondary school, and two had matric; one of the latter was still studying in the university. All the participants reported having encountered both positive and negative experiences with regard to reproductive health services in Durban. Table 4.1 below presents the demographic data for all the participants who were included in the study.

Table 4.1: Demographic characteristics of participants

Pseudonym	Age	Level of education	Country of origin	No. of children	Marital status	Type of document	Occupation
Maria	43	Diploma	Rwanda	3	Married	Refugee status	Unemployed
Amanda	48	Diploma in teaching	Rwanda	4	Married	Refugee status	Social worker
Patricia	25	Matric	Burundi	2	Single	Refugee status	Unemployed
Nadine	40	2 years secondary school	Burundi	2	Married	Refugee status	Small business
Mercy	36	Diploma	Rwanda	3	Married	Refugee status	School librarian assistant
Daniela	26	Diploma	DRC	1	Married	Refugee status	Housewife
Martha	24	Matric	Rwanda	None	Single	Refugee status	Student
Princess	47	Diploma	DRC	3	Married	Refugee status	Housewife

4.3 Overview of themes and sub-themes

The interpretation of the data consisted of a separation of the discussion from the findings. This resulted in two sections: 1) the negative experiences or challenges/concerns of refugee women regarding reproductive health services at public health facilities in Durban and the various themes that emerged in relation to this, and 2) the positive experiences of refugee women focusing on the themes that emerged from data analysis. The most dominant negative experiences fell under the following themes: medical xenophobia; language barrier; discrimination; unprofessionalism; failure to obtain consent and lack of confidentiality; ill-treatment; financial challenges; internalised fear; religious and cultural hegemony; and the shortage of health personnel and overcrowding of public hospitals. The positive experiences were grouped under the following themes: positive treatment and care and social support.

4.4 Major themes and sub-themes that emerged from the interviews

The study findings were presented based on two major themes and several sub-themes that emerged from the interviews. Table 4.2 below presents these.

Table 4.2: Themes and sub-themes

Themes	Sub-themes
1. Negative experiences/ challenges	1.1 Medical xenophobia 1.2 Language barrier 1.3 Discrimination 1.4 Unprofessionalism 1.4.1 Lack of health education and customer care training 1.4.2 Failure to obtain consent and lack of confidentiality 1.4.3 Ill-treatment 1.5 Financial challenges 1.6 Internalised fear 1.7 Shortage of health personnel and overcrowding of public hospitals 1.8 Religious and cultural hegemony
2. Positive experiences	2.1 Positive treatment and care 2.2 Social support

4.4.1 Negative experiences/challenges

4.4.1.1 Medical xenophobia and discrimination

Medical xenophobia refers to the negative attitudes towards migrants and refugees based purely on their identity as a non-South African. (Crush et al, 2014). The same author pointed out that medical xenophobia is deeply entrenched in the South African public health system. Discrimination as described by HRW, (2009), is the most serious barrier to healthcare access for refugees who reported being turned away from the public healthcare facilities simply because they were foreigners.

The first theme that emerged on negative experiences encountered by the participants was that of medical xenophobia. Six (6) out of the eight (8) participants encountered xenophobia firsthand in public hospitals and clinics. In support of this, **Nadine** said:

“She stood up from her chair shouting and pointing fingers at me saying ‘you foreigners you are using our hospitals but you don’t pay tax and you like to have babies’. I didn’t know what to say so I walked out of the room and she followed me saying that I don’t want to listen when she is telling me what to do. I was afraid so I left that clinic and never went back”[said in an angry tone].

Daniela added:

*“When you just start saying hello they can’t even pay attention to you because you are speaking English. But if you are speaking in Zulu they will talk to you nicely. The day I went to give birth it was the worst day of my life, there was no one to take care of me. I was calling the nurse telling them that I feel like pushing and I was feeling the baby’s head coming out but no one came. I put my fingers inside and felt the head, when I called the nurse who was around she said ‘**You kwerekwere** you always like to scream just keep quiet you are still far.’ I begged her to come and check but she shouted ‘**You kwerekwere**’ then she walked away.”*

The locals use derogatory stereotypes against African foreigners such as “makwerekwere” as highlighted by Daniela above. This indicates that language might be symptomatic of xenophobia in some instances. **Mercy** also stated:

*“Recently I escorted my friend who was two months pregnant to Addington hospital antenatal clinic (ANC) because she was in severe pain. When we arrived there as she was trying to explain her problem they shouted saying ‘**you people**’ you only come when you are sick saying that we should go to the other clinic where they treat sick people. But they really chased us away; when they say ‘you people’ they mean ‘you foreigners’.”*

The above quotation from Mercy, in which foreigners are addressed as “you”, signifies what is termed “othering” of people based on nationality, in which a dominant group sees foreigners as “others” who do not belong in their country. The nurses unknowingly practice the process of “othering”. Othering involves constructing an individual or group as the “other”, that is someone who is excluded and seen as inhuman. The fact that the majority of the participants mentioned xenophobia as a challenge is testimony to the fact that there is hidden and overt xenophobia that permeates South African society and that certainly impacts on women who at the end of the day face the double jeopardy of xenophobia and gender inequality.

Almost all the participants encountered some form of discrimination at the public hospital due to being foreigners. **Maria** described one such experience:

“The first time when I went to the hospital I took my child for immunisation, the nurses they looked at us like we are not people like them. They started swearing at us saying we come here to get babies, that we don’t pay anything and we use their tax money, then they continue saying we must stop having babies.”

Not only that, **Patricia** said: *“You can’t be treated the same as the locals if you want to access these services.”* The discrimination is so rampant that it gives rise to a sense of not

belonging and a feeling that being a foreigner means that one is inhuman, as depicted by **Mercy** who said: *“Every time I think of the treatment I get in public hospitals it reminds me that I have no rights because I am a foreigner.”* In addition, the discrimination is visible in the eyes of those discriminated against as they are treated differently from the locals. This point is depicted by **Daniela**: *“Nurses waste too much time talking but when Zulu people start complaining they attend to them quickly.”*

Daniela went on to say: *“The nurses don’t treat us like human being; the challenge is to go to the hospital when you are a foreigner because the treatment we get is very bad. To me being a refugee is a big problem when it comes to accessing health services.”*

Foreigner nationals including women refugees are discriminated against based mostly on nationality.

4.4.1.2 Language barrier

Language barrier is the inability to effectively communicate with others, which may lead to medical errors by impending patient- provider communication. (Crush et al, 2014).

Six (6) out of eight (8) participants faced the challenge of the language barrier in public hospitals because they could not speak the local isiZulu language and this had a negative effect on the nature of services they received at these hospitals. **Patricia** stated:

“It was quite difficult, I couldn’t communicate. I used to take someone along with me to help me translate. It was still difficult because the translator was also a refugee and her English wasn’t good but she was better than me.”

Mercy also faced the same problem: *“so the big challenge was that I couldn’t speak isiZulu, others were shouting in their own language”*. Another participant, **Martha**, also commented:

“I mean you can see that a person is a foreigner, a refugee; you do not need to speak in Zulu [isiZulu], that one of the things I noticed but some nurses talk to the patient in Zulu even if she just said she doesn’t understand. It is fine if I face this in Checkers or in public transport but not at the hospital. So this thing of foreigner hatred should be somewhere else not in the hospital.”

There is a strong relationship between language and power, with those wielding power in society using it as a tool to oppress the powerless. In this instance, nurses hold the power as they are in a position of authority, and they abuse their power through language to oppress powerless refugee women whose powerlessness emanates from their foreignness. There is a stereotype amongst black South Africans, in this case Zulu people, that every black person is an isiZulu speaker, and this gives rise to cultural imperialism in which a dominant group

wants to impose its norms onto another group of people, in this instance foreigners. **Princess** expresses this point:

“The first challenge is a language barrier because people who work in the hospital in public clinic they think everybody is talking their language, if they are black they expect you to come with a Zulu or their language and we as refugees who are struggling in English and we don’t know Zulu and then sometimes they tell you, ‘Why you are not talking Zulu why you don’t talk my language and you look like me? We’re all Africans but you can’t talk my language.’ Yeah so it’s a problem when you don’t talk that language you lose friendship in the beginning because you don’t talk the same language.”

