Exploring factors impacting on sexual and reproductive health service utilisation among immigrant women living in Pietermaritzburg, KwaZulu-Natal

By

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DECLARATION

I, Jabulile Yolokazi Mnisi declare that:

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ii. This dissertation has not been submitted for any degree or examination at any other university.

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Date: 24 August 2022

DEDICATION

Dedicated to my son, Alunamda (Alu), and my late grandmother, Nondu Makalima.

Thank you for your love.

ACKNOWLEDGEMENTS

Honour and Glory be to God, almighty, for taking me this far. Through your grace and mercy, you gave me strength and wisdom, which enabled me to reach the end of this journey, as your word testifies.

To my family, thank you for your tireless support.

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To my son, Alunamda (Alu). I appreciate your presence in my life, you have been the light that shines every day. I will continue to treasure you and continue working hard for you. God bless you, my Alu.

My late grandmother. You may not be with me physically, but I feel your presence every day Bhelekazi. You are always in my heart and your memories always live on within me. Thank you for your sacrifices, care, love, and everything that you did for me when I was growing up. Wherever you are, I know you are in a much better place. I will be forever grateful that you are my grandmother.

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ABSTRACT

While the utilisation of sexual and reproductive health (SRH) services among women significantly impact their health outcomes, research shows growing recognition to understand how access to SRH services impacts individuals' use of these services. Globally, the increased accessibility of SRH services has seen improvements in the utilisation of these services among women. However, studies suggest that there are underlying inequalities in SRH service utilisation between migrant and non-migrant women. In countries of destination, immigrant women often face significant barriers to accessing and utilising sufficient SRH care and claiming their right to health. To understand these barriers, this study explored factors that impact the accessibility and utilisation of SRH services among immigrant women in Pietermaritzburg, KwaZulu-Natal in South Africa. The qualitative data used in this study was collected from 13 immigrant women over the age of 20 years, who were sampled using purposive and snowball sampling in Pietermaritzburg, KwaZulu-Natal. The findings of this study show that there are contextual, predisposing, resource, and need factors that influence the accessibility and utilisation of SRH services among immigrant women in Pietermaritzburg, KwaZulu-Natal. Participants noted experiences of xenophobia, prejudice, discrimination, and marginalisation as a result of the language barrier and inability to produce documentation that allows them to be in South Africa. In addition, while most participants are employed in the informal sector, they noted challenges of not affording medical aid/insurance to seek SRH care in the private healthcare sector when denied in the public healthcare sector. On a positive note, they expressed joy and a sense of relief to be in South Africa because they believed that the socio-economic and health situation of the country is better than the situation in their homelands. The importance and relevance of this study bring advocacy and awareness to the broader aspects of SRH, by taking into consideration the status quo of immigrant women in utilisation of SRH services in South Africa.

Keywords: SRH, immigrant women, access, utilisation, healthcare, xenophobia

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AHU	Andersen Healthcare Utilisation
COVID-19	Coronavirus disease of 2019
DoH	Department of Health
FGC	Female Genital Circumcision
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HSSREC	Humanities and Social Sciences Research Ethics Committee
HSU	Health Service Utilisation
IOM	International Organization for Migration
IPV	Intimate Partner Violence
KZN	KwaZulu-Natal
MDGs	Millennium Development Goals
PID	Participant Identifier
PMB	Pietermaritzburg
PrEP	Pre-Exposure Prophylaxis
PTSD	Post-Traumatic Stress Disorder
SADC	Southern African Development Community
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
Stats SA	Statistics South Africa
SDGs	Sustainable Development Goals
TB	Tuberculosis
UKZN	University of KwaZulu-Natal
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization
WHR	World Health Report

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CHAPTER ONE: INTRODUCTION TO THE STUDY

1.1 Introduction and Background

Utilisation of sexual and reproductive health (SRH) services significantly impacts health outcomes, such as human immunodeficiency virus/ acquired immunodeficiency syndrome HIV/AIDS, pregnancy and birth, perinatal and neonatal mortality, and maternal morbidity and mortality (Yao, Murray and Agadjanian, 2013). Studies show a long recognition that access to SRH services is essential to understanding how people utilise such health services (Higgs, 2009; Meade and Emch, 2010). Globally, the increased accessibility of SRH services has seen improvements in utilisation of SRH services among women (Chawhanda, Levin and Ibisomi, 2022; Menjivar and Salcido, 2002; Yao, Murray and Agadjanian, 2013). Existing literature shows underlying inequalities in utilisation of SRH services between migrants and non-migrants (Chawhanda, Levin and Ibisomi, 2022; Oucho and Ama, 2009; Raben and van den Muijsenberg, 2018). In addition, being a migrant woman has been associated with compromised utilisation of SRH health care, including low contraceptive use, high experience of intimate partner violence (IPV), high maternal morbidity and mortality, high abortion rates and abortion complications and high HIV prevalence (Almeida et al., 2013; Metusela et al., 2017; Oucho and Ama, 2009; Raben and van den Muijsenberg, 2018).

Migration among women has significant health consequences on their access to and utilisation of health services, particularly SRH services (Chawhanda, Levin and Ibisomi, 2022). While there is an increase in women migrating or seeking asylum in other countries, they continue to face more challenges than men in host countries (Albrecht, Pérez and Stitteneder, 2021). For instance, undocumented women and children may receive priority in medical assistance to a certain extent, but typically such help is limited to access to vertical transmission of infectious diseases like HIV/AIDS (Albrecht, Pérez and Stitteneder, 2021). South Africa remains the greatest recipient of immigrants in the Southern African Development Community (SADC) region, where there are high levels of migration, the huge burden of communicable diseases, and struggling public healthcare systems (Hanefeld et al., 2017). Bolarinwa and Boikhutso (2021) noted that barriers to SRH services lead to detrimental health outcomes among all women, and these include unintended

and unwanted pregnancies, teenage pregnancies, unhealthy pregnancies (for mother or baby), termination of pregnancy, obstetric complications; increased vulnerability to sexually transmitted infections (STIs) and HIV/AIDS, and high rates of neonatal and maternal mortality. However, migrant women face a significant burden of these challenges (Chawhanda, Levin and Ibisomi, 2022).

According to Statistics South Africa (Stats SA) (2013), data of documented migrants consist of predominantly young adults who are in their 30s. The age group portrays a youthful population, hence their variations in the use of SRH services cannot be overlooked. In addition, migrant women represent 42.7% of the total cross-border migration and they are concentrated in cross-border trade, domestic work, and informal sector activity, and are usually younger than men, and so often these women hold irregular documentation status, and more susceptible to adverse conditions (Mazars and Matsunyama, 2013). Ivanova, Rai and Kemigisha (2018) noted that existing evidence shows forced migration and human mobility make girls and women more vulnerable to poor SRH outcomes, such as high-risk sexual behaviours and lack of contraception use, placing them at increased risk of unwanted pregnancy, STIs and HIV/AIDS. Several barriers to the utilisation of SRH services by migrant women have been documented (Chawhanda, Levin and Ibisomi, 2022; Zimmerman, Kiss and Hossain, 2011). These include financial constraints, fear of deportation among migrants who do not possess legal documentation, language barriers, discrimination and marginalisation, lack of SRH information and religious/cultural beliefs. Moreover, Marginalisation from health services subsequently means that undocumented migrant women encounter prolonged right of entry to screening, treatment and care, restricted right to use contraception, pregnancy termination, and heightened levels of discrimination, gender-based violence (GBV), all of which cost women's health and propagates health inequities (Albrecht, Pérez and Stitteneder, 2021).

Issues of access and availability of SRH services are highlighted by Ivanova, Rai and Kemigisha (2018) to be often limited due to distances, costs, and stigma. Further, Ivanova, Rai and Kemigisha (2018) argue that there is still a lack of peer-reviewed literature on SRH-related aspects among refugees, international migrants, and displaced girls and young women, particularly in Africa. In the context of migration across the globe, various literature indicates diverse challenges

encountered by migrant women. The poorer health of immigrant women has been linked with pre- and post- migration dynamics (Fritzell and Mwiru, 2013). In addition, many immigrant women lack the awareness to claim their rights, including the right to health care. The United Nations Population Fund (UNFPA) (2011) notes that immigrant women also encounter institutional, legal, economic, social, or cultural barriers in accessing SRH services in the host countries. The International Organization for Migration (IOM) (2013) report points out that the social, cultural, and legal contexts in the country of origin have the potential to impede the empowerment of migrant women (IOM, 2013). While the migration process impacts gender and power relationships, this occurs negatively and worsens the well-being of women, making them more vulnerable to STIs, including HIV/AIDS as well as increasing gender roles and duties expected of them to be productive and reproductive. To broaden the understanding of the utilisation of SRH services by migrant women, it is vital to contextually explore the factors migrants face in the communities they reside and work in. This study explores factors impacting on utilisation of SRH services among immigrant women living in Pietermaritzburg, KwaZulu-Natal in South Africa. This becomes part of efforts to investigate undercurrents of migration and the significance of these undercurrents may have a huge role to play in contriving recommendations for decision-makers in South Africa.

1.2 Problem statement

Access to SRH services is challenging for young women and girls living in refugee settlements or dispersed across host countries (Ivanova, Rai and Kemigisha, 2018). Previous research demonstrates how asylum seekers, refugees and migrants suffer from negative health as a result of multiple factors including legal and political restrictions on their status and rights, and limited access to social and health services at all stages of migration (Chawhanda, Levin and Ibisomi, 2022; Freedman, Crankshaw and Mutambara, 2020; Ivanova, Rai and Kemigisha, 2018). In countries of destination, migrants face significant obstacles for them to access sufficient health care and to claim their right to health. In addition, they are often not provided with sufficient information about accessing SRH services and those who do not have the required legal documentation may be refused treatment by health service providers. These barriers lead to poor

health outcomes such as HIV/AIDS, unwanted pregnancies and birth, and mortality. For that reason, this study explores factors impacting the utilisation of SRH services among immigrant women living in Pietermaritzburg, KwaZulu-Natal in South Africa. In so doing, irregularities of seeking SRH services will be inquired among immigrant women, including the knowledge/awareness of SRH, the accessibility and barriers encountered by taking cognizance of existing policies, and legislations promoting SRH services in the country. Improving accessibility and utilisation of SRH services for these immigrant women is therefore critical for specialised healthcare programs and thus, understanding and evaluation of current access to SRH care is crucial.

