

**THE SOCIAL AND CULTURAL DETERMINANTS OF THE FERTILITY RATE  
AMONG CONGOLESE REFUGEE WOMEN LIVING IN THE INNER CITY OF  
DURBAN, SOUTH AFRICA**

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DECLARATION

I, BELINDA LWABOSHI, declare that this study titled “*Social and cultural determinants of the fertility rate among Congolese refugee women living in the inner city of Durban*” is my own original work. The sources, quotations and references used have been acknowledged. This work is submitted for the fulfillment of my master’s degree in the School of Applied Human Sciences. This dissertation has not been submitted for any degree, course or examination at any other university.

Signed,

12 March 2018

.....

.....

Belinda Lwaboshi

Date

## DEDICATION (SWAHILI AND ENGLISH VERSION)

Kazi hii nimeitowa kwa watu maalumu saaana katika maisha yangu. Kwa mume wangu mpendwa, Lwaboshi Bachigale, pamoja na watoto wetu, Tresor, Sephora na Plamedie Bachigale. Hasa zaidi nimeitowa kwa wazazi wangu walio nyumbani (DRC) kwa kijitowa kwao kihisiya pia kiroho kwa ajili ya elimu yangu. Kwa kaka na dada zangu wote, kazi hii imetolewa kwenu.

This dissertation is dedicated to a number of special people in my life, including my beloved husband, Mr Lwaboshi Bachigale, and our children, Tresor, Sephora and Plamedie Bachigale. More especially, it is dedicated to my parents back home (DRC) for their open- mindedness and unstoppable commitment in their emotional, and spiritual support for my education. To all my brothers and sisters, this work is also dedicated to you.

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“With all the belief in the Almighty God, nothing is impossible.”

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## **ABSTRACT**

Population growth is one of the pressing demographic development problems affecting the world. Despite the growing number of people using up-to-date contraceptive methods, countries in the developing world, including the Democratic Republic of Congo (DRC), are still recording a high fertility rate. This study investigated the social and cultural determinants of fertility among Congolese refugee women living in the inner city of Durban, South Africa.

The study adopted a qualitative method. Primary and secondary data were gathered and 12 semi-structured interviews were conducted. All interviews were audio-recorded and then transcribed with the participants' consent. The analysis of data was done using thematic analysis techniques.

The study found that the fertility rate among Congolese living in Durban, South Africa, is driven by various factors. Seven themes emerged that illustrated the reasons for the fertility rate among the study group. These were: the economic value attached to having children, gender preference (male child preference), the desire to save a marriage/union, the prestige of motherhood, filling the missing gap/replacing lost family members, fulfilling God's recommendation to fill the earth, and other biblical reasons, children as social security during old age, and inadequate use of appropriate contraceptive methods.

The study also found that gender played a pivotal role in determining fertility in the study group: men viewed themselves as decision-makers and heads of the family. The study findings concur with the previous literature on childbearing among refugee communities in developing countries in particular. The pivotal role of the gender of the couple in determining fertility casts doubt on the reliability of family planning methods that rely exclusively on the usage of contraceptive methods. This work provides essential recommendations on how health care services should be used in order to promote refugees' well-being in Durban, South Africa.

**Keywords:** Total fertility rate, refugees, social determinants, culture, DRC, South Africa.

## **LIST OF ACRONYMS**

ART: Antiretroviral Therapy

BMA: British Medical Association

CASE: The Community Agency for Social Enquiry

CSG: Child Social Grant

DoH: Department of Health

DHA: Department of Home Affairs

DRC: Democratic Republic of Congo

HRW: Human Rights Watch

ILO: International Labour Organization

IMF: International Monetary Fund

MDGs: Millennium Development Goals

OAU: Organization for African Union

PMTCT: Prevention Mothers to Child

SGBV: Sexual and Gender-based Violence

STDs: Sexually Transmitted Diseases

TFR: Total Fertility Rate

UNHCR: United Nations High Commissioner for Refugees

WB: World Bank

WHO: World Health Organization

## **TABLE OF CONTENTS**

Declaration.....	i
Dedication.....	ii
Acknowledgments.....	ii
Abstract.....	iv
Abbreviations and acronyms .....	v
Table of contents.....	vi

### **CHAPTER ONE: INTRODUCTION**

1.1 Introduction.....	1
1.2 General background of refugees in South Africa.....	1
1.3 Rationale .....	4
1.4 Objectives and questions to be asked.....	5
1.4.1 Research objectives.....	5
1.4.2 Research questions.....	5
1.5 Significance of the study.....	5
1.6 Scope and limitations .....	6
1.7 Definition of the key concepts.....	6
1.7.1 Refugees.....	6
1.7.2 Fertility rates.....	7
1.7.3 Democratic Republic of Congo.....	8
1.8 Structure of dissertation.....	10

### **CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK**

2.1 Introduction.....	12
2.2 Fertility and culture.....	12
2.3 Social and cultural determinants of fertility rates.....	13
2.3.1 Child and infant mortality.....	13
2.3.2 Children as source of labour and income.....	16
2.3.3 Value placed on childbearing and motherhood.....	20

2.3.4 Women' education.....	22
2.3.5 Use of contraceptive methods.....	23
2.3.5.1 Barriers affecting contraceptive use .....	25
2.4 Gender and control over fertility.....	27
2.5 Refugees accessing health care including reproductive care services.....	29
2.5.1 Language and cultural barriers.....	30
2.5.2 Socio-economic status.....	32
2.5.3 Xenophobia.....	34
2.3.4 Refugee documentation.....	35
2.6 Theoretical and conceptual framework.....	37
2.6.1 Gender.....	38
2.6.2 Gender relations.....	38
2.6.3 Sexual division of labour.....	40
2.6.4 Sexual division of power.....	41
2.6.5 Decision-making power within marriage.....	43
2.6.6 Gendered norms affecting women.....	44
<b>CHAPTER THREE: DESIGN AND RESEARCH METHODOLOGY</b>	
3.1 Introduction.....	46
3.2 Design of the study.....	46
3.2.1 Qualitative research.....	46
3.3. Population and sampling .....	50
3.3.1 Sampling techniques.....	50
3.3.2. Sample size.....	51
3.4. Inclusion and exclusion of criteria.....	52
3.5. Research techniques and instruments.....	53
3.6. Data collection and procedures.....	54
3.6.1. Primary data collection.....	54
3.6.2. Gaining access .....	54



3.7. Data analysis.....	54
3.8. Trustworthiness and credibility.....	55
3.8.1. Trustworthiness.....	55
3.8.2. Credibility.....	56
3.9. Ethical consideration.....	57
3.9.1. Gate-keeping and ethical approval.....	57
3.9.2. Informed consent.....	56
3.7.3Benefits.....	57
3.7.4Potential for harm.....	57
3.7.5 Communication of findings.....	57
3.8Conclusion.....	58
<b>CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS OF FINDINGS</b>	
4.1 Introduction.....	59
4.2 Demographic characteristics of the study participants.....	59
4.3 Social and cultural determinants of fertility.....	62
4.3.1 Economic value of children .....	63
4.3.2 Sex preferences.....	64
4.3.3 Sex preferences and desire to save marriage/union.....	66
4.3.4 Motherhood prestige.....	67
4.3.5 Replacing lost family members.....	68
4.3.6 God’s recommendation.....	69
4.3.7 Children as providers of social security during old age.....	70
4.3.8 Inadequate use of appropriate contraceptive.....	71
4.3.8.1 Barriers towards contraceptive use.....	72
4.3.8.1.1 Husband disapproval of contraceptive use.....	72
4.3.8.1.2 Fear of the side effects of contraceptives.....	73
4.3.9.1.3 Desire to have children.....	74
4.4 Infertility and childlessness.....	75

4.4.1 Family pressure and stigma.....	75
4.4.1.1 Stigma at family/household level.....	76
4.4.1.2 Stigma at society/community level.....	77
4.4.2 Social withdrawal and isolation.....	78
4.4.3 Fear of marriage breakdown.....	79
4.5 Congolese refugees’ experiences with accessing health care services in Durban.....	80
4.5.1 Language barriers.....	80
4.5.2 Affordability of health care.....	82
4.5.3 Attitude and behaviour of health care providers.....	83
4.6 Gender in determining total fertility among Congolese refugees.....	84
4.6.1 Task allocation.....	85
4.6.2 Men as decision-makers.....	86
4.6.3 Men as head of the family.....	87
4.6.4 Women and power bargaining.....	88
4.7 Conclusion .....	89

**CHAPTER FIVE: RECOMMENDATIONS AND CONCLUSION**

5.1 Introduction.....	91
5.2 Summary of major research findings.....	91
5.2.1 To identifying social and cultural factors contributing to the fertility rate among Congolese refugees in the greater Durban area .....	91
5.2.2 To understand the Congolese refugees’ experiences with accessing health care services, including reproductive health care services in Durban.....	93
5.2.3 To examine the role of gender in determining total fertility rate in relationships.....	94
5.3 Recommendation for practice and intervention.....	95
5.4 Recommendation for policy.....	96
5.5 Recommendation for further research.....	97
5.6 Limitation of the research.....	97

References

Appendices

## **CHAPTER ONE: INTRODUCTION**

### **1.1 . Introduction**

Population growth is one of the most important development problems facing the world in the 21st century. Despite the prevailing economic constraints, developing countries have failed to decrease their fertility rate. Lesthaeghe (2014) argues that the majority of African countries still have a total fertility rate of six children. This study focuses on Congolese refugee women settled in Durban CBD, South Africa, investigating the social and cultural determinants of their fertility. The background and research problems, rationale, aim and objectives of the study are presented in this chapter. The chapter defines the key concepts used in the study, and the outline of the dissertation.

### **1.2. General background of Congolese refugees in South Africa**

The major reasons for the presence of Congolese forced migrants and refugees in the Republic of South Africa have their genesis in multiple socio-political conflicts in the Democratic Republic of Congo (DRC). Political and social unrest has resulted in men, women and children leaving their homeland to seek refuge in South Africa. The majority of refugees in South Africa originate from countries such as Rwanda, Burundi, the DRC, Pakistan, Bangladesh and Somalia (UNHCR, 2013). South Africa host large populations of people seeking asylum in the world; it remains a preferred destination for many African nationals who originate from countries experiencing socio-economic and political instabilities (Zihindula, Akintola & Meyer-Weitz, 2017). The recent and accessible UNHCR report estimates that 243948 asylum seekers and 65668 refugees currently reside in South Africa (UNHCR, 2014).

Amisi (2005) argues that South Africa has seen an increase in refugees from many parts of the world, including the DRC. Similarly, Vearey (2014) stresses that, while there are people relocating inside the limits of their country of birth, a large number has crossed national borders. According to the UNCHR 2015 report, approximately 450000 refugees from the DRC remain in neighbouring countries, particularly Burundi, Rwanda, Uganda and the United Republic of Tanzania, mostly because of the conflict in the eastern part of the country. Over 2.7 million Congolese are internally displaced (UNCHR, 2015).

It is estimated that 3.3 percent of the South African population are non-nationals. Improving livelihood opportunities and seeking good health were identified among reasons behind migrants' movements. Deacon et al. (2015) argue that political migration results from conflict and instability in countries such as Mozambique, Angola, and the DRC. However, the majority of refugees migrate for economic reasons, such as better employment or business prospects. Deacon et al. (2015) conclude that Botswana, Namibia and South Africa attract the majority of economic migrants, because these countries have the strongest economies in the sub-Saharan region, and face skill shortages.

A report by the United Nations' High Commission for Refugees (UNHCR) indicates that the Congolese refugees represent the biggest group among the refugee community in Durban (UNHCR, 2013). Political conflict in the DRC has encouraged resettlement not only in South Africa, but also across neighboring countries. According to Arieff (2014), approximately over 2.6 million Congolese are internally displaced, and approximately half a million of them are refugees in neighboring countries. Because of the political unrest in the country, the Congolese population contributes to a humanitarian emergency. The UNHCR (2015) report revealed that Congolese represent 99 percent of the registered refugee population in Burundi and Rwanda, and 63 percent in Tanzania and Uganda. However, the history of forced migration is not necessarily new for DRC nationals. Steinberg (2005) provides a historical account of Congolese refugees in South Africa since 1988. He stresses that Congolese refugees are middle-class people fleeing from violence and economic and political instability that had forced (at his time of writing) more than a million people out of their country, and by the year 2000 many had started living in South Africa.

While conflicts and political disturbance are counted as major causes for Congolese displacement, rape as a contributing factor should not be ignored. Brown (2011, p. 6) stresses that in Eastern DRC, "rape is used to terrorize civilian populations, causing people to flee and leave their homes, belongings and their fields." According to the Institute for Economics and Peace (2010), the DRC is one of the four war-torn African countries that continue to occupy the lowest 10 positions in the Global Peace Index (cited in Liebling, Sleg, & Ruratotoye, 2012, p.19). The war in the DRC led to a mass rape of women and young girls, resulting in unplanned pregnancies contributing to a high rate of uncontrolled births (Zihindula & Maharaj, 2012).

According to the World Fertility Patterns report (2015), sub-Saharan Africa has a high fertility rate of more than five children per woman, with only South Africa, Lesotho, Namibia and Swaziland having a total fertility rate (TFR) below 4.0. The report has shown that the DRC is among the African countries with the highest population growth rates, having a TFR of 6.2 children per woman compared to Botswana's TFR of 2.9, and South Africa's 2.23 children born per woman during her reproductive life (United Nations, 2015).

A biological and cultural construct, fertility has affected forced migrants in different regions. Andersson (2004, p.750) states: "When people migrate to a new country, they bring with them important components of their original culture and behavior." It is understandable, therefore, that as Congolese leave their country and start living as refugees in Durban, the majority follow the practice of having more children, despite the daily challenges of bringing up a family in a strange country (current statistics are unavailable from published sources). Romaniuk (2011) indicated that the DRC still maintains its high rate of fertility regardless of the political and economic challenges that the country faces. Although Congolese people want big families, a study conducted by Romaniuk (2011) shows that many parents face a daily challenge in terms of feeding and meeting their children's basic needs. With the increased fertility, the World Bank report for 1989 revealed that: "Africa will increasingly be unable to feed its children and find jobs for its school leavers" (cited in Ushie et al., 2011). The DRC is a poor country where 63.4 % of its inhabitants live under the national poverty mark. The country has a number of extremely poor people, the second highest in the sub-Sahara after Madagascar. According to the International Monetary Fund (IMF) 2015 report, children in the DRC suffer from malnutrition because some of them skip a meal and others go to bed hungry due to poverty. The report revealed that many people are unable to enroll their children to school, yet the fertility rate remains high (Barlow et al., 2015; IMF, 2015). Lack of infrastructure and instability has been identified as major causes of nutritional deficiencies in the DRC, particularly in the conflict-ridden parts of the country (Barlow et al., 2015). The DRC nationals who are forced to leave their country and come to South Africa are classified among the group of those who are less educated; they can thus hardly compete for formal and professional employment in their host country.

Refugees in South Africa are characterized by having poor access to formal employment, lower levels of education, limited ability to communicate, and other social barriers, rendering them

economically disempowered (Human Rights Watch, 2010; Lakika, 2011; Landau, 2011; Vearey, 2013). Moreover, Amisi (2005) stresses that there is reason to believe that within the Congolese refugee community, livelihoods are not sustainable given the lack of social security in the informal sector, lack of access to trading sites and licences, and the dangerous conditions in which informal traders work. Irrespective of their socio-economic situation and job insecurity, refugees are still continually being documented and classified as a population group with a high fertility rate. Gagnon et al. (2002) argue that refugees have the need to have more children in order to make up the numbers for those who died, including soldiers because migration provides a better and more peaceful setting (Gagnon et al., 2002; Upvall et al., 2009). In contrast, there are people who assume that migration decreases refugees' fertility rates due to the perception of an uncertain future, economic constraints and spousal instability (Gagnon et al., 2002). Considering the above-mentioned background, this work seeks to examine the social and cultural factors affecting fertility rates among Congolese refugee women living in the inner city of Durban, South Africa.

### **1.3. Rationale of the study**

Population growth is a threat to sustainable socio-economic development, and the health and well-being of the people (Kohler & Behrman, 2014; Coale & Hoover, 2015). South Africa and Africa at large have one of the fastest growing populations in the world; this is exacerbated by the ever-increasing number of forced migrants seeking refuge and asylum in the country (Coffee, Lurie, & Garnett, 2007; Dinbabo & Carciotto, 2015). Despite deaths associated with HIV/TB and other communicable and non-communicable diseases in the country, StatsSA (2016) still shows an increase in the population, which might be due to uncontrolled childbearing of migrants and asylum seekers. This study is, however, concerned with refugees' childbearing, and factors that contribute to their high fertility. Somalian refugees living in the United States are categorized as having the highest fertility rates among all refugees' worldwide (Upvall et al., 2009). The same situation might apply among Congolese refugees living in South Africa; however, the lack of fertility statistics limits our understanding of the full picture. While the host country (South Africa) has managed to reduce its TFR to 2.2., the DRC's stands at 6.2 (United Nations, 2015). Although DRC refugees are already classified as economically disempowered and involved in informal jobs for low pay, this has not prompted them to reconsider their childbearing choices (Bigombe & Khadiagala, 2003; Kandala et al., 2014; Osarenren, 2013; Zihindula et al., 2015). This

calls for a need to investigate the forces driving the high TFR of DRC refugees, which, if identified, could assist in designing measures and strategies to address the problem of high fertility among refugees living in South Africa.

#### **1.4. Objectives and questions asked**

##### **1.4.1. Objectives**

- To identify the social and cultural factors contributing to the fertility rate among Congolese refugees in the Greater Durban area.
- To understand the Congolese refugees' experience with accessing health care services, including reproductive health, in Durban.
- To examine the role of gender in determining the total fertility rate in relationships.

##### **1.4.2. Research Questions**

- What are the social and cultural determinants of the fertility rate among Congolese refugee women in the Greater Durban area?
- What are the Congolese refugees' experiences with regard to accessing health care services, including reproductive health care services, in Durban?
- What is the role of gender in determining the total fertility rate in relationships among Congolese refugees?

#### **1.5. Significance of the study**

High fertility rates have a great impact on people's well-being and economic growth. The contribution of this study would be of interest to refugee women, particularly those from the DRC, in terms of encouraging the usage of contraceptive approaches. Raising awareness of family planning contributes to fertility decline and women's empowerment. In this study, the researcher aims to find the effects of childbearing on the reproductive health of women. It is a significant endeavor in terms of encouraging women empowerment, education and the use of contraceptive methods among women. The study is very relevant and timely for the refugee reproductive health care sector, which is based on different ways patient-care is delivered. In this case, available reproductive health programs and services in the host country should assist refugee couples to achieve their fertility preference. As men's domination contributes towards women's oppression

in most patriarchal societies, the study encourages gender equity in relationships, where women should take part in decision-making on matters concerning their household, especially their reproductive health. The study findings will serve as a future reference for researchers on the subject of women's reproductive health problems. In addition, it will contribute to the improvement of women's reproductive health by promoting a good relationship between refugee patients and medical care providers.

## **1.6. Scope and delimitations**

This study is limited to the Congolese refugees residing in the city of Durban, South Africa. It aims to investigate the cultural and social factors behind the fertility rate among Congolese refugees. Despite the unavailability of literature on fertility among refugee in this country, globally, migration is followed with an increase in childbearing (Gagnon et al., 2002). The study includes in its scope both married men and women aged 20-45 years. It is limited to women of reproductive age. Participants' level of education varies. The collection of primary data was done through one on one interview and secondary data through publication materials, the internet, Facebook, etc. Data collection took two weeks. This study focuses only on refugees from the DRC who are members of the Divine Mission church (DMC).

## **1.7. Definition of key concepts**

Defining key concepts is more important for better understanding the meaning of the study. Despite the terms being defined differently by different authors and researchers, for the purpose of this study the following definitions have been adopted.

### **1.7.1. Refugees**

It was reported in 2006 by the United Nations High Commissioner for refugees (UNHCR) that there were about 33 million displaced people in the world (Morris et al., 2009). According to the 1951 Geneva Convention, the term "refugee" includes "any person who is unable or unwilling to return to his or her home country, based on a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular group, or political opinion" (Anand, 1993, p. 98). This definition has been extended by the Organization of African Unity (OAU) to include "every person who, due to external aggression, occupation, domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is compelled to leave



his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality” (Anand, 1993, p. 126). Moreover, the term “refugees” is defined by the UNHCR as people who have been forced to move outside of their countries of birth and therefore come out of a history of hardship, and that includes war, famine and violence (cited in Morris et al., 2009).

Akokpari (1999) argued that as refugees have been displaced for various reasons, they are unable to go back to their regions of origin until the conditions that led to their displacement are stabilized. Moreover, the Refugee Convention specifies that:

a person qualifies as a refugee if (1) the person has already been considered a refugee under prior treaty arrangements or (2) the person is outside the country of his nationality (or not having a nationality) and is unable or unwilling to avail himself of the protection of that country due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group or political opinion (cited in Worster 2011, p. 102)

In addition, Martin (2001) defined “forced migrants” as people who are forced to flee their countries or places of habitual residence due to unsafe circumstances or threats to their lives, such as political unrest, conflict, natural disasters, hunger and abuses of human rights,. According to Martin (2001), migrants include all people who flee their countries seeking refuge, as well as everyone who is internally displaced. Migrants are regarded as people who are not natives of a given country. Lelkes (2007) argued that migrants refer to people who are born elsewhere than the country of residence. This definition is more applicable within the South African context, because the country has become a receiving African country for many people across the world, including those coming from the DRC.

### **1.7.2. Fertility rate**

According to Alkema et al. (2011, p. 816), “The total fertility rate (TFR) is one of the key mechanisms used in population projections; it is the average number of children one woman would be able bear in case if she survived through the end of the reproductive age span, experiencing at each age the age-specific fertility rates of that period.” Studies have shown that the indicator of fertility is the number of children that a women has during her lifetime (Alkema et al., 2011). Kohler and Behrman (2014, p. 3) note that “many of the world’s poorest countries, particularly in

sub-Saharan Africa, continue to face premature mortality, high fertility and often unmet need for contraception”. Ushier et al. (2011) argue that Nigeria is one of the countries with the highest fertility and population growth rates in Africa, where the majority of 87.3 percent of the currently married women want to give birth to six live children. Patterns of fertility differ between countries and changes over time. Norville et al. (2003) have shown that even in the very same country, fertility can vary by culture and/or by region; therefore, it becomes so difficult to find variables that can be used to foretell future fertility rates. Despite the fertility rate being a biological event, a considerable number of factors such a social and cultural have been documented as leading or contributing to the fertility rate among women.

### **1.7.3. The Democratic Republic of Congo (DRC)**

The Democratic Republic of Congo is a large country, approximately four times the total surface area of France. In Africa, it is the second-largest country before Algeria, and boasts the third largest population. The country’s population is about 70 million; its territory is mostly tropical savanna (Romaniuk, 2011). The country is one of the richest in the world in terms of minerals, water resources, and agricultural potential. Despite its resources, the majority of Congolese live in poverty, and many lack access to adequate food. The DRC has the world’s lowest gross domestic product (GDP) per capita (Arieff, 2014). As the country is wealthy in natural resources, control over resources has been counted among the leading causes of political unrest and conflict. The DRC has experienced war, resulting in looting, killings and a large number of girls and women being raped (Arieff, 2014). The problem of sexual and gender-based violence (SGBV) has affected women’s reproductive health all over the country, in regional, class and ethnic categories. Though SGBV affects women throughout the country, the level of sexual abuse in Eastern DRC is especially high (Arieff, 2014). “The sexual and gender-based violence is with extensive reports of gang rape, rape in public, forced incest, rape with foreign objects, and urogenital mutilation by the DRC military and armed groups.” (Arieff, 2014, p. 11)

The sexual and gender-based violence has pushed Michael van Rooyen, who is currently the director of Harvard’s Humanitarian Initiative and an emergency physician with experience in international disaster zones, to say that, in the DRC, “rape is becoming part of the culture” (cited in Brown, 2011, p. 6). He referred to the DRC as “the rape capital of the world” (cited in Brown, 2011, p. 23). Rape in the DRC has led to health-related problems including HIV/AIDS and other

sexually transmitted diseases (ibid). Many women who are raped become pregnant and contribute to the country's population growth. In spite of war and economic challenges, the DRC displays a high rate of fertility, not only resulting from mass rape but from other social and cultural factors. The DRC's TFR is 6.2 compared to South Africa's TFR of 2.2 children per woman (UN, 2015). The DRC has been characterized by high population growth since the 1970s, increasing its population by 3 percent per year. It is estimated that by the year 2050 the DRC will rank among the 10 most populated countries in the world (Mathe et al., 2011). With its increased fertility rate, the global world surpassed six billion at the beginning of the 21<sup>st</sup> century. Coast (2002) argues that developing countries account for 80 percent of the population of the world, while 61 percent is accounted for by the Asian continent, driven by population giants such as China and India. The rapid change that developing countries are experiencing is attributable to the relative numbers of children, working age populations and older people (Coast, 2002). The size of the world population is mostly attributable to countries that have failed to experience fertility reduction, particularly the ones in Africa, including the DRC. Bongaarts and Casterline (2013) give two reasons for fertility increase in Africa, although there are other leading causes: firstly, the desire to have more than five children per woman; secondly, the unmet necessity for contraception for women who want to meet their family size.