Language can be used by the superior group to oppress the inferior one using stereotypes that largely demean and degrade them. In the South African context, the locals use language as a tool to perpetuate oppression towards foreigners. This is summed up by **Daniela’s** quotation, which brings out the dynamic of language as being used by the dominant group to suppress and oppress the inferior group of women refugees:

“We were so many in the clinic and the nurse spoke to me in Zulu; when I tried to tell her that I did not understand asking her to explain in English and she shouted saying, ‘You people go back to your country we are tired of you’. She continued, saying that she has to talk in Zulu because English is not their language.”

4.4.1.3 Unprofessionalism

Unprofessionalism is defined by Campbell & Taylor, (2008), as not conforming with to the standards of a profession or unprofessional behaviour.

All the participants encountered unprofessionalism from the nurses in the public hospitals and clinics. This unprofessionalism is seen at various levels, and various sub-themes emerge from it. These themes are: 1) Lack of health education and customer care training, 2) Failure to obtain consent and lack of confidentiality, and 3) Ill-treatment.

1. Lack of health education and customer care training

The nurses’ duties include explaining health issues to the patients so that they have a clear understanding about the reasons why they are supposed to take certain medication, oral (in this case tablets) and injections. Almost all the participants bemoaned the lack of health education. **Maria** indicated: *“So they want to force us to take injections or tablets without even explaining to us which one is better.”*

In support of this theme **Amanda** said:

“Okay, in public hospitals I went there for family planning; what I did not really appreciate is that they did not give me options to choose from. I went having a bit of knowledge about it but the first thing the lady [a nurse] wanted to do to me was to inject me and I quickly rejected that [bewildered look]. I wanted tablets and the nurse was not happy then she just gave me the tablets without explaining anything so I had to rely on other people outside.”

This indicates lack of professionalism on the part of the nurses, as they do not take the time to explain to patients the advantages and disadvantages of taking certain medication and their side effects. Another participant, **Patricia**, was not told by the nurses not to eat anything shortly following the operation (caesarean section):

“I ate because no one communicated with me about not eating and I heard from other patients that I was not supposed to eat.”

2. Failure to obtain consent and lack of confidentiality

In health care, obtaining consent refers to the process whereby the patient and the healthcare provider engage in a dialogue about the nature of a proposed medical treatment, benefits and risks involved, consequences and harm. This allows the patient to understand what to expect during and after the procedure. It is unethical to make patients sign consent for procedures of which they have no knowledge. All intended or proposed procedures have to be clear to the patients before they sign the consent. The next excerpts from the participants show that the participants were forced to partake of procedures that they did not wholly agree on, which is a gross violation of the rights of patients and lack of professionalism by the healthcare providers concerned. **Patricia** described how she was tricked into signing a consent form even though she did not know the reason why she was signing it in the first place:

“The c/section wasn’t a good experience in government hospital, it was something forced onto me and I was tricked to signing consent but they did not explain that I was going to have an operation.”

This in turn, was highlighted by **Maria**:

“They want to force us to take injections”. Daniela reported: “She forced me to take injection without even advising me about it.” And Princess: “They force you yeah ... they force you to take injection.”

Confidentiality of participants was difficult to observe as at times, because of the language barrier, women refugees needed to have a translator, and some things the translator should not know about, but it came out all the same.

Patricia said: *“There are things a translator is not supposed to know; with a language barrier your problems are not confidential anymore.”*

3. Ill-treatment

Ill-treatment refers to denying someone services, treating him/she badly or poor and abusive treatment. (Crush et al, 2014).

All the participants mentioned that they have been ill- treated at some point in public hospitals, mostly by the nurses. This was indicated by **Maria** who stated: *“The nurses they look at us like we are not people like them they start swearing at us. They are so rude.”*

Amanda pointed out:

“[Irritated] Because I was not only blind in the field but she (the nurse) made me to feel resistant to whatever services she was going to offer me because she did not act friendly, I could not build any relationship with her.”

As for **Nadine**, she had this to say: *“When I had a miscarriage for me it was shocking the way a nurse sent me home, the nurses didn’t even clean me and they discharged me without any medications while I was still weak.”* **Princess** was also ill-treated by a nurse who told her to clean her vomit even though she was in labour:

“She put me in a wheelchair then when I was sitting in a wheelchair I vomited, when I vomited on the floor oh my goodness she asked me ‘Who is gona clean there?’ then I told her please help me when I finish to deliver I will come to clean because I was really in pain. Anyway she pushed me and take me in labour ward then she went.”

Mercy suffered the worst treatment according to her, as she felt like dying after being neglected by the nurses. She explained:

“I was bleeding heavily and so painful but when I called for help they said I was exaggerating I must keep quiet but I couldn’t, ‘How can you keep quiet when you feel like dying!’ They found things inside I don’t know what you call them placenta or what whatever, she (nurse) pushed my tummy until everything came out then pain went down slowly and bleeding stopped.”

Martha who was a victim of rape and required care and protection because her case was highly sensitive and quite traumatic, surprisingly she was ill-treated by nurses who willingly caused secondary trauma to the victim showing lack of professionalism of the highest order.

Martha had this to say:

“Um... eh I don’t know, I don’t think if I had a such sensitive issue in that area [rape], I don’t think I will go to a public hospital because I felt like the nurses are rude [moment of silence],

and when you are in that state you don't wanna be treated with someone who don't care, so I felt like there is no love for the job they are doing. So that will be my first challenge to face such people when I am vulnerable."

Daniela sums up the ill-treatment that they suffered at the hands of the nurses by stating that *"the majority of nurses are very bad"*. This ill-treatment has a negative effect on access to quality and effective reproductive health service by refugee women. Reproductive health services are very important to women refugees and thus public hospitals needs to provide a safe environment and be more accommodating and helpful towards these women refugees in order for them to acquire the knowledge about reproductive health services and safe family planning methods available for them.

4.4.1.5 Financial challenges

Because the participants are refugees who might have been pushed by political instability, civil wars and other contributing factors to migrate to South Africa to start their lives over, it will be difficult for them to settle and adapt to a new environment that is unwelcoming and predominantly hostile to foreigners. This makes it inevitable for refugees to face financial problems, a point validated by almost all participants in this study. Financial challenges make it virtually impossible for them to be able to cater for a bigger family, which forces them to use family planning methods to reduce the number of children. This is highlighted by **Amanda** who said that:

"In South Africa, we are foreigners, people are becoming aware of economic challenges and they are accepting family planning as a must because economic challenges are beating them and they are in a situation where they can't afford to raise many children."

The same sentiment was shared by **Patricia**, who stated:

"Family planning is something I will consider for my own sake as a refugee because back home even if you had many kids it was much easier because you have people/families to help, but being in another country as a refugee kids are a problem when you can't even get a proper job."

Some of the participants also bemoaned the challenge of finances, which forced them to go to public hospitals just because the services were free but the treatment was worse and they reiterated that if they had money they would have preferred to go to private hospitals. To support this is **Daniela**, who said: *"If I had money I will go to private because they take good care of you."* **Princess** also agreed with **Daniela** views by expressing that: *"If I had money I will go to private hospitals because they give you what you want."*

4.4.1.6 Internalised fear

There is an element of fear resonating from all the participants in this study, emanating from the fact that they are foreigners in South Africa, and as such the negative treatment they continually receive, not only in public hospitals but in other public spheres, gives rise to this type of anxiety on their part. This is indicated by **Maria** who stated:

“So they use their language because they think you don’t understand what they are saying but when you read their body language you can figure out what they are talking about then it makes you scared to go there. Even when we tell our friends they are also scared to go the hospital when they are pregnant, they like to go when they are about six or seven months.”