1.3 Relevance of the study

The role of SRH care has also been predominantly recognised and prioritised in developed nations, however, there is a growing recognition of the importance of SRH in developing nations, especially in the sub-Saharan African (SSA) region (Chawhanda, Levin and Ibisomi, 2022; Menjivar and Salcido, 2002). South Africa and other countries, especially in the African continent attempt to meet the escalating demand for SRH services under the preface of universal access. Nonetheless, it is vital to highlight that there are still many challenges pertaining to levels of access and utilisation of SRH services for immigrant women. This study is relevant because it addresses SRH-related matters that immigrant women encounter in South Africa, where marginalisation and uncertainty remain complex for foreign women. In addition, migrant women face far more social challenges than male immigrants, particularly, the health-related challenges, with them being mothers, and being women, they are required to visit health institutions regularly. The emerging uncertainty of receiving contraceptives, pre-exposure prophylaxis (PrEP), antiretrovirals (ARVs) and other significant medications for migrant women locates for more interference, especially at a grass-root level. The number of literature in this area of research is increasing, with others drawing on transnational migration and the rise in migration studies has established new challenges whilst directing us to new and appropriate solutions.

1.4 Aim and objectives

The overall aim of this study is to explore factors that impact the accessibility and utilisation of SRH services among immigrant women in Pietermaritzburg, KwaZulu-Natal in South Africa.

This study has the following objectives:

- To explore the experiences of immigrant women in obtaining SRH services.
- To explore the enabling resources and need factors for immigrant women to access SRH services.
- To explore the characteristics that predispose immigrant women to access and utilise SRH services.
- To explore contextual factors that may impact immigrant women in accessing and utilising SRH services.

1.5 Key research questions

In line with the objectives of this study, the following are the research questions of this study:

- What are the experiences of immigrant women in accessing SRH services, in their country of origin and South Africa?
- What resources are available to immigrant women to enable them to access SRH services?
- What characteristics predispose immigrant women to access and utilise SRH services?
- What contextual factors in their country of origin and South Africa may impact the access and utilisation of SRH services among immigrant women?

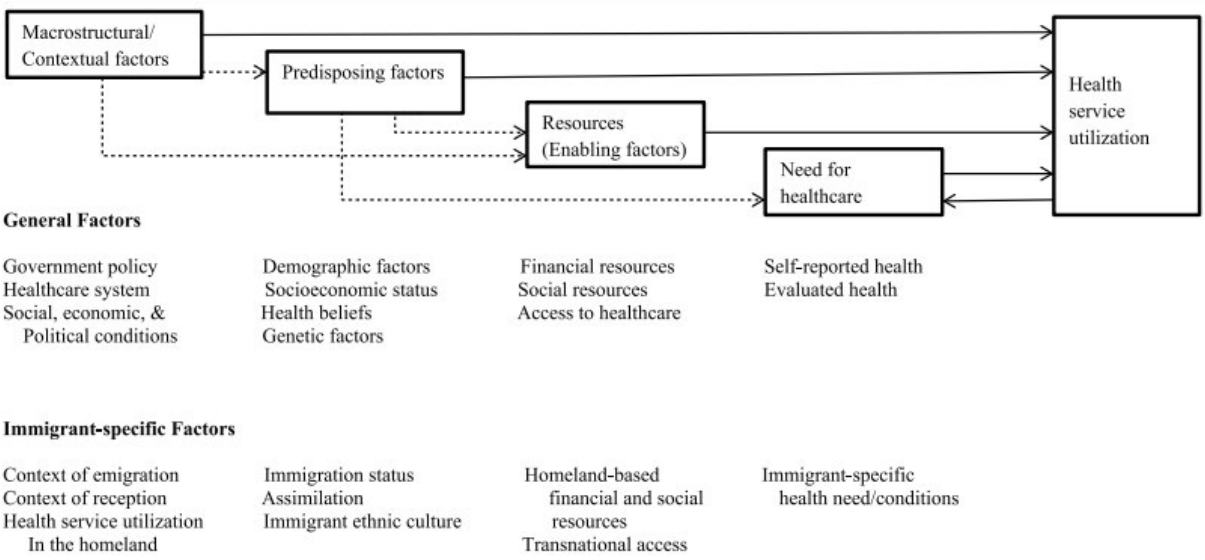
1.6 Theoretical Framework

This study draws upon the Health Service Utilisation (HSU) theoretical framework developed by Yang and Hwang (2016), as part of the contributory work to the Andersen Healthcare Utilisation (AHU) model. The HSU framework expounds disparities in immigrants by four categories of determinants at the general and immigrant-specific levels, and these are (a) need for health care,

indicating motivations for health services; (b) resources, representing ability to receive, and/or access to health services; (c) predisposing factors, signifying predisposition for HSU in terms of demographic, socioeconomic and genetic factors, and health beliefs; and (d) macro social structural or contextual conditions, representing general socio-structural factors in the larger society beyond individual control (Yang and Hwang, 2016). In addition to the determinants at the general level, Yang and Hwang (2016) underscore the HSU framework and its importance when addressing immigrant-specific determinants that differentiate immigrants and the native-born. The factors encompass four classifications: (a) immigrant-specific health needs or conditions; (b) homeland-based financial and social resources and transnational access to health care; (c) immigrant-specific predisposing factors including immigration status, demonstrating susceptibility or invulnerability to obtain health care, and assimilation, indicating immigrants' adaption to the host society that leads them to behave similarly to natives in HSU, and immigrant ethnic culture, prefiguring the cultural tradition of immigrant groups that offer alternatives to standard professional health care; and (d) context of emigration, the context of reception, and HSU in the homeland (Yang and Hwang. 2016).

The HSU model is expounded by Yang and Hwang (2016) to differ from the AHU model in quite a few imperative features. Firstly, is to systematically theorize and classify the circumstances that precisely influence the HSU of immigrants and differentiate immigrants and non-immigrants. It is explained that the model ought to assist researchers, healthcare professionals, and policymakers to focus their attention on conditions particularly relevant to immigrants' use of healthcare services, collect data particularly pertinent to it, and make decisions to improve immigrants' HSU. Secondly, the authors consider the mediating effects of some determinants and stipulate which variable influences immigrant HSU through which mediating variable. Third, resources are divided into three types, including financial resources, social resources or social capital, and access to health care, with emphasis on the significant role of social resources. Fourth, macro social structural conditions are singled out and determining the role of these conditions in immigrant HSU. Finally, differing from the AHU model is the consideration of both health policy and non-health policy that directly and indirectly influence immigrant HSU (Yang and Hwang. 2016). It is for this reason that, Yang and Hwang's (2016) HSU model is selected for the study.

Figure 1.1: Analytical framework for immigrant health service utilisation



Source: Yang and Hwang (2016)

Figure 1.1 depicts the HSU model to understand immigrants' access and use of SRH services. The solid lines represent a direct effect, and the dotted lines show that some of the factors within the category have an indirect effect on health service utilisation via one or more mediating variables. Nevertheless, the mediating relationships do not essentially occur fully. The theoretical framework discussed by Yang and Hwang (2016) considers the complexities involved in health service utilisation by immigrants. The framework further argues that government policy, not necessarily just health policy, can influence the use of health services among immigrants. This can assist in closing the gap identified by the AHU model, which does not sufficiently embrace the immigrants' characteristics that could influence their behaviour of healthcare utilisation.

1.7 Key concepts used in this study

Sexual and Reproductive Health: The purposes of sexual health care should be the enhancement of life and personal relationships, and not merely counselling and care related to fertility or STIs. Reproductive health implies that people can have a responsible, satisfying, and safe sex life and that they can have children and have the freedom to decide if, when and how often to do so

(Pizzarossa, 2018). UNFPA (2022) define sexual and reproductive health as a state of complete physical, mental, and social well-being in all matters relating to the reproductive system.

Migration: Migration is the movement of people from one place/region to another. Migration can be within a country or between countries. Migration can be permanent, temporary, or seasonal, and it happens for a range of push and pull factors (Bakewell, 2008).

Immigrant: An immigrant is a person who moves from their birth region to take up permanent residence in a host region.

Displacement: Displaced populations leave their homes in groups, usually due to a sudden impact, such as an earthquake or a flood, threat, or conflict. Migration and displacement are interlinked but must be distinguished.

Health care: A healthcare system consists of all organisations, people, and actions whose primary intent is to promote, restore, or maintain health. Health care is a fundamental human good because it affects people's opportunity to pursue life goals, reduces pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. The role of health care in the movement of people and the immigration of people from other countries remain an important focus for decision-makers.

Cultural assimilation: Cultural assimilation is the process in which a minority group or culture comes to resemble a society's majority group or assume the values, behaviours, and beliefs of another group whether fully or partially (Abramitzky, Boustan and Eriksson, 2016). Throughout history, there have been different forms of cultural assimilation, including voluntary and involuntary assimilation (Angelini, Casi and Corazzini, 2015).

Socio-economic needs: The socio-economic concept is primarily concerned with the interplay between social processes and economic activities within a society (Baker, 2014). Social and economic factors, such as health care, income, education, employment, community safety, and social support can significantly affect how well and how long people live (Baker, 2014). These

factors affect the ability to make healthy choices, afford medical care and housing, manage stress, and more.

1.8 Organisation of dissertation

This dissertation is divided into five chapters. Chapter one was instrumental in outlining the material concepts linkable to SRH and migration encounters. The assimilation of associated factors of migration leaves a question of why women in particular move from one country to another and this informed the research objectives. The structural and functional hinders of SRH by immigrant women have been identified, with a partial enhancement of important subtleties of development. Against the background, the tracing of dynamics faced by immigrant women has been elaborated as part of this study. The aim, objectives and research questions were well captured to ensure that this research is fully understood, with an opportunity to guide the reader. The theoretical framework guiding this study was also explained and further elaborated with reasons why it is adopted. The second chapter is the literature review, and it presents previous research and studies that have been conducted on SRH both locally and internationally. The third chapter is the methodology, and it explains the research techniques and methods used during data collection. The fourth chapter is the findings that emerged during interviews. The final chapter includes the discussion of the findings, the recommendations, and the conclusion.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter examines the literature on immigrant women's access to and use of SRH services. This takes into consideration the work done in this subject matter and the contributions of previous knowledge have an important attribute of any literature review (Rowley and Slack, 2004). The literature examines survival approaches in terms of accessing knowledge of SRH and general women's healthcare services in a host country. The literature draws on significant experts' arguments relating to challenges, causes and factors centred around migration and access to health care. As elaborated in the previous chapter, the overall aim of this study is to explore factors that impact the accessibility and utilisation of SRH services among immigrant women. Hence the purpose of this chapter is to highlight significant literature that has shaped the area of migration and health service utilisation and provide insights into the utilisation of SRH services among migrant women in their countries of destination.

