

**HEALTH NEEDS OF IMMIGRANT WOMEN FROM
THE AFRICAN GREAT LAKES LIVING IN SOUTH
AFRICA**

By

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DEDICATION

I dedicate this work to my daughter Kiese, and all the daughters of Africa.

DECLARATION

I declare that **HEALTH NEEDS OF IMMIGRANT WOMEN FROM THE AFRICAN GREAT LAKES LIVING IN SOUTH AFRICA** is my own work, and that all the sources I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any institution.

DESIREE MORAKANE MULEMFO

Date

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ABSTRACT

This study investigated the health needs of immigrant women from the African Great Lakes living in South Africa in the province of Gauteng, Tshwane Metropolitan city. It described their challenges and related factors compromising their holistic wellness, and identifies their context specific health needs as a gender group. A qualitative approach was utilised concurrently with participatory action research method. Data collection involved triangulation of instruments. A literature study was conducted to select relevant information usable as basis for this study. Data analysis and interpretation revealed factors that make it difficult for immigrant women from the African Great Lakes region to gain access to health care services in South Africa, identifying their specific women's health needs. Recommendations proposed that policy makers and implementing professionals rendering women's health care services should consider utilising a holistic and interdisciplinary approach to meet these basic needs.

KEY TERMS

Immigrant women; African Great Lakes; Women's health; Holistic wellness; Gender health; Immigrant women's health; Women's health needs.

LIST OF ACRONYMS

AU	:	African Union
AIDS	:	Acquired Immuno Deficiency Syndrome
CTF	:	Critical Theory Framework
CEDAW	:	Convention on the Elimination of All Forms of Discrimination Against Women
CNN	:	Channel Network News
C/O	:	Country of Origin
DRC	:	Democratic Republic of Congo
DVA	:	Domestic Violence Act
EU	:	European Union
GHCS	:	General Health Care Services
HIV	:	Human Immuno Virus
ICCPR	:	International Covenant of Civil and Political Rights
IOM	:	International Organization of Migration
ISS	:	Institute for Security Studies
IW	:	Immigrant Women
MBFI	:	Mother and Baby Friendly Initiative
NCCAM	:	National Centre for Complimentary Alternative Medicine
NGO	:	Non Government Organization
NPA	:	National Prosecuting Authority
OAU	:	Organization of African Unity [now African Union (AU)]
PAR	:	Participatory Action Research
PEP	:	Post Exposure Prophylaxis
PHC	:	Primary Health Care
PMTCT	:	Prevention of Mother to Child Transmission
PRWHCS	:	Private Women’s Health Care Services
PTSD	:	Post Traumatic Stress Disorder
PUWHCS	:	Public Women’s Health Care Services
RSA	:	Republic of South Africa
SADC	:	Southern African Development Community
SAHRC	:	South African Human Rights Commission
SAMP	:	Southern African Migration Project

SAPS	:	South African Police Services
SHCS	:	Specialised Health Care Services
SRC	:	Social Research Council
TB	:	Tuberculosis
TOP	:	Termination of Pregnancy
UN	:	United Nations
UNFPA	:	United Nations Population Fund
UNHCR	:	United Nations High Commission for Refugees
UNICPD	:	United Nations International Conference on Population Development
UNIFEM	:	United Nations Development Fund for Women
UNISA	:	University of South Africa
US/USA	:	United States of America
USCR	:	United States Commission for Refugees
VCT	:	Voluntary Counselling and Testing
VOT	:	Victim of Trafficking
WHCS	:	Women's Health Care Services
WHO	:	World Health Organization

KEY TERMS USED IN THE STUDY

African Great Lakes

Geographical region, physically covering areas including countries as Congo, Democratic Republic of Congo, Burundi, Rwanda, Tanzania, Kenya and Uganda.

Asylum Seeker

A person who is looking for shelter and protection from another country after having left his/her native country.

Focus Group

A number of people assembling as respondents in a research process, openly discussing issues arising from responses as guided by the researcher.

Gender

A social and cultural construct that differentiates men from women by defining ways in which they interact with each other. It is a culture-specific construct referring to expectations and norms within a society about what is appropriate male or female behaviour.

Health

The state of physical, mental and social wellbeing, and it is not merely the absence of disease or infirmity.