Maria also said:

“Because of these experiences I can never have more children in this country.”

This indicated that foreign women are rather sceptical of going to public hospitals when they are pregnant, but in most instances, they are left with no choice but to go there because private hospitals are very expensive. Another participant **Nadine** said bluntly: *“and to be very honest I am very afraid to go to the public hospitals. If I had a choice I will never go back to public hospitals. From my experience I don’t wish to go back there.”*

Amanda indicated, *“I did not have a good or positive feeling of going back to public hospitals again.”*

4.4.1.7 Shortage of health personnel and overcrowding of public hospitals

Another challenge raised by some of the participants was the shortage of staff and overcrowding of public hospitals, which gives rise to inefficiency of services rendered to patients. This was raised by **Mercy**, who stated:

“The big challenge was when I was giving birth, a nurse who was attending to me was attending two patients at the same time; when my baby was about to come, she (nurse) was still helping the other lady, so I don’t know if it was a shortage of nurses.”

This is a reality in public hospitals, in which they are sometimes understaffed, and patients’ lives can be in danger without anyone available to attend to them. Mercy could have lost the baby because of this challenge.

Martha reported: *“We had to wait for quite some time for a doctor. We went there like 3am and we had to wait until 9.30am, the doctor came at 9.30.”* This shows that there is a shortage of doctors in public hospitals, which can have detrimental effects and repercussions on the patients’ health, and in this case Martha and her friends, who were victims of rape, needed

emergency medical attention as soon as possible to prevent HIV and pregnancy, but she had to wait for so many hours to see a doctor. **Martha** drove the above point home by stating:

“I was very worried because such incidents [rape] usually happen in the night, so to go to the hospital in the middle of the night and sit until the next morning waiting for a doctor it is not right, the waiting put more pressure on the victim.”

Mercy also was a victim of a shortage of staff and she had this to say:

“As soon as my baby came out the nurse had to rush back to the other lady and I bled until I was gone. It was like my blood was finished, I couldn’t see, I was like blind.”

This patient was mismanaged due to shortage of staff and this could have resulted in her losing her life.

Another problem experienced by the participants was of the overcrowding of the public hospitals and clinics mainly because everyone who is poor accesses them, as private hospitals are expensive. **Princess** explained: *“Its long queues in that clinic it was so many people there and you have to wake up 4o’clock it’s like the whole day you are there.”* **Mercy**, in agreement with the above, stated:

“Oh I forgot to tell you the experience I had when I attended Lancers Clinic. That was very bad; there is a lot of people and you have to go very early to join the queue everyone including pregnant women, babies for immunisation, TB patients, all kind of sickness on the same queue; imagine small babies next to TB patients! That wasn’t a good experience.”

4.4.1.8 Religious and cultural hegemony

Religion and culture are in most cases used as structural weapons to oppress women in terms of their reproductive health. Women are expected to behave in a certain way and going against such ways is tantamount to committing sin and running the risk of shaming the family. This has seen most women secretly using FP methods although they are prohibited and go against their religious and cultural beliefs and values. All participants indicated that women are not allowed to take FP pills or any other methods for that matter, or have an abortion, as this goes against their religious and cultural beliefs. Condoms are also not allowed, said one of the participants. The same thing goes for sex before marriage. However, at the end of the day they are forced to use these methods secretly without anyone knowing, with the hope and trust that God will understand their plight and the need to do what they are doing in the face of adversity.

As **Maria** explained:

“Family planning is not allowed, is considered as a sin. If you’re using it you are a sinner, you are killing babies. But if you use it you hide, you only tell your family. Things like abortion also not allowed and they don’t allow sex before you get married. Meaning no small girls not married yet are expected to be pregnant so no one talks about family planning when you’re not even married. Abortion you can’t even mention it.”

Amanda added to this:

“In my church we believe that God is the one who can care for everybody and if you want to rely on the leadership to tell you how to live or manage your life or your family life you can’t get any help in our church because they don’t believe in family planning. Those who use family planning is like committing a sin because they are like preventing what God meant to multiply. And then abortion is something you can never mention in my church. Is like killing.”

Patricia had this to say:

*“My religion doesn’t accept certain things that are part of reproductive health services such as abortion, treatment of infertility also not allowed because they believe that when the time is right God will give you a baby. Abortion is not even an option. If you fall pregnant you have to keep the baby and you will be like given a punishment for a certain period not to attend the church then you have to repent when you comeback. But the abortion is like a **Taboo**, is not a usually thing to see or hear. Family planning is not acceptable either because they believe that if God wants you to have babies it should be so, and the belief that every child is a blessing so preventing babies from being born is seen as a sin.”*

In relation to culture, **Nadine** stated:

“Using an example of family planning, my culture is against it, a woman is supposed to have children until God stops it, until there is no more coming. [Laughing] My culture also is against abortion. If it happens for a girl to fall pregnant, she will have to keep the baby no other choice. First of all sex before marriage is not allowed so girls are not expected to even use FP before they get married, they are expected to keep their virginity, that my culture [laughing].”

Nadine’s perception on this cultural practice judging from her nonverbal acts of “laughing” as denoted in the quote above, may signify the ridiculousness of these cultural norms in her eyes, but as a woman she is powerless to question and unlearn such practices for fear of shaming her family. Additionally, as **Daniela** pointed out:

“My religion doesn’t approve abortion. Is like a sin. Family planning is not approved same as my culture, even my mother I never saw her using family planning; they expect you to have babies.” **Daniela** also added:

“You can’t use condoms. If you use condoms, in my culture is like you are keeping something from your husband. When you are married no condoms allowed [laughing].”

There is general consensus among all the participating women in this study that religion and culture prohibit the use of FP methods, including pills and injections or any other method. Nevertheless, the women at the end of the day utilise these FP methods so that they can have few children in order to be able to provide for them in a hostile foreign country. Most of the participants indicated that due to the financial reasons, they cannot afford many children as a result they decided to put aside their cultural and religious beliefs concerning the use of reproductive health services such as FP methods and condoms. There is a general sense emerging from the participants that things could maybe have been different if they were in their respective countries of origin, as this would have led them to subscribe to the religious and cultural beliefs of not using FP methods and rather having more children.

4.4.2 Positive experiences

4.4.2.1 Positive care and treatment

When analysing this theme, it was very clear that the participants had the tendency to compare the care offered in public and the care in private institutions. Some of the participants acknowledged good customer care services in private health care institutions but they are aware of the cost involved as opposed to public institutions where they get free healthcare services.

In some rare instances, the participants received good treatment from the nurses or doctors in public hospitals. Some of the participants in the study confirmed this, but the majority of the participants did not share these sentiments. For example **Nadine** said:

“After that I used family planning for a year then I fell pregnant and I attended the clinic. There my experience was good, the care was good, and they followed me up until I gave birth.”

Princess also received good treatment from a doctor and nurses in a public hospital, as indicated by the following:

“Yaa.... After delivery it was okay and I thank God that I met a good doctor who helped me and comforted me. Yeah after delivery I didn't have any problems, they were passing and greeting and ask if I didn't have any problems.”

Another aspect that came out from the participants is that of getting better treatment in private hospitals than in public hospitals. This is indicated by **Amanda**, who said:

“First you pay a lot [laughing]. I paid a lot of money in private even for a simple touch. The time to deliver I had to pay while in government [public sector] I never paid a cent. But in terms of treatment I was very much satisfied. In government is free but the treatment is better in private.”