2.2 SRH in South Africa: laws, policies, and guidelines

South Africa's laws, policies, and guidelines on contraceptive service provision in the public sector are progressive and inclusive, and they promote integrated services and rights-based service delivery. South Africa adopted development commitments through Millennium Development Goals (MDGs) and the current Sustainable Development Goals (SDGs) which both established domestic commitments for Family Planning (FP) as well as the National Contraception and Fertility Planning Policy and Service Delivery Guidelines (Lince-Derochei et al., 2016). Moreover, the country's outstanding laws, policies and guidelines provide a supportive, rights-based framework for the delivery of SRH services and access to health care esteemed at the highest levels (Lince-Deroche et al., 2016). The laws and policies are not limited to the Constitution and the Bill of Rights (1996), National Population Policy (1998), The Choice on Termination of Pregnancy Act 92 (1996), and Amendment Acts (2004, 2008). HIV/AIDS STI and TB (National Strategic Plan, 2012-2016) and The No Violence against Women and Children (2013-2017) support a rights-

based framework for SRH and are aligned with international strategies and frameworks such as those developed in the 1994 International Conference on Population, 1995 Beijing Fourth Conference on Women (National Adolescent Sexual and Reproductive Health and Rights Framework Strategy, 2014-2019**).** In addition, the 2012 National Contraception and Fertility Planning Policy and Service Delivery Guidelines also consider the needs of vulnerable groups including immigrant women (Department of Health, 2012).

The above-mentioned policies aim to ensure that comprehensive quality contraception and fertility management services are available and accessible to all people in South Africa, including a broader SRH package prioritising immigrant women. However, it has become evident through the existing literature that various socio-economic factors inversely shape the perspective of reproduction for women and affect mostly those who are vulnerable groups such as immigrants (Blas and Kurup, 2010). For example, as highlighted by Morrison-Breedy, Xia and Passmore (2013) inadequate information, and inaccessibility of medical care remain a challenge. In addition, investigating SRH issues solely in terms of choice critically overlooks fundamental societal inequities, and the most obvious is the public-private divide in access to healthcare. Social injustices destabilize women's SRH outcomes and decision-making at the personal, familial and community levels, with very real health consequences (Morrison-Breedy, Xia and Passmore, 2013). Moreover, immigrant women may be faced with challenges related to their migration status, particularly those who are undocumented, in accessing and utilising women's health services including SRH (Hiralal, 2017; Wångdahl et al., 2018). Research in South Africa show that asylum seekers and migrants who have section 22 permit should be able to access SRH services, but due to lack of information and xenophobic attitudes from health care providers, this is not always a reality for them (Freedman, Crankshaw and Mutambara, 2020). This suggests that lacking documentation is likely to be a barrier to accessing SRH services and remains an obstacle to adequate health care in South Africa.

2.3 Reasons for immigration

Migration is common in the contemporary world and is triggered by push and pull factors at the centre of the development of globalisation (Barriga, 2013). Typically, destinations which have

been identified as the core of industrialisation have many socio-economic benefits and social stability, and the level of social advantage enables people from outside borders to settle in these zones (Faist, 2000). The past few decades have shown higher numbers of displacement and migration (Bakewell, 2008). The events that led to the large-scale movement have caused great hardship and trauma as many lost their lives. The displacement of millions of people due to conflict in countries such as the Syrian Arab Republic, Yemen, the Central African Republic, and the Democratic Republic of the Congo has happened. This has been an illustration of extreme violence resulting in severe economic and political instability, as faced by millions of people. Despite the above-recognized causes of migration and displacement, the role, and the impact of environmental and climate change on human mobility are undeniable. This is because environmental destruction brings in the issue of food security and this has, in many cases, resulted in such planned migration/relocation and displacement (Bakewell, 2008). The accessing of large-scale displacement generated by climate and weather-related hazards happened in numerous parts of the world during 2018 and 2019, in countries such as Mozambique, the Philippines and India. There are many implications of migration which require attention, among them the social networks and institutional barriers are included.

2.4 Immigrants in South Africa

Due to its perceived economic and political stability, South Africa has for many years been a country of destination for asylum seekers, refugees, and immigrants from across the region (Freedman, Crankshaw and Mutambara, 2020). With long-standing patterns of labour migration, conflict and economic hardship in neighbouring countries, South Africa has become a primary destination and transit point for migrants from throughout the region (Landau, Ramjathan-Keogh, and Singh, 2004). The United Nations High Commission for Refugees (UNHCR) estimated that there are 275 000 asylum seekers and refugees in South Africa, 185,000 of whom are asylum seekers awaiting a decision on their claims. Countries of origin of refugees and asylum-seekers include, but are not limited to, Burundi, the Democratic Republic of the Congo, Rwanda, South Sudan, Somalia, and Zimbabwe (UNHCR, 2021). These immigrants often face several challenges ranging from xenophobic attacks, violence, and lack of access to health care services.

2.4.1 Xenophobia

Since 2008, there has been a growing literature on xenophobia in South Africa (Tella, 2016). Through an irrational fear of outsiders (refugees, asylum seekers and migrants), xenophobia manifests itself in various forms and its roots vary equally (Landau, Ramjathan-Keogh, and Singh, 2004). South Africa has been regarded as a hotspot of xenophobic attacks, given the high levels of xenophobia and violence towards African immigrants in South African society (Tella, 2016). Sigsworth, Ngwane and Pino (2008) argue that it is not surprising that stigmatisation and discrimination have carried over into the values of healthcare providers, and many have not been appraised of the rights of migrants under the law.

Evidence suggests that foreign migrants, more so than local populations, experience the brunt of the challenges that affect their utilisation of healthcare services (Klugman et al., 2014). The fear of being attacked is described by Mukondwa and Gonah (2016) as resulting in limited social movement, especially in public spaces and impacts greatly on SRH services, given that public spaces are often seen as starting points for distribution and access. Mukondwa and Gonah (2016) also further argue that living in exclusion and hiding often impact community integration and weakens social support structures, with potential implications on social participation in economic, social, and political spheres, which is a pre-requisite for the successful realisation of SRH service access and use.

2.4.2 Language barrier

A higher level of local language proficiency and a longer host residency is indicative of a higher degree of assimilation to the host country. Research shows that language barriers often limit the use of health services (Mengesha et al., 2018). Vearey and Nunez (2011: 23) suggest that "language is often used as a marker of belonging, and an indicator of who does and does not belong." From the first interaction, immigrants are positioned as not belonging. As indicated by Vearey and Nunez (2011), some cross-border migrants do not speak South African languages and communication is therefore difficult. In addition, Mukondwa and Gonah (2016) postulate that language differences emerge as a leading factor encouraging fear of inappropriate diagnosis as

well as the development of misleading and biased understanding of the operations of the health system.

Higginbottom et al. (2015) argue that migrant women are discouraged to utilise SRH services and other community services as a result of language barriers. This also impedes an understanding of healthcare information, which is expressed in local languages. Consistent with another study, Ellawela et al. (2017) found that migrants encounter difficulties in accessing good health because of discrimination, language and cultural barriers, indeterminate legal status, and economic and social exclusions. In addition, access and use may also be more problematic for immigrants when they have to communicate the SRH problem using a local language.

2.4.3 Cultural barriers

Cultural beliefs and practices are perceived to hinder women's help-seeking. Ellawela et al. (2017) stipulate that migrants with social and cultural backgrounds varying from the host country may feel uncomfortable conversing SRH matters with a healthcare provider or their partner. One important aspect highlighted by most studies is that health services are not always culturally appropriate to meet the needs of migrant women (Schmied et al., 2017). SRH is shaped by socio-cultural factors which result in barriers that influence access and use of SRH services (Metusela et al., 2017). According to Hiralal (2017), cultural factors play a significant role in silencing women from reporting domestic abuse. In addition, the needs and privileges of immigrant women are most likely to be shadowed by cultural practices within families and communities, and occasionally by legislation (Higginbottom et al., 2015).

Esmeal et al. (2016) highlight a very common practice in several African countries called Female Genital Circumcision (FGC), noting that in a foreign country, it becomes a contributory barrier to accessing SRH services. For instance, the practice of FGC may impose women into numerous vulnerabilities, which include losing confidence, feeling different and vulnerable, and feeling exposed to the encounter with foreign health care personnel (Esmeal et al., 2016). Alvarez-Nieto et al. (2015) argue that SRH in immigrant women is found to be in a susceptible state and their needs should be well-thought-out from a public health care perception. Metusela et al. (2017) also

note that cultural constructions about the aetiology and treatment of illness act as a barrier to accessing and utilising SRH services.

2.4.4 Social networks and institutional barriers

Robertson (2019) highlights the aspect of social networks as a form of additional support needed by migrant women. A caring relationship is said to assist migrant women to manage more on their own, realise their strengths, be more at ease and prepare better for childbirth (Robertson, 2019). Nonetheless, women have experienced diverse barriers when accessing and utilising SRH services (Robertson, 2019). The further disposition is entrenched in the health workers' attitudes towards immigrants. The grass-root engagement with issues of the social network has demonstrated elements of social deprivation. On arrival in destination countries, many migrants struggle to establish social networks, which may limit their access to significant social and health care information. In addition, the lack of social networks has produced institutional barriers that hinder access to social necessities. According to Robertson (2019), institutional or structural barriers are driven by poor support from social institutions such as health care facilities. The institutional role is based on its ability to cater for people. The encounter accompanying institutional support for migrants is the absence of support and lack of systems to accommodate foreign nationals. In addition, the rules concerning the availability of translators, being attended to with ignorance or lack of response, lack of trust, ethnic biases, and being ill-treated or treated as legally incompetent (Freedman, Crankshaw and Mutambara, 2020).