Health Belief

Individual's evaluation of the benefits he/she can get from taking specific actions to restore their level of "good health" and his/her evaluation of how likely the actions taken are to result in the benefits sought.

Health Needs

Wellness enhancing necessities, including clinical treatment, alternative methods of treatment and behavioural change.

Health Professional

One competently trained and engaged in health related activity as a paid occupation.

Holistic Wellness

Overall satisfactory state of health, free of illness and ability to perform as expected mentally, physically and socially.

Immigrant

A person who has left his/her country of origin to settle in a foreign country.

Refugee

A person who has been forced to leave his/her country in order to escape war, persecution or natural disaster.

Specific Group

A gathered number of individuals sharing particular characteristics that give them a recognisable identity.

Women's Health Care Service

A process of looking after the system and organs, diseases, discomforts and dysfunctions of reproductive and all female functions.

ORGANISATION AND STRUCTURE OF THE STUDY

CHAPTER 1: ORIENTATION TO THE STUDY

This gives an orientation to the research project. It also introduces the structure of the research and motivation for undertaking the study. In this chapter, the objectives, design, methodology and ethical matters are outlined.

CHAPTER 2: LITERATURE REVIEW

This chapter provides the review of the literature already available in the area of study. It sets out scientific information about what is already known, and thus allowing an in-depth look at the conceptual context to help illuminate the research.

CHAPTER 3: THEORETICAL FRAMEWORK

In this chapter, focus is laid on the theoretical framework designed or adopted for this study, as well as the effects of related social factors. It further highlights the realities within which the study is located.

CHAPTER 4: RESEARCH DESIGN

This chapter attends to the adopted research design. It further explains the suitability of the methods chosen for the study. This includes the focusing and framing of the said research methods. Other aspects dealt with in this chapter include the acquired sample, setting, the pilot study, as well as issues of ethics.

CHAPTER 5: DATA GATHERING AND ANALYSIS

In this chapter focus is on the description and explanation of data collected from the field notes and transcripts.

CHAPTER 6: RESEARCH FINDINGS, SUMMARY AND CONCLUSION

This chapter entails reporting on the findings of the research, summary of the observations, recommendations by both the researcher and the research participants. The conclusion essentially states the recommendations for future research.

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

This chapter serves to provide the background and motivation for undertaking the study. The study seeks to explore particularly the health needs of immigrant women from the African Great Lakes Region, living in South Africa.

1.2 STATEMENT OF RESEARCH PROBLEM

The United Nations International Conference on Population Development (UNICPD) held in Cairo in 1994 and the 1995 Fourth World Conference on Women in Beijing were central to the advancement of women's development and empowerment. These became the main tools for women's development paradigm shifts in world populations (UNFPA 2004: 86).

In 1994, South Africa saw the creation of Women's Health Programmes within the National Department of Health geared towards improving the well-being of women. These programmes covered areas such as violence against women, termination of pregnancy, contraceptive services, cervical cancer screening, breast cancer screening, antenatal care, voluntary counselling and testing, genetic services, mother-baby friendly initiatives, nutrition and development projects, and growth monitoring. The implementation of these programmes yielded encouraging results with positive impact on South African women's lives (Department of Health [Sa]: 3).

Although women's development and empowerment have been successful, international efforts in developing countries' health care initiatives do not specifically provide for the health care needs of immigrant women (Barnette 2002: 41). Literature reviewed indicates that immigrant women from traditional cultures are vulnerable to limited access to health information and services. South Africa is no exception to this phenomenon.

Immigrant women adhere less to preventive or self-care health practices. This is largely due to their multiple responsibilities, as well as their resettlement adjustment challenges that they have to deal with. Immigrant women are a disadvantaged group with respect to health information, access to specialised health resources and adequate use of preventive health services. Bridging the gap between efficacy and effectiveness of health promotion programmes and service-rendering initiatives proves to be a challenge when serving underserved groups (Ahmad, Shaik, Vanza, Cheung, George and Stewart 2004: 26). Service delivery is further complicated by the fact that little is known about the experiences, perceptions and needs of immigrant women as a homogeneous or specific group.

The lack of effective screening procedures for immigrants entering South Africa's borders exacerbates the problem. Their bio-psycho-social factors remain unidentified, unknown and thus unattended. It is the researcher's observation that, internationally, the consequences of immigration on health are mainly viewed and addressed in terms of risk of infection to the host population. Areas such as women's health care are therefore neglected (Council of Europe 1995: 41).