Patricia also echoed the same sentiments: *“The services for private were quite good comparing to what I would have gotten if I went to the public hospital.”* Another participant also spoke glowingly on the care she received from Netcare, as indicated in the next quotation from **Martha**:

“It was Netcare that came first and treated us well but crisis centre insisted it was a state case and refused to let us go with Netcare. The ladies from Netcare Company were friendly and they came with a kit and medications to calm us down. With Netcare we felt like we had someone next to us.”

4.4.2.2 Social support

Social support refers to the support, care and assistance from other people. It could be a family support or from friends.

In the face of adversity in an unfriendly environment, families' and friends' support makes it possible for people who are discriminated in a foreign country to cope. The participants in this study all mentioned a family member or a friend as someone important to help them bear the pain of the negative experiences they encounter as they seek reproductive health services in Durban public hospitals. To support the above theme **Maria** stated: *“My husband was with me and kept on calling them to come.”*

Family members are not the only ones that provide support systems to the participants but also fellow patients. This point is highlighted by **Patricia**, who pointed out that: *“Patients show more concern than health workers, I am not sure if it is because they are going through the same thing as patients.”* In this case, patients were more supportive than nurses. Friends also form an important support system for women with regard to reproductive health services as highlighted by **Nadine**, who said: *“A friend came home and gave me some medications and*

advised me to go back to the hospital if I have problems.”**Mercy** also told of an instance when a friend helped her: *“My friend has to raise money for me to go to a private doctor.”*

4.5 Summary of the chapter

This chapter presented the results of the study. Refugee women’s access to reproductive health services that are effective, acceptable and safe is being curtailed in South Africa by the negative effects of xenophobia, discrimination, language barrier, unprofessionalism from nurses, ill-treatment, failure to obtain consent, religious and cultural values, and financial challenges. To maintain their sexual and reproductive health, refugee women need access to accurate information and a safe, effective, affordable and acceptable contraception method of their choice without being forced, as evidenced from some of the quotations in the study. The findings above suggest that the negative experiences outweigh the positive experiences of refugee women regarding reproductive health services. All women, regardless of nationality, race or class, have the right to make their own choices about their sexual and reproductive life. Lastly, support from friends and families are very important for refugee women in connection to reproductive health services as highlighted in the analysis above. The findings of the study covered well the two research objectives as the participants described their day to day experiences with reproductive health services and pointed out the major challenges they face in utilizing those services.

CHAPTER 5

DISCUSSION OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses the findings presented in the previous chapter. In addition, this chapter presents the conclusions and recommendations of the study. The discussion attempts to respond to the study aim, which was to document the day-to-day experiences of refugee women and uncover their challenges regarding reproductive health services in Durban-based public health facilities.

5.2 Negative experiences regarding reproductive health services

Eight (8) sub-themes emerged from the major theme in relation to refugee women's experiences regarding reproductive health services in public healthcare facilities in the city of Durban, South Africa. During the discussion, some sub-themes could not be isolated, thus they were combined accordingly.

5.2.1 Medical xenophobia and discrimination

In this study, the findings revealed that all participants experienced medical xenophobia and discrimination in public healthcare facilities while seeking reproductive health services. The participants in this study reported facing negative attitudes from healthcare professionals, mostly nurses, due to the fact that they are non-citizens. The study also revealed that in some instances the participants were neglected and others denied treatment by nurses simply because they were foreigners. Findings in this study were similar to previous research revealing that refugees face discrimination and medical xenophobia when seeking healthcare services at public health facilities in South Africa (Crush et al, 2014; Zihindula et al., 2015). Similar results were verified by other researchers including Nkosi (2014). With specific focus to reproductive health access and utilization, the existing limited research suggests that women have negative experiences with reproductive health services (Krause, 2015). These findings were also supported by a study of reproductive health services for refugee women done in Botswana, which revealed that they face discrimination, xenophobia, language barriers and other cultural and financial challenges when seeking reproductive health services (Oucho & Ama, 2009).

5.2.2 Language barrier

The findings in this study revealed that refugee women who participated in the study face challenges of language barriers and bad attitudes from the healthcare workers in public hospitals and clinics when seeking reproductive health services. The findings revealed that the majority of nurses in the public sector insist on speaking isiZulu to the foreigners who hardly understand a word of it. The findings also revealed that, while attending the public sector for reproductive health services, the women who are able to speak isiZulu are helped efficiently, as opposed to women refugees and other foreign nationals, who cannot explain themselves in isiZulu. The findings indicated that even when the women refugees try to communicate in English, the nurses don't pay attention simply because they want foreigners to speak in isiZulu. In this study, women reported that they have no interpreters at public health facilities and that they struggle to communicate with the healthcare professionals. These findings were supported by Apalata et al. (2007) in their study which revealed that refugee women face many negative experiences with reproductive health services, not only because they cannot communicate but because there are no interpreters or facilities to convey their messages. As a result, refugee women end up either returning home untreated or have to bring their children or friends who are also not fluent in the local languages to assist with interpretation. Yet, literature shows that when interpretation is done by an untrained person, there are risks to transmit a wrong message resulting in wrong diagnosis and treatment which later affect the client negatively (Langlois, Haines, Thomson, & Ghaffar, 2016).

5.2.3 Unprofessionalism

This sub-theme includes lack of health education and lack of good customer care training, failure to obtain consent and lack of confidentiality, and ill-treatment

5.2.3.1 Lack of health education and lack of good customer-care training

Dalton-Greyling (2008), pointed out that the number of refugees and foreigners entering South Africa is increasing, South Africans will have to be educated concerning refugees and their wellbeing. In this study, the findings identified lack of health education and lack of good customer-care training as examples of unprofessionalism on the part of healthcare workers. The findings revealed that lack of understanding of the refugees' situation and their rights to healthcare services and limited or non-existent good customer-care behavior affect refugees' healthcare access and usage. Some of the participants mentioned that the healthcare professionals do not give them any health education regarding reproductive health services

and the choice of treatment to use; instead they impose their own choices on women refugees. The other participants reported that they had little or no knowledge regarding different types of family planning methods and the nurses in the public sector did not explain. The findings revealed that nurses in the public sectors lack training in how to treat or deal with vulnerable people, in this case women refugees in the host country. These findings were supported by a study conducted by Ross, Harding, Seal and Duncan (2016), which focused on improving the management and care of refugees in Australian hospitals. Refugees reported negative experiences which they associated with negligence by healthcare professionals, ignorance, lack of education about refugees' background and very limited customer-care training.

5.2.3.2 Failure to obtain consent and lack of confidentiality

The findings in this study revealed that the healthcare providers fail to get consent from clients before doing medical procedures and giving medication. Some of the refugee women who participated in this study reported being tricked and forced into having medical procedures, such as caesarean section and HIV testing, without their consents. Other participants reported being forced to have an injection for family planning against their will. The findings also revealed lack of confidentiality mainly due to the fact that the women refugees are obliged to have a third party to translate into local languages when interacting with healthcare providers. These findings were supported by Apalata et al. (2007), who pointed out the lack of consent and confidentiality, and in their study, refugee women reported being forced to deliver by caesarean without their consent.

5.2.3.3 Ill-treatment

Refugees feel rejected and ill-treated when attending public healthcare institutions. As a result the majority have decided to no longer attend public hospitals. (Apalata et al, 2007).

The findings in this study revealed that refugees are ill-treated by healthcare providers in the public sector. All the participants mentioned that they have been ill-treated at some point in public hospitals and clinics, especially by nurses. The participants also indicated that if they had a choice they would not return to the public hospitals or clinics. Some participants reported that they would never have any more babies in South Africa due to the ill-treatment they received while attending antenatal clinics, during and after delivery. While the above are the results of ill-treatment of the refugees at public health facilities (Nkwinika et al 2014; Zihindula et al 2016), this creates an internalized fear in the refugee women which leads them to not seeking health care services at public health facilities in South Africa. Many of them as

reported in this study, end up visiting private doctors even though they do not have money to afford their services, but they still feel confident and trust the private sector than public

5.2.4 Internalised fear

All participants in this study reported that they are scared to go to the public sector when they are sick or in need of reproductive health services due to the previous bad experiences and the fear of facing the very same healthcare providers who mistreated them. The findings then revealed that ill-treatment resulted in an internalised fear amongst women refugees.