As the majority of the DRC population is found in patrilineal societies, childbearing is encouraged to ensure the continuity of the lineage. Modern contraceptive method is another factor affecting fertility in this country. Romaniuk (2011, p. 12) argues that "family planning is still in its infancy in Congo, as it is in many other parts of Africa." The above explains why women in the DRC rely on traditional methods such as post-natal abstinence, breastfeeding and withdrawing than the use of modern methods such as pills, injections and implants. A study conducted in eastern DRC has shown barriers to contraceptive use because of the lack of knowledge, the fear of side effects, religious considerations and husband opposition (Marthe et al., 2011). Although fertility in some regions, particularly developed ones, have reached fertility regression, sub-Saharan Africa is still experiencing fast population growth (Bigombe & Khadiagala, 2003; Anderson, 2004; Gerland et al., 2014; Kandala et al., 2014).

Population growth hinders economic growth, as it is associated with unemployment, low wages, poverty and environmental problems including depletion of natural resources, deforestation and

pollution. Health problems resulting from population growth are comprised of high maternal and child mortality (Coast, 2002; Kohler & Behrman, 2014). The above-mentioned challenges affect the well-being of poor people, particularly among those living in rural areas (Kohler & Behrman, 2014).

### **1.8. Structure of the dissertation**

This dissertation comprises five chapters.

Chapter One provides the study background and incorporates factors contributing to the migration of the Congolese to South Africa, a statement of the problem, primary objectives and research questions.

Chapter Two explores literature that is relevant to the study; it deals with refugees in Africa and elsewhere around the world. It considers both social and cultural determinants of fertility rates; challenges refugees face, in terms of accessing health care services; gender roles in determining fertility rates in marriage, and the theoretical framework that guides this study. Chapter Three presents the research design, sample selection, population sampling size and study limitations. The researcher describes the data collection tools used, methods of analysis and ethical considerations.

Chapter Four presents and discusses the findings of the study. It explores the major findings of the study on the basis of the following: value placed on childbearing and motherhood construction, women's education level, contraceptive methods, barriers faced by refugees in trying to access health care services; and sex preference within marriage.

Chapter Five presents the study conclusions, and recommendations for further research, interventions, and policy.

### **1.9. Conclusion**

This chapter has introduced the research problem, rationale, aim and objectives, theories and methods used in the present study. Although fertility rate has led to population growth and increased both socio-economic and environmental problems in many developing countries, Congolese refugees still value a big family; unfortunately, researchers have not investigated the topic. This study investigates the social and cultural determinants of fertility among Congolese refugee women living in the inner city of Durban. The next chapter will present both national and

international literature related to socio-cultural determinants of fertility among women, with a specific focus on forced migrants and or refugees.

## **CHAPTER TWO: REVIEW OF LITERATURE AND THEORETICAL FRAMEWORK**

### **2.1. Introduction**

The literature review chapter discusses the determinants of fertility rates among women around the world. It then focuses on aspects that determine DRC women's fertility rates before they become refugees, and after resettling in the host country, South Africa. Data from a few Western and African countries, including South Africa, are used to compare the total fertility rate (TFR) in different regions. Refugee and non-refugee women are compared on a range of issues. These include child and infant mortality, children as a source of labour and income, the value placed on childbearing and motherhood, women's education, and the low use of contraceptive methods. Barriers such as language and cultural differences, documentation, economic status and xenophobia are documented as challenges faced by refugees in the bid to access health care. The review makes usage of the gender and power relations theory to understand the role of gender in determining fertility within relationships.

### **2.2. Fertility and Culture**

Previous research on refugee women around the world shows that, despite their economic status, they still value large families. According to Romaniuk (2011), in the DRC and elsewhere in traditional African societies, there is great pressure on couples to produce as many children as possible in order to enhance the power and continuity of the lineage. Most cultures and African ones in particular, place a high social value on fertility. Araoye (2003) points out that in Nigeria, for instance, couples suffer stigmatization if the wife shows no evidence of pregnancy a few months after marriage. In Uganda, on the other hand, marriage is not considered consummated until the birth of children and their survival through infancy (Araoye, 2003). Wealth has often been measured in part by the number of children per couple; therefore, because of the high value placed on childbearing, couples can go to any length to have children; this includes resorting to criminal activities such as buying babies, which have been reported in Nigerian media (ibid).

In Africa, there are only five countries with a TFR of fewer than four children per a woman. These countries include Cape Verde (2.9), the Republic of South Africa (2.1), Lesotho (3.3), Namibia (3.6) and Swaziland (3.8). The remaining parts of the continent have shown an increased fertility of six children per woman, the DRC (6.3) included (Lesthaeghe, 2014). It is possible that

Congolese living in South Africa tend to display the same desire for a big family, highlighting the situation in their country of origin. Refugees in some places display a high rate of fertility within their host countries compared to their citizen counterparts (Robards & Berrington, 2016).

In many parts of the world, migration has been associated with an increased fertility rate. Anderson (2004) argues that the majority of migrant groups are likely to showcase higher levels of childbearing shortly after they have settled. Robards and Berrington (2016) state that over the last decade, the proportion of births among refugee women in England and Wales has increased from 16.4 percent to 25.5 percent. The authors conclude that an increased fertility rate among refugees is associated with age at arrival in the host country. Thus in the UK, for instance, women in their late twenties display high rates of childbearing compared to their counterparts in their thirties (Robards & Berrington, 2016). As African societies and other parts of the world have displayed high rates of childbearing, several studies have explained factors that contribute to fertility rates among women (Araoye, 2003; Adsera et al., 2011; Romaniuk, 2011), and these will be discussed in detail in the upcoming chapter.

### **2.3. Social and cultural determinants of fertility rates**

A number of factors have been documented as leading or contributing to fertility rates among women. The following were identified: child mortality; children as a source of labour and income; the value placed on childbearing and motherhood; women's education; and the low use of contraceptives. These factors are discussed below to show their roles in increasing fertility rates.

#### **2.3.1. Child and infant mortality**

The demographic pattern of the developing countries is characterized by the coexistence of high fertility and child mortality (Fitaw, Berhane, & Work, 2004). In sub-Saharan Africa, the Democratic Republic of Congo is classified among the most challenging surroundings in terms of health development with high rates of infectious diseases and child mortality (Kandala et al., 2014). It is estimated that the DRC has 159 of under-five-mortality (U5M) per 1000 live births. And this figure could even be much higher, were it not for the lack of registration equipment: displacement and conflicts often influence record-keeping (Chirwa et al., 2014; Kandala et al., 2014 ;). Similarly, the lack of reliable vital statistics on migrants has hindered the estimations of child mortality among refugees living in South Africa. Since they are vulnerable groups, their child

mortality might be higher compared to their national counterparts. The level of child mortality is excessively high within the DRC, and is explained by many factors including hygiene, environmental conditions, socio-economic and cultural variables as well as ongoing conflicts. In addition, short birth intervals have led to high maternal and child deaths. It is explained by the fact that in developing countries, the DRC in particular, women do not use contraception after giving birth (Izale et al., 2014). As a result, many of them become pregnant once fecundity returns. A certain number of studies have revealed that U5MR is associated with short birth intervals (Davanzo et al., 2004; Chirwa et al., 2014; Kandala et al., 2014). It is explained by “the rate of 214.3 deaths per 1000 live births among children from short birth intervals compared with 133.5 deaths per 1000 live births among those from long birth intervals” (Chirwa et al., 2014, p. 2).

The reduction in under-five mortality was one of the Millennium Development Goals (MDGs) which was established at the United Nations Millennium Summit in 2000, and intended to be achieved in 2015. However, the MDGs could not be achieved as many developing countries failed to reduce the mortality rate of children by two-thirds between 1990 and 2015. Kandala et al. (2014) argue that the DRC cannot attain the MDGs unless it reduces its U5M by two-thirds, from the current 159 to 60 per 1000 live births. The above can only be achieved if continued efforts and investments are made in the whole country, not only in the most affected areas.

Developing countries have failed to control their child mortality rates, resulting in increased fertility rates, which have led to high population growth that affects people’s well-being and health.

The UNICEF report (2003) revealed that every year nearly 11 million children die before their fifth birthday. Davanzo et al. (2004) estimate that 99 percent of these deaths happen in developing countries. The above statement justifies the reasons behind high fertility in developing countries, where parents experiencing the death of their children try to fill the gap by having more. Whenever there are high rates of child mortality parents tend to replace their deceased children. For example, Verwimp et al. (2004) studied fertility rates in Rwanda, and concluded that childbearing was justified by the fact that women were giving birth just to replace their children who died during the 1994 genocide. Fitaw et al. (2004) agree that parents whose children die tend to have more children than they would have if all the children planned had a good chance of survival. Cleland et al. (2006) write that In Niger, for instance, children’s mortality rate remains considerably high



with over than a quarter of children dying by the age of five. Couples tend to increase their family size and even go beyond what they consider ideal whenever their children die (Fitaw et al., 2004).

Nanda (2005) states that when a child dies, it is built in the mindset of couples that more children have to be given birth to meet the desired family size. Wherever infant and child mortality is high, the fertility rate is high as well, and people tend to have children at random intervals, and whether family planning services are available or not (Fitaw et al., 2004). In addition, child mortality is associated with early age in marriage. Adhikari (2010) highlights that in Nepal the majority of women who got married at an early age (below 16) had lost a child compared to those who had married at the age of 16 or later. Norville, Gomez and Brown (2003) had also noted this phenomenon and added that children who are born to a very young mother have a risk of dying, especially if the mother already has many children. The early age of marriage is not only associated with a high rate of fertility, but with child and infant mortality as well. Ushie (2009) stresses that in Nigeria, women as young as 14 are married and at the risk of pregnancy and childbirth (cited in Ushie et al., 2011). It seems that women who marry very young tend to have more children than those delaying marriage. Nanda (2005) argues that people who marry between 18 and 24 tend to have fewer children than those married below 18 years of age.

Factors influencing child mortality are documented, including the geographical location of the family (Mondal et al., 2009). According to these studies, people living in urban areas experience a lower child mortality rate compared to their rural areas counterparts. Mondal et al. (2009) point out that this is due to the greater accessibility and availability of health care services in urban than rural areas.

Rural people lack access to sanitation and clean water, which leads to diverse infectious diseases and the death of many children. Moreover, social and economic factors such as the mother's education and father's occupation have a strong impact on infant and child mortality (Mondal et al., 2009). This justifies the situation in many developing countries where life is not sustainable, and children lack the means to survive. The majority of parents cannot afford to provide better health care for their sick children. Mondal et al. (2009) show the relationship between women's education and child mortality. They believe that education is associated with the health of the child in that educated mothers can provide better care for their children than uneducated women or those with a lower level of fertility (ibid). In addition, with education a woman is advanced and free

from traditional values, and changes her pattern of behaving and attitude. Improved women's education is the key to reducing child mortality rates, and improving the well-being of the population.

### **2.3.2. Children as a source of labour and income**

Child labour is an economic contribution found all over the world, predominantly in developing countries. It is estimated that a third of the children in developing countries, particularly those in west and central Africa, are involved in paid or unpaid work and do it either full- or part-time (Thorsen, 2012). The International Labour Organization (ILO) has defined child labour as follows:

All children below 18 in harmful occupations or work activities in the labour market or their own household; all children undertaking work in the labour market or household interfering with their primary education; all children under 15 in full-time employment; and all children under 13 in part-time work. (Rena, 2009, p.1).

Children are seen as contributive elements in the family economy. In Uganda, for instance, rural people who are relying on agriculture perceive children as a source of labour, and others view girls specifically as a source of income with the payment of bride price (Chytilová & Streblov, 2007). In Botswana, although the government has encouraged free primary schooling for all children, many of them are widely involved in economic activities and household tasks rather than attending school (De Hoop & Rosati, 2014).

Thorsen (2012) has revealed that in terms of child labour, many parents try to balance their desire to increase productivity against their children's school attendance. He states that farmers who lack money to hire workers fail to send their children to school in order to engage in the family's economic activities. Child labour becomes one of the ways of improving livelihoods whereas childless women suffer economic deprivation since they do not have children to help them.

In some places, cultural beliefs have created economic difficulties for childless women. In Nigeria and Cameroon, for example, land claims are negotiated based on the number of children a woman has. A childless widow in some developing countries may face poverty or have no right to inherit from her deceased husband (Dyer & Patel, 2012). Childlessness is a major problem faced by many women. In Nigeria, an infertile woman is not recognized as an elder owing to her failure to bear a son. In addition, she is left without a home or money. It simply means that an infertile woman does

not have a right to her husband's property (Rouchou, 2013). Preferably, if a woman fails to conceive, it is better she goes back to her parents' compound, otherwise her husband's family will mistreat her. A study conducted in Rwanda shows that "children are currency" (Rouchou, 2013). A husband of an infertile woman is not allowed to buy food or clothing for his wife if she cannot give him a child in return (Rouchou, 2013). In contrast, infertility does not only affect women, but it economically, psychologically and physically affects the lives of men in many developing countries. A study conducted in Bangladesh shows the link between poverty and infertility. It suggests that childlessness generates poverty among rural families compared to urban middle-class ones (ibid). Infertile men are forced out of their workplace since they do not have any offspring to support (Dyer & Patel, 2012; Rouchou, 2013). As childbearing is important in developing countries, it has increased their populations.

Ethiopia is the second-poorest nation in the world, with a GNP per capita of \$US 100 (Heissler & Porter, 2013). The country has one of the highest proportions of working children in Africa, and the third-highest fertility rate of seven children per woman (Heissler & Porter, 2013). In the rural areas, the high fertility rate is explained mostly by the fact that children play the main role in terms of contributing to the well-being of the family. Heissler and Porter state that in Ethiopia, children begin their economic usefulness at a very early age, by performing tasks such as gathering fuel, fetching water, carrying messages, and caring for younger children. Authors conclude that over 40 percent of Ethiopian children aged 10 to 14 work on their family farm. They believe that parents desire to have many children because their income contribution to the family exceeds their costs. Thorsen (2012) concludes that child labour is important for parents in developing countries because in most cases child wage rates and earnings are high, and parents tend to raise more children, and school them less. This in turn leads to the short-term benefit of the children contributing to the family income.

The allocation of tasks to children has contributed to defining the sexual division of labour, even among children, with girls specializing in domestic activities and boys in herding and agricultural production (Cockburn, 2002). As children grow older, they move into different activities requiring increased physical and mental development. For example, in Ethiopia, boys assume responsibility for the care of cattle at about eight or nine, whereas girls begin to participate in most rice processing and food preparation between nine and ten (Cockburn, 2002).

Rena (2009) stresses that in terms of task allocation, in some areas the oldest girl in the family has a greater chance comparing to other children in the household of being involved in domestic work and not going to school, while boys, in particular those with older sisters, are more likely to go to school (Rena, 2009). In many developing countries, poverty might be identified among other leading factors that contribute to fertility rates by the fact that poor parents tend to have as many children as possible, to ensure the family's financial support resulting from their children's labour. Schultz (2005) emphasizes that fertility is often higher in poorer families within a society, and across countries; those with higher than average fertility tend to have lower than average income.

There is a close relationship between child labour and poverty. Rena (2009) argues that poor families cannot sustain themselves when their income is unstable. As a result, some parents put children to work as part of a survival strategy to decrease the risk of an interruption of income that could be caused by unsuccessful harvests or loss of employment by an adult and a member of a household (Rena, 2009). The International Labour Organization (2010) revealed that the high rate of poverty has caused children to work for their survival. It said that many parents depend on their children's labour, although they know it is very wrong (ILO, 2010). Children are pulled out of school to provide labour to complement their family income. Edet and Etim (2013) point out that a possible reason parents in developing countries have many children is because they can be profitable. These authors believe that in developing countries, children are much less of an economic burden compared to their counterparts in developed countries.

The relationship between family size and poverty indicates that a household with a big number of children tend to be poorer, compared to families with fewer children (Edet & Etim, 2013). Children from a larger household are more likely to work in order to earn an income to support their family. Instead of going to school, children in developing countries contribute to their household incomes by involving themselves into labour mostly due to poverty (Edet & Etim, 2013). In contrast, children in developed countries are perceived by their parents as burdens because the latter spend more on their education than sending them to work at an early age (Edet & Etim, 2013). Children in developing countries seek employment, simply because there is no access to schools. Edet and Etim (2013) argue that schools in developing countries' schools suffer from problems such as the lack of formal teaching and curricula, overcrowding, inadequate sanitation, cost of schooling, lack of government presence and apathetic teachers. As a result, parents might find it useful to leave

their children at home to learn skills such as agriculture and supplement the family income rather than send them to school (ibid). The World Bank (2005) report revealed that child labour has become an obstacle to achieving MDGs of universal education because millions of children in sub-Saharan Africa are working instead of going to school.

However, the high cost of rearing children has led to a decline in fertility in both Europe and America, where parents spend too much on their children's education. Cleland (2006) stresses that whenever people have many children they become poor and unable to recover from poverty. According to economic theory, having children is a rational decision that couples should take into account by considering both the costs and benefits of childbearing. This theory encourages parents to invest in the quality of life of their children, instead of their quantity, by having fewer children when the costs of raising them are higher (Tanturri et al., 2015). This differs from developing countries, where poor parents tend to have more children with no means of survival. Cleland et al. (2006) argue that poor parents need more children for help and security in old age. Consequently, children from a family with many children experience malnutrition and illiteracy compared with their counterparts in smaller families.

A study by van Groezen et al. (2003, p.237) offers a slightly different perspective on the reasons for high fertility rates. "People choose children because descendants have the characteristics of a capital good, in that it will provide services to the retired parents."

This statement assumes that parents believe their children will provide them with social security in their old age, particularly in developing countries where the pension scheme is not guaranteed for retired people (Van Groezen et al., 2003). In contrast, Boldrin et al. (2015) argue that in Europe and America, fertility has declined because their governments provide pension systems for retired people. Thus parents do not want children for support in their old age (Boldrin et al. (2015). Authors conclude that fertility rates were much higher in the US and Europe around 1950, when the elderly in those countries had smaller pensions than they have now. However, since the late 1970s fertility rates have been persistently declining in Europe. This is partially enlightened by the fact that European countries have larger pension systems compared to the US (ibid).

Urbanization has played a major role in determining the countrywide fertility level. Gries and Grundman (2014) argue that in urban areas, children are less likely to contribute to family income at an early age, comparing to their counterparts in rural areas. As a result, the net benefit of having

children is reduced (Gries & Grundman, 2014). Although space is so expensive in urban settings, having more children requires parents to provide more space. Therefore parents tend to promote their existing children's health and education rather than having more children. A town or city has better health services which make birth control much easier (Gries & Grundman, 2014). Urban women are therefore more likely to use contraceptive methods and prevent unwanted pregnancies than their counterparts in rural areas.

### **2.3.3. Value of childbearing and motherhood**

In most African societies and elsewhere in the world, the great value placed on childbearing and motherhood should be taken into consideration, as far as the social and cultural determinants of fertility are concerned. In African cultures, childbearing has defined the position of women within societies. Okome (2001) states that: "motherhood is very important in all African societies. Respect for the woman, however, is underscored by her fecundity, fertility and fruitfulness" (cited in Methuselah, 2014, p.216). The author reports that "any woman whose womb is therefore fertile can hold her head up high with all pride in the community" (Methuselah, 2014, p.213).

Thus, women's status is increased when they give birth to children, especially sons. Osarenren (2013) states that in some African communities, young couple will pray to have sons only or both sons and daughters, with sons taking priority over daughters (cited in Methuselah, 2014).

Motherhood in Africa accords the highest form of respect to a woman. In contrast, barren women suffer the stigma of childlessness on a daily basis. A study conducted in Cape Town reveals that childless women were being called names such as "idlolo", which means barren, and "stjoekoe", meaning failure. (Tabong & Adongo, 2013). They suffer stigmatization in their families and communities. As a result, barren women exclude themselves from celebrations such as birthdays and baby showers in order to conceal their involuntary childless status (Tabong & Adongo, 2013).

While childbearing gives women high status, barrenness is viewed as a curse; it is one of the reasons for polygamy in many African societies. Studies by Engels (2004) reveal that in case of barrenness, a man is allowed to take a second and a third wife, if the first two cannot give him children. Falola (2001) points out that in traditional societies, a man is allowed to marry as many wives as he wants to be able to have sons to keep the kinship line going (cited in Methuselah, 2014).

However, a study conducted in Pakistan indicates that women are blamed for their husbands' infertility, even if the latter are clinically proven infertile (Mumtaz et al., 2013). In highly patriarchal societies, men's infertility receives little attention. In India, for instance, men might be aware of their infertility, but they are reluctant to seek medical treatment, for fear of social disgrace (Mumtaz et al., 2013). As a result, women suffer from depression, unhappiness and rejection, and may even commit suicide. Men are not prepared to take the responsibility for failing to produce children; instead, women are victimized and suffer the consequences (Mumtaz et al., 2013). A woman often undergoes treatment, although her man has been identified as the infertile partner (ibid).

A study conducted in Moshi, Tanzania revealed that barren women suffer a lot at the hands of their husbands and in-laws. They are viewed as useless if they fail to give birth (Hollos & Larsen, 2008). In case of barrenness, bride price cannot be paid unless the woman gives birth or becomes pregnant (ibid).

In many cultures, womanhood is determined through motherhood, and infertile women are usually blamed for the inability of the couple to conceive. However, Cleland et al. (2006) argue that there is a huge relationship between childbearing and household poverty. In the developing world, poor women have a fertility rate of six children compared to the 3.2 of richest women. Contrary to African views of childbearing, Okome's study (2001) of childbearing in Western industrialized societies shows that motherhood is perceived as a burden, and the art of childbearing as enslavement of women (cited in Methuselah, 2014).

Miller (2011) writes that in the United States of America a year of delayed motherhood increased women's earnings by nine percent, their work experience by six percent, and average wage rates by three percent. Studies (Nicoletti & Tanturri, 2008) reveal that in Europe women postpone childbearing in order to pursue higher education, to establish themselves in the labour market, accumulate material resources and enjoy different kind of leisure that might be incompatible with family life (cited in Tanturri et al., 2015). It simply means that childbearing in many developed countries hinders people from achieving their goals because of everyday childrearing tasks. While some women postpone childbearing, there are others who are voluntarily childless and describe themselves as "childfree". For them childbearing is meaningless. Several qualitative studies, such as those by Tanturri (2010) and Tanturri et al. (2015) provide proof that the "voluntary childless

frequently report their desire for independence, freedom and spontaneity, for a life without constraints” (cited in Tanturri et al., 2015, p. 15).

This means that women in industrialized countries prefer further education and working for a wage to raising children. It is the opposite with African women, who gain more respect through childbearing. Parents in advanced societies tend to have fewer children as they fear the costs of raising them (cited in Balbo et al., 2013).