Unfortunately for some immigrant women, by the time they seek medical advice and care, it is when the physical pain has become unbearable. Under such circumstances it is usually much too late, and damage to sensitive organs has already occurred. This is really concerning as some of the physical damage could have been prevented or intercepted by general health screening procedures or effective health orientation programmes. Specialised immigrant women's health care programmes in South Africa can help in the education and the raising of awareness of immigrant women on these aspects. These programmes may thus be used in the dissemination of knowledge and information on the risks and benefits of some well-researched cultural and traditional practices as well as health beliefs which they continue to practice (Jirojwong & Manderson 2002: 6).

Immigrant women have different concerns and needs. They described how they are often exposed to harsh social conditions and traumatic experiences. This is compounded by the added pressure of having to face an uncertain future. It is

believed that empowering them with awareness and knowledge will improve the quality of their lives (United Nations Development Fund for Women 2002: 9).

1.3 BACKGROUND TO THE STUDY PROBLEM

Manderson and Alldey (2003: 76) view societies as being composed of unequal interest groups competing for scarce resources among which power is one of the compelling rewards. Immigrants bring skills, needs and problems with them to the host country, whose society is characterised by its own array of resources, priorities and problems. From this perspective, one can view the health care system as a mechanism of social and political control at the micro and macro level.

In sub-Saharan Africa, many countries experiencing high immigration influxes are also faced with negative economic growth, reduced government revenue and increased poverty. South Africa faces similar challenges of increased immigration patterns. Although the country has always had immigrants, the numbers have greatly increased since the post-apartheid era (Solomon 2003: 18). As a young democracy, South Africa is still struggling to transform its health sector. It has to address matters of inadequate staffing, poor infrastructure and limited budgets as some of the problems. A few identified challenges include the impact of the privatization of health care and accelerated user-fees which automatically segment privatised services (Global Health Watch 2005: 77).

Among immigrants and refugees from the developing world, women are a highly vulnerable population. This is primarily because of the traditional cultural roles and perspectives that place them at an inferior and subservient level. These render them as second-class citizens in their own countries and as invisible in host countries. It is acknowledged that in general, women tend to have lower educational levels, more health problems and less treatment for their health problems (United Nations High Commission for Refugees 2004: 4). This is to some degree still the case in South Africa, although brilliant measures are put in place to correct this state of gender inequality and other discriminatory acts against women. Policies that offer provisions such as free primary health care and antenatal care services are well-meant privileges. These are, however, not easily accessible to immigrant women as well as

native women from marginalised communities, who do not understand the health systems and procedures. Consequently, services such as these are thus under-utilised due to a lack of proper orientation and what might be seen as uninformed health promotion planning methods in the area of women's health care.

Jirojwong and Manderson (2002: 198) make the point that obtaining good gynaecological and obstetric care in a new medical system and unfamiliar language is difficult for immigrant women. They often feel intimidated and depressed by the difficulties they face in gaining access to health care services. The United States Commission for Refugees (USCR) point out that although women and children comprise eighty percent (80%) of refugees, even the most fundamental health services for women as reproductive health care are a low priority before and at arrival in the new country. It still remains a challenge to gain access to these resources after arrival in the new country (Global Health Watch 2005: 122).

1.4 OVERVIEW OF THE LITERATURE REVIEWED

An extensive literature review was done to establish how much research and/or knowledge has already been generated on this and related themes locally and internationally. With an increased and better understanding of the phenomenon, the need to conduct such research in the South African context was realised.

A study conducted by Jirojwong and Manderson (2002: 8) describes the health status of Thai women in Australia. This entailed looking at their physical health, use of health services and adherence to preventative health behaviours. Their results were based on data derived from a descriptive study involving hundred and thirty nine (139) women living in Brisbane. They completed a questionnaire, and data gathered from interviews with seventeen (17) more women to allow a closer look at issues as immigration, language, social support and the use of health care services. The study concluded that women's understanding of health education and information was largely influenced by their language skills. Language difficulties and the perceived high costs of medical care in Australia were contrasted with lower medical costs and perceived efficiency of Thai medical practitioners. As a result, some immigrant women delayed needed medical attention until their home visits to Thailand.