The report in the study by Zihindula et al (2016) shows that refugee women refused to test for HIV following the fear that nurses and counselors would disclose their status after the test results. This explains that not only refugee women are hunted by the fear based on previous bad treatment and attitudes received from the healthcare providers, but they also don't trust the healthcare workers. The study conducted in India amongst refugees, revealed that ill-treatment influenced an internalised fear amongst refugees who sought reproductive health services at public health facilities (Parmar, Aaronson & O' Laughlin, 2014).

5.2.5 Financial challenges

Findings from this research study revealed that refugees face financial challenges in the host country making it impossible to access healthcare services in the private sector. The financial challenge was reported in this study as one of the barriers to refugee women in accessing reproductive health services, and as a result they have no choice but to go to the public sector and face the other challenges mentioned above. Due to financial challenges refugees, especially women are unable to further their education and this leads to unemployment, hence they cannot afford to take care of their basic needs and this makes them more vulnerable and prone to diseases. These findings were supported by Frenz & Vega (2010) in their study of refugees which revealed that they face serious financial constraints which do not enable them to afford their basic needs. A similar study published by the Human Rights Watch (HRW) revealed that, due to the financial challenges facing refugees, they become vulnerable to health-related problems (HRW, 2010).

5.2.6 Shortage of health personnel and overcrowding of public health facilities

The findings in this study revealed that shortages of staff and overcrowding in public hospitals and clinics are a serious issue facing not only refugees but the citizens as well.

Some participants reported being mismanaged while in labour and post-delivery due to shortage of staff, and on many occasions others could not be attended to while seeking reproductive health services including antenatal care due to overcrowding and not enough staff on duty to attend to every patient; they were either turned away from public health facilities or decided to return home untreated after a long period of waiting unsuccessfully.

It is worth noting that South Africa has long suffered from a shortage of healthcare professionals in its public health sector. A number of reports revealed that the country is currently struggling to fill the gaps of medical doctors, nurses and other healthcare workers, both in rural and urban areas. The shortage of skilled healthcare professionals is not a new phenomenon in the post-apartheid South Africa. Sources indicate that despite the highly reported shortage of skills, the most affected sector remains the National Department of Health (Erasmus & Brier, 2009; Rasool & Botha, 2011). The problem of staff shortage is further exacerbated by the problems of staff retention and the high turnover rates associated with skills migration that sees a high number of skilled healthcare professionals leaving the country in search of highly paying posts overseas (Theron, Barkhuizen & Du Plessis, 2014). This migration phenomenon affects not only the citizens, but also refugees who reportedly fail to access and utilise reproductive health services.

5.2.7 Religious and cultural hegemony

The findings in this study, revealed how religious and cultural beliefs influence refugee women' health-seeking behaviours. It was noted that religion and culture play an important role in relation to reproductive health services among refugee women from the Burundi, Rwanda and DRC and their health seeking behaviors. The findings revealed that both religion and culture in the same way do not accept or support certain services which are a part of reproductive health services. All participants pointed out that family and abortion are not allowed nor supported by their religion and culture. In terms of family planning, they believe that God wants people to multiply as long as they are married. No sex before marriage allowed and abortion is considered as a taboo. Others reported that the use of condoms in a marriage is not something to talk about; it is believed that if a wife wants to use a condom, she is unfaithful thus hiding something from her husband. Some of the participants also reported that treatment of infertility is not supported by their religion as they believe that God will make things happen in due time. However, due to circumstances in the host country, refugee women found themselves in a position where they have to decide to go against religious and cultural expectations.

5.3 Positive experiences

5.3.1 Positive care and treatment

Irrespective of all negative experiences faced by the participants, the findings revealed some positive care and treatment at some point. In this study, some refugee women who participated in the study reported positive care and treatment which they received from few employees of the public sectors. Participant reported positive care they received from doctors in public institutions while utilising reproductive health services.

5.3.2 Social support

Social support is very important in every situation, especially where a vulnerable group of people is concerned, in this case refugee women. As seen in the previous chapter, families' and friends' support makes it possible for people who are discriminated against in a foreign country to cope. The participants in this study all mentioned a family member or a friend as someone important to help them bear the pain of the negative experiences they encounter as they seek reproductive health services in Durban's public hospitals. Participants reported receiving social support mostly from friends and family, which plays an important role in times of need, especially in the case of refugee women seeking reproductive healthcare services. In addition to family members' and friends' support, some participants also reported being supported by their fellow patients and in a few cases they received support from healthcare professionals in the public sector.

5.4 Summary of the study findings

The findings in this study suggest that refugee women continue to face negative experiences regarding reproductive health services in public health facilities of Durban South Africa. This study revealed that refugee women in the city of Durban remain the most vulnerable and their negative experiences and challenges with sexual reproductive health services expose them to a number of health problems mostly related to reproductive health, including contracting diseases such as HIV and STIs, complications during pregnancy and post delivery which in turn becomes a big issue, not only for refugees but for citizens as well. Furthermore, religion, culture and financial challenges were shown to influence the way refugee women seek reproductive health services.

5.5 Limitations of the study

Although possible measures were taken in order to avoid inconveniences, this study encountered the following limitations:

- **Sample size:** On the basis that the study was a Masters' research component, it did not involve a bigger sample size. Hence, generalising the results from a limited sample size limits the scope of the findings.
- **Funding:** The researcher is a self-funded student, and the limited amount of money available to spend on the study also dictated the sample size, site and length of the study. This may also have indirectly interfered with timeous completion of the research.
- **Time constraints:** The deadline for submission of the thesis at the university also became a limitation, putting the researcher under pressure.
- This study could have been better if it involved the non church goers participants, as this would have provided more information and views on the topic

5.6 Recommendations

Based on the findings, this study recommends the following to be done by specific institutions and individuals.

5.6.1 Recommendations to the Department of Health

- The Department of Health should train the healthcare workers in handling refugees issues, in customer care, as well as in the refugee rights to accessing and utilising healthcare services in South Africa. Creating awareness about refugee issues will also improve the healthcare providers' attitudes towards refugees.
- Furthermore, policy-makers in the health sector should consider involving refugee community leaders during the formulation of policies, and specifically refugee women, who have been shown to be vulnerable and the main victims of negative experiences at public health facilities.
- Lastly, the Health Department, despite its challenges, should consider either providing an interpreter at facilities most visited by refugees or employing one of the refugees trained and qualified to offer such services.

5.6.2 Recommendations to refugee community

- Refugee communities should understand that the Department of Health is over-stretched and highly challenged. They should thus be patient when their expectations are not met

and consider that resources are sparse and that some local citizens sometimes do suffer the same experiences.

- The refugee community should also approach the institutions that are in charge of refugees, such as the United Nations High Commissioner of Refugees and the Department of Home Affairs and ask for specific support needed. There are also a number of institutions that support refugees and these should be visited as well.
- The refugee community churches and other non-religious institutions should partner with government and non-governmental organisations active in the area of refugees, in order to remediate the challenges faced by refugee women.

5.6.3 Recommendations for further research

- There is a need to conduct research among refugee women specifically, documenting their experiences with sexual and reproductive health services in all parts of South Africa and everywhere in the Southern Africa region where refugees are hosted.
- Research that looks at alternative ways used by refugees when they fail to access reproductive health care services at public health facilities should be undertaken.
- It is also crucial in this era of HIV, to conduct research that explores the risk factors associates with refugee women lack of reproductive health services.