2.5 Immigrants' unmet needs and vulnerabilities

According to Hiralal (2017:162) "migrant women suffer violence, unconcealed hostility, social exclusion, as well as economic exploitation." This is further highlighted in the International Organization for Migration (IOM) (2013), suggesting that socio-economic factors increase vulnerability to HIV/AIDS among mobile populations and the communities that they interact with. This includes poor quality and standards of accommodation, boredom and loneliness, dangerous working conditions, disadvantaged social environments, where alcohol and sex are the only forms

of entertainment, and low access to healthcare facilities. Vulnerabilities specific to migrants and particularly women are not limited to discrimination, which prevents them from seeking health care, but also a lack of access to HIV/AIDS prevention information and programmes (IOM, 2013). Furthermore, vulnerability factors, including risk-taking behaviours, are linked to the poor state of community, social, financial and career dimensions of well-being.

According to Hiralal (2017) women often find it difficult to navigate new and complex spaces that they find themselves in, including spaces where they have to embrace multiple responsibilities as wives, mothers, and women, facing many obstacles which often compromise their level of access and use of SRH services. The vulnerability of living under poor overcrowded conditions, struggling to secure formal employment and vulnerability to police harassment, sexual abuse and patriarchal domination have made women more susceptible to contracting HIV/AIDS and exposure to GBV (Hiralal, 2017). In addition, intimate partners also take advantage to endorse their masculine and physical control over women who at times, feel defenceless to look for help from the local police and local people (Hiralal, 2017).

2.6 Lack of legal documentation

"Lack of documentation means immigrant women encounter many obstacles when trying to access social services and resources, including public health care" (Makandwa and Vearey, 2017: 76). In principle, immigrants with precarious status have no access to public healthcare and any emergency care received is at their own expense (Vanthuyne, et al., 2013). Further, Vanthuyne, et al. (2013: 79) stipulates that "families with some members who have precarious migratory status may also fail to seek care for administrative reasons". Mazars and Matsunyama (2013) note that one of the challenges that are encountered by immigrants in foreign countries is associated with their immigration status. Immigration laws primarily focus on discouraging the settlement of unauthorised immigrants; however, this adversely affects health care access and with consequences beyond those originally envisioned (White et al., 2014).

Undocumented immigrants are perceived by Carriker (2008: 25) as "illegal or undocumented aliens or immigrants." Many parts of Asia, Africa and Latin America have long and permeable

borders that people frequently cross without going through migration posts, as with the DRC in Africa (UNFPA, 2011). The IOM (2013) report pinpointed that the management of undocumented migration is ineffective and results in human rights abuse through expatriations of illegal migrants. Furthermore, the local government planning policies, including infrastructure planning in South Africa do not take into consideration the migration patterns and this leads to reinforced hostile sentiments against foreigners who are perceived to compete with nationals for limited resources such as job opportunities and government services (Kalitanyi and Visser, 2010). This is evident in the context of xenophobic attacks, which is an issue that perpetuated protests since 2008 in South Africa (IOM, 2013; Tella, 2016). Moreover, the socio-economic context in turn shapes sexual behaviours and decisions concerning potential SRH needs which are not considered and can lead to the transmission of HIV/AIDS and STIs and other poor health outcomes **(**Mukondwa and Gonah, 2016).

Undocumented immigrant women often face unplanned pregnancies, which result in noteworthy emotional and economic adversities. According to Korinek and Smith (2011), undocumented immigrant women and girls often have more limited access to contraception and family planning methods. Moreover, Korinek and Smith (2011) further note that restricting access to contraception and termination of pregnancy has a particularly negative impact on undocumented women and girls, as this results in poor health outcomes. Limiting undocumented migrant women's entitlement to maternity care fails to recognise their broader health needs, including those linked to prevention and health promotion. Klugman et al. (2011) also argue that despite the policy guidelines and frameworks, many challenges continue to be experienced by international migrants, including those with documentation, when they attempt to access public health services in South Africa, as the protective policy has not been transformed effectively into protective practices.

2.7 Violence and mental health

Migrant and refugee women are at increased susceptibility to poor mental health outcomes and GBV and IPV. Klugman et al. (2011) suggest that this is primarily due to dynamics relating to gender power relations. Violence against immigrant women is perceived as unescapable while they

are in transit (Klugman et al. 2011). According to UNFPA (2011), female migrants are at high risk for GBV, sexual harassment and SRH risks, even when migration is voluntary and not as the result of trafficking, conflicts, or other humanitarian emergencies. It has been reported that immigrant women often experience violence as they attempt to enter South Africa from neighbouring countries and are susceptible to being raped and beaten and forced to pay to be assisted to enter South Africa (Klugman et al., 2011). The link between GBV and the poor well-being of migrant women has been documented, with highlights that migrant women struggle to obtain support as they do not have the same network that they have in their home country. Furthermore, they have difficulties accessing government support as a result of xenophobia and deportation. Redwood-Campbell et al. (2008:326) note that "one of the crucial aspects highlighted is that reproductive health and mental health issues are often prominent for recently arrived women refugees." Schmied et al. (2017) stipulate that poor mental health, particularly depression and anxiety during pregnancy and the year after birth, is a global public health issue, associated with poorer outcomes for women and their infants. Further, immigrant women are more likely to have experienced post-traumatic stress disorder (PTSD). Redwood-Campbell et al. (2008) argue that healthcare issues for refugee women arriving in host countries may be different from the needs of women from the host country.

2.8 Conclusion

This chapter has reviewed literature that was conducted both internationally and locally. It was clear that the socio-economic and socio-political situations faced by immigrants are concerning. The long historical changes have shaped the contemporary shifting of people from one place to another. This literature has offered an inside perspective on the dynamics of migration and health, the exact experiences, and the emerging contests. The literature became very important in the documenting of written narratives about migrants and their experiences when accessing and utilising healthcare services. The descriptive writing in this chapter navigated claims that concluded for the immense role being played by globalisation in transforming people's lives whilst it distorts others, and these collisions produce social challenges for migrant individuals which were discussed in this chapter.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

The chapter presents research methodological approaches and processes undertaken in the study. The significant role of this chapter is to offer a structured guideline of methods of data collection and analysis, the area where the study is conducted, the information about study participants and the ethical considerations, which all form part of the path taken during the study. Furthermore, this involves the used qualitative research design which allowed the use of research instruments such as interviews for data collection. As previously stated, the overall aim of this study is to explore factors that impact the accessibility and utilisation of SRH services among immigrant women in Pietermaritzburg, KwaZulu-Natal in South Africa. Hence, this study focuses on the issues of SRH service utilisation by immigrant women and the interest to oversee the challenges of immigrant women became important to the researcher after subsequent events of foreign international attacks in South Africa between 2008 and 2017.

3.2 Research site

The study is conducted in the city of Pietermaritzburg, also known as PMB, which is under the Msunduzi Local Municipality in KwaZulu-Natal. The Msunduzi Local Municipality is one of seven local municipalities, which make up the uMgungundlovu District situated in the Kwazulu-Natal Province, South Africa. The city of Pietermaritzburg is the capital of KwaZulu-Natal. Pietermaritzburg is one of the primary urban centres of uMgungundlovu District's administration, and it is a flourishing and contemporary capital of KwaZulu-Natal. The city is a vigorous commercial and industrial centre. According to Stats SA (2020), the mid-year population estimate of uMgungundlovu is 1,133,713, however, only 62.3% of the population is in Msunduzi Local Municipality where Pietermaritzburg is situated**.**

The steady but increasing population of Pietermaritzburg is informed by various economic activities and academic prospects which brings an influx of different groups of people**.** The city of Pietermaritzburg has recorded an increase in the number of migrants coming into the perimeter

and this makes the focus of the study an easier task. The city of Pietermaritzburg is one of the places that are dominated by migrants in South Africa (Bollaert and Maharaj, 2018) and the way they have established their lives and identity is through listening to music from their countries of origin and using the local languages to communicate, which indicates some degree of integration but with a level of independence. In addition, they experience social exclusion and their passion for informal work is motivated by the state of their living (Bollaert and Maharaj, 2018). However, their enthusiasm to become financially stable is hindered by the low level of formal social integration.

3.3 Research methods, techniques, and instruments

3.3.1 Qualitative strategy

As a strategy in social science research, the use of qualitative techniques in this research has presented a strong point that allows a detailed description of the phenomena studied (Esterberg, 2002). According to Al-Busaidi (2008: 11), qualitative research is defined as "an umbrella term covering an array of interpretative techniques which seeks to describe, decode, translate and otherwise come to terms with the meaning of certain more or less naturally occurring phenomena in the social world." The facilitation of the easy data collection phase becomes possible through the interpersonal requirement of the method, which is face-to-face interaction. This works with non-numerical data to interpret the meanings and experiences of study participants to understand and support existing conclusions about the social issue through the study of populations (Esterberg, 2002).

The expressive nature of the qualitative research method allows for the identification of trends, which explains the connections between people and their surroundings through research. Within social science, qualitative research typically focuses on the most personal elements of social interaction that comprise everyday life in the community of interest. The capacity of the qualitative method allows for the characterisation of behaviour and other possibilities of human interaction (Esterberg, 2002). For this study, the passion to engage with immigrant women is important to develop a first-hand data collection process to understand the promoting and inhibiting factors to

access and use SRH services. The interview process was challenged by the unavailability of some participants, which was due to COVID-19 lockdown restrictions. However, qualitative techniques are flexible and easily adaptable to any unforeseen changes in the targeted study area (Esterberg, 2002).

3.3.2 In-depth interviews

An interview process is described as a conversation accelerated to gather information (Legard, Keegan and Ward, 2003). This study conducted 13 in-depth interviews with immigrant women in Pietermaritzburg during the stringent lockdown period from May to August 2020. This study reached a minimum sample size of at least 12 participants for the point of saturation which is sufficient for the analysis and scale of this study, as recommended by previous research (Guest, Bunce and Johnson 2006). Boyce and Neale (2006) note that in-depth interviewing seeks to conduct individual interviews with a smaller number of respondents to explore their perspectives on the social phenomenon that is being studied. For this study, in-depth interviews were done to understand the lived experiences of immigrant women and to explore factors that promote or inhibit their use of SRH services. However, the process of data collection was not as easy as anticipated as a result of recruiting enough participants for the study. When conducting interviews, researchers often choose from face-to-face or telephone structures. For this study, interviews were face-to-face and unstructured, which were aimed at confirming the application of qualitative analysis. The in-depth interviews were coordinated by the principal investigator (researcher). The study participants in the process of interviews also had an opportunity to ask questions that were significant and related to this study. On average, in-depth interviews took about 32 minutes.