Ahmad *et al* (2004: 30) focus on health promotion strategies and factors associated with successful transfer and uptake of health messages among Chinese and Indian immigrant women in Canada. Focus groups were conducted with forty-six (46) immigrant women: that is, twenty-two (22) from China and twenty four (24) from India. All of these had lived in Canada for five years. Data was audio-taped, transcribed, translated and analysed through identification of themes and sub-categories within and between the groups. The results revealed that, despite the identification of several diverse sources of health information in the adopted country, Indian and Chinese women perceived most health strategies as not effective for them. This was due to barriers limiting access and comprehension of the health messages, as well as limited prior exposure to formal health institutions and promotion initiatives. The conclusion was that existing health communication and promotion models in Canada needed to be re-orientated from a one-way information flow to a two-way dialogue model to reach immigrant women.

A study by Stewart and Do (2003: 62) assessed the health needs of immigrant Vietnamese women in Australia. This research was precipitated by the realisation of the increased urgency of the health needs of this group of women. This followed the decreased capacity for their support on the part of their children and families. A qualitative research strategy involving focus groups and in-depth interviews was used. Included in this were interviews with Vietnamese health care providers. Some of the challenges these women had to deal with were culture shock, lack of friends and relatives, low self-esteem, unrecognised professional skills, as well as low socio-economic and health status. Significant barriers to access health services and the improvement of their health and wellbeing were also identified. The study concluded with the recommendation that the requirements of a sub-population in terms of socio-economic and cultural determinants of health be recognised as a guide to a more effective planning and implementation of health promotion strategies. The researchers also recommended that the changing health needs of these populations should, over a period of time, be fully considered.

1.5 THEORETICAL FRAMEWORK

Participatory Action Research (PAR) and Critical Theory Framework (CTF) will be the main approaches in this study. The application of PAR approach in the study seeks to de-mystify women's health discourses by enabling greater participation of both users and providers. This method is meant to encourage a collective self-reflective enquiry to improve the understanding of women's health systems and the needs involved (Greenwood & Levin 2007: 13). It is in this context that the study will take a feminist bias.

Immigrant women come from a background of life characterised by experiences of the struggle for safety, social justice, common liberation and personal freedom. Critical theory perspectives are more practical to use as a guide. Critical theories are based on everyday struggles of particular groups, especially those of marginalised people. They are created from numerous perspectives that share historical patterns originating from resistant movements such as fascism, colonialism, racism and exploitation of women. Stevens and Hall (1992: 87) maintain that the basic tenet of critical theory is that liberation and empowerment occur as a process of action and reflection known as *praxis*. It is through this process that critical consciousness develops.

Burns and Grove (2001: 32) refer to critical theory as a philosophy with a unique qualitative research methodology. They explain that researchers use this theory to uncover distortions and constraints that impede free and equal participation within the society through research. Through the use of this theory, power imbalances are exposed and people are empowered to make changes. The empowerment process involves reflecting on the reality of the situation. This explains why empowerment recognises contradictions contained in a particular situation and moves towards action to bring about change that will correct the imbalances.

1.6 SIGNIFICANCE OF THE STUDY

Merriam (2002: 14) is of the opinion that critical theory focuses on how injustice and power relations affect the experiences of people and their understanding of their

circumstances. Paradigms included in this theory are feminist, post- structural and queer homosexual theory. Patton (2002: 42) postulates that it has a framework based on being political and change oriented.

The importance of this study is to uncover new knowledge in the area of women's health care. Through this study, awareness amongst the professional health community, especially women's health care practitioners, will be raised. They will be enlightened about the specific challenges relating to barriers encountered by immigrant women in gaining access to health care services. This research should also identify specific health needs of immigrant women from the African Great Lakes region (Lincoln & Guba 1995: 68).

1.7 PURPOSE OF THE STUDY

This study aims to:

- Identify health needs of immigrant women from the African Great Lakes Region living in South Africa, in order to raise awareness of the health practitioners as service providers.

The study is aimed at informing health practitioners in general, and women's health care providers specifically, about areas in need of special attention with regard to the health care needs of this group of immigrant women. It is meant to challenge women's health care professionals and promoters to produce programmes that target the issues of immigrant women and empower them to improve the quality of their health (World Health Organization 2004: 38).