5.7 Fieldwork experience

My fieldwork experience was not very different from that of other scientists. However, some particular challenges were faced during the stage of data collection, and the discovery of new information made the fieldwork experience dissimilar from that of others. The experience of doing this study has proved difficult and challenging. Conducting interviews with refugees, especially refugee women who have been exposed to traumatic experiences is quite challenging as most of them hoped that the healthcare system in South Africa would take their concerns into account. In most cases the participants' reports revealed many other issues going on in their lives. Although not anticipated for the study, the information became crucial as it shed light on the general experiences of refugee women regarding reproductive health services in Durban-based public healthcare facilities.

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Annexure 1



17 March 2017

Mrs Yvonne Munyaneza (204512882)
School of Nursing & Public Health
Howard College Campus

Dear Mrs Munyaneza,

Protocol reference number : HSS/0224/016M
New Project Title "Experiences of Women Refugees from the African Great Lake Region regarding Reproductive Health Services in the City of Durban, South Africa"

Approval notification – Amendment Application

This letter serves to notify you that your application for an amendment dated 15 March 2017 has now been granted Full Approval as follows:

- Change in Title

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study must be reviewed and approved through an amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

Best wishes for the successful completion of your research protocol.

Yours faithfully


Dr Shenika Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

cc Supervisor: Dr Mballi Mkhongo
cc Academic Leader Research: Professor B Sartorius
cc School Administrator: Ms Carolline Dhanra

Humanities & Social Sciences Research Ethics Committee

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110 YEARS OF ACADEMIC EXCELLENCE

Regional Campuses: Pietermaritzburg Howard College Medical School Pietermaritzburg Westville

Annexure 2

INFORMATION GIVEN TO PARTICIPANTS INFORMATION DOCUMENT

Study title: **EXPERIENCES OF WOMEN REFUGEES REGARDING REPRODUCTIVE HEALTH SERVICES IN THE CITY OF DURBAN, SOUTH AFRICA**

Dear participants,

INTRODUCTION

I, Y. Munyaneza, am a student at University of KwaZulu-Natal doing a Masters in Maternal and child health. As part of my studies at the University I am required to conduct a study in an area of my interest. My study title is: "**Experiences of women refugees regarding reproductive health services in the city of Durban, South Africa**". I am requesting your participation in this study because you meet the criteria of the people who are eligible to participate in the study. The aim of the study is to document the day-to-day experiences of refugee women and uncover their challenges regarding reproductive health services in Durban-based public hospitals. This study will contribute not only to the currently scarce literature on refugee women accessibility to reproductive health services in South Africa and Southern Africa at large but also it carries other benefits. The study will expand the body of knowledge and will benefit the discipline as the latter will be the producer of new knowledge in this area. This study will also fill the gap in literature about refugee women and their reproductive health in South Africa, which will be taken into consideration for the formulation of health policies. Please note that there are no incentives for the participation.

If you agree to participate, you will be requested to answer the questions during the interview upon your voluntary agreement to participate in the study. The researcher will liaise with you to do the interviews at the time that is convenient for you. Your information you give will be treated with the utmost confidentiality. Any personal information will not be disclosed unless required by law. Your names will not appear anywhere in the interviews or the study findings. You are free to participate or not to participate in this study. You are free to withdraw from the study at any stage without repercussions. There will be no risks attached to your participation. The results of the study will be made available to you on completion of this study.

Please feel free to ask any questions you may have so that you are clear about what is expected of you.

Thank you for your time and cooperation.

Yours sincerely

.....
Y. Munyaneza

Date: 09December 2015.....

Contact detail of the researcher-for further information /reporting of study related matters.

Y. Munyaneza

Contact number: 0834242042

Email address: evonne989@gmail.com

Supervisor's contact details

Dr Mbali Mhlongo

Howard College Campus

School of Nursing and Public Health

5th Floor Desmond Clarence Building

Durban 4041 South Africa

Email address:Mhlongoem@ukzn.ac.za

Contact number: 031 260 1210

HSSREC Research Office: Premlall Mohun

Contact number: 031 260 4557

Email address: MOHUNP@ukzn.ac.za

Annexure 3

INFORMED CONSENT FORM

Consent to participate in research

Dear Participant,

I, Y. Munyaneza, a student at the University of KwaZulu-Natal, as one of the requirements to complete my studies, I am conducting a study through the College of Health Sciences, School of Nursing and Public Health, University of KwaZulu-Natal.

The title of the study is: **Experiences of women refugees regarding reproductive health services in the city of Durban, South Africa**

You have been asked to participate in a research study on: Experiences of refugee women regarding reproductive health services in the city of Durban, South Africa. The purpose of the study is to document the day to day experiences of refugee women and uncover their challenges regarding reproductive health services in Durban-based public hospitals.

You have been informed about the study by: Y Munyaneza, contact number 083 4242042, Email: evonne989@gmail.com. You may contact me at any time if you have any questions about the research.

You may contact the researcher's supervisor, Dr Mbali Mhlongo, contact number 031 2601210, Email: Mhlongoem@ukzn.ac.za.

You may contact the HSSREC Research Office: Mariette Snyman contact number 031 2608350, Email: snymanm@ukzn.ac.za.

Your participation in this research is voluntary and you will not be penalized if you refuse to participate or decide to stop at any time. If you agree to participate, you will be given a signed copy of this document and the participant information sheet, which is a written summary of the research.

The research study, including the above information, has been described to me orally. I understand what my involvement in the study means and I voluntarily agree to participate. I have been given the opportunity to ask questions that I might have about my participation in the study.

All interviews will be recorded and information will be kept confidential.

Declaration of consent:	Yes/No
I hereby consent to have this interview recorded	
I do not consent to have this interview recorded	

Signature of participant.....

Date.....

Annexure 4

CONSENT/PERMISSION TO CONDUCT A RESEARCH STUDY IN PARAN PENTECOSTAL CHURCH

Dear Leaders of Paran Pentecostal Church,

I, Yvonne Munyaneza, a Masters student at the University of KwaZulu-Natal, have undertaken a research project to focus on the experiences of refugee women and uncover their challenges regarding reproductive health services in public hospitals.

STUDY TITLE:

“Experiences of Women Refugees Regarding Reproductive Health Services in the City of Durban, South Africa”

This project is supervised by Dr Mhlongo from the University of KwaZulu-Natal. I hereby wish to request your permission to conduct the above-mentioned research study in your church. Should you require further information you may contact me on:

Cell number: 0834242042

Or email me at: evonne989@gmail.com

Signature:

Date

Name & surname

Annexure 5

CONSENT/PERMISSION TO CONDUCT A RESEARCH STUDY IN DURBAN MISSION CHURCH

Dear Leaders of Durban Mission Church,

I, Yvonne Munyaneza, a Masters student at the University of KwaZulu-Natal, have undertaken a research project to focus on the experiences of refugee women and uncover their challenges regarding reproductive health services in public hospitals.

STUDY TITLE:

“Experiences of Women Refugees Regarding Reproductive Health Services in the City of Durban, South Africa”

This project is supervised by Dr Mhlongo from the University of KwaZulu-Natal. I hereby wish to request your permission to conduct the above-mentioned research study in your church. Should you require further information you may contact me on:

Cell number: 0834242042

Or email me at: evonne989@gmail.com

Signature:

Date

Name & surname

Annexure 6

RE: CONSENT/PERMISSION TO CONDUCT A RESEARCH STUDY IN DURBAN MISSION CHURCH

Study title: "Experiences of Refugee women regarding Reproductive Health Services in the City of Durban, South Africa"


Dear Yvonne Munyaneza,

This letter serves to confirm that your request to conduct your research study in Durban Mission Church has been granted.