#### **2.3.4. Women’s education**

Dr Sadia Chowdhury, a reproductive and child health at the World Bank, has noted that encouraging girls and women in education and providing opportunities for success are very necessary in decreasing the rates of birth in the long run through the promotion of contraceptives and family planning (cited in McCrary & Royer, 2006). The spread of education and literacy among women is believed to be important to changes in reproductive behavior (Palamuleni et al., 2007). Educated women tend to postpone marriage and pursue their careers. In terms of contraceptive use, some women are not aware of information about family planning, while others do not use contraceptives because of their desire to have more children. Palamuleni et al. (2007) argue that fertility tends to rise with education, and thereafter it decreases significantly as soon as one reaches a certain level of education. The author concludes that fertility declines a country’s population becomes urban and women become more highly educated.

In Jordan, for instance, uneducated women have 6.9 children per woman, while those with secondary school or higher education have, on average, only 4.1 children (cited in Norville et al., 2003). Basu (2002) assumes that the more women are educated, the more they gain autonomy and the ability to make decisions on household matters, the use of resources, and their reproductive health. OsayiOsemwenkha (2004) argues that when a women attains a certain level of education she may end up in a marriage that gives her a more equal relationship with her husband (Basu, 2002).

If there is conflict in reproductive preferences, there is always resolution in the woman’s favour when she is educated (Basu, 2002). Education is an important factor that should be taken into consideration if someone wants to achieve a healthy and organized family. Muhindo et al. (2015) argue that education is the key to empowering women, as they are more likely to understand the



benefits of child spacing by considering their own health choices, the children's health, and the goal of their family size. Moreover, with education women are more likely to negotiate contraceptive practices with their partners than their counterparts with only primary education or no education at all. Uneducated women, on the other hand, are more likely to report lack of support from their partners, which lead to short intervals between births in less than two years (Muhindo et al., 2015). Asekun-Olarinmoye et al. (2013) argue that women with a tertiary level of education are more likely to use contraception than those with secondary education. Women's education obviously has a great impact in reducing fertility and preventing unwanted or unplanned pregnancies. In terms of women's education and the use of contraceptive methods, Asekun-Olarinmoye et al.(2013) stress that better educated women are likely to look out for information about reproductive health, and even have the power to influence their husbands on the need for contraception in a situation where men might be perceived as obstacles to the practice.

### **2.3.5. The use of contraception**

The motivation for healthy spacing of births and the desire for small families has increased in developing countries (Darroch & Singh, 2013), which will be able to decrease their fertility rates as soon as women and their partners realize the importance of effective contraception to prevent unplanned pregnancies (Darroch & Singh, 2013). Studies have shown that uncontrolled population growth will hinder the achievement of development and health goals in Africa (Cleland, Ndugwaa, & Zulu, 2011). Hence, the population needs to adopt effective modern methods of contraception as seen in other parts of the world, particularly in the developed countries. The practice of contraceptive methods is effective in terms of avoiding unwanted and unintended pregnancies among women of reproductive age. Methods of contraception fall into two groups, as reported by the WHO (2008; 2013): modern and traditional. Modern methods comprise female sterilization, male sterilization, pills, depot implants, male condoms, female condoms, intra-uterine devices (IUD), the locational amenorrhea method (LAM), and emergency contraception (cited in Andi et al., 2014). Traditional methods comprise the rhythm method (periodic abstinence) and withdrawal, but they are always questionable because of their ineffectiveness (WHO 2008; 2013). In order to maximize the impact of these methods in preventing unintended pregnancies and their consequences among women, consistent and correct use is required (Darroch & Singh, 2013). Moreover, the use of condoms should be encouraged since they are less likely to be used among

married couples in many parts of Africa (ibid). In other parts of the world such as the USA, France, and Pakistan, studies have indicated that two to nine percent of oral contraceptive pill and injection users become pregnant within 12 months of starting the methods, mainly because they use them inconsistently or incorrectly (Muhindo et al., 2015).

The traditional methods are much preferred among women in Burkina Faso because of health concerns and fear of side effects. In Ghana, abstinence among married women is strongly associated with temporary spousal separation (Cleland, Harbison, & Shah, 2014). The low use of contraceptive methods in developing countries is explained by its unavailability in some places. WHO (2013) reports reveal that there are an estimated 222 million women in developing countries who want to space or prevent childbearing, but lack access to modern contraceptive methods. Izale et al. (2014) point out that 80 million of the 210 million pregnancies that occur each year in the developing world are unplanned. Most women experiencing unplanned pregnancies want to terminate them; but those who undergo unsafe abortions may die at the hands of untrained staff and the generally poor quality of health care services. Asekun-Olarinmoye et al. (2013) argue that in Nigeria, for instance, illegal abortions arising from unwanted pregnancies have increased, and this constitutes a major reproductive health problem since abortion is illegal under most conditions. (Asekun-Olarinmoye et al, 2013).The failure to access and use contraception results in a high level of maternal mortality, particularly amongst the poor (Cleland et al., 2006; UNFPA, 2012). Izale et al. (2014) report that approximately 99 percent of deaths among women experiencing abortions occur in the developing world. Furthermore, a study conducted in Ghana shows that the low use of contraception and illiteracy among women are contributing to high fertility rates. DeRose et al. (2002) have shown that female education is influencing the desire to have a big family size by reducing fertility. In addition, Beekle and McCabe (2006) believe that there is a great importance in terms of improving women's education and economic opportunities because educated women tend to be more independent and influence their family size by using family planning programs. Palamuleni et al. (2007) argue that fertility has the tendency of rising with education and thereafter it decreases significantly as soon as one reaches a certain level of education. According to Chytilová and Streblov (2007), fertility has increased in developing countries because modern methods of contraception are considered to violate the natural course of reproduction. People believe that the usual lengthy period of breastfeeding and postpartum abstinence guarantee sufficient spacing between children – unfortunately an incorrect assumption. Studies have revealed

that Niger, Benin, Sierra Leone, Guinea and the DRC have high fertility rates, which is explained by the fact that contraceptive use is lower, and mostly used for spacing children rather than limiting their numbers (WHO, 2006; Izale et al., 2014; Lesthaeghe, 2014). A study conducted in Nairobi, Kenya shows that many women who were sexually active were not using any form of contraception after giving birth; they had to wait for the return of their monthly menses to adopt the type of method they wanted to use (Cleland & Machiyama, 2015). This practice increases the risk of unwanted and unplanned pregnancies. Cleland and Machiyama (2015) state that although unplanned and unwanted pregnancies might have a severe impact on the lives of women and their babies, religions and other cultural realities forbid the use of modern contraceptives in many parts of Africa (Cleland et al., 2011).

#### **2.3.5.1. Barriers to contraceptive use**

Despite the wide range of effective contraceptive methods available to women in both developed and developing countries, unintended and unplanned pregnancies continue to occur in large numbers and rates of sexually transmitted infections remain high (Srikanthan & Reid, 2008). Cleland et al. (2006) identify four key barriers to contraception among women, including “the insufficient knowledge about contraceptive methods and how to use them; fear of social disapproval; fear of side effects, health concerns; and women’s perceptions of husbands’ opposition” (Cleland et al., 2006, p. 1814).

In Nigeria, for instance, the side effects of using contraceptive methods such as irregular menstruation, abdominal pain, headache, and fear of infertility are among factors that hinder the use of contraceptives among women (cited in Asekun-Olarinmoye, 2013).

A study by Izale et al. (2014) found that socio-economic constraints are among factors limiting the use of contraceptive methods in the DRC where: most women cannot afford them. Studies (Silverman, Torres, & Forrest, 1987; Cleland et al., 2014) have revealed that their non-accessibility and affordability is another hindrance to contraception. In many parts of the DRC, family planning services are only free at the non-governmental clinics, and are sometimes out of stock (Izale et al., 2014). As a result, it might be much to the disadvantage of poor women. In South Africa, and elsewhere in developing countries, refugee populations are vulnerable to having unmet contraceptive needs. Krause et al. (2005) conclude that although refugee women may show their willingness to use contraceptives, they always have barriers such as lack of supplies. In South

Africa, services are free and accessible by locals in public healthcare facilities, but not easily accessible by refugees (Landau, 2012; Vearey, 2013; Crush & Tawodzera, 2014), who thus find no difference between similar services in their country of origin and those in the host country.

In South Africa, 30 to 50 percent of women present with unwanted and unplanned pregnancies, and then seek termination. In some places in Africa contraceptives are unavailable, and in others people do not want to use them despite their availability. In Ethiopia, contraception is very low despite the free family planning services provided in both governmental and NGO health facilities, including hospitals, clinics and health centers (Mohammed et al., 2014). In most cases, husbands' disapproval, the contraceptive side effects of being infertile, and ailments such as hypertension were the main causes of the low usage of contraceptives among Ethiopian women (Mohammed et al., 2014). As a result, couples tend to use traditional methods that are perceived to be less harmful to health (Cleland, Harbison & Shah, 2014).

Cultural norms and beliefs have played an important role in hindering the practice of modern contraception in some places. In the DRC, Catholic couples are permitted to use natural contraceptive methods such as abstinence and the rhythm method, which are mostly ineffective in preventing unwanted and unplanned pregnancies resulting in infant and maternal mortality (Izale et al., 2014).

Catholics believe that the primary purpose of marriage and sexual intercourse is procreation, so every act of intercourse must be open to conception (Srikanthan, & Reid, 2008). Members of Protestant churches, on the other hand, are allowed to use birth control, but only after the family is complete. In Ethiopia and other places, the case is similar to that of the DRC, where religion prohibits women to use any modern method of contraception. Instead, it encourages the traditional ones, which are notoriously unreliable. It means that family planning is used for birth spacing rather than restricting the number of children, which explains the TFR of 6.9 in the DRC (Izale et al., 2014) and 7.0 in Ethiopia (Mohammed et al., 2014).

#### **2.4. Gender and control over fertility**

Gender power relation is understood through the subordination of women. It plays a major role in controlling women's reproductive health choices. Paulina Makinwa-Adebusoye (2001) indicates that in Nigeria, a patriarchal society, women are rated lower than men, and cannot talk even about

matters that threaten their well-being. A study by Adebuseye (2001) shows that the lower status of women has affected the use of contraceptives since men have to make decisions on fertility matters (cited in Ekane, 2013). On the one hand, women want more children, but on the other, dominant males control their fertility rate. Makinwa-Adebuseye (2007) argues that early marriage, patrilocal residence after marriage and polygynous unions are institutions that perpetuate women's subordination and make them voiceless and powerless in matters affecting their productivity. Studies (Dodoo&Tempenis, 2002) show that the payment of the bride price (lobola) to the bride's family by the groom always transfers to men the authority to make decisions regarding the number of children, and when to have them. Hague, Thiara and Turner (2011) point out that the payment of bride price is considered a symbol of gratitude and agreement amongst families. It is common knowledge to legalize customary marriages in African societies by the exchange of gifts such as livestock, cash, goats, or sheep, depending on the particular society (cited in Asiiimwe, 2013). In sub-Saharan Africa, a central purpose of the bride price is to create an alliance between kinship groups. It differs from a dowry, which is paid to a groom's family in a country like India (Anderson, 2007). However, with increased modernization, the practice has lost its original value, and become highly commercialized and commoditized, which leads to affordability problems for the majority of people, particularly the poorest (Anderson, 2007; Asiiimwe, 2013). As the bride payment has changed, the practice has involved the exchange of money and valuable goods rather than animals that were considered the main items in most African societies (ibid).

In Uganda, for instance, land tenure, modern gifts such as land titles, electrical goods, furniture, home theatre systems, cars and other items have been introduced into the process to go hand in hand with the so called "traditional" items. This practice is problematic to the groom with poor income because he cannot afford the bride price. Dodoo & Tempenis (2002) state that the bride price has varied across countries depending upon economic conditions, societal structures, institutions, and family characteristics. Anderson (2007) argues that in Senegal, the more a woman is educated, the higher the bride price. Rich people tend to give their children's hand in marriage to their fellows (Pamporov, 2007). As women are treated as commodities owing to the rise of bride payment, the practice has increased their subordination and made them powerless, since men believe they have spent so much in exchange for their woman that they are entitled to possess her in every possible way.

Pamporov (2007) highlights that within Roman law the main function of the bride price payment before or during the marriage was precisely to define the social status of children born to that union. In return for the bride price women are expected to produce children for their husbands and lineage. Ngide (2013) contends that with the bride price, women become men's property, which encourages the marginalization of women. Pamporov (2007) states that in Roman culture, children belong to their paternal kin, so that in case of divorce the woman may end up losing everything, including the right to see her children. Living within patriarchal societies, African women have a low status in terms of making decisions in the family. Upadhyay and Karasek (2010) regard gender inequality as a universal characteristic of developing countries, where women are silent and voiceless owing to economic and cultural factors, unlike women in developed countries, who are economically empowered and have a powerful voice that demands an audience and positive action (Upadhyay & Karasek, 2010). Jayachandran (2014) points out that gender inequality has created the invisibility of African women through the process of capturing men and leaving women behind in the development process. Akyeampong and Fofack (2012) argue that women always produce more food crops in sub-Saharan Africa, yet their enterprise is not recognized, as colonizers promoted cash cropping and assigned it to men, instead of valuing the subsistence farming that women did. As most of African women are economically dependent on their husbands' incomes, this has enforced their subordination and made them powerless to make decisions on general household matters, including their reproductive health.

In Africa, most societies are patriarchal where men are the sole decision-makers, and women have no control in various important matters, including their reproductive health. Wendo (2004) states that "bride price payment makes the wife a property of the husband, reducing her capacity to defend and control her body" (cited in Asiimwe, 2013, p. 10). Studies have revealed that the majority of women suffer from unwanted pregnancy due to their partners' reluctance of using birth control, and wanting them to become pregnant (Gee et al., 2009; Odimegwu et al., 2015). The majority of women face violence in trying to reinforce the use of birth control denied by their partners. Studies have suggested that contraception might be more difficult for women experiencing violence, leading to a higher incidence of unplanned pregnancy (Gee et al., 2009). Women have been shown to have little power when it comes to making a decision on the timing and number of children they should have because of male dominance. Men engage in certain behaviour such as forced sex, refusing to use birth control so that women can become pregnant

and give birth (Williams et al., 2008). Conversely, they prevent women from having children by forcing them to have abortions (Williams, 2008).

As culture has encouraged the suppression and subordination of women, they are not only victims of unwanted pregnancies, but at high risk of sexually transmitted diseases (STDs) such as HIV. Dunkle et al. (2004) state that the presence of violence and controlling behaviour of male partners is associated with the high levels of HIV infection among women. As patriarchal societies view men as superior to women, men are considered to control sexual activity, which exposes women to unprotected and unwanted sexual encounters. Liberal feminists such as Lorber (1997) states that both men and women should be treated equally as their gender differences are not biologically constructed; women should have the same rights as men, and the same educational and work opportunities.

## **2.5. Refugees accessing health care, including reproductive health care services**

Accessing health care, particularly family planning, is essential for refugee women in controlling fertility rates. Since they come from war-torn zones and have witnessed various types of violence and crime, a large number of refugees are in need of counseling, for mental health problems. Zihindula (2015) highlights that self-settled urban refugees in developing countries face challenges in accessing available health care, and are particularly vulnerable to diverse health problems because of their poor living conditions and lack of money. Krause et al. (2000) state that a significant number of women who are in need of spacing or limiting births cannot access appropriate health care and cannot even afford it. They stress that “this issue is always in refugees’ settings in which family planning services are frequently limited to basic principles and women struggle with unwanted, unplanned and poorly spaced pregnancies” (Krause et al., 2000, p.183). However, Swartz (2009) says that South African women generally have good access to family planning services, and they generally trust modern contraceptive methods to achieve their goal of either spacing or limiting the number of children they intend to have. Poor health care and family planning services have contributed to an increased fertility rate among refugees owing to their inability to access and use these services in public hospitals. After the first fully democratic general election in 1994, South Africa adopted a policy of providing health care for all, and declared free and universal access thereto of migrants, refugees and asylum seekers who live in South Africa (Republic of South Africa, 1996; South African National Department of Health, 2014). However,

there is limited access to any form of health care by refugees in South Africa. Accessing health care remains complicated and influences their health-seeking behaviour despite the official policy of inclusion (Landau, 2011; Vearey, 2013; Crush & Tawodzera, 2014; Institute for Security Studies, 2014). Myriad issues have been documented as barriers to accessing health care by refugees living in South Africa, including: language and cultural barriers, socio-economic status, xenophobia and refugee documentation.

### **2.5.1. Language and cultural barriers**

Refugees, particularly those from non-English-speaking countries such as the DRC face language barriers when using health care services. The British Medical Association (BMA, 2000) considers that language is the most important barrier which hinders refugees from having access to health care in South Africa (cited in Nkosi, 2014). Moreover, section 27 (1) of the South African Constitution stipulates that “everyone has the right to have access to health care services, including reproductive health care. Section 31 (1) concludes that people may not be denied their right based on cultural affiliation, religious beliefs or even linguistic community (Republic of South Africa, 1996).

The majority of refugees in South Africa come from war-torn countries, including the DRC, Rwanda, Burundi and Angola. Most of them do not speak the language that would enable them to access health care services in the host country. Failing to speak the language of the host country can lead to feelings of discrimination. Studies such as that by Ascoly and Van Halsema (2001) have revealed that language barrier when accessing health care is not only a South African problem. In the Netherlands, for instance, language was used as an instrument of discrimination against refugee women who were using antenatal services, because they could not communicate in Dutch (Nkosi, 2014). “Language can be easily be used as an instrument of discrimination against refugees and asylum seekers to access health care as they may not understand and can be ignored or not given the kind of assistance they are entitled to receive”(Nkosi, 2014, p. 25). In the United Kingdom language difficulties in general practitioners’ surgeries have led to refugees being turned away, and in most cases they have resulted in miscommunication, misdiagnosis, and lack of appropriate follow-up(Lamb & Smith, 2002). In Saudi Arabia, poor quality of care and patient dissatisfaction is associated with expatriate health care providers (Almutairi, 2015). According to the Ministry of Health (MOH), the majority of health providers in Saudi Arabia, such as nurses,



are expatriates from countries like India, Malaysia and other parts of the world. Almutairi argues that health care providers and patients not only have different cultural backgrounds, but their language differences serve as barriers to communication. In Saudi Arabia, the failure of communication among parents of sick children and health care providers affected asthma management since most nurses were not Arabic speakers (ibid). It is very difficult to communicate during patient-physician interactions when refugees and healthcare practitioners speak different languages. Naidoo (2014) argues that good communication is the cornerstone of health provider and patient relationships. The lack of English proficiency is likely to affect the quality of care refugees receive (Lerner, 2014). Other studies, including that by Derose, Escarce, and Lurie (2007, p.1261), have shown that the majority of refugees have reported low dissatisfaction with care and poor understanding of their medical situation because of language differences (cited in Lerner, 2014).

The Community Agency for Social Enquiry (CASE) in 2001 revealed that language barriers are one of the key problems, and health providers are impatient when communication is unclear, resulting in their not attending to patients. Zihindula et al. (2015) point out that whenever communication is limited between the health provider and health seeker; patients end up receiving a poor quality health care service. White (2012, p. 146) mentions “numerous issues pertaining to the access of health care, including lack of transportation or insurance, long waiting times, appointment availability, and financial hardships in general”. In addition, communication between patients and medical practitioners increases psychological stress and pain when patients lack linguistic skills and interpreters are not available. However, at some hospitals, there are free telephone interpreter services but most medical practitioners are reluctant to use them (Lamb & Smith, 2007). As a result, patients will make use of bilingual relatives who are not medically experienced, or other non-medical staff who will end up compromising the quality of care and worsening health outcomes for migrant communities (Meuter et al., 2015).

### **2.5.2. Socio-economic status**

Socio-economic status is another problem hindering refugees from receiving appropriate services in hospitals and clinics in their host country. Facione and Facione (2017) argue that access to health care is often discussed in purely economic terms. This is a major problem because many refugees are unemployed, and living in extreme poverty, so they cannot afford proper health care. Peberdy

and Majodina (2000) argue that both unemployment, and the fact that refugees and asylum seekers may find themselves in low-income employment, will affect their ability to access health services. Landau and Segatti (2009) stress that refugees and asylum seekers are vulnerable groups and may lack the economic, social, or political influence that would enable them to improve their status and give them access to medical and health facilities in the host country (Landau & Segetti, 2009).

Due to financial constraints and unemployment after their arrival in the host country, newly arrived refugee groups have significant problems that affect their health, and might be contagious for the local population if no care is taken. Studies (Lamb & Smith, 2002) have revealed that in the United Kingdom, newly arrived refugees have oral health care needs and their reliance on public dental services is problematic. Their limited finances explain their not using private dentists (Lamb & Smith, 2002).

Owing to high medical costs, refugees are unable to pay their hospital bills. Onuaha (2006) argues that a Somali refugee woman gave birth in the reception area of one of South Africa's big hospitals because her husband could not afford to pay the maternity ward admission fee. This led Kaajal Ramjathan, a human rights lawyer, to conclude that: "Though South Africa has free emergency medical services, the hospital departments do not regard pregnancy as an emergency case except where there is complication" (Onuaha, 2006, p.95).

The cost of public transport has been identified in some countries as another problem that can influence refugees' decisions about accessing care as few of them own a car (Nkosi, 2014). A study conducted in Johannesburg revealed that:

clients participating in the ART [antiretroviral therapy] access study reported a lack of money for transportation as a barrier to collecting treatment, and also that it was problematic to take time away from their livelihood (especially if they were employed by someone else (Vearey, 2008, p.368).

In this case, refugees relying on public transport stay indoors regardless their health conditions since they cannot afford to pay transport and hospital fees.

According to the South African Constitution, every single person has the right to access health care. This is in line with the WHO principle of "health for all". It means that health care is a good social service which must be available for everyone regardless of his or her citizenship and

nationality, as long as they are still living in South Africa (Nkosi, 2014). In its section 7 (1), the Constitution states that: “This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom”(Mavenika, Odeku, &Raligilia, 2014, p.153).This constitution emphasizes that every person living in South Africa, irrespective of the country of their origin, has the same right as South Africans to access social services. The Freedom Charter reinforces the idea of equal rights for all, stating that: “We, the people of South Africa; believe that South Africa belongs to all who live in it, united in our diversity” (p. 154). Despite all these declarations, refugees are facing discrimination grounded on different issues, including their way of talking and their dress code, all of which arouse hatred towards them. Although everyone in South Africa is eligible for lifesaving medical care, Landau (2007) stresses that emerging reports indicate that many foreign nationals are denied access to treatments at clinics and hospitals. Leong (2009) believes that this is explained by the fact that those who provide health care sometimes may refuse to give services to refugees because they are confused about the kind of service and payment foreigners are entitled to and liable for, or because of outright discrimination. Xenophobia has been another barrier in terms of accessing health care services in South Africa.

### **2.5.3. Xenophobia**

The increase in the number of refugees and people seeking asylum across Africa and other parts of the globe has been accompanied by xenophobia against non-nationals in South Africa. Like apartheid, xenophobia is among major problems facing refugees in South Africa in accessing health care and other social services. Nosiviwe Mapisa-Nqakula, former Minister of Home Affairs, has described it as “racist in its nature” (Onuaha, 2006).

Geddo (2002) argues that many South Africans blame refugees and asylum seekers for competing with them over scarce resources, resulting in intolerance and xenophobia. This social intolerance has affected the lives of many refugees who need care services. The UNHCR has observed that:

Calling people derogating names is one way that xenophobia shows its ugly face. Harassment, hostility and violence are some of the other serious consequences of xenophobic attitudes in South Africa. Most victims of xenophobia are black African foreigners. Xenophobia is caused by ignorance and intolerance. Poverty, unemployment and crime in South Africa today make xenophobia worse because many people are

completing for scarce resources. South Africans tend to blame black foreigners for the social and economic problems of the country (Onuaha, 2006, p. 88).

The Southern African Conference report released on 1 May 1995 by one of the Catholic bishops had condemned xenophobia, appealing to the public to be more human in treating immigrants, refugees and displaced people living in South Africa (Onuaha, 2006).