3.3.3 Interpretivist paradigm

A research paradigm is a set of assumptions or beliefs about fundamental aspects of reality which give attention to a particular worldview (Maree, 2016). Lincoln and Guba (1985) regard paradigms as representations of ideologies regarding the world that people hold, which shape human

behaviour. This study was underpinned by an interpretivist paradigm because of its focus on exploring factors impacting SRH service utilisation among immigrant women living in Pietermaritzburg, KwaZulu-Natal. According to Cohen et al. (2000), an interpretive paradigm attempts to understand the behaviours, attitudes, perceptions, beliefs, and experiences of participants concerning the social phenomena occurring in the world. As Collis and Hussey (2009) assert that an interpretive paradigm is mostly utilised in qualitative research to explain social phenomena as opposed to measuring it.

The researcher had to understand how each participant perceives the factors underlying utilisation or no utilisation of SRH services. The researcher's role was therefore to interpret the participants' realities and the focus was on a more personalised form of research, as the researcher entered with an open mind that individuals have different perspectives. Furthermore, as an interpretivist, the researcher developed a relativist ontology which unpacks that one phenomenon may entail numerous interpretations rather than a truth that can be determined by the process of measurement. The distinct experiences of study participants gave the researcher meanings relating to the capacity of immigration to offer full SRH benefits, without denying the purposes it serves. Therefore, this paradigm fits perfectly in this study as the level of individual interaction was more productive and intense, and the participants' views became the most fundamental characteristic. In addition, the researcher obtained a more critical understanding of the phenomenon and its complexity in the unique context instead of attempting to generalise and base their perspective on the whole population (Creswell, 2014).

The researcher strived to understand the existing diverse ways of seeing and experiencing the host country through distinct contexts and objective lenses. First, the researcher identified multiple views of the social phenomena and as an interpretive researcher, they could not only describe objects, and social events but understand them in a social context. In addition, the interpretive paradigm became a critical method for an interactive interview, allowing the researcher to investigate and record things that cannot be observed but review them through the thoughts, values, perceptions, views, feelings, and perspectives of the participants (Wellington and Szczerbinski, 2007). The level of distress expressed by the women immigrants could be seen in their eyes, and body gestures as they answered the questions about access and use of SRH services. Thus, valuable

data collected provided the researcher with better insights for further exploration of the social phenomena.

3.4 Sampling

Sampling is one of the required processes when conducting a research study. The requirement is between choosing the kinds of available sampling methods that are suitable for that investigation. The study adopted two sampling techniques to sample the study participants. The nature of each method of sampling served a different purpose, but they worked perfectly well when combined. This will be reflected below with the significant process of how it all unfolded. The total number of sampled individuals is 13 immigrant women in Pietermaritzburg.

3.4.1 Purposive sampling

According to Bernard (2013), in purposive sampling, the principal investigator decides on the purpose they want the participant to serve, and informants are usually judged according to their qualities partaking in the study. The inclusion criteria of this study were women who are immigrants, residing in Pietermaritzburg, over the age of 18 years and who have access to or used SRH services. Participants were conducted based on these criteria. It was impossible to conduct this study without these individuals because they were the right people to answer the questions prepared by the researcher, and their experiences and perceptions were important to understand this social phenomenon better. The first participant is a well-known migrant hairstylist who works at a local salon where the researcher does hair and was recruited using a purposive sampling technique and selected based on the previously mentioned study criteria The purposive sampling is common in the social science discipline, particularly where detailed descriptions of phenomena are required (Nora, 2019). Some experts contemplate this sampling technique as a strategy in which persons or events are deliberately selected, to provide important information that cannot be obtained from a distinct criterion.

3.4.2 Snowball sampling

The use of snowball sampling in this research was used to identify potential participants as international migrants can be hard to find if one is not initially known by the researcher. According to Heckathorn (2011), snowball sampling was developed as means of studying the social network structures and it was relevant in studies that require hard-to-reach and hidden populations. Hence, the use of snowball sampling became helpful to recruit participants that are not easy to find (Etikan, Musa and Alkassim, 2016). Based on the researcher's observation, immigrant people are very hard to find, and if one does find them, they may feel discomfort opening up, especially when they are undocumented. In addition, their safety remains their first concern because some have experience xenophobia first-hand, and some can feel exposed and vulnerable and could decline to partake in the study.

After the first interview that was sampled purposively, the participant was asked if they knew anyone who may be willing to participate in this study. The participant was able to refer the researcher to other people and more data was accumulated. For example, in this study, the researcher was most interested in immigrant women, and in many instances, immigrants knew each other, as they engage with each other more than they do with South African women. In addition, they ensured the recruitment process goes well as they directed the researcher to other immigrant women. Thus, this is a non-random sampling method that uses the few cases achieved to help trace more cases, thus increasing the size of the sample (Etikan, Musa and Alkassim, 2016). This tactic of snowball sampling is the most applicable in small populations that are difficult to find, especially secret societies and inaccessible professions. However, the disadvantage of selecting friends and acquaintances of subjects already interviewed is a significant risk of selection bias.

In terms of the recruiting process, the researcher recruited the first participant (Participant 1) through purposive sampling from a local salon and the process began very smoothly with a significant interaction. This created a platform for every participant to follow using snowball sampling, as the participant referred the researcher to her friends, Participants 2 and 3, and this accelerated an excellent and gradual elevation of data. The two participants were happy to participate and were able to give attention to the friendly conversation taking place. This action

meant the researcher had a total of three participants. Therefore, after the interviews, they provided the researcher with the contact details of their other friend, Participant 4, who works in the Salon. The researcher's arrival at the salon where Participant 4 was met with fear, as many people seemed not to be interested, and others wanted to know whether the researcher was from the Department of Home Affairs. However, the interview with Participant 4 was successful and more people were willing to participate.

3.5 Ethical considerations

Ethical approval for this study was obtained from the University of KwaZulu-Natal's Humanities and Social Science Research Ethics Committee (Protocol Reference Number: **HSS/0256/019M**)

The following were adopted as guiding principles for ethical considerations:

- Ensuring that COVID-19 protocols were put in place to protect the health of the researcher and participants.
- Interviews were conducted at the safest, but most public location/space suggested by the participants.
- Avoid subjecting participants to harm in any way.
- Maintaining respect and dignity for participants was prioritised.
- Full consent was obtained from the participants before an interview was conducted.
- The study was voluntary.
- Maintaining privacy and confidentiality of research participants.
- Ensuring that data was stored in a private and secured storage device that was only accessible to the researcher and supervisor.
- Ensuring anonymity of individuals participating in the study by using pseudonyms/ participant's identifiers (PID).
- There was no deception or exaggeration of the research aim and objectives.
- There were no affiliations of any form with sources of funding, as well as any possible conflicts of interests for this study.

- Maintaining communication concerning the research to ensure honesty and transparency.
- There was no misleading information, as well as the representation of primary data findings in a biased way.

3.6 Data analysis strategy

This study adopted thematic analysis to allow the researcher to categorise qualitative data into salient themes. Thematic analysis was used to identify the patterns in data that related to the HSU model, and other themes outside of the theoretical framework which proved to be advantageous. The solidification of the qualitative research's position, in this case, was achieved by the thematic analysis, along with critical engagement with the responses of immigrant women (Guest, MacQueen and Namely, 2011). Moreover, the simplicity of this analysis strategy is inclusive of its flexibility, consisting of a richer, detailed, and continuous accumulation of information. The creative side of the qualitative method was demonstrated with a robust focus on the words, expressions, and other significant observations. According to Guest, MacQueen and Namely (2011), the thematic analysis offers insightful meanings to the qualitative data collected. The researcher was able to project and note trends in the answers offered by participants. The commonality is the perceptions and expressions that are identifiable, through the use of themes, and these may relate to a particular topic. The creative part of using thematic analysis is arranging the information in a manner that summarises findings and explains them in a meaningful way. The element of accessibility is in its tendency to suit multiple methods, even in research where there is a variety of qualitative experts. Further, there are always elements to note when utilising themes, with few limitations of qualitative countenance.

3.7 Limitations of the study

The major limitation of this study is the incapability approach of immigrant women who were eloquent enough to talk about their experiences in English. As previously elaborated, this study was conducted in English, and most of the sampled immigrant women were not eloquent English speakers as they only knew French, Swahili, and other indigenous African languages. With such level of language barrier, this also negatively contributed to a decreasing number of participants

in the study. However, the interviews that were conducted underwent a validity process to ensure that the results presented are authentic and trustworthy. Despite the key strengths of the interpretive paradigm adopted in this study, this paradigm had some disadvantages. One of the noted limitations is that interpretivism aims to advance the greater understanding and knowledge of a phenomenon within its complexity of the setting rather than to generalise these results to other people and other contexts. This kind of action tends to leave out a gap in verifying the validity, as well as the usefulness of the research outcomes by using a scientific procedure. Another massive notable criticism of this paradigm is its ontological view which tends to be subjective rather than objective (Shisanya, 2019). For this reason, the results of this study could be unquestionably affected by the interpretation of the researcher, which is derived from belief systems and through many ways of thinking which result in many biases. The last limitation of interpretivism is based on its deficiency to address the political, and ideological impact on knowledge and even social reality.

Issues with sample and selection presented a challenge especially regarding recruitment and participation, although the researcher ended up finding all targeted participants. Therefore, instead of finding at least 20 participants as initially planned, it was a struggle to find the initial target participants due to the nature of their work schedule which also depended on field work. This ended up being 13 participants, however, data saturation was reached. Lack of detailed previous research studies on the topic within the African context. The application of SRH seems to have been more intense abroad. The contextualised information for Africans is also limited to South Africa which affects the broader perspective on SRH issues. Limited access to data was seen as some participants lack clear elaboration, especially regarding the scope of SRH. Their response left a gap as much as many had some knowledge of the subject. Time constraints were also noted as a limitation.