Pastor MARCEL M. MIRINDI
Name & Surname (Church leader)

DURBAN
Place

10 DECEMBER 2015
Date


Signature

Stamp (if applicable)



Annexure 7

RE: CONSENT/PERMISSION TO CONDUCT A RESEARCH STUDY IN PARAN PENTECOSTAL CHURCH

Study title: "Experiences of Refugee women regarding Reproductive Health Services in the City of Durban, South Africa"

Dear Yvonne Munyaneza,

This letter serves to confirm that your request to conduct your research study in Paran Pentecostal Church has been granted.

Pastor Eugene Mvungu
.....
Name & Surname (Church leader)

Durban
.....
Place

11.12.2015
.....
Date

[Signature]
.....
Signature



Annexure 8

My position as a researcher

BRACKETING DOCUMENT

1. Introduction

Bracketing is a process where the researcher sets aside his/her experiences, as much as possible, in order to take a non-biased look at the phenomenon in question. The goal of bracketing is for the researcher to set aside his/her own experiences to be in a position that is as non-biased as possible (Creswell, 2007). For the purpose of this study, the researcher will complete the bracketing process by writing down her lived experiences with regards to reproductive health services in public hospitals/clinics prior to beginning the interview process with the participants and hearing their lived experiences regarding the study in question.

2. The researcher as a client

The researcher did notice that sometimes the healthcare providers carried out some procedures such as screening for cervical cancer and Pap smear without explaining and prepare her prior to commencing the procedure. The Pap smear procedure was a very bad experience in public clinics and after that the researcher decided to only do it with a private gynaecologist who was gentle and took her time to explain everything. These procedures were being done in other public clinics other than Addington and the researcher was transferred there. The researcher was only given the date and time to be in the clinic for tests but she was told nothing more and she had no idea what those tests meant. The researcher was afraid to ask questions for fear of being criticized about not being able to speak the local language properly.

3. The researcher as a nursing student

The researcher as a student during her training from 2005–2008 while she was doing the undergraduate course, has worked in almost all the departments of Addington hospital which is the nearest public hospital to the community under study. The researcher created a mutual relationship with the healthcare

providers, which made it easier for her whenever she needed assistance whether from doctors or nurses. At this point the researcher did not experience any problems accessing reproductive healthcare services in Addington hospital/clinic until today should there be any need for the researcher to seek assistance in Addington gateway clinic she is always welcome.

4. Experiences with clients

Part of the above-mentioned hospital is a gateway clinic where most women, including refugees and other foreign nationals, attend for services such as family planning mostly, treatment of sexually transmitted infections, and other conditions. The researcher had opportunities to interact with women refugees mostly in Addington Hospital during her clinical placement while she was a student. The language barrier was identified by the researcher as one of the problems faced by women refugees while attending the clinics. The other issue was that the clients, refugee women in this case, had the tendency of not trusting health workers due to previous bad experiences. Some refugee women confessed that they only felt comfortable with the researcher after they realized that she was treating them like human beings. The researcher experienced generalization from one bad incident by refugee woman.

5. Conclusion

The researcher is aware that having some knowledge about the community and some of its members, including those under the study, having her own lived experiences regarding reproductive health services, views and preconceived ideas, all these could influence the study. There is also the possibility that the researcher might know something that may have an impact on the way she interprets the participants' views. Setting aside her own lived experiences will help the researcher to avoid being biased during the interviews and avoid judgments while analyzing findings.

Appendix 9

Interview guide

Research Topic

Experiences of Women Refugees Regarding Reproductive Health Services in the City of Durban, South Africa

I am going to ask you a few questions about your health condition and your experiences regarding reproductive health care services at public hospitals in the city of Durban. Reproductive health services include: Family planning; Antenatal care; Safe delivery and post-natal care; Prevention and appropriate treatment of infertility; Prevention of abortion and management of its consequences; Treatment of reproductive tract infections; Care and treatment of sexually transmitted infections (STIs) and HIV/AIDS; Information, education and counselling; Prevention and surveillance of violence against women; Care for survivors of violence and other actions to eliminate traditional harmful practices; and Appropriate referrals for further diagnosis and management of the above.

Please feel free to stop me for clarity at any stage of our interview.

Interview guide

1. Have you ever been at the public hospital/clinic for reproductive health services before?
If yes which services did you seek?
2. What do you understand by reproductive health services?
3. Tell me about your experiences regarding reproductive health services provided in public hospitals/clinics?
4. Please share with me the major challenges you've encountered in accessing reproductive health services in public hospitals/clinics.
5. What does your religion/faith say about the use of reproductive health services?
6. What does your culture say about the use of reproductive health services?
7. Tell me about your alternative ways through which you address your reproductive health needs besides going to public hospitals/clinics.

Annexure 10

Interview transcript

Demographic Characteristics of the participant

Name: Princess (not real name)

Gender: Female

Age: 47

Marital status: Married

Country of origin: Congo

Period of stay in Durban: 19 years

Level of education: Diploma in teaching from country of origin

Employment: unemployed/house wife

Number of children: 3, and 2 grandchildren

Area of residence in Durban: Umbilo area

Date of interview: 28 May 2016

Place of interview: Paran Pentecostal Church situated at 45 Pickering Street, Durban 4001

KwaZulu-Natal (South Beach)

Yvonne Munyaneza

Princess Interview

28 May 2016

Persons present: Y. Munyaneza (Researcher)
Princess (Participant)

Key: R= Researcher; P= Participant

R: Hi how are you?

P: I am fine thanks and you?

R: I am fine thanks

Thank you for coming I really appreciate you taking your time to come for this interview. I will not take so much of your time, just some few questions I would like to ask you, if you have questions you are more than welcome to ask me or if you don't understand you can always stop me and ask me for clarification.

R: Have you been at the public hospital for reproductive health services before?

P: Yes I've been there.

R: Can you please tell me what you went there for?

P: I went there when I was pregnant; I went there to deliver the baby, and I also went there for family planning after having a baby.

R: Which hospital or clinic was this?

P: It was Addington hospital. And I have been also at King Edward when I went to check if I don't have uterus cancer.

R: So this test for cancer was done in King Edward?

P: Yeah.

R: Did they treat you there for this cancer, did they check?

P: Yeah they did. I don't know if I will say operation but they cut a piece of my body to go to test if I have cancer. Luckily the test was negative.

R: Please tell me what do you understand by reproductive health services?

P: Well I understand it's about going to the clinic or to the hospital, for example when you go to deliver the baby or when you are pregnant then you go to the clinic and they do all the checking they supposed to do until you have a baby. And maybe also after having a baby and you need to stop or to put interval, yeah if you want to start a family planning that what I understand

R: Can you please tell me about your experiences regarding reproductive health services provided in public hospitals/clinics.

P: My own experience was in 1998 when I went to deliver my baby and the nurse who received me didn't treat me well when I was in labour pain because yes I was a refugee, even now I am still a refugee and I couldn't speak very well English and I didn't even know Zulu [isiZulu], but she was talking to me in Zulu and she was asking me about the voucher and those vouchers it was the vouchers we received from refugee social service.

R: So was this nurse aware of the vouchers?

P: I think she saw people shopping with the vouchers because they were using those vouchers in Shoprite and in Checkers, looks like she knew. And I was in labour pain and yes I was screaming and I was asking for her to help me but she told me to keep quiet and I told her I need help then she told me okay give me the voucher where is the voucher then I say please help me after I have the baby I will go home to ask if I can have a voucher then I will give to you because at that moment I had no voucher.

R: So in other words she wanted to you to pay in order for her to help you?

P: Yeah uhh... but she didn't ask for money because she knew that we don't have money we are surviving on those vouchers.

R: Which hospital was this?

P: It was Addington in 1998 [moment of silence] and I didn't have a voucher but she put me in a wheelchair then when I was sitting in a wheelchair I vomited, when I vomited on the floor oh my goodness she asked me who is gona clean there then I told her please help me when I finish to deliver I will come to clean because I was really in pain. Anyway she pushed me and take to the labour me in labour ward she went. The doctor came and helped me then I had my baby.