Sisulu (2001) argues that xenophobia is exacerbated in South Africa in that South Africans are not educated on the issues of refugees, the causes of their displacement and the role of the government towards them (cited in Onuaha, 2006). She maintains that the difference of refugees from other migrants, and the financial struggles of many South Africans, have led them to see the presence of non-nationals as a threat to their jobs, education and other benefits provided by the state. Similarly, Moge kwu (2005) argues that most xenophobes have inadequate information about the people they hate, and see them as a threat since they do not know how to deal with them.

Xenophobia has not only led to discrimination against refugees; it has encouraged violence and prevented access to public health, education and other social services for which refugees and asylum seekers are eligible (Onuaha, 2006). Rutinwa (2002) argues that one cause of xenophobia is the failure of citizens to value the special situation of refugees and their contribution to society. Onuaha (2006) adds that xenophobia has increased because of the struggle for jobs between refugees and South Africans. Several studies have revealed that migrants experience xenophobia when using public transport, resulting in violent attacks and verbal abuse since they are unable to speak the local language. Sometimes they are blamed for not paying the bus fare, although they have paid (Onuaha, 2006). In terms of accessing medical care, migrants experience xenophobia when medical providers accuse them of spoiling their country, spreading diseases, but still wanting to come back and use South African taxpayers' money for free medical treatment. Refugees are denied treatment as a result of xenophobia unless they have money to pay for private health care. Zihindula (2015) argues that the use of private health services is a financial burden for refugees as they are relatively poor. In terms of medical treatment denial, migrants make use of pharmacies, buying medicines and treating themselves. Those who have no money remain at home until the sickness disappears (ibid). Xenophobic behavior and discrimination by health care providers hinder migrants from seeking medical attention that might prevent serious illness or death.

#### **2.5.4. Refugee documentation**

Documentation is another problem that hinders refugees' access to health care. When they arrive at a clinic refugees are requested to provide an identity document. Munywende et al. (2011) emphasize that most refugees fail to access health care as they are afraid to be asked to produce legal documentation, the lack of which could lead to expulsion from the host country. Section 27 (g) of the Refugees Act 130 (1998) guarantees refugees the right to receive basic primary medical services similar to those provided to South Africans from time to time. Even though the South African Department of Health (DoH) has recommended the rights of asylum seekers and refugees to obtain care, Human Right Watch (HRW, 2010) found that health care workers repeatedly violate that provision and discriminate against patients because of their nationality or lack of proper documentation (cited in Zihindula et al., 2015). Taylor (2000) argues that it is a disgraceful and inhumane to deny non-nationals treatment on the grounds of citizenship as well as turning away sick people because they do not have valid travel documents (cited in Mavenika, Odeku, & Raligilia, 2014; Walls et al., 2016).

In Section 27(3) of the South African Constitution, it is clearly stated that no one should be refused emergency medical treatment regardless of nationality, documentation, or residency status (Republic of South Africa, 1998; Landau & Segetti, 2009; Human Rights Watch, 2015). This means that refugees should receive the same assistance as their South African counterparts in similar social and economic circumstances (cited in Stone & Winterstein, 2003). However, the Human Rights Watch Report (2015) found that refugees and asylum seekers had been denied emergency medical care, often because of improper documentation or ignorance on the part of the admitting nurses. Onouha (2006) adds that migrants are victims of police harassment, corruption and arrest, although they are in possession of valid documents. Several studies reveal that "many non-nationals report not being able to access anti-retroviral treatment, for example, because they do not have green, bar-coded ID documents" (Landau & Segetti, 2009, p.42).

Accessing health care in South Africa is very problematic. Mavenika, Odeku and Raligilia (2014) argue that the "National Health Act 61 of 2003 and the Patients' Rights Charter as well as the existing official policy documents are all silent on the right of access to health services of foreigners" (p.154). As a result, refugees who need medical attention find themselves in a situation where service providers who were supposed to provide much needed health care are incapable of

doing so owing to uncertainty on whether foreigners are entitled to it or not (Mavenika, Odeku, & Raligilia, 2014). Veary (2008) states that the only document that deals with the rights of foreigners is an internal memorandum which allows everyone to be treated in emergency situations and given antiretroviral treatment without first providing an identification document (Mavenika, Odeku, & Raligilia, 2014). However, Chigavazira et al. (2012) state that in a country such as Botswana refugees are excluded from the government's program for free ARV provision and the prevention of transmission from mother to child (PMTCT) care.

Despite all efforts that have been achieved in promoting access to HIV services, refugees, asylum seekers and other migrants are, on a daily basis, facing significant challenges in accessing the anti-retroviral treatments (ART) to which they are entitled (CRMSA 2007). Refugees have been falsely accused of bringing HIV/AIDS with them into host countries of asylum. As they interact day by day with local populations, refugees should be integrated into host government HIV/AIDS policies and programs to ensure effective HIV/AIDS prevention and care (Spiegel & Nankoe, 2004). Zihindula et al. (2015) indicate that in terms of treatment denial, some refugees with infectious diseases, such as tuberculosis, HIV and sexually transmitted infections (STIs) might pose a health risk to the refugees and local communities. Mavenika, Odeku and Raligilia (2014) stated that as refugees fail to access care services in host countries, the government should ensure that refugees are not excluded, as antiretroviral medications have become more widely available in developing countries.

Chigavazira et al. (2012) point out that in Angola, for example, no documentation is required to access health care services. Despite the challenges in the health system, indications are that refugees living in Angola have access to health facilities as citizens (Zihindula et al., 2015).

CRMSA (2007) is concerned that the planned end to the suspension of the deportation of undocumented Zimbabweans in mid-2011 has hindered access to public health and continuity of treatment for HIV and TB. As a result, the majority of migrants avoid using public hospitals and other healthcare services in fear of being arrested and deported back home (CRMSA, 2007; Zihindula et al., 2015).

## **2.6. Theoretical and conceptual framework: Connell's theory of gender and power relations**

Developing countries are characterized by gender inequality whereby men are treated differently from women. The level of gender difference is more found in health, education and a way of controlling power within marriage (Jayachandran, 2014). The in-depth analysis of the Ethiopian Demographic and Health Survey (EDHS, 2005) revealed that the type of employment, access to media, age at first marriage and fertility preference or desire for children in marriage are among leading factors contributing to women's marginalization and suppression in many developing countries.

The present research draws from Robert Connell's theory of gender and power relations which was developed in 1987 to address the power differences in relationships. This theory argues that "gender" is not biologically constructed; it is influenced by gender-related, societal expectations. The theory emphasizes the reasons behind sexual inequity and gender and power differences that exist between men and women. The theory has been applied to different fields of sexual and reproductive health, including the prevention of STIs and the impact of gender imbalances on women's health, sexuality and education (Bui et al., 2010, Wingood & DiClemente, 2000). Connell (1985) has written various studies on theories of sexual inequality, gender and power imbalances between men and women based on their roles. For proper understanding, concepts such as gender and gender roles need clarification.

### **2.6.1. Gender**

Ezumah (2003) refers to gender as socially constructed characteristics of men and women including their roles, attitudes, behaviour and values. Though people are born with a defined gender, societies influence their norms and behaviour such as having good relations with people of the same or opposite sex within households, the workplace and their communities (Ezumah, 2003). Gender characteristics are allocated to both men and women during their childhood, and these characteristics vary across cultures and overtime. Gender comprises two categories: masculine and feminine, the former being perceived as tough and strong, while the latter is soft and weaker. Ezumah (2003) stresses that gender is neither a biological nor a genetic construct; rather, gender and the roles that people play within their societies and families are allocated to them and shaped by the society in which they live. He concludes that these gender roles are defined in ways that encourage male dominance and female subordination.

### **2.6.2. Gender relations**

These are relations of power between men and women that have always disadvantaged and suppressed the latter (Ezeah & Achonwa, 2015). Gender roles comprise different activities and practices that men and women play within their families based on their gender (Ezeah & Achonwa, 2015). These activities are assigned to them at birth and affect them differently. For instance, women are assigned to do housework, cooking, cleaning, fetching water, sewing and caring for their children. Men, on the other hand, are allocated tasks such as paid work out of home, splitting wood as well as dressing up in suits and ties (Ezeah & Achonwa, 2015).

Wingood and DiClemente (2000) have shown that Connell's work on gender and power relations has been extended to develop a public health model that examines exposures, risk factors and biological factors that unpleasantly affect the health of women. Public health is much concerned about sexual behaviour in terms of protecting women from unplanned and unwanted pregnancies and its consequences. Studies (Blanc, 2001; Pulerwitz et al., 2010; Puri et al., 2010a) have revealed that the unequal power relationships between men and women contribute to health consequences by hindering communication between partners on health matters. Puri et al. (2010) conclude that gender-power imbalance affects the negotiation of safe sex practices and reproduction choices that women can express within the family.

Connell has identified three major structures that characterize the gendered relationships between men and women, including the sexual division of labour, the sexual division of power, and the structure of cathexis (Wingood & DiClemente, 2000). However, both the sexual division of labour and the sexual division of power had been identified as the most important structures that to some extent explain gender relations (Wingood & DiClemente, 2000). These three corresponding but distinct structures are used to explain the cultural gender roles played by men and women in different societies. In order to understand Connell's theory of gender and power relations between men and women, and the socio-cultural determinants of fertility among women, the two important structures (the sexual division of labour and the sexual division of power) will be unpacked below.

### **2.6.3. Sexual division of labour**

The sexual division of labour refers to the allocation of women and men to certain occupations (Wingood & DiClemente, 2000). It is categorized in three groups including productive,



reproductive and community activities. Reproductive activities include every kind of work that women accomplish for income generation, such as production of goods and services. Reproductive activity includes childbearing and rearing, as well as all performed activities for household maintenance, such as fetching water, cooking, collecting firewood, etc. Community activities include those performed for the well-being of the community, such as attending community meetings (EDHS, 2005). Among these three activities, reproductive activity defines the role of women in most cultures, while productive and community activities are deeply controlled by men. At societal level, men and women are regarded as playing different roles based on their gender differences whereby gender-based inequities and disparities fall on the women's side (Wingood & DiClemente, 2000). In terms of occupations, women occupy a lower position compared to men; they often face many challenges as well as promotion in work and occupation. In Japan, for instance, an egalitarian country in matters of demography and to a greater extent in educational level, elevating the levels of employment and occupation is still more problematic for women than men (Sen, 2001). In developing countries, gender inequality has been explained in different ways where the lack of access to economic activities has enforced the subordination of African women and made them dependent on their partners for most of their lifetime. Men have been afforded opportunities and resources that are not allocated to women. However, women can do equally well if given the same opportunities and support as men. Jayachandran (2014, p. 2) argues that "On the whole, men make better business executives than women do", and are three times as likely as women to be working. The majority of women spend most of their time doing unpaid work, which is recognized as a female responsibility in many places (Ferrant, Pesando, & Nowacka, 2014). It includes cooking, cleaning and caring for children, while men work in the labour market. The unpaid work later has significant implications for women's ability to actively take part in the labour market, particularly with the type/quality of employment opportunities that are available to them (Ferrant, Pesando, & Nowacka, 2014). All over the world, particularly in developing countries, women are economically deprived because of their limited participation in paid work. Whenever women experience poor socio-economic conditions, they are vulnerable to health risks caused by childbearing (Ferrant, Pesando, & Nowacka, 2014; Jayachandran, 2014). The global division of labour actually restricts work opportunities for women in the Third World. Consequently, the type of employment available often marginalizes them in the low paying, informal economy (Ferrant, Pesando, & Nowacka, 2014).

The majority of women in developing countries are economically dependent on their husbands' income, which has enforced their subordination and makes them voiceless on various matters, including health reproductive issues (Beekle & McCabe (2006). However, women in developed countries are economically empowered and have a powerful voice that demands an audience on matters relating to their well-being. Beekle and McCabe (2006) believe that there is a great need to improve women's education and economic opportunities because educated women tend to be more independent and influence their family size by using family planning programs. Paid employment is one instrument that makes women less economically dependent on their husbands, and frees them from patriarchal oppression (Beekle & McCabe, 2006).

The more women participate in activity outside their home, including the labour market, the more they tend to have fewer children compared to those without any occupation. Women's participation in the labour market plays a pivotal role in fertility rate reduction and contributes to women's well-being. Falcao and Soares (2007) argue that the increased participation of women in the labour market has positive outcomes in women's lives, such as the bargaining for power within households, the enhancement of independence, and the ability of parents to invest in their children. Increased female employment can be seen as one of the demographic transitional developments that contribute to increased life expectancy and reduction in family size (Falcao & Soares, 2007). Inequality between men and women based on their gender roles gives men the control over their wives that might affect the latter's reproductive health. Authors argue that childbearing responds to women's economic opportunities, which simply means that if a woman's employment opportunities increase, then fertility decreases too due to the decrease in the relative cost of childbearing. Several studies have revealed that the gender equality of men and women, in both the labour market and at home, is associated with declining fertility rates in the developed world (Pande, Malhotra, & Namy, 2012). Therefore, women should be empowered and given equal opportunities to men, which are essential for enhancing fertility.

#### **2.6.4. Sexual division of power**

The differences in power between men and women have been the foundation for the sexual division of power. "The empowerment literature defines power as having the ability to act or to change in a desired direction" (Wingood & DiClemente, 2000, p. 543).

Pulerwitz et al. (2000b) argue that power in sexual relationships refers to the ability of one partner to dominate decision-making or being in control of a partner's actions, and engaging in certain behaviour that is against the partners' wishes (cited in Blanc, 2001). The problem of gender-based power in sexual relationships is its unbalanced character, whereby women have less power than men. As a result, women within unbalanced relationships are more likely to experience health problems since they do not have control over their lives.

A study conducted by Hindin (2005) showed that in Zambia, for instance, men have the final say over women's health, household purchases, the number of children to have and the time to have them. In the DRC, gender equality concept is irrelevant; men are hypersexual, and have the final say in their homes. According to the International Men and Gender Equality Survey (IMAGES, 2014), women's empowerment is far from being attained in the DRC; men believe that their ancestors and parents taught them to be superior to women.

Studies have revealed that the sexual division of power is maintained by social mechanisms such as the abuse of authority and control in relationships, where women tend to depend on their male partners because men usually earn more money than they do (ibid). Studies have shown that the payment of the bride price has given men the authority to decide on matters regarding the number of children and time to have them (Dodoo&Tempenis, 2002). Having more power than women do, men have enforced the practice of unprotected sex, leading to unintended pregnancies and increased sexual infections among women, including HIV. Blanc (2001) stresses that as men have more power over women; the latter are incapable of negotiating the use of condoms with their partners.

Studies indicate that within an unbalanced gender-based relationship, there is a lack of communication on various matters, including those related to contraception. Consequently, verbal communication on health reproductive issues is low among couples in many developing countries (Blanc, 2001). In fact, there are many consequences of unequal power within a gender-based relationship. Kapoor (2000) argues that women within an unequal relationship experience both physical and mental problems. He believes that the damage to women's physical and emotional well-being can lead to stress, anxiety and gynecological problems such as chronic pelvic pain, miscarriages and pregnancy complications (Kapoor, 2000). When men use power as a weapon of sexual abuse, women become victims of sexually transmitted diseases and unwanted pregnancy,

including HIV/AIDS as mentioned earlier. Wingood and DiClemente (2000) argue that HIV is more associated with sexual power that lead to little or non-use of condom among women. According to the WHO (2014) report, women have a longer life expectancy than men, which was disproportionately decreased by the HIV pandemic that has hit the continent of Africa. Gender-based violence is not only associated with physical and psychological problems, but it has affected fertility preferences within many relationships as women fear to raise the issue of contraceptives such as a condom. A study conducted by Jewkes et al. (2001) showed that in South Africa, forced sex and physical abuse such as beating were associated with high levels of unwanted pregnancy. Elsewhere, in countries such as India, gender-based violence is a leading cause of pregnancy-related death (Heise et al., 1999).

#### **2.6.5. Decision-making power within marriage**

Decision-making power within households is an aspect of gender inequality that has received a great deal of attention from academics as well as policy makers (Jayachandran, 2014). The participation of women in a family's or communities' decision-making is important for their well-being. Female empowerment is of great value because it is believed to be a means of improving children's outcomes. Women in developed countries have decision-making power and less tolerance of gender-based violence than their compatriots in less developed countries.

Jayachandran (2014) argues that empowered women have the ability to control resources and influence decisions that affect their lives. In developing countries, women are excluded from most opportunities and privileges availed to men, including participating in paid work and politics. Women's exclusion from economic activities makes them unable to decide on household matters, including family income. Belay et al. (2016) argue that women do not only have low decision-making power over family income expenditure, but face many challenges in deciding on their own health care. They conclude that most married women wait for their husbands' approval in order to get health care for themselves and their children. Despite the government's improvement in providing contraception and maternal health services, Ethiopia's TFR remains high. Belay et al. (2016) argue that less than a quarter of Ethiopian women are able to decide on the use of a contraceptive method by themselves. The ability to make independent decisions on contraceptive use is crucial in preventing women from unplanned and unwanted pregnancy and reducing maternal and child mortality (Belay et al., 2016). Myriad factors are associated with women's

decision-making power and contraceptive use; these include their age, educational level, occupation and partner's educational status. The more women are employed the more they are likely to decide individually on family planning (ibid). Kinoshita (2003) concludes that both education and paid employment are key positives to contribute to women's empowerment. In marriage and other relationships, questions on matters such as: household purchases, freedom of mobility, spending of the husband's income, the number of children to have, buying and selling land, sending children to school, and rearing children are always problematic in understanding who has the final say in family matters (Kinoshita, 2003). In developing countries, women have less control over their own lives than those in developed countries. Jayachandran (2014) argues that rich women have more ability to influence decision-making in their households than poor ones. The former do not only have more decision-making power, but freedom to visit family and friends (Jayachandran, 2014).

#### **2.6.6. Gendered norms affecting women**

In many developing countries, cultural norms favour males, leading to subjugation and health problems that women experience daily. For example, parents' preference for male children contributes to gender inequality; investing in girls is viewed as a waste of time and money, particularly in a patriarchal society. Under some patriarchal systems, when a woman gets married she ceases to be a member of her biological family, and joins her husband's family (Jayachandran, 2014). These customs discouraged parents from investing in education and other issues related to their daughters' well-being, as they might not be useful in the family's economy. Sen (2001) argues that Afghanistan might be the only country in the world that excludes girls from schooling because of the Taliban regime and other features of massive gender inequality; but there are many Asian, African and Latin American countries where girls have far fewer opportunities of schooling than boys (Sen, 2001). According to the United Nations Girls' Education Initiative (UNGEI) 2002 report, it is estimated that 885 million people are without access to education of whom the majority are women and girls, though millennium development goals demand equality for all in education (UNGEI, 2002).

There is an often-quoted Indian saying: "Raising a daughter is like watering your neighbour's garden". This sentiment is echoed in a Chinese proverb that describes raising a daughter as "ploughing someone else's field" (Jayachandran, 2014, p. 11). Preference for sons not only

increases gender bias, but has increased female infant mortality in many developing countries (Bhalotra & Gomes, 2014). The previous sentence explained why Kabeer (1999) has advocated women's empowerment, believing that once they are empowered, women will have access to resources, participate in agencies and household decision-making, and achieve their well-being

## **Conclusion**

This chapter has focused on various publications addressing issues on fertility rates among women in both developed and developing countries. Various determinants of fertility are explained, including infant and child mortality; the great value placed on childbearing and the construction of motherhood; the low use of contraception and illiteracy among women. The economic contribution of children to household income has been identified as a major factor in developing countries, particularly in rural areas where agriculture is the main source of livelihood. The chapter has shown that fertility has increased in many parts of the world as a result of a failure to use contraception effectively. Social and cultural beliefs, contraceptive side effects and the difficulty of obtaining husbands' approval are mentioned as major hindrances to the use of contraception among women. In terms of accessing health care, Congolese refugees experience several challenges that hinder proper treatment. Although Congolese refugees have been living in South Africa for many years, few published sources are currently available to understand their particular challenges. From the few available sources, language is identified as their main disadvantage, since they come from a French-speaking country to a host country that uses English. Their inability to speak English incites xenophobic behaviour from health care providers, which deters refugees from using public health services. The Congolese's financial situation contributes to their poor health since most of them work in informal jobs with poor income; as a result private health services are not affordable. Moreover, the failure to produce proper documents also results in treatment denial.

The following chapter presents the research methodology adopted in this study.

## **CHAPTER THREE: DESIGN AND RESEARCH METHODOLOGY**

### **3.1. Introduction**

This chapter discusses the research design and methodology used in the study. This includes strategies, instruments, and descriptions of the method of sampling from the target population, data collection and analysis methods. The stages and processes involved in the study are also explained. The qualitative research design that was adopted is discussed, as well as the procedures that were employed to enhance the trustworthiness of the study design. The chapter concludes with a discussion of the ethical considerations.

### **3.2. Design of the study**

A research design is a plan for collecting and analyzing evidence that will make it possible for the investigator to answer whatever questions he or she has posed. “The design of an investigation touches almost all aspects of the research, from the minute details of data collection to the selection of the techniques of data analysis” (Flick, 2009, p. 128).

The present study is an exploratory, descriptive and contextual qualitative study looking at the social and cultural determinants of fertility rates among Congolese refugee women in the inner city of Durban. Qualitative research seeks to understand the “social phenomena” or causes of changes in social facts, from the participants’ perspectives (Firestone, 1987, p.16). According to Domegan and Fleming (2007), “Qualitative research aims to explore and to discover issues about the problem on hand, because very little is known about the problem. There is usually uncertainty about dimensions and characteristics of problems. It uses ‘soft’ data and gets ‘rich’ data” (p. 24). This design was considered relevant in exploring the social and cultural determinants of fertility among Congolese refugee women living in the inner city of Durban, South Africa.

#### **3.2.1. Qualitative research**

The study adopted a qualitative methodology drawing on in-depth interviews. Burns and Grove (2003) have referred to qualitative research as inductive, holistic, subjective and process-oriented methods used to understand, interpret, define and develop a theory on a phenomenon or setting. It is a systematic, subjective approach that is used to describe life experiences and give them meaning (cited in Mamabolo, 2009).

According to Myers (2009), qualitative research is designed to help researchers to understand people and the social and cultural contexts within which they live. Similarly, Thomas (2010) argues that qualitative research methods help researchers to study social and cultural phenomena. Domegan and Fleming (2007) indicate that human learning is best researched by using qualitative data. Guba (1981, p. 76) suggests that “it is proper to select that paradigm whose assumptions are best met by the phenomenon being investigated” (cited in Thomas, 2010, p. 306). As the objective of this study was to explore the social and cultural determinants of fertility among Congolese refugees, a qualitative method was appropriate.

Thomas (2010) defines the qualitative method as a type of research involving the interpretation of non-numerical data and attempts to understand phenomena in natural settings. It differs from the quantitative method, which uses questionnaires, surveys and experiments to collect data that are derived and arranged in numbers, which later allows the data to be categorized by the use of statistical analysis. Both qualitative and quantitative methods are useful in conducting a study. Terrell (2012) stresses that neither of these two methods is more important than the other. However, some researchers prefer the use of mixed methods (quantitative and qualitative) by taking advantage of their differences, and combining the two methods for use in a single research project depending on the kind of study and the methodological foundation (Terrell, 2012). Many scholars argue that when using qualitative and quantitative research in harness it is always important to know that each method offers a different way of knowing the world, even if they are addressing the same research problem. (Ritchie, Lewis, Nicholls, & Ormston, 2013). The two methods will provide a different reading or form of solution on the investigated issue (Ritchie et al., 2013). As far as research is concerned, the main purpose in linking qualitative and quantitative methods is to achieve an extended understanding that one method alone cannot offer. The researcher has to explain why the data and their meaning are so different. However, Malina et al. (2011) highlight that many researchers have avoided the use of mixed methods because the findings of one approach or method might become more dominant, and conflicts between the data may be somewhat hidden from view. Such avoidance has explained why qualitative research has primarily been adopted as an independent method of investigation in this study.