3.8 Conclusion

This chapter has discussed all the methodological approaches and strategies that are significant for this study. The qualitative method geared towards the exploration of SRH service utilisation by immigrant women provided the platform to apply different styles of collecting and analysing data. The combination of different research techniques has proven strengths in terms of responding to the key research questions of this study objectives. The qualitative research implemented by the interpretive paradigm was adopted to allow the researcher to gain an insight into each participant's experiences when they accessed and/or utilised SRH services in Pietermaritzburg. The study draws from 13 in-depth interviews conducted with immigrant women residing in Pietermaritzburg who were recruited using purposive and snowball sampling techniques. Ethical concerns were considered, and this study was voluntary and maintained the confidentiality and privacy of study participants. As a result, the next chapter reports findings/results from in-depth interviews and is reported using thematic analysis, which allows the researcher to group the collected qualitative data into salient themes.

CHAPTER FOUR: DATA PRESENTATION AND ANALYSIS

4.1 Introduction

The qualitative data collected was very instrumental in shedding light on the issues of immigrant women when it comes to accessing and utilising SRH services. The findings of this study are drawn from 13 in-depth interviews collected among immigrant women in Pietermaritzburg, KwaZulu-Natal. The main themes for this study were drawn from the Health Services Utilisation (HSU) model, which unpacks the context factors, predisposing factors, resources, and need for health care. These themes were also in line with the objectives of this study and sub-themes were also separated according to the main themes. The first segment of this chapter gives background information on the socio-demographic characteristic of study participants and the second segment gives the experiences and perspectives of participants on the access and use of SRH services in Pietermaritzburg, KwaZulu-Natal.

4.2 Socio-demographic characteristics of study participants

Table 4.1 presents the socio-demographic characteristics of study participants. The final sample for this study was 13 immigrant women aged between 21 and 41 years from Pietermaritzburg in KwaZulu-Natal, South Africa. All participants are older than 20 years, but the oldest participant was 41 years. Ten (10/13) participants were single. The majority of participants (6/13) were born in Zimbabwe, followed by those born in Somalia and Mozambique (2/13 respectively). In terms of employment status, all participants reported some form of employment, however, the majority (8/13) reported informal employment. In addition, all participants have some form of education, but only three (3/13) reported tertiary education. All participants have at least one child, with nine (9/13) reporting more than one child.

Table 4.1: Study sample characteristics

Participant number	Age (years)	Country of origin	Marital status	Employment	Education	Number of children
1	29	Zimbabwe	Single	Hair stylist	Secondary	1
2	32	Zimbabwe	Single	Hair stylist	Primary	2
3	38	Zimbabwe	Single	Street vendor	Secondary	4
4	33	Zimbabwe	Single	Hair stylist	Primary	3
5	27	Mozambique	Single	Waitress	Secondary	2
6	37	Malawi	Single	Business owner (salon)	Secondary	3
7	21	Zimbabwe	Single	Retail worker	Tertiary	1
8	34	Nigeria	Single	Hair stylist	Secondary	1
9	41	Mozambique	Married	Human resource worker	Tertiary	4
10	27	Somalia	Married	Shop keeper	Secondary	2
11	35	Somalia	Single	Shop keeper	Secondary	2
12	26	Namibia	Single	Retail worker	Secondary	1
13	39	Zimbabwe	Married	School teacher	Tertiary	3

4.3 Factors impacting SRH service utilisation

The interview results identified several social, cultural, and economic aspects that influenced the utilisation of SRH services among immigrant women in Pietermaritzburg, KwaZulu-Natal. These aspects evaluated some contextual, predisposing, resource and need factors outlined by the Health Service Utilisation (HSU) model.

4.3.1 Contextual factors

To explore the experiences of immigrant women in obtaining SRH services, the contextual factors allow us to understand the conditions at the societal or community level that are beyond immigrant women's control. The macro conditions that relate to socio-economic status also impact the use of SRH services among immigrant women. The progression in socio-economic factors in neighbouring countries where immigrants migrate or seek refuge continues to influence the lives of many immigrants across developing and under-developed regions. Further, socio-economic factors have a way to impact the individual's access or use of healthcare services. While immigrant women's healthcare needs, resources and predisposition reflect their life choices, social structures such as legal documentation dignify their life chances. How immigrants exit their countries of origin affects how they use healthcare services in the host country (Yang and Hwang, 2016).

4.3.1.1 Context of emigration

The context of emigration remains an essential predictor of immigrant women HSU. While immigrants leave their countries of origin for specific reasons, how they exit impacts their chances to access and use SRH services. During the interviews, participants mentioned a number of push factors that led them to migrate to South Africa. They noted:

> *"All I can say is that there are few opportunities, especially for poorly educated females and many jobs are male-dominated. The skills we have also cannot guarantee us a better life back home, so I came because of money and better conditions for my child."* (Participant 4, 33 years)

> *"To tell the truth, I needed better a life because South Africa is better and developed. We cannot feel the same level of social difficulty, especially for our children, me, and my husband"* (Participant 6, 37 years)

While participants mentioned the reasons for migrating to South Africa, the researcher also asked about how they perceived the accessibility and utilisation of SRH services in the country. Participants mentioned that in most African communities, especially where they come from, there is an issue of power and gender dynamics, and women are still influenced by patriarchal norms that oppress the SRH rights. Two participants mentioned fear to access or use SRH services because their husband does not approve. They noted:

> *"My husband is a very cultural man and does not approve of contraceptives."* (Participant 13, 39 years)

Inequalities and economic growth instabilities have become evident in determining the quality of SRH services, and it is apparent that the poor tend to suffer the most when it comes to accessing the services, especially the marginalised group such as migrants. During the interviews, some participants noted challenges in accessing SRH services as a result of poor experiences with healthcare in their home country. However, they believed that the situation was better in South Africa. This suggests that their experience of HSU in their countries of origin before emigration had a lingering effect on HSU in South Africa. One participant noted:

> *"Well, where can I start, I feel that access to sexual and reproductive health facilities is not properly channelled in my country. So, it is hard accessing and using such services here in South Africa."* (Participant 7, 21 years)

However, others believed that even though the SRH information was not well distributed and shared in their home countries, they noted that the situation was better in South Africa. In addition, many factors are causing the shortage of SRH availability in home countries of immigrant women, and this includes less government effort in promoting SRH education and knowledge. They noted

> *"SRH access in my country is not generally known this could be because of poor government effort."* (Participant 1, 29 years)

"The nature of SRH in my home country is not taken serious like most things that affect women, but the situation is better here." (Participant 4, 33 years)

4.3.1.2 Context of reception

While many factors influence the movement, the change could be uncomfortable, and adaptation can also be challenging for immigrant women in host countries. The issue remains with acceptance in the new destination. South Africa is well known for the incidence of xenophobic attacks against foreign nationals. The incidence of xenophobia in South Africa has produced a negative impact on the social well-being of foreign nationals, and this presents an opportunity to further discover the contesting ideas around acceptance in a new country and social institutions. During the interviews, participants mentioned the issue of documentation and noted that they are prone to violence and discrimination when they do not present legal documentation to be in South Africa. They noted:

"We face a lot of social neglect despite being documented and undocumented, but the hustle is going well although days are different." (Participant 4, 33 years)

"All I can say is I have a good job, good life, and my family is safe. But I did experience forms of discrimination when I first came into this country because my documentation was not finalised at that time." (Participant 11, 35 years)

When the researcher dwell on SRH service utilisation, participants noted some challenging experiences of discrimination and marginalisation when they accessed SRH services. One participant noted that South Africa offers them a better life, but their experience when accessing and utilising SRH services is not always pleasant. They noted:

"I think life is better in South Africa, but, sadly, we face discrimination in all its forms, especially in the clinic." (Participant 6, 37 years)

"Sister, it is ups and downs. I think I have had my fair share of injustice and abuse from the locals such as people in my community, officials, and healthcare providers, but this becomes an issue of patience" (Participant 9, 41 years)

4.3.2 Predisposing factors

Before accessing SRH services, immigrant women possess certain socio-cultural and demographic characteristics which influence their accessibility and utilisation of SRH services. General disposing factors include, but are not limited to, gender, age, marital status, ethnicity, nationality, and health beliefs toward the healthcare systems. In addition, these factors can be general and immigrant-specific.

4.3.2.1 Immigration status

Yang and Hwang (2016) note that immigration status is associated with rights, benefits, resources, and psychological status, and therefore HSU. The legal status of immigrant women is the most important status that affects the likelihood of immigrant HSU. In this study, immigrant women cited experiences of discrimination as a result of their legal status. It was clear that an undocumented immigrant status remains a critical barrier to accessing and using SRH services in Pietermaritzburg. In addition, participants noted that their legal status prevents them from seeking medical care because of fear to be reported to the Department of Home Affairs and police officials. They noted:

> "*To tell you truth, I am not documented, and I fear going to clinics to seek medical care because I might be returned home."* (Participant 7, 21 years)

> *"I am even afraid to say this, but I am illegally here in South Africa. It is very tough to go seek help from public institutions because I have not renewed my documentation since I came to this side."* (Participant 10, 27 years)

Participant 7 also noted being denied SRH care because she could not present legal documentation and a passport allowing her to be in South Africa.

> *"There was a time where I needed free contraceptives from the clinic, and I was not assisted because I could not present a passport and other legal documents allowing me to be here."* (Participant 7, 21 years)

In a positive light and as expected, participants who have legal documentation to be in South Africa did not report any challenges with accessing and utilising SRH services in Pietermaritzburg. They noted:

> *"I have a legal status to be in South Africa and I do not face any issues going to the clinic or hospitals to seek health care."* (Participant 2, 32 years)

> *"I am a documented person and I still renew my visa application although I would like to be a permanent citizen of South Africa. To be honest, I don't face challenges when it comes to seeking medical care."* (Participant 9, 41 years)

4.3.2.2 Assimilation

Compared with people born in the host country, most immigrants have no medical aid and do not seek medical care because of prejudice and discrimination. While immigrant women have to adapt to the South African culture and society, they are also introduced to a different healthcare system that is quite different from that in their home country. In this study, it was clear that methods of prevention and family planning were foreign to them when they accessed and utilised SRH services. In addition, they were very amazed at how people in South Africa speak freely about sex and disease prevention methods.