As this is an exploratory study, its findings should command an urgent need for an in-depth study on the subject (Smith & Hunt 1997: 37). These findings should influence policy in all affected national departments, and thus trigger adequate implementation and practice monitoring. They could also secure excellent women's health care service programmes that can be modelled throughout Africa and the world.

1.8 RESEARCH OBJECTIVES

The main objectives of conducting this study are to:

- acquire necessary information (from research participants) that could assist women's health practitioners and promoters to render effective services that could vitally enhance the quality of immigrant women's lives
- identify immigrant women's health needs and related service accessibility problems

1.9 LIST AND DEFINITIONS OF KEY CONCEPTS

Immigrant

For the purpose of this study, the word "immigrant" in this report shall refer to all categories listed under International Immigration Forms: refugees, asylum seekers, economic migrants and victims of trafficking (VOT's).

Immigrant women

Immigrants of a female gender. In the case of this study, the concept is mainly used to refer to immigrant women from the African Great Lakes Region.

Health

"State of complete physical, mental and social well-being; and not merely the absence of disease or infirmity" (World Health Organization 1998: 9).

Health belief

Health belief is determined by two elements: the individual's evaluation of the benefits he/she can get from taking actions and his/her evaluation of how likely the actions taken are to result in the benefits sought (Mikhail & Petro-Noustas 2001: 39).

Health needs

Health-enhancing necessities, including clinical treatment, alternative methods of treatment and behavioural change (Northrup 1998: xxxi).

Women's health care service

Health service providing care of a female's system and organs, dealing with diseases, discomforts and dysfunctions of women (Northrup 1998: 708).

African Great Lakes Region

In this study it is referred to as Great Lakes (see Appendixes C & D). These include Congo, Democratic Republic of Congo, Burundi, Rwanda, Tanzania, Kenya and Uganda.

1.10 RESEARCH METHODOLOGY

An exploratory qualitative method of research will be used for this study. This approach was chosen because exploratory studies are suitable for unfamiliar social systems. They enable the researcher to secure access and legitimacy in unstudied areas, and can enhance identification of new concepts. Qualitative methodologies often adopt the perspectives of naturalism, a focus on meaning, understanding and flexible research strategies (Green & Thorgood 2004: 25).

In this study qualitative research will be used to generate empathetic understanding of the researcher in her attempt to identify possibilities for change. It will be used with ethnographic research techniques of interviews and observation, as well as natural settings. The flexible character in qualitative research, especially in Action Research, enables it to be easily adaptable as data is gained. This allows the researcher to devise and utilise methods as research demands in its progression towards more refinement. Its descriptive nature provides relevant details on participants' behaviour, beliefs and their context. It allows recognition of the contextual nature of knowledge and behaviour observed while respecting different world views (Albertse 2007: 44).

In dealing with health-related matters, qualitative research will be used to answer the social aspects (that is, the what, how, why) of health, illness and health care. It will be utilised to broadly explain health behaviour and health provisions, including interpretive and critical traditions. It will further be used to investigate social and cultural complexities (Murphy & Dungwall 2003: 13).

1.10.1 Reasons for Applying Qualitative Method

Stringer and Genat (2004: 2) refer to the following as basic reasons for applying a qualitative research method:

- It is able to reach social areas that quantitative method cannot reach, and the meanings contribute to evidence.
- It is pragmatic as it sensitises the researcher towards participants and their views.
- It takes an epistemological position about understanding different perspectives and reality constructions.
- This method has the power of informing policy, as it can generate better data that can be used to offer evidence to specific population needs and implementation strategies.

1.10.2 Research Design

Participatory Action Research (PAR) will be the approach followed to address the research problem. It is appropriate in the sense that it is a systematic method of inquiry that enables people to extend their understanding of problems and formulate action directed at resolving those issues (Stringer & Genat 2004: 4). Greenwood and Levin (2007: 68) maintain that PAR seeks local understanding that is specifically relevant to a particular context of a study. It flexibly draws upon the equally important experiences of the researcher and the research participants. It is oriented towards change. Researcher knowledge or expertise is viewed and used as a liberating tool for implementing activities that will shift the balances of knowledge. It is thus very explicit about the relationship between knowledge and power. In its application, PAR directly produces an understanding that is useful to the group the researcher is

working with. In other words, there is an intention to empower the group rather than just to derive information from them in order to serve the researcher's objectives. PAR is a dynamic and collaborative process which changes the phenomenon while studying it.