Antwi and Hamza (2015) argue that qualitative research is holistic in the sense that it tries to bring about a contextual understanding of the complex interrelationship of causes and consequences that



affect human behaviour. It is also defined as a rigorous approach to the study of psychological or social phenomena in which the researcher examines qualitative differences in a phenomenon (Chenail, 2004). Qualitative research is grounded in an epistemological commitment to a human-centred approach to research whereby it underlines the importance of understanding how people think about the world and how they act and behave in it (Given, Winkler, & Willison, 2014).

In order to understand how individuals make sense of their worlds, Given et al. (2014) argue that the researchers' role is to ask people questions directly on what they believe to be important about the topic or issue under study. It is understood that a qualitative method is more important when people's lives are involved. Qualitative projects acknowledge that knowledge is socially constructed and inseparably linked to peoples' backgrounds, histories, and cultural place (Given et al., 2014). The above research design is significant since it has explained the meaning that Congolese people place on childbearing by means of information derived from participants during fieldwork.

A qualitative approach is more suitable for a study of this nature, which seeks to understand the reasons behind fertility in refugee women living in the inner city of Durban. The qualitative research approach, as explained by Babbie and Mouton (2007), sought to describe and understand rather than explain refugees' behaviour. In qualitative research, greater insights are gained through examining the qualities, characteristics or properties of a phenomenon (Henning, 2004). It is a kind of research that does not rely on numerical strength in order to arrive at results, but rather interprets meaning through a simple representative sample. Antwi and Hamza (2015) indicate that the value of qualitative research lies in the validity of the information received. Babbie and Mouton (2007) add that qualitative data provides in-depth descriptions and also reveals individuals' personal understanding of events/actions, which can help the researcher to gain insight into the why and how of those events/actions, rather than just obtaining a representation of the phenomenon under study.

### **3.3. Population and Sampling.**

The Divine Mission church (DMC) was purposely selected as the area for data collection, primarily because of its relevance to the aim of the study. The aim of the present study was to understand the reasons behind fertility rates among Congolese refugee women in Durban. The area was chosen for its accessibility to DRC migrants. According to the UNCHR statistical yearbook, the majority

of refugees living in South Africa come from the DRC, followed by those from Somalia, Angola, Burundi and Rwanda (cited in Apalata et al., 2007). Although Congolese are among various groups of refugees living in South Africa, no published source has revealed the refugee population of DRC origin in Durban.

### **3.3.1. Sampling techniques**

Both purposive and snowball non-probability sampling techniques were used to select and reach the participants. Designing and selecting samples are general features of social enquiry. It does not matter whether the research is qualitative or quantitative. This means that decisions about people to participate in the research settings or action still need to be made, even if a study involves very small populations or single case studies (Ritchie et al., 2013). Purposive sampling, according to Oliver (2006, p. 245), is a non-probability sampling technique which allows the researcher to decide, based upon specific criteria in relation to the purpose of the study, “about the individual participants who would be most likely to contribute appropriate data, both in terms of relevance and depth”. In order to preserve validity in the present study, the researcher has ensured that the selection criteria are consistent with the aim and study objectives, knowing that this type of sampling can be a “potential source of bias” (Oliver, 2006, p.245).

In a non-probability sample, people are intentionally selected to reflect particular features of groups within the sampled population (Ritchie et al., 2013). In qualitative research, the sample is not statistically representative. Contrary to probability sampling, in which participants are selected using randomization, qualitative research sampling is characterized by purposefulness: the aim is to identify participants who are most knowledgeable, and hence stand to provide quality data about the phenomenon of interest.

A purposive sampling was employed consisting of Congolese refugee women living in the inner city of Durban and members of the Divine Mission church, Durban. Morse (1991, p. 129) argues: “When obtaining a purposeful sample, the researcher selects participants according to the needs of the study” (cited in Coyne, 1997, p. 628). Patton (2002) argues that purposive sampling involves ways of identifying and selecting people or groups of people who are knowledgeable and experienced with the phenomenon of interest. Bernard (2002) notes that participants’ availability, willingness to participate and the ability to communicate experiences and opinions in a coherent,

expressive, and reflective manner are important in qualitative research (cited in Palinkas & Hoagwood, 2015).

Snowball sampling was used, whereby respondents were asked to suggest further potential respondents within the church. Thompson (2002) highlights that snowball sampling is used when “few identified members of a rare population are asked to identify other members of the population for the purpose of obtaining a non-probability sample or for constructing a frame from which to sample” (cited in Handcock & Gile, 2011, p.369).

Snowball sampling has been used in numerous disciplines; it is viewed as a particularly effective tool to obtain information on and access to a certain group of people which the researcher cannot easily access – for instance, HIV/AIDS carriers, drug users, unemployed men, etc. (Noy, 2008).

The problem with snowball sampling, on the other hand, is that it can also result in bias because the initial respondent may identify other respondents who may not be able to provide relevant information for the study (Oliver, 2006). However, snowball sampling was used in this study, as the researcher did not know every member of the Divine Mission church who met the research criteria. This method was relevant when the researcher wanted to identify women who did not have children. In this case, two respondents, who were accustomed to the researcher, played an important role in identifying and locating other potential and relevant respondents.

### **3.3.2. Sample size**

A sample is a “subset of the population used to gather information about the entire population” (Momo, 2009, p. 35). Twelve people participated in this study, including six women with children and three without children in one-to-one interviews (Table 5). In addition, a sub-sample of three men and members of the same church was chosen to examine the role of gender in determining total fertility rates in marriage. Participants were between 25 and 45 years of age, and had been living in Durban for at least two years. Sandelowski (1995 p. 179) noted that, “a common misconception about sampling in qualitative research is that numbers are unimportant in ensuring the adequacy of a sampling strategy” (cited in Onwuegbuzie & Leech, 2007). Sampling selection is more important in qualitative research as in ethnographic or field studies; it is required simply because the researcher cannot observe or record everything that occurs (Ritchie et al, 2013). According to Onwuegbuzie and Leech (2007):

Sampling involves more than just the number of participants included in the study; sampling is a process that incorporates the number of participants, the number of contacts with each participant, and the length of each contact. It is important for researchers to consider how much contact will be required in order to reach saturation” (p. 15).

Richie et al. (2013) highlight that a large sample in qualitative studies increases obstacles to the quality of data collection and analysis that can be achieved. Onwuegbuzie and Leech (2007) argue that a too large sample size in qualitative research is not desirable as it is a hindrance in terms of achieving rich data. In general, the size of the sample in qualitative research should not be so big that it becomes difficult to extract thick, rich data. On the other hand, Oppong (2013) argues that a smaller sample size is likely to limit perceptions and information that could have been gathered. As a result, data saturation cannot be reached. Horsburgh (2003) argues that initial sampling decisions should be purposive; participants’ selection is made based on their ability to provide relevant data on the area under investigation. Table 1 describes the composition of the respondents in terms of their gender, age, number of children, level of education, type of dwelling and the occupation of each participant.

In general, the size of the sample in qualitative research should not be too big that it becomes difficult to extract thick, rich data. At the same time, as stated by Sandelowski, the sample does not have to be too small so that it is difficult to achieve data saturation (Flick, 1998; Morse, 1995).

### **3.4. Inclusion and exclusion criteria**

Participants included in this study were selected to meet specific criteria:

They were:

- Congolese refugees living in the inner city of Durban, South Africa
- Living in the host country for at least two years
- Men and women between 25 and 45 years of age, all married
- Members of the Divine Mission church
- Willing to participate

Participants who had children and childless individuals were included to understand the reasons behind fertility within a Congolese refugee community living in Durban.

However, the study excluded:

- South Africans
- Migrants from other countries
- Refugee single parents from the DRC
- Refugees who are not members of the above-mentioned church.

### **3.5. Research techniques and instruments**

The researcher employed different methods of data collection, including semi-structured interviews (see Appendix 5), participant observation and field notes. A qualitative interview involves an interaction between the interviewer and the respondent, whereby the former has a topic to be covered, and specific questions that need to be asked in a particular order (Patton, 2002). Semi-structured interviews allowed flexibility in exploring new themes and ideas that came up during interviews. The semi-structured interview guide was derived from the literature; it sought to elicit the social and cultural determinants of fertility among women, and the role of gender in determining fertility rates among women. Semi-structured interviews give the researcher room to probe and request explanations from the participants, when in doubt. In addition, face-to-face interviews enable the researcher to make observations as they proceed. These include paying attention to participants' non-verbal cues, which may be indicative of how they feel about the topic. The personal nature of interviews might result in respondents being more open to the discussion. The researcher also has room to make notes of her observations, which become part of the data to be analyzed.

Interviews were conducted in Kiswahili (Appendix 6), which is one of the widely spoken vernacular languages among Congolese forced migrants in Durban. The researcher, who, as noted above, is fluent in the language, conducted the interviews. All interviews were transcribed and then translated by the researcher from Kiswahili into English. Some interviews were tape-recorded, depending on participants' consent. Interviews were audio-recorded using the researcher's smart phone as a sound recorder, depending on participants' consent. Only six participants' voices were recorded during interviews; the rest of the participants were reluctant to be recorded, and their wishes were respected. The researcher used probing techniques to keep respondents focused on the research question and to follow up on their responses. Each interview

took approximately 45 minutes. The researcher used a notebook to capture participants' reactions, such as non-verbal cues.

### **3.6. Data collection and procedures**

#### **3.6.1. Primary data collection**

The primary data were collected partly through observations, but mainly through in-depth semi-structured one-to-one interviews.

#### **3.6.2. Gaining access**

Before the interviews started, the researcher introduced the study to seek the gatekeeper's permission from the senior pastor of the church. Thereafter, permission was asked from the respondents' husbands, as many women depend on their husbands. Interviews took place on the church premises as there was a room allocated for the sake of safety and confidentiality. The church is located at 38A Glass & Mirror Building, corner of Mazeppa and Winder Streets, Durban 4001. To introduce the interviews, the researcher did explain the aims of the study to participants and read out the content of the consent form to ensure they understood it before signing. Ethical issues were taken into consideration.

### **3.7. Data analysis**

Data analysis is a method of understanding and clarifying the findings, "giving importance to results, and putting patterns and themes into an analytical framework" to answer the research questions (Momo, 2009, p. 38).

The researcher used thematic analysis to analyze the data obtained from the interviews. The researcher translated and transcribed the tape-recorded interviews. For thematic analysis, the researcher familiarized herself with collected data by reading and rereading the transcripts, and listening to the recordings on many occasions to establish themes (Braun & Clarke, 2006). As data were analyzed manually, coding was done with the use of highlights whereby the researcher could identify themes that belong in the same group. Once data were coded, main themes were identified, while others formed subthemes according to Braun & Clarke (2006). However, other themes stood on their own, which means they belonged in neither main themes nor subthemes. At this stage, the researcher created a miscellaneous theme to house the codes. Similar themes, sub-themes and all

data extracts were put together in groups where they belonged. After putting all themes together, the researcher named them based on what aspect of the data each theme captured. Thereafter, the final analysis and -up of the research took place by combining all extracts related to each theme (Braun & Clarke, 2006).

Thematic analysis is “a method for identifying, analyzing and reporting patterns (themes within data). It organizes and describes the data set in (rich) detail and interprets various research topics” (Braun & Clarke, 2006, p. 79).

Boyatzis (1998) argues that thematic analysis illustrates the data in detail and deals with various subjects via interpretations (cited in Alhojailan, 2012). Marks and Yardley (2004, cited in Alhojailan, 2012) opined as follows regarding thematic analysis:

Thematic analysis moves beyond counting explicit words or phrases and focuses on identifying and describing both implicit and explicit ideas. Codes developed for ideas or themes are then applied or linked to raw data as summary markers for later analysis, which may include comparing the relative frequencies of themes or topics within a data set, looking for code co-occurrence, or graphically displaying code relationships. (p.40)

### **3.8. Trustworthiness and credibility of the findings**

#### **3.8.1. Trustworthiness**

Data collected in qualitative research needs to be interpreted and coded in a way that is valid and reliable (Moretti et al., 2011). Trustworthiness is one of the tools used by researchers to ensure data collection is done accurately. Although in quantitative research we talk about reliability and validity, in qualitative research we refer to credibility and trustworthiness. To ensure the study's trustworthiness, the researcher needed to build a strong relationship with the study community in order to gain their trust and establish rapport (Hadi & Closs, 2016). By so doing, it was easy to receive more in-depth information from the study group. Since the researcher was part of the study community, she could identify relevant characteristics concerning the issues under investigation to ensure the subject was carefully explored (Hadi & Closs, 2016).

Elo et al. (2014) argue that for collecting accurate answers, the researcher should be mindful of how to collect the most suitable information by choosing the best data collection methods that could enable participants to address, correctly, the research questions.

Asking the wrong question is actually the source of most validity errors. However, the researcher was more likely to ask participants the right questions which were related to the study, in order to receive correct answers, otherwise data could be influenced by haphazard errors (Loh, 2013). To ensure quality control during recording, the researcher held interviews in a quiet environment in order to avoid strange sounds that could affect participants' voice recordings. Elo et al. (2014) argue that tools such as interview tapes, videos and transcribed texts should be examined carefully in order to validate the researcher's actions. A recording instrument such as the researcher's smart phone was made certain to have enough space in the memory. To ensure the quality of data transcription, the researcher listened attentively to the tape to avoid errors and ensure that all participants' responses were captured appropriately. She understood that the greater the degree of error the less accurate and truthful the result (Brink, 1993). To enhance trustworthiness, a copy of the data transcription was sent back to each participant to make sure the transcription reflected his/her views. This was done only after the data had been transcribed.

### **3.8.2. Credibility**

Polit and Beck (2012) conclude that "Credibility deals with the focus of the research and refers to the confidence in how well the data address the intended focus" (cited in Elo et al., 2014, p.3).

To ensure credibility in this study, the researcher listened to the data recorded on many occasions before transcription. After she had done with the transcription of the data, she read the transcripts many times to try by any means to minimize errors that could occur. Credibility was ensured by peer examination whereby the researcher discussed the research process with other colleagues who were doing qualitative research, especially those who were more experienced in the research. Peer examination enabled the researcher to be honest in the study, and peers' contributions were crucial in deeper reflexive analysis. In addition, they helped in identifying useful issues which were not covered by the research questions (Anney, 2014).



Another way of improving the quality of collected data was through a reflective journal whereby the researcher could keep her handbook to include all events that happened in the field. With her handbook, the researcher wrote down participants' personal reactions to the study (Anney, 2014).

### **3.9. Ethical considerations**

#### **3.9.1. Gate keeping and ethical approval**

Gaining access to research participants in order to collect data requires the researcher to go through gatekeepers or facilitators, and even through high levels of management (Nind, 2008). It means the researcher needs to approach the senior figure in an organization in order to have permission to conduct interviews (Nind, 2008). With regard to this study, permission was obtained from the senior pastor of the DMC, who made it easier to gain access to respondents (see Appendix 3).

Before starting the fieldwork, the researcher submitted the project for ethical approval, which was obtained from the Humanities and Social Sciences Research Ethics Committee of the University of KwaZulu-Natal. Approval was granted on 20 July 2016 under the protocol, reference number HSS/0262/012M/ (see Appendix 4).

#### **3.9.2. Informed consent**

The need for informed consent is crucial to any ethics protocol and the start of any research project (Nind, 2008). Women willing to participate in the study signed an informed consent document. Participants were informed of their freedom to withdraw from the study at any time they decided to. They were informed that information received from them was only to be used for purposes of the study and nothing else. The consent forms were signed after the researcher had explained the nature of the study. In addition, the researcher asked permission from participants' husbands, since they were all married and depended on their husbands. Although, husbands gave their permission, the researcher ensured participants' willingness to take part in the study. Participants were aware that their information would be kept confidential between them, the researcher and the research supervisor. In addition, participants' anonymity was guaranteed by using pseudonyms.

Voice recordings were done only if the participants consented to them. This aligns with the precepts of Bailey (1982), who described some basic ethical principles in research, including not harming participants during the process of the research, and afterwards not deceiving participants

about the true purpose of the study, avoiding invasions of their privacy, and asking questions that cause extreme embarrassment, not causing anxiety, or falsifying data obtained, and or committing other offences not permitted in a research field.

### **3.9.3. Benefits**

The purpose of this study was to better understand the socio-cultural determinants of fertility among women. The benefits of participation are personal: participants could gain insight into their own educational choices and learn the value of their individual experiences. Participants were informed that the study benefits were meant to improve refugee women's reproductive health as well as the use of health care services in Durban and South Africa in general.

### **3.9.4. Potential for harm**

This study could cause emotional discomfort to participants because of the personal nature of some questions.

As this project studied a vulnerable group of refugee women who had experienced trauma, the possibility of secondary traumatization was taken into consideration. Martin (2004) stresses that refugees face difficulties such as having witnessed and experienced violence, insecurity, breakdown in education, loss of property and all form of economic and social vulnerability. Counseling was arranged in case of emotional discomfort during interviews; a distressed participant could be sent to the Hope for the Hopeless Counseling Centre. The Church arranged for the participants to consult with a psychologist in the event of secondary traumatization (see Appendix 3.); but no one had an adverse experience as a result of this study, and the counseling option was not used.

### **3.9.5. Communication of findings (feedback to participants)**

Giving participant feedback is one of the problems experienced by researchers. Nind (2008) argues that problems always arise when it comes to checking authenticity and the benefits of participation if participants do not access research findings. Lewis and Porter (2004) conclude that at least some, if not all participants should expect feedback for their participation. With regard to giving feedback, it was determined that study findings would be presented in a workshop or community forum where refugees could access information provided during fieldwork. In addition, the

researcher would print an illustrated summary of the research findings in bullet form, and present it to each respondent.

## **Conclusion**

This chapter has outlined the research paradigm, research methodologies, strategies and design used in the study, including procedures, participants, data collection tools, data collection, analysis methods, and data credibility issues. The research has been conducted as a qualitative study of the socio-cultural determinants of fertility among Congolese refugee women living in the inner city of Durban. Primary data were purposively collected through in-depth semi-structured interviews with 12 participants, including both men and women with and without children. The study was conducted ethically despite some limitations in terms of time and money.

The following chapter looks at the presentation and analysis of findings.

## **CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS OF FINDINGS**

### **4.1. Introduction**

This chapter presents and analyses the data collected from 12 informants, men and women refugees who originally come from the Democratic Republic of Congo (DRC). The chapter comprises four sections: Section 1 consists of analyzing the socio-demographic characteristics of informants. Section 2 looks at the social and cultural determinants of fertility rates among the study group. Section 3 focuses on challenges faced by refugee women when visiting health care services in their host country. The final section looks at gender role in determining fertility rates within relationships. Study findings were: the economic value attached to having children, sex preferences (male child preference), the desire to save marriage/union, the prestige of motherhood, replacing lost family members, fulfilling God's recommendation to fill the earth/biblical reasons, children as social security during old age, and inadequate use of appropriate contraceptive methods.

### **4.2. Demographic characteristics of the study participants**

This section considers the data collected with a focus on age, marital status, educational achievement, religious affiliation, and years of stay in South Africa since the participants left their native country. The section examines the type of accommodation of respondents since the majority of them have several children in spite of their low income. This helps the researcher understand the participants' fertility rate and economic challenges in raising children. The background information of the research participants was obtained from 12 Congolese refugees living in the inner city of Durban. Six women with children and three women without were selected to participate in the study. Three men were included in the sample in order to examine the role of gender in determining fertility within relationships.

**Table 1: Participants' Demographics**

Participant #	Gender	Age	No. of Children	Additional Children Expected	Employment Status	Education	Dwelling Type
1.	Female	36	4	0	Unemployed	Primary	1 Bedroom Flat
2	Female	28	2	2	Unemployed	Technical	1.5 Bedroom Flat
3	Female	36	5	1	unemployed	Primary	2 Bedroom Flat
4	Female	26	0	4	Unemployed	Secondary	Bachelor Flat
5	Male	40	2	2	Shop Assistant	Secondary	Bachelor Flat
6	Female	35	6	0	Unemployed	Secondary	2 Bedrooms Flat sharing
7	Female	30	0	3	Manicure/pedicure	Secondary	1 Bedroom Flat
8	Female	25	0	2	Hairdresser	Secondary	1 Bedroom sharing
9	Female	32	3	0	Student Assistant	University	2 Bedrooms Flat
10.	Female	35	2	2	Pedicure	Secondary	Bachelor Flat
11.	Male	37	5	1	Security Guard	Secondary	2 Bedroom Flat sharing
12.	Male	45	3	2	Unemployed	Secondary	2 Bedroom Flat sharing

Table 1 shows that all respondents were married with their average age being nearly 34 years (33.75). This means that all the respondents were in their reproductive age at the time when the interview was conducted. Although the current sample does not represent the entire migrant population of the Durban, it is of interest to note that most migrant women have been noted to be of reproductive age (Sudhinaraseti et al., 2016).

Respondents maintained a heterosexual life, and in terms of marital status, they were staying with their spouses at the time of the interviews. In many African societies, marriage is a way of constituting a family. Adulthood is proved through marital relationship with childbearing expectations. Only married people were selected in the study, although refugees find themselves in cohabitation relationships, and some of them are widowed. In the DRC, “cohabitation is a rare phenomenon and there it is considered as perverted behavior” (Amisi & Ballard, 2004, p.21).

In terms of educational background, eight participants had completed secondary school, which is the standard level of education attained by the majority in many African countries, the DRC included. Two women had a primary educational level of education, and one was enrolled for a master’s degree.

Although most of the time incomes are underreported in research, Table 1 shows that refugees remain a vulnerable group in terms of accessing decent jobs. As a result, their incomes are too low to support their families. Women are the most affected, which contributes to their economic deprivation: five of them were unemployed by the time of the interview. Two women were doing manicure and pedicure, one was a hairdresser and another was a student assistant at the Durban University of Technology (DUT). One man was working as a shop assistant, and the other was a security guard. Uwabakulikiza (2009, p. 26) argues that: “Due to the lack of formal jobs, refugee women work in informal activities, regardless of the qualifications they may have. Congolese female refugees mostly work in hairdressing salons and as traders in different market niches around Durban and flea markets.”

As the majority of refugees have little income, paying house rent is very problematic. In this situation, many share their flat with family and in most cases with strangers in order to share the household expenses. Most respondents in this study share their flats with either their relatives or other refugees from different countries, South Africa included. Those living in a bachelor flat find it difficult to share because their children occupy the whole sitting room. Of the 12 respondents in

this study, half of them share accommodation with other people. Four respondents live in bachelor flats with their children, the latter sleeping on the floor. Only two respondents occupy two-bedroom flats without sharing with anyone.

Although refugees experience financial hardship, the majority of respondents expect to have more children despite their current number. Table 1 shows that fertility rates among refugees is high compared to South Africans, who have a TFR of 2.23per woman (United Nations, 2015).

**Table 2: Respondents’ children by gender**

Participant #	Gender		Total
	Male	Female	
1.	4	0	4
2.	1	1	2
3.	2	3	5
4.	0	0	0
5.	1	1	2
6.	0	6	6
7.	0	0	0
8.	0	0	0
9.	1	2	3
10.	0	2	2
11.	1	4	5
12.	2	1	3

The above table gives the summary of respondents’ children including their number and gender. Three participants have two children each, two have three each, one has four, two have five each and one has six children. Three women participants were childless at the time of the interviews. Some respondents have children of both genders and others have either male or female children. Respondents who gave birth only to female children showed gender dissatisfaction, and plan to exceed their family size in the hope of having a baby boy.

### **4.3. Social and cultural determinants of fertility**

The following themes emerged as the main social and cultural determinants of fertility for the study sample: economic value of children, sex preferences, and prestige of motherhood, replacing lost family members, God's recommendation to fill the earth /biblical reasons, and inadequate use of appropriate contraceptives.