> *"The government from home does not invest in these things. Ever since I came to South Africa, I am so amazed about how freely people talk about sex and how we can protect ourselves from getting HIV and other sex-related diseases."* (Participant 5, 27 years)

> *"I am surprised that South Africa has better health care, and SRH information is available but, in my country, I doubt it even exists, you know."* (Participant 6, 37 years)

During interviews, participants also raised issues of communicating their health problems with healthcare providers because of language. When migrants move to another country, they are also expected to adapt to social and cultural changes, and language remains a barrier to communication with people in the host country. Participants noted that they had been discriminated against in health services because of their language.

"I can say we face a lot of verbal abuse and name calling when you can't speak well the South African languages, even from health providers and especially if you don't have legal documentation present when accessing SRH services." (Participant 3, 38 years)

"*Well, I feel we are not entirely integrated. You see I am from Malawi and speaking any of the indigenous languages has been a struggle, and as much as I understand here and there, it is still difficult to communicate my health problems with healthcare providers."* (Participant 6, 37 years)

In contrast to the above experiences, one participant from Zimbabwe noted that she can speak IsiZulu and has never experienced any discrimination or marginalisation from healthcare providers and even outside healthcare facilities. This participant noted:

"I am originally a Zulu speaker, but from Zimbabwe. I have not yet experienced severe marginalisation from healthcare providers or security in health facilities because of how I speak." (Participant 7, 21 years)

4.3.2.3 Immigrant ethnic culture

Immigrant ethnic culture refers to norms, values, behaviours, and other cultural patterns brought by immigrants from their homelands to the host country. During the interviews, it was clear that immigrant ethnic culture influences how immigrant women access and utilise SRH services because they have different views and perspectives on how to deal with certain health problems which are quite different from those in South Africa. One participant noted hesitation to access and utilise SRH services because they believed that the service is not specifically for them.

"Well, what can I say is that we, as immigrants know the importance of staying healthy, but for us using any SRH facilities comes with stigma linked with our cultural beliefs. Some of us believe that when a woman gets ill, it is probably anger from God

or ancestors and we would prefer to go the traditional route than seeking medical care." (Participant 11, 35 years)

Another participant who has four children noted that her husband does not believe in family planning because it is against the African traditions and values of fertility. They noted:

"My husband is a very cultural man, and he does not understand why women should prevent getting pregnant because women were born to bear children." (Participant 9, 41 years)

4.3.3 Resources

The matter of resources defines access to basic needs and the standard of living for many immigrants. In the context of SRH service utilisation, resources refer to the means that enable individuals to access and utilise healthcare services, and they can be financial, social, and based on their accessibility.

4.3.3.1 Financial resources

During interviews, immigrant women emphasized that they must have financial resources to receive SRH care. Twelve (12/13) participants indicated that they do not have medical aid/insurance. While most participants do informal employment, most raised financial challenges to afford medical care. They noted:

"With the little money I get from doing people's hair, I still have to send it home and try to also make myself happy. But from that, I cannot even afford medical care." (Participant 1, 29 years)

"I cannot afford to see a doctor when I'm sick because I do not have enough financial means to pay for medical care. I still have to pay for my children's school fees and ensure that they have lunch for school. Besides, women's health is very expensive." (Participant 10, 27 years)

4.3.3.2 Homeland-based resources

During the interviews, immigrant women mentioned the challenges with resources in their home countries, noting the reasons for migrating to South Africa. They believed that the SRH care they receive in their homelands is not adequate for their health and wellbeing. In addition, they noted that one of the reasons for migrating to South Africa was seeking better health because the country is known to have available resources that cater for its population. They noted:

> *"Me and my husband come from a small and impoverished village in Zimbabwe, which lacked necessities such as clinics and good schools, so that is why we are here today. I always thank the opportunity to come here because I have learnt a lot of things about women's health."* (Participant 2, 32 years)

> *"South Africa is well-resourced compared to my home country. Here we truly feel the government's support for its people. The available resources may look scarce but back home we do not even have half of what I found here in South Africa, more schools and clinics which allow us to know our health status so we can live longer."* (Participant 4, 33 years)

4.3.3.3 Accessibility resources

Access to health services is regarded as a resource because it suggests that having access to healthcare providers can be associated with the utilisation of healthcare services. While participants expressed discrimination when accessing SRH services, they also emphasized that these services are available and not all healthcare providers are discriminating. They noted

> *"This country has a lot of health services you know, and I can say that in the clinics, nurses do help."* (Participant 2, 32 years)

> *"Well, this country has many good clinics, and it becomes easy for us, as foreigners to get help. We face challenges at times, but there is help and there are better nurses who do not discriminate."* (Participant 4, 33 years)

One participant also expressed challenges when it comes to accessing SRH services. She noted the issue of documentation and mentioned that without legal documentation, it is difficult to access SRH services.

> *"I have been to hospital 3 times since I came into this country. The issue is that not all of us can visit the clinic and use the services, as some of us are undocumented but health care is really good my sister"* (Participant 7, 21 years)

4.3.4 Need for health care

Before accessing and utilising SRH services, individuals tend to view their general health status, as well as how they experience symptoms of pain, worries, and illness to judge their health problem to be of sufficient importance to seek professional help. Hence, SRH service utilisation depends mostly directly on the needs for such services and health conditions. During the interviews, the researcher picked up a sub-theme of immigrant-specific needs.

4.3.4.1 Immigrant-specific needs

Poor health care becomes the focal point of women emigrating to other countries, especially if they have children. Immigrants have some special needs for certain health problems as a result of disease prevalence in their country of origin. During the interviews, immigrant women mentioned the reasons to move to South Africa, noting the challenges with healthcare systems in their countries of origin. They noted that women's health is not prioritised in their homelands.

> *"Health care is important and is a need when you are a woman, and it is usually not met in our homelands. South Africa has one of the best, so I heard, and I have seen it since my baby has a chronic illness."* (Participant 1, 29 years)

> *"My sister, health care is poor in my country, and South Africa has a good health system. As a person who gets sick frequently, it is an advantage to get help when it comes to my sexual health and reproductive health."* (Participant 11, 35 years)

Other participants noted the advantages of living in South Africa, where contraceptives are free and talking about SRH is not foreign to healthcare providers.

> *"I came to South Africa and health care was a major priority. I have a baby, but now I am not prevention pills because I'm not planning to have another child anytime soon. Where I come from, we don't know anything about contraceptives."* (Participant 1, 29 years)

> *"As immigrant women, we leave our countries because of the unorganized and poor health care. Women are not prioritised when it comes to health, and we want to have access to contraceptive because falling pregnant make us not work."* (Participant 13, 39 years)

4.4 Conclusion

The overall aim of the study was to explore factors that impact the accessibility and utilisation of SRH services among immigrant women in Pietermaritzburg, KwaZulu-Natal in South Africa. The findings indicated that there are contextual, predisposing, resource and need factors that influence the accessibility and utilisation of SRH services among immigrant women. It was clear that immigrant women need SRH care, but challenges such as discrimination, language barrier and un-documentation prevent them from utilising the SRH services. The enlightenment in this chapter accelerated a crucial understanding of the SRH service utilisation among immigrant women in South Africa.

CHAPTER FIVE: DISCUSSION, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

This chapter seeks to share the discussion, recommendations, and conclusion of this study. The impression is to collate the significant features which have been essential to the research and ensure that the research questions were answered. The link of the recommendations signals the possible solutions for testing and improving the feasibility of the SRH services for immigrant women. These connections have allowed for the integration of information across all 13 female immigrants that participated in this study. In addition, their views, experiences and perspective elevated migration and health studies and contributed to the broader literature on immigrant women in South Africa.

The overall aim of the study was to explore factors that impact the accessibility and utilisation of SRH services among immigrant women in Pietermaritzburg, KwaZulu-Natal in South Africa. As stated in Chapter 1, the main key objectives of the study were to; 1) explore the experiences of immigrant women in obtaining SRH services, 2) explore the enabling resources and need factors for immigrant women to access SRH services, 3) explore the characteristics that predispose immigrant women to access and utilise SRH services, and 4) explore contextual factors that may impact immigrant women in accessing and utilising SRH services. These objectives were successfully answered, as participants managed to share their experiences to understand the factors that impact their accessibility and utilisation of SRH services in Pietermaritzburg, KwaZulu-Natal.

5.2 Discussion

In this study, it was clear that there are contextual, predisposing, resource and need factors that influence the accessibility and utilisation of SRH services among immigrant women. This study has shown some consistency with previous literature that was reviewed in Chapter 2. Socio-economic factors have a way to impact immigrant women's access to and use of SRH services. During the interviews, the context of immigration was an essential predictor of the SRH service

utilisation among immigrant women, and participants mentioned migrating to South Africa to seek better health care. However, how these women exit their countries also affects their chances of receiving quality care in host countries. Whether fleeing war or seeking to meet healthcare needs, more women migrate independently throughout Africa and many settle in South Africa (Mbiyozo, 2018). In the interviews, immigrant women vouched for the SRH care they receive in South Africa, noting the advantages of preventing pregnancy and STIs, which is something they were denied in their home countries. South Africa's regulatory framework around SRH allows the protection of rights to make decisions regarding reproduction and the right to access healthcare services for both adults and children (Müller et al., 2016).

Undocumented immigrants emerge as a challenge when moving into a new country, with many of them referred to as criminals or diseases carer (Crush and Tawodzera, 2013). During the interviews, immigrant women mentioned the issue of documentation and noted that they are prone to xenophobic violence and discrimination when they do not present legal documentation to be in South Africa. In addition, they noted being denied SRH care because they could not provide legal documentation or passports. Studies show that legal status affects the likelihood of immigrant HSU and undocumented immigrant status itself is a critical barrier to health care services (Chavez, 2012). This is in line with findings by Crush and Tawodzera (2013) who found that the most important obstacle for Zimbabwean migrants trying to access public health care in South Africa was the denial of treatment and care to those who cannot produce the ‘correct’ documentation. This remains an issue because everyone is entitled to healthcare, regardless of their nationality. This is also related to the incidence of xenophobia in South Africa, which has produced a negative impact on the social well-being of foreign nationals (Tella, 2016).