R: Oh so this nurse ended up not the one who assisted you to deliver?

P: No she didn't carry on, the doctor came and took over and really I couldn't accept her to carry on with me I couldn't trust her, a person who told me to clean and to bring the voucher while I am in labour pain.

R: But this doctor did everything?

P: Yeah she did everything, she helped me.

R: Is that the only experience?

P: Huhh...that is a bad one. I can't forget that with that voucher I can't forget that I don't know if I can forget really.

R: After delivery did you see this nurse again? Did she come to see you?

P: I couldn't know [couldn't identify her] because I was in labour pain the time I was asked to clean and to bring a voucher.

R: Was everything fine after delivery?

P: Ya... after delivery it was okay and I thank God that I met a good doctor who helped me and comforted me while I am delivering then it's like she wiped my tears, she was very good to me.

R: And nurses in general after delivery were they good to you?

P: Yeah after delivery I didn't have any problem, they were passing and greeting and ask if I didn't have any problems, but the night sisters were not okay, they were not good. The one who asked for a voucher was on night shift, it happened in the night, day shift they were good.

R: If I may ask what happened before you had baby? Did you attend the clinic?

P: Oh my goodness [smiling], I went to the clinic, they asked me so many questions including what I am eating, if I am drinking, probably I was drinking, I was drinking alcohol.

[Laughing loud] I remember when the nurses asked me how many bottles a day then I told her I take two she screamed she couldn't believe how a pregnant woman can drink alcohol.

Okay I told her I didn't know that is bad to drink and then she explain to me how alcohol is bad for the baby and when she tested me also she found out I had infections and she told me that I have to stop drinking alcohol and drink water so my baby can be okay. Yeah then I stopped alcohol and I started drinking water. Then the first month it was hard to stop the alcohol and only at 8months I had no infection and I was drinking a lot of water, yeah I was okay and the nurse was happy yeah it was good I had a good time with nurses.

R: Please tell me about family planning.

P: About family planning when I finished to deliver they asked me if I need more children and what I am planning to do, I told them I don't want another baby soon, then they advise me family planning then **they gave me injection but I wasn't really happy about the injection I was willing to take tablets.**

R: Is there any particular reason to why you didn't want the injection?

P: **Injection makes women sick and they bleed sometimes, yeah it's bad and you take so long to be pregnant after stopping it.**

R: Which clinic did you go to for family planning?

P: I went to the Addington then after two injections they sent me to Lancers Clinic. Then they want to test if I had no problem in the uterus then they found out that I have infection so they referred me to King Edward where I went to do that test.

R: But the family planning method was it given in Lancers Clinic?

P: Yeah.

R: Okay tell me about your experiences there.

P: **It's long queues in that clinic it was so many people there and you have to wake up 4 o' clock it's like the whole day you are there yeah it's a headache.**

R: These many people were there for different reasons?

P: Ya, but first you had to stand outside while waiting for the hospital to open you are on the road on the queue which is not even safe. I don't know how it is going but that time it wasn't safe no chair no way to sit.

R: Was this the last time you went there to the clinic?

P: Ya because that was my last child.

R: Except for these long queues and so many people, were the healthcare workers friendly to you?

P: Ya they were friendly and they were trying to work fast.

R: Can you share what you consider to be the major challenges you've encountered in accessing reproductive health services in public hospitals/clinics?

P: **The first challenge is a language barrier because people who work in the hospital in public clinic they think everybody is talking their language**, if they are black they expect you to come with a Zulu or their language, and we as refugees who are struggling in English and we don't know Zulu, and then sometimes they tell you why you are not talking Zulu why you don't talk my language and you look like me? We're all Africans but you can't talk my language yeah so it's a problem **when you don't talk that language you lose friendship in the beginning** because you don't talk the same language. I remember even the doctor when I went to the hospital escorting my husband then I was trying to explain in the small Zulu that I knew but he was shouting to my husband saying why him doesn't speak Zulu? Which shows that the language is a major problem but if you talk Zulu they are quick in helping you and they listen to you but if you come then you start talking English in front of African person [black Zulu] it becomes a problem

R: Tell me about your religion, what does your religion say about the use of reproductive health services?

P: **Firstly my religion doesn't allow abortion**. You know sometimes you can fall pregnant and you don't want the baby and you want to do abortion and religion doesn't accept that and **also the religion doesn't support family planning, it doesn't accept because is against the word of God**. The bible says multiply [laughing] there is no way the bible says stop giving birth to babies so we have to multiply until we die [laughing].

R: You have used family planning; do you see it as something you consider for your own good?

P: Anywhere when you want to do family planning you don't go to stand on the road or in the church and say I am gona use family planning [laughing]; you look at your budget, you look at your ability, you look at the future of the children you gona have and you make a plan that means family planning is a secret, you do what is best for you and your family.

R: Tell me about your culture, what does it say about the use of reproductive health services?

P: Yeah well **my culture also doesn't allow abortion because is not good, is a sin. And my culture doesn't allow to sleep or to have sex with anybody if you are not married** means whenever you have children when you are married you're welcome. So the culture won't allow abortion because it doesn't allow people to have sex outside the marriage.

R: What about family planning, is it acceptable in culture?

P: **Is not acceptable because the culture also wants people to multiply**, they want to have a big family; they want to see children, husband and wife; it's like that religion and more children more power, yeah more respect.

R: And they don't consider the costs?

P: The culture doesn't care about costs [laughing] but they say God gave you the children he will raise them up; but it's where people who look very far in the future they will do the planning without consulting the culture. If me and my husband we agree to use family planning we won't go to tell our parents because we know they will disagree so they will see we are not having children anymore then they will think God stopped it [laughing].

R: Tell me about your alternative ways through which you address your reproductive health needs besides going to public hospitals/clinics.

P: If I had money I will go to private hospitals because they give you what you want, for example if you want injection they will give you injection, or if you want tablets they will give you tablets yeah, **but sometimes the government (public hospitals) they force you yeah...they force you take injection they won't even wait for you to pass through counselling; you will give birth before you leave the bed they will give you injection.**

R: So you don't have a say?

P: No you don't have a say they force you. And also I believe that you and your husband , you can use **natural method** also by counting and understand each other and approaching people who can help you to know that natural method.

R: So this is the method you're using?

P: Yeah, I **use condom** also and it works.

R: We have reached the end of the interview; do you have any questions or suggestions?

P: Oh yes I wish we could have a meeting us women refugee or even refugees in general with the nurses and other professionals in government hospital. Maybe if we sit and talk to them they will know how we feel when they treat us so bad when we need help. They need to change their behaviours towards us.

Annexure 11



7 Woodlands Rd
GLENWOOD
DURBAN
4001
083 415 2531

11 December 2016

Reg. No. 2006/156780/23

Yvonne Munyaneza

EDITING OF RESEARCH DISSERTATION OF YVONNE MUNYANEZA

I have an MA in English from University of Natal (now UKZN) and have been performing editing services through my company for eleven years. My company regularly edits the research dissertations, articles and theses of the School of Nursing, Environmental Studies and various other schools and disciplines at the University of KwaZulu-Natal and other institutions, as well as editing for publishing firms and private individuals on contract.

I hereby confirm that Shirley Moon edited the research dissertation of **Yvonne Munyaneza** titled "Experiences of Women Refugees regarding Reproductive Health Services in the City of Durban, South Africa" on behalf of WordWeavers cc and commented on the anomalies she was unable to rectify in the MS Word Track Changes and review mode by insertion of comment balloons prior to returning the document to the author. Corrections were made in respect of grammar, punctuation, spelling, syntax, tense and language usage as well as to sense and flow. A guideline to assist in making corrections was also supplied.

I trust that the document will prove acceptable in terms of editing criteria.

Yours faithfully

C Eberle

Catherine P. Eberle (MA: University of Natal)