#### **4.3.1. Economic value of children**

In this study, respondents associated a large family size with wealth. The economic value that parents tend to attach to childbearing contributes to a high fertility rate. In some African cultures and other parts of the globe, couples are pressurized to have many children for economic reasons, among others. A 36-year-old mother of four children said:

*Having more children is part of African culture; my grandparents always advise me not to have a small number of children because the more children you have, the wealthier you are.*

Another woman said:

*Children are treasures to their parents; if a woman gives birth to many children, for example, she will always be counted among other people who are wealthy because her children will be working and contribute to their family economy.*

Respondents believed that childbearing is associated with economic and social mobility; this pushes some parents to give birth to as many children as possible. Similar observations have been made in Ethiopia (Rena, 2009) and Uganda (Chytilová & Streblov, 2007), where children contribute to their household economy by getting jobs. In Rwanda, "children are currency" (Rouchou, 2013, p.177). Since children contribute to the family's economy, childless women suffer economic deprivation. In some countries such as Nigeria and Cameroon, childless women do not have access to land (Dyer & Patel, 2012). During the interviews, participants described different factors that lead to fertility in the study community. One woman expressed the belief that children are the weapons to fight poverty within households, especially if one has many children.

*There are various reasons why childbearing is so important. You see, if you are a poor woman, your children are the only weapon to fight poverty in the near future.*



For many parents, children play pivotal roles when it comes to their contribution to the income of the household. This is more so in the rural areas and other poor environments. Childbearing is very important in contributing to the household economy and continuing the lineage. Childless couples are afraid of not having offspring to look after them. Mwape et al. (2014) conclude that the prospect of economic benefits is among major factors that influence the decision to have children. Mwape et al. (2014) states that couples need children to ensure there is someone who would be able to financially sustain the family in the future. According to respondents, children are an asset; they help to fight against poverty. However, respondents do not take the cost of raising children into consideration with their poor income. Amisi (2006, p.47) notes that “refugee incomes are very low and less reliable because in most cases the type of jobs they do require no formal training, [are] easily accessible and [are] less dangerous”. He adds that “male refugees occupied jobs such as hairdressing, repairing electronic appliances, and security, but prefer working in a formal employment due to its fixed and secure salaries compared to self-employment”. Despite the expense of rearing children; respondents still value the economic benefits that their children will provide in the future.

#### **4.3.2. Sex preferences**

Sex differences play an important role in terms of the number of children one should have within African societies. In some African countries, married couples that fail to give birth to boys are considered as “childless”, although they may have girls. This has increased gender inequality and discrimination against women. Eguavoen et al. (2007) argue that if men and women are given the same value, parents should not show preference for one sex and despise another. Sex preference is responsible for the lower status of women in many parts of the world. Since some African traditions forbid women to inherit; couples prefer to give birth to boys who will bear the family name rather than girls who change it at marriage (Eguavoen et al., 2007). One can therefore conclude that cultural beliefs contribute to high rates of fertility since some respondents believe that having more children, especially boys, is associated with their cultural beliefs. One woman responded:

*In my culture, if you do not have many children, especially boys, you are just a useless woman and nobody will care about you.*

However, refugees who are not satisfied with their family size want to give birth to as many children as they can, in the hope that they will eventually get boys.

*My wife has given birth to four girls.... The fifth child was a boy; that is why I need one more boy to finish up with childbearing.*

However, some refugee couples affected by the absence of male children within their family want to have them after being resettled by the UNHCR in America or Europe. Respondents having only girls showed dissatisfaction with their family size because of the absence of male children. One woman expressed her feelings as follows:

*For now, I'm not satisfied with the number of children that I have. I need boys as well since I only have girls. But this [getting boys] can only happen after resettlement.*

The absence of male children does not only end with the parents being dissatisfied; it affects the number of children they want to have. Having female children only results in many parents exceeding their ideal family size.

*I reached this number (6) of children because of hoping to have a baby boy; otherwise I wanted only four [children]*

Many couples prefer having boys since it is associated with the continuation of the family lineage. Osarenren (2013) concludes that a prayer of some couples is to have sons first rather than daughters. Male preference is crucial because there is a common belief that if a man dies, his son will inherit and keep the family going.

*In my tribe, men are known through their descendants; if you do not have children, especially males, when you die, there will be no one to continue your lineage.*

Eguavoen et al. (2007) conducted a study and found out that in one of Nigeria's province showed that women preferred to have at least one male child in the middle of girls to feel secure in the marriage. Parents believe that male children provide support in their old age unlike female children, who move away from their families. "The traditional idea that a boy belongs to us and a daughter to someone else" has become widespread (Eguavoen et al., p. 46). In contrast, other women in the same study thought that female children were crucial in caring for their old parents, especially if they married prosperous men.

### 4.3.3. Sex preferences and desire to save marriage/union

The absence of a male child not only affects the ideal family size that one should have, but may also encourage polygamy and marital breakdown. For instance, if a wife in the house “fails” to give her husband a baby boy, he may go and look for another woman outside the marriage who will be able to give him the desired child. A woman told her story as follows:

*I have six children already, all girls, but now my husband wants a baby boy, and he is serious about the matter. I am afraid he will go and have him [the boy child] with another wife.*

Women fear marital breakdown resulting from their failure to give their husbands male children. In some African cultures, polygamy is encouraged. A man needs to marry as many wives as he wants in order to beget male children, if his first wife fails to do so (Methuselah, 2014).

Asked why she cannot try to have a seventh child, as there is an equal chance of getting a boy, the participant replied as follows:

*This matter is giving me so much concern now. The doctor said it is very dangerous for me to have another child since I have already had three caesarean sections ....No, I cannot take more risks just because I want a baby boy....I love my daughters and value them more. If my husband will not be able to care about my life, which is in danger, he should do whatever looks good in his sight.*

Women’s lives are in danger if men cannot understand that there is no difference between boy and girl children. Culture and patriarchy perpetuate gender imbalance between sexes and encourage gender inequality (Connell, 2003). Although having male children is something to be content with within a family, men should understand that it is the father that determines the sex of the child by contributing the X chromosome. Thus, from a scientific point of view, if a woman does not get male children, the father needs to be “blamed”. However, in some African societies, women are blamed for failing to give birth to male children. A woman under pressure of having a baby boy relates:

*I'm so confused and do not know what to do. My husband wants me to keep on giving birth until I have a baby boy....He forgets that God is the giver of children.*

The preference for male children is found in a number of African societies. In some African countries and in Nigeria in particular, there is a great tendency for couples to show preference for male over female children (Eguavoen et al., 2007). The strong tendency for son preference is explained by the role they play of taking care of their parents during old age and maintaining the family line. The desire to have one or more sons might lead to a larger family size and becomes “a significant barrier in many countries (Eguavoen et al., 2007, p.46).The failure to give birth to male children pushes couples to go beyond their overall desire family size for them to achieve their sex preference. This preference of one sex over the other increases inequalities between both sexes. In this case, women are marginalized due to the patriarchy system that encourages women suppression. In contrast, a slight tendency to prefer girls to boys is observed in Latin America and the Czech Republic (Rai et al., 2014).

#### **4.3.4. Motherhood prestige**

“Woman’s glory is crowned in childbirth” (Baloyi, 2017, p. 1). Childbearing is one of the experiences that bring prestige to women. Within African societies, a childless woman suffers stigma from different people, including her in-laws (Bamidele & Pelumi, 2017). At marriage, there is an expectation that couples should provide grandchildren for their parents. The failure to give children is mostly attributed to women. Consequently, most women want to spend even their last energy in having children. The majority of the study participants believed that childbearing is associated with women’s prestige, and a childless woman has nothing to say among other women who have children. One of the respondents related her experience as follows:

*Childbearing makes a woman proud; the whole community will recognize you because if you do not have children you cannot say anything before other women who have children....You know. I only spent one year without showing a sign of pregnancy, but all my neighbors started pointing fingers at me and talked bad about me.*

Another woman stated:

*You know my friend (addressing herself to the researcher), having children is the answer to every woman’s prayer. I am so proud of having children around me because they grant*

*me respect from both my family and in-laws. If a woman knows that she has children, she is very proud of herself and walks with dignity because of what she has (children).*

Having children is one of the ways women receive respect from families and neighborhood. Methuselah (2014) maintains that a fertile woman walks with dignity and holds her head up high in the community. Childbearing defines women's position within societies and increases respect for them. Many women believe that without offspring no one will grant them respect. According to respondents, having children is very crucial within any relationship, more especially if a woman is married. In African societies, childbearing is a major foundation for a happy marriage. Taghizadeh et al. (2016) contend that having children is important for the strength and duration of any relationship. Some African families expect their daughter to show signs of pregnancy a few months after getting married. Asked what could have happened if she had failed to have children as expected, the respondent answered:

*I am not sure we could still be together by now....My husband could have gone for a second wife a longtime ago.*

Many women believe that children are the reason their marriage has remained stable; however, the failure to give birth contributes to marriage dislocation and separation. According to some African traditions, women are primarily viewed primarily as child bearers. Childbearing determines the social status of women and the value they have within societies (Baloyi, 2017). It simply means that womanhood is proved by motherhood. However, the failure to conceive makes women more vulnerable. Since childbearing guarantees dignity to women, Baloyi (2017) concludes that there is joy within the family when a woman is pregnant. He adds that a pregnant woman should be granted more respect than ever before. A study conducted in Sub-Saharan Africa revealed that participants reported "being held in high esteem and gaining prestige within the community when they had children" (Mwape et al., 2014, p.6). With motherhood, women gain more influence within the family and community at large (Mwape et al., 2014).

#### **4.3.5. Replacing lost children/family members**

A high mortality rate plays a major role in determining fertility rates (Nargund, 2009). As refugees flee from their native countries (DRC), many lose their relatives due to social and political instabilities. After arriving in their respective host countries, they believe that it is their right to

replace their family members that died back home during the political crisis. A 36-year-old woman opined as follows:

*During the war back home, my husband and I both lost our parents and many relatives, therefore, we have agreed together to have many children and replace some of our family members who died in order to cover the gap.*

Other people feel that because their parents did not give birth to many children, they should fill that gap. A 30-year-old woman added as follows:

*I am ready to give birth to as many children as I can because I want to fill the gap left by my parents. You see, in my family, we are only two of us, my brother and myself. Therefore, I feel that it is my duty to give [birth to] more children to fill the family since my parents failed to do so.*

The desire to fill the gap left by deceased family members contributes to high fertility rates among refugees. In Rwanda, for instance, many people lost their lives during the 1994 genocide. As a result, women gave birth to replace the children who had died (Verwimp et al., 2004). During the interviews, some of the respondents felt that it was their duty to fill the gap left by their parents. However, the means of survival should be taken into consideration since many among the study group are not working. Many are in informal jobs, which are badly paid.

#### **4.3.6. God's recommendation**

Some Christians use bible verses as excuses for their fertility rates. They usually quote Genesis 1:28: from the New Living Translation, which says: "Then God blessed them and said, 'Be fruitful and multiply. Fill the earth and govern it. Reign over the fish in the sea, the birds in the sky, and all the animals that scurry along the ground. Some respondents believe that as God told Adam and Eve to be "fruitful", it is their responsibility to give birth to as many children as they can, without taking into consideration the means to support them.

*My reasons to have children is that they are gifts from God and I have to fulfill God's command of filling the earth by giving [birth to] many children.*

*The big reason to have children is to fill the world as the Holy Bible says. Since we are married, it is not good to stay without children because it is against what God has recommended us.*

According to study findings, many of these respondents are unemployed; therefore, paying rent, children's school fees, transport and other household expenses is very problematic. Most of the study group believe that God is the one giving children, He will surely provide for them. One man relates:

*I have not been working for the past four years; my wife is the one running a home-based care business with a small number of children, but I believe that God is the giver of children and whether I work or not he will always provide for them.*

The study group being Christian, they quoted the Bible whenever they wanted to support their views about increasing family size. The majority of these respondents experienced poverty and hardship since they had failed to find jobs in the formal sector (Amisi, 2005). However, caring for children is expensive, if one considers schooling, shelter, food, health care, etc. Childbearing, in some respondents' view, bore no relation to their slender means. They believed that if God blessed them with children; he must surely provide for their needs.

#### **4.3.7. Children as providers of social security during old age**

In Africa, parents believe that having children is crucial, particularly for their old age. In contrast, childless people fear for their future, because they do not have children who will take care of them. During the interviews, the majority of respondents highlighted the importance of having children, for various reasons. Others thought that children are a blessing from God and providers of social security during old age. One woman stated:

*Having children is more important than having cars and houses, you know. In old age, everyone will need the support from his/her children, in one way or the other.*

Olivier (2013) states that in developing countries, parents tend to have many children, anticipating that they will take care of them when they are old. This is unlike the situation in developed countries, where parents do not expect their children to provide for them because they have pensions.

*You see, my friend (addressing herself to the researcher,) children play major roles in parents' lives. I have four children for now; I believe that I will never experience the same struggle during my old age as someone who does not have children.*

According to Mwape et al.(2014, p.6), “Women made reproductive decisions to become mothers because children served as an assurance of someone to take care of them in old age when abilities begin to slow down”. Childbearing gives parents an assurance that their old age is secured with the presence of their children on their sides. However, findings indicate that childless women fear getting older without someone who will take care of them during their old age. Nevertheless, owing to their religious beliefs, having a child out of marriage is prohibited. A 26-year-old woman said:

*It is not only that I need someone who will take care of me during my old age....My husband needs children as well, but as a Christian he cannot have a child outside wedlock; that's why we keep on praying and trusting God for children. Even if we only have one, we will be grateful.*

#### **4.3.8. Inadequate use of appropriate contraceptives.**

The neglect of modern contraceptive methods by women in their reproductive age continues to increase fertility in some parts of the world, including developing countries. Although some women have access to contraception, others prefer not to use it, for various reasons. All the women said that they knew one or two types. The ones most often cited by the study group were pills, injections, the calendar and condoms. Only one woman mentioned breastfeeding as a contraceptive method, although it looked traditional. Most of the women were using injections rather than other contraceptive methods offered at the clinic. However, they were not effective. Asked why she likes having injections, a participant replied:

*I prefer injection to pills and other contraceptive methods because it is more reliable....When you are given an injection you are safe because there is no need to panic like someone who takes pills every day at a specific time.*

Although the women were aware of many contraceptive methods, they were reluctant to use them, owing to their perceived ineffectiveness. One participant commented:



*I know injections, pills, condoms and other traditional methods such as the calendar, abstinence and withdrawal, but no one can trust them since they are not effective most of the time.*

Women should be aware of different types of contraceptive method in order to know the specific one that will be helpful for their reproductive health. Although there are many modern contraceptive methods offered at both public and private hospitals/clinics, refugee women are not well informed about them. Raising awareness is necessary, as there are women who only know traditional contraceptive methods. Some participants believed that traditional methods are good to use since they have no side effects. However, they are not effective most of the time.

*I only know pills and the calendar method, but I fear using the calendar method because it is not reliable: you can find yourself being pregnant while using it.*

Family planning is one of the major practices women should adopt to avoid unplanned and unwanted pregnancies. However, despite its effectiveness, women reported barriers to its practice.

#### **4.3.8.1. Barriers towards contraceptive use.**

Although contraceptives play a crucial role in spacing children and in women's well-being, several barriers were identified to the use and continuation of contraceptives among women who are still in the reproductive age. The study findings show that women in the community group knew various types of contraception, though they tended to avoid using them because their husbands disapproved of contraceptives, they were afraid of side effects, and they wanted to have children.

##### **4.3.8.1.1. Husbands' disapproval of contraceptives**

Gender imbalance has not only led to women's subordination; it has contributed to increased fertility rates in many relationships. While some female participants were willing to use contraceptives, they indicated that their husbands were not ready for that decision since childbearing was their major priority. One woman said:

*During my last pregnancy, I did not use any contraceptive method because my husband wanted me to become pregnant to have a baby boy; unfortunately, it was the opposite [I gave birth to a baby girl].*

Although women were willing to use contraceptives to reduce fertility rates and improve child spacing, their partners were opposed to the idea. In some societies, marriage and procreation are inseparable. The sacredness of procreation is crucial for some couples: their religion influences their sexual behaviour and their views on women's reproductive health. They believe that God designed sex for pleasure and having children. Niekerk (2017) argues that sexual intercourse is good because it brings about new life. He maintains that "Sex is primarily meant for human procreation, and its [religion's] consequent opposition to artificial measures of birth control such as condoms and oral contraceptives remain unchanged"(Niekerk, 2017 , p.8).

Religion encourages procreation; some couples consider the use of contraceptives to be a sin and against the word of God (Niece, 2017). Since religion [the Roman Catholic religion] does not allow the use of artificial contraceptives, religious women have resorted to traditional methods, which are less effective (OlaOlorun, 2016). It is very problematic when couples fail to use any means of contraception to avoid unwanted and unplanned pregnancy.

*We have mostly failed to abstain, but my husband refuses to use condoms, saying that it is against his faith and a sin before God.*

Culture and religion are hard to separate. For most respondents who are Christians, the use of contraception is not allowed, as it is against their faith. Cultural and religious beliefs unfortunately are damaging to livelihoods, and the damage cannot be reversed. Family planning will help parents to enjoy their sexual relationship by reducing the fear of unplanned and unwanted pregnancy (OlaOlorun, 2016).

#### **4.3.8.1.2. Fear of the side effects of contraceptives**

Contraceptive methods help in child spacing and improving women's reproductive health, but the fear of side effects was what mainly discouraged the use of contraceptives among childbearing women in the sample. Despite the benefits of family planning, a woman in this study group raised a concern about side effects, which have led some women to discontinue their use. One woman recounted her experiences with family planning:

*The family planning that I was given was the three months injection, which gave me so many problems such as headaches and stomachache, that I stopped [using] it.*

Contraceptives cause different reactions in women. For instance, if injections prove harmful a woman can change to something she can tolerate. Most of the women had shifted from injections to pills, thinking that the latter were the best option. Another woman said:

*I decided to take pills because injections gave me so many problems such as headaches, bleeding every month and loss of weight.*

On the other hand, those who were offered pills felt after some years that they no longer suited their bodies, and decided to give them up.

*I was taking pills for the past three years. After that, I started having headaches, dizziness, and then I stopped taking them and found myself pregnant.*

Some respondents showed lack of interests in using contraceptives due to different experiences. They therefore chose to continue giving birth regardless of their abilities to take care of their children. Emma Goldman (1996) advocated that women should not always keep their wombs open. For her, women need to use contraceptive methods to prevent pregnancies. Contraceptive methods were useful and helped some of respondents in terms of childbearing spacing; nevertheless, side effects were major factors contributing to its discontinuation.

*They offered me injections and they helped me in terms of child spacing, but [came] with so many complications such as headaches, bleeding and loss of weight.*

#### **4.3.8.1.3. Desire to have children**

African societies value children and most parents even go beyond their ideal family size. The desire to have children negates contraception since many women would rather fall pregnant. Although they have given birth to other children, some participants in the current study expressed a desire to have more children, despite their financial constraints. During the interview, a 28-year-old female and mother of two said:

*I stopped taking the contraceptive I was using because I am planning to fall pregnant since my wish is to have three children before attaining menopause.*

*I was taking pills before my last pregnancy and they were helping without any problem, but now I have stopped taking them because I want to get pregnant and see if I will give birth to a baby boy because I only have girls.*

Having children, for some African people, is a priority in marriage (Baloyi, 2017). Although some of the female respondents were using contraceptives without any side effects or complications, they decided to discontinue using them, as they desired to have more children. The use of contraception in the study community can be regarded as a way for childbearing spacing only and not for limiting the family size as in Niger, Benin and Sierra Leone (WHO, 2006; Izale et al., 2014; Lesthaeghe, 2014). While some of the respondents complained about the side effects of contraceptives, others, especially those with female children, showed no interest on contraception, explaining that they wanted to fall pregnant and have at least a male child. Cleland and Machiyama (2015) argue that despite the severe impact of childbearing on women's lives and their babies, contraceptives have no major value in some parts of Africa.

#### **4.4. Infertility and childlessness**

Infertility is a global reproductive health issue affecting both married and unmarried people (Tabong & Adongo, 2013). African cultures perceive infertility as a curse, for which childless couples are socially stigmatized and excluded from leadership roles in their communities (Tabong & Adongo, 2013). For the purpose of this study, three women without children were selected to participate. The major reason was to understand the value placed on childbearing. Among these three women, one had given birth once to a baby boy who, unfortunately, died a few hours after his birth. At the exact time of the interview, two years had passed since she lost her child, and she had not been able to conceive thereafter. The other two women had not experienced motherhood: none of them has ever been pregnant or experienced a miscarriage. There is always a tendency to blame the woman for the failure to conceive, even if the fault lies with the man. During the interview, three themes were associated with infertility and childlessness among women: family pressure and stigma, isolation, and fear of the breakdown of marriage.

##### **4.4.1. Family pressure and stigma**

Offspring are sources of happiness within families and communities as a whole; couples without children are not respected as are those who have children (Bamidele & Pelumi, 2017). The three

childless women recounted their daily challenges in living without children. In some African societies, living without children can be stigmatizing in that childlessness is viewed as a sign of an abnormal relationship. Stigma operates at three different levels: it affects the couple's relationship, how they are perceived within the family/household, and society at large, and it affects women the most (Mumtaz et al., 2013). The study findings showed that childless women were in good relationships with their husbands, despite their childlessness, but were stigmatized in both the household and society as a result of their failure to produce children.

#### **4.4.1.1. Stigma at family/household level**

Although all three childless women reported no abuse from their husbands, some family members, their in-laws in particular, perpetuated stigmatization. As migration is associated with young people, many refugee couples live in South Africa, while their families are in the DRC. However, in-laws always pressurize their daughters-in-law, by means of repeated telephone calls, to give them grandchildren. A 30-year-old childless woman said:

*It has been seven years since we got married, and I was living peacefully with my husband until my in-laws started calling me and told me that they need to see their grandchildren. It always gives me concern since they do not stop calling. It has affected our relationship because I do not take their phone calls anymore for fear that they might ask me the same question again.*

Although the stigma associated with childlessness affects both sexes, women experience greater stress and pressure. During the interview, these women felt that even their own family members, who should give them support, rejected them.

*It always hurts me when my own mother calls and starts asking when I am planning to have a child. Am I God who gives children? Instead of keeping on encouraging and praying for me, they are adding more pressure the same way my in-laws are doing (A 30-year-old childless woman).*

Stigma attached to childlessness has a bad effect on women's lives. Mumtaz et al. (2013) argue that women carry the blame for not conceiving even it was the men's problem. Women in the study group felt rejected, even by their own families, who were supposed to support them. In Africa and other part of the world, whenever couples fail to give birth, women receive the blame and in most

cases, they suffer serious economic deprivation. In Cameroon and Nigeria, for instance, childless women do not have the right to acquire land distributed by their husbands (Tabong & Adongo, 2013). As stated earlier, in Africa, parenthood is important; its failure leads to many challenges in a couple's relationship. Tabong, and Adongo (2013) argue that in some African communities, parents of the bride and groom expect the announcement of a pregnancy within a year of their children's marriage. The failure to show any sign of pregnancy after many years of marriage increased respondents' pressure from their parents back home. Participants felt that their childless situation had affected their relationship with both their family members and in-laws, who were all eager to see their grandchildren. Childless women in this study expressed how people view them. They described how they were disgraced, shouted at and cursed, especially within their husbands' families, but felt particularly stigmatized and mocked in their own families and communities.

#### **4.4.1.2. Stigma at societal /community level**

Childless couples experience stigma and other childlessness-related problems within a community that promotes and encourages parenthood (Nahar & Richters, 2011). Coping with childlessness is not always something pleasant due to the negative social image of childless people. In most cases, women were at high risk of being stigmatized when motherhood is failed. There is a saying in Bangladesh that: "Even a fox or a dog does not eat the dead body of a childless woman" (Nahar & Richters, 2011, p. 331). Respondents in this study were affected by communities' perceptions about their childlessness. They considered that the community enforced the stigma attached to their condition. As a result, staying indoors was an alternative, to avoid community gatherings. One woman said:

*Eish, my sister (addressing herself to the researcher) childlessness is worse than anything that you can think of because if you do not have a child of your own everyone is pointing a finger at you. Sometimes you feel like not going out just to avoid people and give yourself peace of mind (a 30-year-old childless woman).*

Infertility, according to women in the study group, is a shameful abnormality, which makes them unhappy every time they think about it. Ganguly and Unisa (2010, p. 132) argue that "childlessness is of particular concern because of the global extent of the problem and the social stigma attached to it." Respondents reported stigmatization from their neighbours and communities at large. The stigma experienced by infertile women makes them feel unwanted and rejected by everybody.