Participants also mentioned the issues about culture and stigma around SRH efforts. In this study, immigrant women noted fear to propose family planning options to their husbands because of cultural beliefs and values of African traditions that a woman should be able to reproduce anytime. This is consistent with findings from a recent study done in Nigeria where women face opposition to contraceptive use from their husbands and families (Sinai et al., 2020). In addition, this presents a significant barrier to modern contraceptive use, because men are the decision-makers in the family, and women often cannot obtain health services without their husband’s explicit approval

(Sinai et al., 2020). With changes in culture and society when migrating to South Africa, it was interesting to see that immigrant women still raised fears of accessing contraceptives because their husbands would not approve.

Immigrant women also noted issues of language to communicate with healthcare providers about their health problems. During the interviews, immigrant women noted that they had been discriminated against in health services because of their language. According to Hussey (2012), the language barrier continues to compromise a large proportion of the population's quality of and access to healthcare services in South Africa. A study conducted in South Africa shows that although reports of nurse abuse of patients are not specific to migrants, participants' perception of language as a vehicle of discrimination was exacerbated by participants' experiences of discrimination outside the healthcare system (Hunter-Adams and Rother, 2017). This was relevant in this study because participants mentioned discrimination from health providers because of a language barrier and they noted that this also prevents them from accessing and utilising SRH services.

In the context of SRH service utilisation, resources refer to the means that enable individuals to access and utilise healthcare services. During interviews, immigrant women reported challenges with having enough money to access and utilise SRH services. While most of them are doing informal employment, they also noted financial challenges to afford medical care, which is important to quality health. Consistent with a previous study, migrants are economically disempowered and consequently, affording health care services can become a challenge (Zihindula, Meyer-Weitz and Akintola, 2015). In addition, research also shows that most immigrants must have financial resources to receive health care, and this is a predictor of immigrant HSU (Yang and Hwang, 2016).

5.3 Recommendations

The importance and relevance of this study bring advocacy and awareness to the broader aspects of SRH by taking into consideration the status quo of immigrant women in the utilisation of SRH services in South Africa. The findings show that immigrant women encounter marginalisation,

discrimination, and uncertainty, which are common to all immigrants in South Africa. The emerging uncertainty of receiving contraceptives, treating STIs and HIV/AIDS and antenatal care is influenced by the need and enabling resources to access SRH services. With this said, satisfactory SRH means being in a position of comprehensive physical, mental and social well-being in all aspects of the reproductive system. Inversely, poor SRH can result in poor health outcomes, and socio-economic burden and even contribute to strain on government resources. To uphold balance and access to utilisation of SRH services, consideration of all vulnerable populations is fundamental.

SRH services should be flexible enough to meet the needs of all women including pregnant teenagers, those with learning and physical disabilities, women from ethnic minorities, vulnerable women, hard-to-reach groups, asylum seekers and refugees. Moreover, all pregnant immigrant women should be offered information on the full range of options available to them throughout pregnancy, birth, and early parenthood, including locally available services, screening tests, types of antenatal and postnatal care and place of birth. Maternity services should ensure that there are comprehensive, culturally sensitive, multidisciplinary policies, standard operating procedures, services and facilities for the management and support of families who have experienced a maternal loss, early or mid-pregnancy loss, still-birth, or neonatal death. In addition, there should be effective systems of communication between all team members in each discipline as well as with immigrant women and their families.

Migrant women may be at increased risk from previously undiagnosed existing medical conditions and clinicians should ensure that a comprehensive medical history has been taken at booking and, where appropriate, a full clinical assessment of their overall health is undertaken as soon as possible. Local protocols should be developed to support equal access to healthcare needs for all vulnerable groups, including the migrant population and those who do not speak the host country's language. Respecting cultural differences relating to women's health and modesty should be a priority. Clinics need to be aware that in some cultures, women are reluctant to share information relating to women's health with males and men should also be involved when it comes to SRH to provide support and to also break some cultural barriers which result in women not utilising the SRH services. Where possible clinics should be sensitive to this issue and identify a way to

communicate that builds trust. Finally, clinics should ensure regular training of their frontline staff in communication skills, cultural/gender awareness, equality and diversity and safeguarding vulnerable individuals.

5.4 Conclusion

The overall aim of the study was to explore factors that impact the accessibility and utilisation of SRH services among immigrant women in Pietermaritzburg, KwaZulu-Natal in South Africa. In this study, it was clear that there are contextual, predisposing, resource and need factors that influence the accessibility and utilisation of SRH services among immigrant women. For that reason, this chapter provided a summary of findings and presented recommendations for policy implications. In summary, the first chapter helped describe the material principles related to SRH and migratory experiences. The relevance of the study was elaborated. The aim and objectives were also involved to guarantee that the research is thoroughly understood, with a platform to guide the researcher and the reader. The second chapter dealt with the review of previous literature that is relevant to this study. This literature provided an inside look at the processes of migration and health, giving specific experiences, focus and the rising contests. The literature had a significant role in documenting written narratives of migrants when accessing and utilising SRH services. The third section provided the methodological underpinnings of this study. Qualitative research methodologies and techniques were adopted to understand and explore factors influencing access and use of SRH services among immigrants. The fourth chapter was the interpretation of results using thematic analysis, which helped to make this chapter a reality to understand the experiences and perceptions of immigrant women when accessing and utilising SRH services. The researcher commends the bravery and strength of all immigrant women that participated in this study. It was their courage and openness to share their experiences that allowed the researcher to understand the status quo of immigrant women when it comes to accessing and utilising SRH services. In addition, it was clear that they continue to face challenges when accessing and utilising SRH services, and this suggests the need for inclusive SRH services and the importance of raising awareness and advocacy around the SRH issues that immigrant women face in host countries.

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APPENDIX A: INTERVIEW SCHEDULE

Topic: Exploring factors impacting on Sexual and Reproductive Health service utilisation among immigrant women living in Pietermaritzburg, KwaZulu-Natal

Socio-Demographic characteristics

1. Please provide information on the following:
1. What is your age
2. Your gender?
3. Where were you born, the name of the place and the country?
4. Were you living there prior to living here in South Africa? If no, where else did you live prior to coming to South Africa?
5. What motived or influenced your decision to leave your birth country?
6. What motivated or influenced your decision to relocate to South Africa (rather than elsewhere)?
7. How long have you stayed in the country?
8. What language(s) do you speak?
9. What is your marital status?
10. Do you have children? If yes, how many?
11. What is your highest educational status?
12. What did you do for a living in your birth country?
13. What do you do for a living here in South Africa?

Personal Experiences

1. How often do you visit health care facilities?
2. What services do you normally seek for at the health facilities?
3. Between the public and private health care facilities, which one do you utilise the most? What is the reason for that?
4. What is your understanding of SRH services?
5. What SRH services would a woman your age commonly requires?
6. Which SRH services did you utilise in your birth country?
7. Which SRH services have you utilised in South Africa?
8. How does this compare to the SRH services you utilised in your home country?
9. Are you currently using any contraceptive methods? If yes, what are those? If no, what is the reasons

10. What are your personal experiences with obtaining contraceptive methods in South Africa? What is your partner's attitude towards contraceptives?
11. Have the SRH services met your expectations? Probe: why? Why not? How?

Perceptions

1. What are your views on SRH services in South Africa?
2. In your point of view, do you feel that SRH services sufficiently accommodates immigrant women? Probe: why?
3. In comparison with the country of your origin, do you think it has become easier or harder for immigrant women to access SRH services in South Africa?
4. Are there any particular barriers that you would say have stalled you from accessing SRH services?
5. Please rank the barriers from the highest to the lowest that are hindering accessibility of SRH services.
6. What are your thoughts about health providers at health facilities, their attitudes when it comes to providing services and dissemination of SRH information?
7. What have been your coping strategies for dealing with difficulties in accessing SRH services? Probe: for any
   alternative means taken when not able to access SRH services?
8. What are some of the ways you believe the barriers towards accessing SRH services be eradicated?

Awareness

Are you aware of any of your rights with regards to accessing SRH services in South Africa? Probe: If yes, what are they? If no, why not?

1. To what extent do you see yourself as South African?
2. In an ideal world, to what extent would you feel South African?
3. To what extent would you like your children to feel South African?
4. To what extent do you think South Africans see you as South African?
5. What is your status here in South Africa (refugee, immigrant, permanent resident)?

APPENDIX B: 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 copy to be signed by the respondent and kept by the researcher.)

My name is Jabulile Mnisi (student number 205508912). I am a Population Studies Masters student researcher enrolled at the University of KwaZulu Natal- Howard College Campus. I am doing a research study entitled, The accessibility of Reproductive Health Services in the public health facilities by immigrant women: Pietermaritzburg, KwaZulu-Natal, South Africa. The study aims to ascertain the accessibility of public health care services particularly SRH services by immigrant women, to explore the opportunities and barriers that are brought about by such services into their lives.

Cell: 0664748486
Email: 205508912@ukzn.ac.za
This study is supervised by Dr Kerry Vermaak from the school of Built Environment and Development studies, University of KwaZulu Natal. She is managing the study and should you have any questions my contact details are:
School of Built Environment and Development studies, University of KwaZulu-Natal, Durban 4041, South Africa.
Telephone: 031 260 2285
e-mail: Vermaak@ukzn.ac.za

You are further able to contact the HSSREC Research Office (Telephone : 031 260 3587, Email: ximbap@ukzn.ac.za) about the legitimacy if this research project.
Thank you for agreeing to take part in the study. Before we start, I would like to emphasize that:

- Your participation is entirely voluntary;
- You are free to refuse to answer any question; and
- You are free to withdraw at any time and this will not result in any disadvantage.

If you agree to participate, I will interview you for about an hour. Should we run out of time during the first interview, one more appointment will be arranged. There is no risk to you in participating in this project. The interview and recordings will be kept strictly confidential and will be available only to members of the research team. Excerpts from the interview may be made part of the final research report but I will not use your name or any information that may identify you. Shredders certified to an appropriate security level will be used for destroying paper and CDs discs with recordings.

Please sign this form to show that I have read the contents to you.

…… (signed) ……..
(date)
…….. (print name)

APPENDIX C: DECLARATION BY PARTICIPANT

I ……. (full names of the participant) herby confirm that I understand the contents of this document and the nature of this research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from this project at any time, should I desire to.

I consent ☐ /I do not consent ☐ this interview to be recorded.

Signature of the participant Date

…….. ……