They are viewed as luckless people who can cause harm to the community. Thus, most respondents prefer to isolate themselves from community events rather than be heartbroken by people's attitude toward them.

#### **4.4.2. Social withdrawal and isolation**

Childless respondents said they avoid community gatherings and public spaces, fearing that people will start asking them about childbearing. These women said how they exclude themselves from gatherings such as baby showers or birthdays. Their infertility had affected their relationships with pregnant friends, since they did not want to remind themselves of their failure to conceive.

*I always like to go out and meet with people who are celebrating their birthdays, but in most cases, my situation (infertility) does not allow me to go because I will be surprised with people's questions such as "When are you expecting your baby?" Such questions hurt my heart, and remind me of my infertility; therefore, I rather stay indoors than be heartbroken.*

Childlessness had made women in the study group believe that they did not have the right to advice or touch someone's child, for fear of being labeled a "witch" or other names that might disgrace them in public.

*I like children so much, maybe because I do not have one of my own. When I see a child crying I always feel like going and holding him/her, but I remember one day when my neighbour warned me not to touch her child, even if I see her crying. She told me: "Witch, you have finished eating all your children inside your womb, now you want to eat mine."*

In situations such as this, childless women prefer to avoid social contact by staying indoors most of the time. Childless women experience loneliness, believing that public spaces enforce the abuse associated with their childlessness. Tabong and Adongo (2013) showed that childless women avoid public gatherings such as baby showers, birthdays and other meetings that can cause them to feel bad about their situation. These women even avoided their pregnant friends for fear that they might talk about their pregnancy experiences (Tabong & Adongo, 2013).

#### 4.4.3. Fear of marriage breakdown

Childbearing plays a crucial role in marital stability (Bamidele & Pelumi, 2017), therefore, the failure to give birth might affect the bond between the couple. During the interviews, one woman explained that before, her husband was the most important source of support when all his family turned against her. However, she believed that her husband's behaviour had started changing because of her childlessness. As mentioned earlier, childless women in most African societies feel rejected by some of their family members and friends whenever they fail to give birth. Nevertheless, some of them who found support from their husbands lived in constant fear that they might withdraw their support.

*I pray that my husband never changes towards our situation of childlessness. Before, he used to encourage me with positive words such as: "God will give us a child one day the same way he did to Abraham and Sarah in the Bible." However, today he has totally changed towards me. I think he might go and have a child outside our marriage since I cannot do it.*

Because of their infertility, participants felt that their marriages were at risk of breaking down and their husbands could go out with other women, to have children. What Baloyi (2017, p. 2) concludes shows that: "If there is not yet a child in the marriage there is no guarantee that the marriage will endure". The author states that marriage and childbearing are inseparable; they are regarded as a unit. Mwape et al. (2014) conclude that children are a source of happiness and contribute to the stability of their parents' marriage. Children play a pivotal role as peacemakers; they strengthen the marital bond. Riessman (2000) argues that childlessness contributes to separation and divorce. He emphasizes that the failure to bear children falls mostly on women. Consequently, a man in a childless relationship might consider a childless union as a legitimate reason to get another wife with or without being separated from the first one. Two childless women expressed the fear of separation if they failed to give children to their husband:

*Though I do not know my husband's mind, I believe he wants children more than I do, and he might change his mind [and] go for another woman if nothing happens on my side (a30-year-old childless woman).*



Sex was created for both pleasure and procreation. However, the marital relationship is affected when the couples fail to conceive. A childless woman reported that her childlessness had affected their sexual relationship since her husband felt that having sex was fruitless and a waste of energy. She explained:

*It has been three months since I had sex with my husband....He told me that he cannot keep on wasting his energy because he does not see the outcome of what he is doing (a 25-year-old childless woman).*

This comment means that, for most men, sex should be both pleasurable and procreative. If it is not, there is a high probability of a marriage breakdown.

#### **4.5. Congolese refugees' experiences with accessing health care services in Durban**

Refugees face many barriers in their attempts to access health care. Since the majority of refugees come from a war zone, they could have experienced problems in accessing quality health care in their own countries. The host country should provide better treatment for them to avoid their spreading various infectious diseases among the host population. The following were identified as the main challenges: language barriers, affordability of health care, and the hostility of health care providers. Some refugee women face all of these, and thus need advice regarding family planning as well as sexual and reproductive health, which would educate them in childbearing. In South Africa, and Durban in particular, the health and medical needs of refugees are not met.

##### **4.5.1. Language barriers**

Encountering an unfamiliar language and culture is one of the major challenges refugees face all over the world. Congolese and other migrants, particularly those from French-speaking countries, experience many challenges in language. The majority of female respondents reported language as their major hindrance in accessing health care services. Some of these women could not speak isiZulu or English, and this made communication with health care providers difficult.

*I have many problems when using health care services....Language is the major one, since I cannot speak English and isiZulu properly (a 36-year-old woman).*

Asked how she communicates with health care service providers, she replied:

*Sometimes nurses use sign language to make me understand, but it is not easy because most of the time I leave my medication not knowing that he/she wanted me to collect it from the pharmacy.*

The use of sign languages is very problematic when one is trying to get/provide proper treatment. Since patients and care providers speak different languages, communication between the two of them is very challenging. Using sign language for refugees who are trying to get treatment could worsen the situation since communication is not clear. Naidoo (2014) argues that communication is the cornerstone between patients and health providers; it plays a crucial role in treatment quality. Therefore the failure to communicate might lead to poor treatment. Patients could even get different treatment from what they are supposed to get. A 28-year-old woman said:

*I always have good service whenever I visit the hospital. However, sometimes nurses force you to speak in their local language (isiZulu) although they know that you cannot speak it.*

Nkosi (2014) argues that it is very important to communicate in the health seeker's language because it bridges the gap between him/her and the health provider. The failure to communicate when patients receive treatment might have negative effects on the quality of treatment and medication prescriptions. Hospitals should make use of translators for patients who cannot communicate clearly with health care providers. However, if translators are not trained in medical terminology, it can lead to misunderstanding and misdiagnoses (Nkosi, 2014). The use of translators may also be problematic in terms of ethics and confidentiality because there might be patients who feel uncomfortable about sharing their health experiences with strangers. One woman said:

*My biggest challenge when using public health is language because I do not speak isiZulu, and nurses intentionally ask you questions in that language while they know you cannot speak it.*

When I asked her how she felt when she was addressed in a language that she could not understand, she replied:

*Eish... sometimes I feel so embarrassed because Zulu-speaking patients will start laughing at you...eish... it is not a good experience, I am telling you (a 32-year-old female).*

The failure to speak or understand the host country's language has denied refugees their right to access health care like their South African counterparts. As a result, they suffer from rejection and discrimination at the hands of health care providers. The participants felt that language was used as a weapon to punish refugees and to discourage them from accessing healthcare.

*You know, nurses use their language (isiZulu) to discourage us from using public hospitals. Now I am used to their discriminating behaviour against foreigners. If you do not know how to speak isiZulu, they will not care about you, although you speak English correctly (a 34-year-old female).*

Although it is prescribed in the South African Constitution that everyone has the right to access health care, refugees feel that they have been denied access. According to the Community Agency for Social Enquiry (CASE), language is the key problem in accessing proper care. Health care providers are impatient when communication is unclear, and they neglect patients. Lamb and Smith (2007) argue that when there is miscommunication between health care providers and patients, the latter experience psychological stress because of their inability to speak isiZulu.

#### **4.5.2. Affordability of health care**

Refugees experience economic hardship, as most of them have only casual jobs (Amisi, 2006). Many of them are too poor to access private health care or buy medication when they are sick. Limited access to medication was cited as another problem which affects the quality of health care that is available to refugees. Asked about the challenge she faced when using health care services, one participant stated:

*The public hospital is the worst and last place someone should wish to go. You see, most of the time when I go to the clinic/hospital they tell me that medication is out of stock, and I do not have money to buy it at the pharmacy. I will end up going home regardless of my health condition (a 36-year-old female).*

Some of the women think that poverty hinders their access to private hospitals; otherwise they would not make use of public health care because of its deficiencies. When she was asked what she does when seriously sick, and the medication is out of stock in the public hospitals, she replied:

*That is my biggest problem because I am not working and my husband is a barber. If there is a need to buy medication, I will always end up borrowing money from friends and families, and paying back becomes a problem for me.*

According to this woman, public hospitals are not reliable in an emergency, as patients usually receive poor quality service. Economic challenges faced by the study community force them to use public hospitals although they are unhappy about that. Some of the respondents believed that in emergencies there should be other ways to save lives rather than using public hospitals. One woman concluded that:

*If I have money, no one in my family will ever use public hospitals, especially if the situation requires major interventions. A person might lose his/her life at public hospitals due to lack of money to pay the bills at private care where better treatment is guaranteed.*

Onuaha (2006) notes that a Somalian woman gave birth in the reception area in one of South African's big hospitals because her husband could not afford to pay the maternity ward admission fee.

#### **4.5.3. Attitude and behaviour of health care providers**

Refugees reported that the carelessness of some health care providers towards them has led not only to poor services; it has resulted in the loss of many lives as well. Refugees complained that nurses and other members of staff at public hospitals do not care about emergency medical cases if migrants are involved. A 25-year-old childless woman explained how she lost her child because of the negligence of the staff:

*I think public hospitals are not good to use in times of major problems because nurses do not care about people. When I was in labour, the doctor asked one of the nurses to prepare me to go for a caesarean section since my child was big. Instead of taking me to the theatre immediately, she took several hours doing her own things. I went to the theatre when my child was dead already because of waiting for a long time.*

In such cases, refugees might feel that health care providers violate their human rights, since their health and well-being are not considered. This childless woman blamed care providers for losing

her child due to their negligence. She said that it had been more than two years since she lost her child, and since then, she had been unable to conceive again. She explained:

*I am not happy at all with the kind of experience I went through at that hospital. It is now more than two years since I lost my child and I have failed to conceive again. It concerns me when I see my fellow women with their children, especially those who got married after me.*

This woman felt that nurses were responsible for the stigma associated with her childlessness, as they failed to adhere to the ethics of their profession.

Refugees complain about long queues at the public hospital, regardless of their health problems.

*I only visit health care services when I have serious problems. Long queues are a very serious issue at the hospital, because even though you are seriously sick, you have to wait in that long queue until your time arrives.*

Faced by many health problems, the study group felt that the attitudes and behaviour of health care providers were increasing discrimination that could hinder the quality of services they should receive. The study community believes that being non-nationals lead to discrimination and xenophobia.

*You see, when you visit the public hospital and nurses see that you are not a South Africa; suddenly they treat you differently (a 35-year-old female).*

Refugees believe that the attitudes and behaviour of some health care providers discouraged them from accessing good treatment. Nkosi (2004) stresses that sometimes health care providers have stereotyped ideas about immigrants, which might discourage their use of health care services.

#### **4.6. Gender in determining total fertility among Congolese refugees**

This section examines the effect of gender differences in determining childbearing. The findings show that men in the study group were far different from women in taking certain decisions about the household and having children. The following findings were identified in this section: task allocation, men as decision-makers, and men as heads of the family.

#### 4.6.1. Task allocation

The sexual division of power encourages task allocation for men and women based on their gender. Within the study group and in other parts of Africa, childbearing and rearing are mostly performed by women, while men are supposed to work and do other activities of a “masculine” nature (Ezeah & Achonwa, 2015). The female respondents believed that taking care of children was their task; men viewed themselves as breadwinners and decision-makers. The differences based on gender contributed to gender inequality. One man said:

*I always go to work while my wife does nothing at home; therefore, it is her duty to take care of the children. Taking care of our children is her full-time job (40-year-old man).*

In some African societies, men and women perform different tasks based on their gender. This study is guided by the gender and power relations theory (Wingood & DiClemente, 2000) which assigns certain activities to men and others to women. The study community being in a patriarchal system, women cook, clean the house, and care for their husband and children, amongst other tasks related to their “feminine nature” (Ezeah & Achonwa, 2015). Men were expected to go out and work. However, some women in the sample were working mothers, doing manicure and pedicure, or hairdressing. But despite their contribution to the household income, they were still responsible for taking care of their children. Asked if he would take care of the children if his wife was working and he was not, one man replied:

*Honestly speaking, childrearing is only a women’s responsibility; no men can do it. Whether my wife is working or not, she is the only one to care for our children.*

In the present study, almost all the women reported that taking care of children was their main responsibility. However, some women said that even though they were working, their husbands did not take care of the children since they believed it was women’s work. The women felt that they were being overused by their husbands:

*I do all the work in my house such as cleaning, cooking, washing and taking care of our children. On top of that I am doing pedicure and manicure to help my husband to cover our family expenses.*

Women who help with paying their household expenses believed that it was unfair if the division of labour was unequal. They believed that men should help them with household chores since they bring money home. However, participating in informal work enforces women's subordination. The World Bank (2015) noted that women participate less than men in the labour force because they leave to have children and look after them. Hence most of them do part-time jobs in order to balance the responsibilities of workplace and household.

#### **4.6.2. Men as decision-makers**

Male supremacy compounds women's subordination. It also affects fertility in cases where men are the ones deciding on the number of children to have. Cultural and societal beliefs encourage male dominance, which leads to sexual division of power. Female respondents reported having less power than their husbands in taking decisions in the house. Asked if she had the same power as her husband in their relationship, a 36-year-old woman said:

*In our marriage, I do not have the same power as my husband; he is always on top of everything and has the last word in terms of taking decisions.*

Other women felt that they did not make decisions within their family because, unlike their husbands, they had no paid work.

*Since I am not working, my husband brings the money and decides himself on the household spending... I think if I was working, we could decide together as a couple on what to do in terms of the family expenditure.*

Unemployment enforces the subordination of women, making them dependent on their husbands (Jayachandran, 2014). The majority of women in the current study had no occupation; therefore, some of them were not involved in household spending decisions. The sexual division of power theory enforces the abuse of authority and control in a relationship. Dodoo and Tempenis (2002) argue that the payment of bride price gives men authority to decide on various matters, including childbearing. Whenever men have power over women, it affects women's reproductive lives in terms of contraceptive use, as discussed in the previous section. A 35-year-old female confirmed this:

*My husband decides about the number of children we must have in our relationship. This is very serious because he is looking for a baby boy.*

As indicated earlier, the desire for boy children incites couples to go beyond their preferred family size. Since men have power, they force women to give birth to as many children as they can, until a baby boy is born. As these women are poor, they are not able to influence any decision within their relationships (Jayachandran, 2014). Some women reported that men take decisions without their participation when it involves major issues, such as buying land, a car, etc. Eguavoen et al. (2007) argue that most couples do not discuss important things together, and if they do, men still take the final decision, whether their partners approve or not.

*My husband does not need my opinions in most cases as he decides on major issues without consulting me (a 28-year-old female).*

Although some women felt excluded from household decisions, others reported participating in those regarding household expenditure:

*Although we do not have equal power within our relationship, we decide together on family spending, although he is the one who brings the money.*

Women's participation in household decisions differs from one couple to the other. In this study, few women agreed that they participated in matters regarding household purchase and other decisions. Being unemployed makes women unable to take part in household decisions (Jayachandran, 2014). Whenever women fail to take decisions in their relationships, it affects their reproductive health in that men might control even what kind of contraception to use (Baley et al., 2016).

#### **4.6.3. Men as head of the family**

Some men reported consulting with their spouses about household decisions, but others felt that it was not a good idea when a decision involved serious matters.

*Men have more power than women do in the house, I cannot consult my wife every time I want to make decisions, and otherwise it will be a sign of weakness (37-year-old man)*

Asked why he does not involve his wife in the household decisions, he replied:



*Sometimes I do involve her when I want to do something, but in most cases, I do not need to consult with her....I do what I feel is good by me.*

Although the study participants were all married, decision-making was the responsibility of men.

*I am the head of the family, which means there are certain decisions that I must take without her approval (40-year-old male).*

Being “the head of the family” led to differences between husband and wife, not only about the household economy, but the number of children as well:

*My husband decides on the number of children we must have in our family (36-year-old woman).*

Asked if she had tried to give her own opinion on the issue, she replied:

*In most cases, he does not want my opinions....He says he is the head of the family.*

Some men involve their wives in decisions,-but do not expect their approval. Two male participants agreed to discuss family issues with their wives, but most of the time they take decisions whether their partners agree or not.

#### **4.6.4. Women and power bargaining: The role of education**

Education is very crucial in development. This conviction led Suen (2013) to conclude that “If you educate a man you educate an individual; however, if you educate a woman you educate a whole family (nation)” (p. 61). However, within an unequal society, the gap between male and female literacy is an indicator of gender discrimination. Therefore, promoting women’s education is important because it enables women to confront their traditional role and make positive changes to their life (Suen, 2013).

Education and economic independence are very important in terms of empowering women. The study findings revealed that educated and employed women influence decision-making in a positive way (Kinoshita, 2003). Among the three male participants, one was without occupation, and he felt that he was not in a good position to decide on childbearing, since he could not support his family financially. He explained:

*I am not working, my wife is the one running home-based care, therefore, she decides on the number of children to have since I cannot provide for my family as a man (40-year-old male).*

Accessing and having control over resources does have a positive impact on women's position. As already noted, economic deprivation makes women suffer at the hands of their spouses. Women should be educated and employed, rather than staying at home taking care of children. The findings in this study showed how a financially independent woman was able to decide on household matters, including childbearing. One participant (a 32-year-old woman) with a master's degree explained:

*I think we compromise and decide together on the number of children to have.*

Asked if she had the same power as her husband to make decisions, she replied:

*No, we do not have equal power because African men see themselves as superior to women. However, most of the time we discuss and decide together on major issues in the family; for instance, buying car, family land and other plans that we have.*

The power to participate in decision-making depends on the economic and education level that one has attained. Educated and employed women participate in decisions affecting their households. In this study, an educated woman confirmed that taking decisions, her husband always sought her opinion. The husband of a woman running a childcare facility agreed that his wife takes decisions in the house since she is the breadwinner. Whenever women are empowered, they are able to participate in household decisions and contribute positively to their well-being. Kinoshita (2003) concludes that education and employment are crucial for empowering women.

#### **4.7. Conclusion**

This chapter has presented data collected from twelve Congolese refugees who reside in the inner city of Durban. It comprises four sections: the first one presents the demographic characteristics of the respondents such as age, marital status, type of occupation, dwelling size and respondents' educational backgrounds. The second section comprises information on the fertility rate among this study group. Different subthemes are identified, including considerations of childbearing, child gender preference, filling the missing gap, God's recommendation, the desire to have

children, and the use of contraceptive methods. The third section looks at the challenges faced by refugees in accessing health care such as: language deficiency, financial constraints, and the attitude and behaviour of health care providers. The fourth and last section considers the gender issues in determining fertility rates among Durban- based refugees. There is a sparse literature documenting those specific themes, and it is highly recommended that research be conducted in those areas.

## **CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS**

### **5.1. Introduction**

This chapter summarizes the research study. The objectives of this research were to identify the social and cultural determinants of fertility among Congolese refugee women in the city of Durban. The study sought to explore Congolese refugees' experiences within the health care system, and to identify the gendered dimension of decision-making about fertility. The research approach used in this study was qualitative. The research population was Congolese refugees living in Durban and members of the Divine Mission church (DMC). Purposive sampling was used in this study, because it was believed that the most important information could be obtained from this sample. The study was conducted with 12 participants using a semi-structured interview schedule. A content analysis, through thematic analysis technique, was used to analyze data. The current chapter summarizes the study findings and provides recommendations for further research and policy/intervention. The study's limitations are also highlighted.

### **5.2. Summary of major research findings**

#### **5.2.1. Social and cultural factors contributing to fertility rates among Congolese refugees in the greater Durban area**

The findings of this research revealed that childbearing in this community is, for various reasons, very important. The findings indicated that this community has mainly viewed the presence of children as being of great value. According to the findings, the social and cultural determinants of fertility in this study group include the economic value of children. Respondents viewed children as important contributors to the family economy. As having many children is part of African culture, the study group believed that the more children people have, the wealthier they are. Children are treasures in their family. Couples with children indicated that those who have many children are always counted among wealthy people. These people believe that their children will in time be working, and therefore contributing to the household income. In many African countries, children involve themselves in economic activities, particularly those in rural areas and poor households. The respondents, being refugees and living in hardship believed that having children was the only weapon to fight future poverty. Respondents also indicated that gender preference was the motive behind their fertility rate. They believed that despite the number of female children

one could have, if they did not have a male child, the family would be incomplete. Lacking boys, some respondents showed that they were ready to exceed their family size just to have even one boy. Other women in the study group indicated that if they didn't have a boy, women were "useless" and nobody should care about them. The research findings revealed that some couples who lacked boy were ready to have another child, but only after their resettlement. This could be because refugees were keen to leave South Africa and relocate abroad. Another motive for gender preference among the study group was the continuation of the lineage. The respondents indicated that men are known through their descendants. They believe that if a man dies without leaving a male child, there would be no one to continue his lineage. In some African cultures, girls cannot inherit their fathers' properties. Parents know that girls can get married and change their family name. Therefore boys, according to the research findings, are the right successors for continuing the family lineage.

The failure to have male children could lead to marriage breakdown among the study group. The majority of women who had no male children at the time of their interview were afraid of that. They feared that if they failed to give birth to boys their husbands would go and have them with another woman.

The research findings showed that the prestige of motherhood and the way people were trying to replace their children and relatives that died during the war were among the causes of high fertility rates within this group. Female respondents indicated that childbearing was the major reason for their pride within their community. They believed that a childless woman had nothing to say if their counterparts with children were talking. Respondents assumed that childbearing grants them respect in their families. In contrast, the stigma attached to childlessness leads to loneliness and family pressure. Childless women were in constant fear of losing their marriage if they failed to give birth. The findings of the research showed that both childless women and their counterparts with no male children feared separation. In terms of filling the gap, some respondents indicated that they were responsible for replacing their relatives lost during war back home. Others showed that they were giving birth because their parents could not give birth too many children. Respondents indicated that childbearing was God's recommendation. They quoted *Genesis 1:28*, where God blessed Adam and Eve by telling them to be fruitful and fill the earth. Being Christians, respondents showed that they were accomplishing what God had said. Despite their economic

challenges, the majority believed that as God gives children, he would surely provide for them. Children were viewed as providers of social security during old age. The research findings revealed that respondents were of belief that their children were more important than cars and houses. Having many children made respondents believe that their old age would be different from that of their childless female counterparts. Childless participants were afraid of getting old without anyone to take care of them. They wanted children, but as Christians they would not go outside their marriage to have them. As a result, they kept on praying while trusting in God. The findings also indicated that the low use of contraceptives among the study group was among the leading factors behind their fertility rates. Respondents indicated that injections and pills were the most used contraceptive methods. Nevertheless, some preferred having an injection because they believed that women who have it are safe compared to others that take a pill every day at a specific time. Some believed that most contraceptive methods were not trustworthy. A woman might have an unwanted and unplanned pregnancy if contraception was carelessly used.

The research findings also indicated hindrances to the use of contraceptives among the study group that contributed to the low use of contraceptives and increased fertility rates in this community. Some respondents said that their husbands discouraged them from using contraceptives. Indeed, the findings showed that men who wanted their wives to become pregnant, particularly men who wanted male children, did not allow them to use any type of contraceptive. Some women indicated that the fear of side effects was the major reason to avoid contraceptives. Respondents showed that they were experiencing many problems such as bleeding, headache and stomach pain when having an injection, so they had to discontinue that or change to a pill. However, respondents who were using a pill complained of headache and dizziness too. Thus, unwanted and unplanned pregnancies were the result of this community's discontinuing contraception. But most respondents gave up contraception because they wanted to have children. The research findings indicated that women who had only female children deliberately abstained from contraception because they wanted to be pregnant again.

### **5.2.2. Congolese refugees' experiences with accessing health care services in Durban**

According to the findings, refugees faced many problems when trying to access health care. The respondents indicated that language was their main difficulty. Most of them said that their inability to speak isiZulu and English discouraged them from using health care facilities. The language they

brought with them was French. Respondents indicated that their inability to speak their hosts' languages was used to discriminate against them. They felt that if they did not speak isiZulu, although they could speak English, the nurses would not care about them. Respondents said that sometimes they used sign language, but they mostly ended up receiving wrong medication when they used it.

Lack of funds was identified as another hindrance that respondents faced in trying to access public care services. Most of the respondents were unemployed, and others did poorly paid in informal work. They did not have the money to pay for private hospitals. Respondents reported that public hospitals were the last place one should wish to go to, especially in a critical situation. Most of the time the only medication they received was Panadol. Respondents believed that they might die in a public hospital because they could not afford to pay the private hospital bills. In terms of accessing good treatment quality, many believe that private hospitals were the best option to choose.

The respondents also indicated that the attitude and behaviour of health care providers was another hindrance to receiving good treatment. They felt that nurses in public hospitals failed to adhere to the ethics of their profession. They thought that nurses' negligence could lead to loss of life in an emergency. Nurses usually kept patients waiting for a long time in the queue even when they were critically ill, and required major attention. One respondent revealed that carelessness at public hospitals made her lose her child, and she was still childless when she was. Respondents believed that nurses' discriminated against them because they were xenophobic. They always changed their attitude if patients were not South Africans, and became very arrogant. Being non-nationals contributed to respondents' fear of receiving poor treatment.

### **5.2.3. The role of gender in determining total fertility rates in relationships**

The findings revealed that gender plays a great role in contributing to fertility rates in the study community. Men and women played different roles based on their gender. Men maintained that childbearing and rearing were merely women's responsibilities, which no man could handle. Working and supporting their family were men's duties. The research findings also indicated that men were the sole decision-makers in their families on various matters, including women's reproductive health. Women showed having less power in their marriage in terms of taking decisions. They believed that their husbands are always on top of everything and have the last

words in terms of taking decisions. The women thought their husbands were the decision-makers because they were working and bringing money into the house. They believed that if they were working as well they could decide together as a couple on family expenses. Some respondents indicated that their husbands decided how many children they should have, especially when they did not have male children. They said that their husbands did not consult them about their decisions. However, other respondents said that although they did not have equal power within their relationship, they decided together on the family expenditure and about having children

The research findings indicated that men in the study believed they were the heads of their households. They maintained that as such, they could not consult their wives whenever they wanted to make a decisions; it would be considered a sign of weakness. Some respondents believed that there were certain decisions they should take whether their wives approved or not. Although women were sometimes consulted, men made the final decision. However, one man said that since he was not working, his wife decided on many family matters. His wife was running a home-based care business, so she decided on the number of children to have too. With this finding, it can be concluded that financially independent women were able to take decisions on household matters. One woman with a master's degree showed that within their family they have compromised and decided together on major issues such as buying a car, family land, etc. Women should therefore be empowered in order to have a positive impact on their family life.

### **5.3. Recommendation for practice and intervention**

Based on this study's findings, some recommendations needed to be formulated in order to determine how this community can be assisted in addressing its current fertility rates. The recommendations include, but are not limited to, the following:

1. The study community should be made aware of the implications of a high fertility rate for their well-being.
2. Refugee women should be educated on the importance of attending family planning, birth control and spacing.
3. The South African National Department of Health and the United Nations High Commission of Refugees should facilitate refugee women's access to sexual and reproductive health programs.



4. The refugee church and community leaders should assist the women with information necessary for their children and other family by showing them that God will not come from heaven to limit their childbearing, neither will he provide Manna to feed them.
5. Upon arrival, the health department office should provide refugee women with necessary information regarding reproductive health in the country.
6. Refugee women need to be supported to develop skills to find jobs so that they can look after themselves and support their families financially.
7. It is strongly recommended that women use contraceptive methods during sexual intercourse. Beside condoms, other methods including pills and injectable contraceptives should be considered.
8. Both men and women need to visit clinics to be counseled about this issue. Men must bear in mind that family planning is not only for women. Both should visit the clinic regularly.
9. Promoting women's participation in reproductive health decisions is crucial, whereby women will be able to challenge the traditional perception of male dominance, and take independent decisions to defend and protect their reproductive rights.
10. Religious institutions should show the effectiveness of communication among couples to enable women to participate in issues that threaten their lives.
11. Research needs to be conducted on teaching refugees their right to use the host country's services, including health care.

#### **5.4. Recommendations for policy**

1. The Department of Health (DoH) should provide training to health care service providers on how to treat refugees who seek treatment in public hospitals/clinics.
2. Since language is among the major barriers that hinder refugees from accessing good quality treatment, the DoH should provide interpreters to make public care services more welcoming.
3. The Department of Home Affairs is encouraged to issue identity documents to refugees without requiring several appointments, and making them waiting queues for a long time, which discourages some refugees, who end up being stateless.
4. Participation of community leaders in health policy formulation should be encouraged in order for them to raise awareness and contribute to communities' well-being.

### **5.5. Recommendation for further research**

1. Further research is recommended among Congolese refugees living in other provinces of South Africa to compare these findings with theirs.
2. Studies are needed to collect both quantitative and qualitative data and expand the research to other refugee groups.
3. It requires attention from future researchers to conduct a study investigating the impact of women's poor education on childbearing.

### **5.6. Limitations of the research**

Every study, no matter how well it is conducted and constructed, has limitations (Wiersma, 2000). "Because qualitative research occurs in the natural setting it is extremely difficult to replicate studies" (Wiersma, 2000, p. 211).

This work only focused on the social and cultural determinants of fertility rates among Congolese refugee in the Durban CBD. The choice of methodology and design made by a researcher always comes with certain limitations over which he/she may have little control. A sample size cannot always represent the whole population. The fact that this study was conducted in Durban means that the researcher cannot generalize the findings to other provinces of South Africa. The fact that the participants were drawn from a small religious community was one of the major limitations. The study excluded refugees who were not members of the Divine Mission church. Congolese who are non-Christians could have different views from the study group.

Both time and financial constraints limited the study group sample to 12 respondents.

In addition to the study limitations, some respondents were reluctant to participate in the study without being paid. Others were against being audio-recorded for personal reasons. They believed that the researcher was not truthful about the purpose of the study; therefore their information could be used for non-academic purposes. Only a few respondents were tape-recorded, which could affect data transcription; but the researcher was able to use her notebook to write down important information.

Primary data were supplemented by secondary data, which provided a good understanding of childbearing in the Congolese refugee community in the inner city of Durban. The other limitation

of this study was associated with the researcher's financial situation as a self-sponsored refugee student. She was unable to oblige respondents who were unwilling to participate without being paid. They could have provided extra information.

Interview translations could be affected by the use of both Kiswahili and English; however, thanks to the researcher's multilingual skill, the problem was overcome.

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## APPENDICES

### Appendix 1

#### Information Sheet

My name is Belinda Lwaboshi. I am a master's student at the University of KwaZulu - Natal (UKZN). As part of my degree, I am conducting research on "Social and cultural determinants of fertility rates among Congolese refugee women living in the inner city of Durban".

I would like to ask you to participate in this research please. If you agree to participate, it is important to note that your participation is voluntary and you will not be forced to participate. You are encouraged to express yourself freely and informally. You are also free to withdraw at any time if you wish, without any negative consequences. Your identity will be kept confidential at all times by using a fake name (pseudonym). This pseudonym will be used in transcriptions and in the final research project report.

Participating in this study would mean you are part of this study community, refugee Congolese based in Durban.

The study will use semi-structured interviews. You will be asked to give appropriate answers related to questions asked. The individual interview will be approximately 45 and will be audio recorded.

All the data for the study will be available to and from the researcher working on the project and her supervisor. The findings of the study might also be presented at conferences, and they might be used to write a journal article. The data may also be used in future research. In all of these, your identity will be kept confidential by using your pseudonym. You will never be referred to by your real name.

The transcriptions of the discussions will be kept for future research purposes. To keep your identity confidential, all data will be stored separately from information which links it to your actual name.

If you have any questions you would like to ask, you are welcome to contact me, the researcher, by using the details at the bottom of the page. If you have any questions you may also contact my supervisor, Prof. N.J. Mkhize, via telephone or via email. If you have any complaints about this study you may contact Ms Phume Ximba of the Humanities and Social Science Research Ethics Committee via phone (031) 260 3587 or email [ximbap@ukzn.ac.za](mailto:ximbap@ukzn.ac.za)

Thank you for your time and participation.

Sincerely,

---

Mrs. Belinda Lwaboshi  
Researcher, Masters Student  
Discipline of Psychology, UKZN  
Email: [belbonk2007@yahoo.com](mailto:belbonk2007@yahoo.com)  
Contact number: (+27) 840742620

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Prof. N.J. Mkhize  
Research Supervisor  
School of Applied Human Science  
Email: [Mkhize@ukzn.ac.za](mailto:Mkhize@ukzn.ac.za)  
Telephone number: (031) 260 2006

Appendix 2.

Informed Consent Form

(To be read out by researcher before the beginning of the interview. One copy of the form to be left with the respondent and one other to be signed by the respondent and kept by the researcher)

My name is Belinda Lwaboshi (Student number 211550830). I am doing research on a project entitled: “Social and Cultural determinant of fertility among Congolese Refugee Women in the inner city of Durban/South Africa.”

Thank you for agreeing to take part in this project. Before we start, I would like to emphasize that:

- Your participation is entirely voluntary;
- You are free to refuse to answer any question;
- You are free to withdraw from this project at any time might you feel uncomfortable

The interviews will be recorded. The interview will be kept strictly confidential and will be available only to the researcher and the supervisor. Excerpts from the interview may be made part of the final research report. Do you give your consent?

Declaration of consent:            Yes/No

I hereby consent to participate in this interview

I do not consent to have this interview recorded

This project is supervised by Professor Nhlanhla Mkhize from the School of Applied Human Sciences at the University of KwaZulu-Natal, in Durban, South Africa. Below are his contact details:

School of Applied Human Sciences, Howard College, University of KwaZulu-Natal, Durban 4041, South Africa. Telephone number: 031 260 2006 or Mkhize@ukzn.ac.za.

You may also contact Ms Phume Ximba of the Humanities and Social Science Research Ethics Committee via phone (031) 260 3587 or email ximbap@ukzn.ac.za. . I am managing this project and should you have any questions or concerns my contact details are:

0840742620 or belbonk2007@yahoo.com.

Please sign this form to show that I have read and made you understand the contents of this consent form.

----- (Signed) ----- (Date)

----- (Print name of Participant)

----- (Signed) ----- (Date)

----- (Print name of Researcher).

Consent for the interviews to be audio-recorded.

I voluntarily consent for the interviews to be audio-recorded

----- (Signed) ----- (Date)  
----- (Print name of Participant)

----- (Signed) ----- (Date)  
----- (Print name of Researcher)

Appendix 3

Gate Keeper's letter



25 September 2015

To whom it may concern

This letter serves to confirm that Belinda Lwaboshi, student number, 211550830 has approached us to conduct her research among the members of the Durban Mission Church and we have agreed. However, given the kind of topic she is researching, we have decided to avail a psychologist from our Counseling Centre called HOPE FOR THE HOPELESS to assist her in case if any of the respondents need a psychosocial support.

For further clarification or any inquiry, do not hesitate to contact us on 031 837 2060 /076 662 9899 or bumazig2002@yahoo.fr.

Sincerely yours,

Peter Z. Buhendwa (Reverend Pastor)

## Appendix 4

### Ethical Clearance



20 July 2016

Mrs Belinda Lwaboshi (211550830)  
School of Applied Human Sciences – Psychology  
Howard College Campus

Dear Mrs Lwaboshi,

Protocol reference number : HSS/0262/016M

Project title: Social and cultural determinants of fertility amongst Congolese refugee women in the inner city of Durban, South Africa

#### Full Approval – Full Committee Reviewed Protocol

With regards to your response received on 07 July 2016 to our letter of 05 April 2016, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the 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.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

  
.....  
Dr Shamila Naidoo (Deputy Chair)

/ms

cc Supervisor: Professor Nhlanhla Mkhize  
cc Academic Leader Research: Dr Jean Steyn  
cc School Administrator: Ms Ayanda Ntuli

---

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

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Website: [www.ukzn.ac.za](http://www.ukzn.ac.za)



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## Appendix 5

### Interview guide

#### Greetings,

My name is Belinda Lwaboshi, student at KwaZulu-Natal University in Durban South Africa, (student number, 211550830). I am conducting a research on a project titled:

“Social and cultural determinants of fertility among Congolese refugee women in the inner city of Durban, South Africa”.

Professor Nhlanhla Mkhize from the School of Applied Human Sciences, University of KwaZulu-Natal, supervises this project. It aims:

- To identifying, social and cultural factors contributing to fertility rate among Congolese refugees.
- To understand the Congolese refugees’ experiences with accessing health care services, including reproductive health care services, in Durban.
- To examine the role of gender in determining total fertility rate in the marriage.

Thank you for willing to take part in this project. The information obtained from this interview is for the sole purpose of research. The interviews will be recorded and the main reason behind this recording is to have the set of accurate data, your responses and opinions. In addition, it will facilitate the analysis of the data I will collect during the course of the project. From the fact that these data will be used for research purpose, I expect you to give true and honest responses to the interview questions. The interview will take about 40-45 minutes. With your permission, Let us begin the interview if you are ready to respond to the questions.

#### **Part 1. Socio-Demographic characteristics**

1. What is your name?
2. Where do you live?
3. For how long have you been living in South Africa?
4. What is your marital status?
5. What is your religious affiliation?
6. Did you complete?
  - Primary school?
  - Secondary school? Or
  - College/University?



7. Please take me through your daily life, do you work?
  - If yes, is your salary/income enough to sustain your family?
  - If no, how do you support yourself and your family?

## **Part 2. Information on Fertility determinants**

Please tell me about your children

1. How many times have you ever given birth, in total?
2. How many children do you have?
3. Are they schooling?
4. What are the ages of your children?
5. Are you considering falling pregnant in a near future?
6. Could you describe the family planning method that you have been using during your recent pregnancy and how was this helpful to you?
7. Was your last pregnancy wanted/timed? Please justify your answer
8. How many children do you plan to have before attaining menopause?
10. What are your reasons for childbearing?
11. Are you happy/satisfied with the number of children you have or not? Do you need more children? If yes, what are the reasons why you want more/ many children?
12. What are the decisions of your partner regarding child bearing?

## **Part 3. Information on accessing Health Care including reproductive Health Care Services**

1. How often do you seek health care services?
2. What are the challenges that you face when seeking healthcare services /reproductive health services/family planning services?
3. What are the methods of family planning that you know?
4. What kind of family planning method have you been offered?
5. Are you using family planning method currently? If yes, could you please explain your reasons for choosing this specific contraceptive method?
6. If you are not using any contraceptive method, are there other methods that you use to avoid unplanned/ unwanted pregnancies?
7. Is there anything else that you would like to bring to my attention?

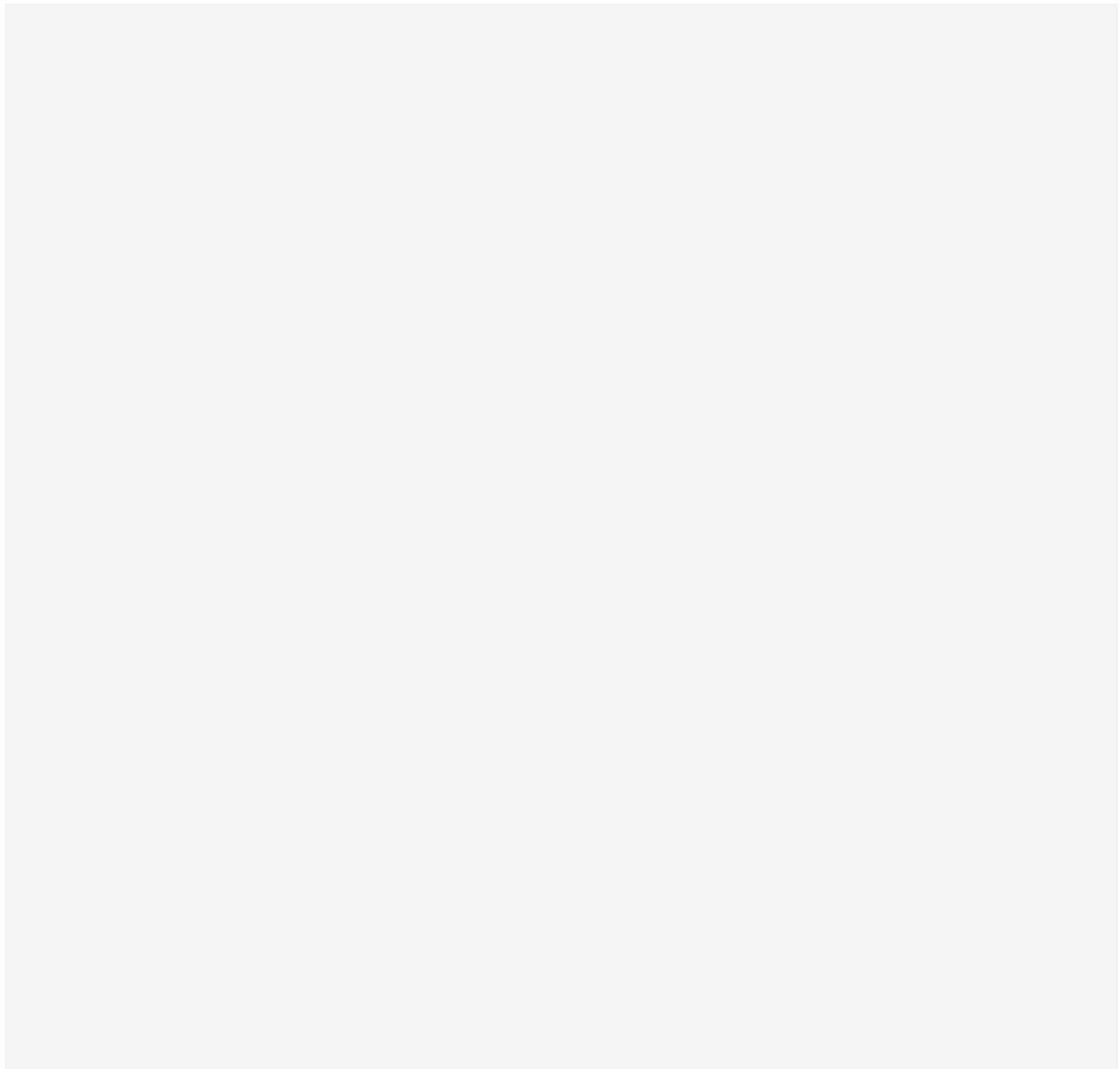
## **Part 4: Dealing with gender issues.**

1. Why do you think is important to discuss family planning with your husband/partner?

2. In your relationship, who decides about the number of children to have?
3. Who is responsible for the household economy, bringing in money and spending it?
4. Who is responsible for taking care of the children in your relationship?
5. Do you have equal power with your husband/ partner in terms of deciding on family issues?

Justify your answer.

THANK YOU VERY MUCH FOR AVAILING YOURSELF FOR THE INTERVIEW.



## Appendix 6

Nyongezo 6: kiongozi cha mahojiano (Interview guide, Swahili version)

Salamu,

Jina langu ni Belinda Lwaboshi, mwanafunzi wa Chuo Kikuu cha KwaZulu-Natal mjini Durban, Afrika Kusini, (idadi ya mwanafunzi , 211550 830). Nasababisha mradi wa utafiti haki:

**" Jamii na utamaduni ya vigezo vya uzazi katika wanawake wakimbizi wa Kongo katika mji wa Durban, Afrika Kusini, "**

Mradi huu unasimamiwa na Profesa Nhlanhla Mkhize wa Shule la Sayansi ya Jamii, Chuo Kikuu cha KwaZulu-Natal. Mradi huu unalenga:

- Kutambua sababu za kijamii na kiutamaduni zinazo ongeza viwango vya uzazi miongoni mwa wakimbizi wa Kongo.
- Kuelewa changamoto ambazo wakimbizi wa Kongowanapata kwa kutumiyahuduma za afya, pamoja na huduma za afya ya uzazi katika muji wa Durban.
- Kuchunguza jukumu la jinsia katika kuamua viwango vya rutuba katika ndoa.

Asante kushiriki katika mradi huu. Taarifa zitakazopatikana kutoka mahojiano haya ni kwa madhumuni pekee ya utafiti. Mahojiano yatawekwa kwenye rikodi na sababu kuu ya kurekodi ni kuwa na takwimu sahihi ya majibu na maoni yako . Sababu takwimu hizi zitatumika kwa madhumuni ya utafiti, ninakuomba kutoa majibu ya kweli na uaminifu kwa kujibumaswali. Mahojiano itadumu dakika 40-45 . Kwa ruhusa yako, hebu tuanze mahojiano kama upo tayari.

### **Sehemu ya kwanza: idadi ya watu**

1. Jina lako ni nani?
2. Unaishi wapi?
3. kwa muda gani sasa unaishi nchini Afrika Kusini?
4. Je, umeowa/umeolewa?
5. unashiriki dini gani?
6. Je, ulikamilisha:
  - Shule ya msingi?
  - Shule la secondari? au
  - Chuo / chuo kikuu?
7. Tafadhali niambie kuhusu maisha yako ya kila siku, unafanya kazi?

- Kama ni hivyo, mshahara wako/ kipato chakochakutosha kusaidia familia yako?
- Kama siyo, unafanya nini kusaidia familia yako?

### **Sehemu ya pili: Taarifa juu ya vigezo ya uzazi**

Tafadhali niambie kuhusu watoto wako.

1. Ni mara ngapi umewahi kuzaa kwa jumla?
2. Una watoto wangapi ?
3. Je, watoto wako wanaenda shule?
4. watoto wako wana umri gani?
5. Je, una mupango ya kupata mimba katika siku za usoni?
6. Je, unaweza nielezea mupango wa uzazi uliyo tumiwa wakati wa ujauzito wako wamwisho? na ilikuwaje msaada kwako?
7. Je, mimbayako ya mwisho ilikuwa kwenye mupango / wakati ? Tafadhali eleza jibu lako
8. Ni watoto wangapi unawataka kabla ya kumaliza kuzaa?
10. Sababu yako yakuzaa ni nini?
11. Je, unafurahi / kuridhika na idadi ya watoto unawo? Je, unahitaji watoto zaidi? Kama ni hivyo, sababu gani unataka watoto wengi ?
12. Ni nini maamuzi ya mume/mpenzi wako kuhusu kuzaa?

### **Sehemu ya tatu. Taarifa juu ya upatikanaji wa huduma za afya pamoja na huduma za afya ya uzazi.**

1. Ni mara ngapi wewe upata huduma za afya?
2. Ni changamoto gani wewe hupata wakati unatafuta huduma za afya, pamoja na huduma za kupanga uzazi?
3. Unajuwa mbinu gani za mpango wa uzazi ?
4. Ni aina gani ya mpango wa uzazi ulikuwa umetolewa?
5. Je, unatumia mbinu gani za mpango za uzazi kwa wakati huu? Kama ni hivyo, unaweza tafadhali kueleza sababu zako kuchagua njia fulani ya mpango wa uzazi?
6. Kama wewe hautumiyi mbinu za mpango wa uzazi, je, kuna njia nyingine unatumia ili kuzuia mimba zisizo kuwa kwa mupango ?

### **Sehemu ya Nne: kutibu masuala ya kijinsia.**

1. Je, unadhani ni muhimu kujadili mpango wa uzazi na mume wako / mpenzi?

2. Katika uhusiano wenu, nani anaamua jinsi yakuwa na watoto wengi ?
3. Ni nani anawajibika na uchumi , kutafutapesa na matumizi yake?
4. Ni nani anawajibika kwa kutunza watoto katika uhusiano wenu?
5. Je, una uwezo sawa na mume wako / mpenzi katika suala la kuamua juu ya masuala ya familia? eleza jibu lako tafadhali .
6. Je, kuna kitu kingine chochote unataka kuongeza ?

ASANTE KWA KUJITOWA KWA MAHOJIANO