This research method is cyclical in nature. The research cycle occurs as the phases of research are repeated over time throughout the research process. In the first phase, the participants "Look" at the problem to clarify the nature of the problem. They next "Think" or reflect on its significance and then "Act" by implementing the action. In the next phase, they "Look" again (reviewing the actions they have taken), "Think" (evaluating the effectiveness of actions taken), and then "Act" again (refining or extending the actions). The process continues until the solution to the problem has been reached (Stringer & Genat 2004: 5).

PAR has the ability to identify common themes in the experiences of participants through dialogue. It is in this respect that the participants are afforded the space to validate each other, and thereby creating a shared meaning. Through this method, research participants find that their sense of self-identity is legitimised and their experience of normalised coping behaviour is enhanced (Heron & Reason 2001: 16).

1.10.3 Sample

For any research that involves collection of new information, the researcher needs to decide from which people to collect it. This suggests that the researcher should, at the outset, define the population that she/he is interested in to enable selection (Payne 1999: 53).

1.10.3.1 Inclusion Criteria

Data will be collected from a sample of immigrant women representing these countries, who have at some stage during their settlement in South Africa used women's health care services within the country. They must have been exposed to either health promotion information, or have consulted at a public or private health care service institution. All participating women from the Great Lakes Region (that is,

Congo, Democratic Republic of Congo, Burundi, Kenya, Rwanda, Tanzania and Uganda) meet these criteria.

1.10.3.2 Setting

Green and Thorgood (2004: 94) assert that the setting of an interview impacts on the kind of data generated. Individual interviews will be conducted at the participants' own homes. The intention with this arrangement is to ensure confidentiality, to enhance their self-confidence and respect their privacy. Focus group discussions will take place at a church hall (where they normally gather) after their skills workshop meeting.

1.10.4 Sampling Technique

The purpose of sampling is to ensure that the particular assumptions and understanding of people involved in a specific context are taken into account in seeking effective solutions to the issue studied (Stinger & Genat 2004: 41).

Purposeful sampling technique was used in order to ensure that the diverse perspectives of people who are likely to actualise the issues researched are included in the study. It selects participants who can intentionally generate appropriate data. In this study, immigrant women from the Great Lakes region living in the Tshwane municipal area (Gauteng Province), who have used health care facilities in South Africa before will be the critical reference group. The service provider's perspective will be collected from the health professionals specializing in women's health care. This group will be made up of health practitioners from the Great Lakes area and those from South Africa.

1.10.5 Data Collection

The interview will be the primary tool of data-gathering in this research. Interviewing is accomplished as a sociable series of events and a means by which the researcher is able to hear the voice of the other; that is, the interviewee. Green and Thorgood (2004: 45) assert that the method of data collection selected in a research project

should be capable of producing the kind of information that will answer the research question. Focus group discussions have been found to be appropriate to use. A focus group is selected on the basis of the relevance to the topic under study. It is by definition a group interview with questions providing a stimulus for capturing people's experiences and perspectives.

Focus group discussions promote interaction, permit an instant comparison of information and are able to produce considerable and rich information in a short space of time. They have the advantage of allowing participants to share information and experiences. This has the effect of triggering new ideas and insights. A focus group is reliable in engaging the participants (who are respondents) in the process of investigation, and expanding their understanding of the issues researched. Focus group discussions follow a cyclical process of investigation. In this vein interviews lead to individual accounts that are shared and then formulated into joint accounts recording both commonalities and divergences of experience and perspective (Stinger & Genat 2004: 70).

An interview guide will be used by the researcher to facilitate the interviewing process. A key element of an interview guide is that it encourages responses that are more spontaneous without deviating from the objectives of the exercise, and therefore permitting more flexibility in terms of using probing questions. Telephonic interviews will also be conducted with the professional health practitioners to draw information regarding the challenges they encounter when providing services to immigrant women. Recording of observations (field notes), tape recordings, narratives, internet and literature searches will be other data-gathering instruments utilised.

1.10.6 Validity and Reliability

Validity refers to the degree to which an instrument measures what it is supposed to measure, and reliability refers to the accuracy of an instrument (Grinnell 1998: 134). In order to enhance validity and reliability of the selected design, the researcher has to guard against certain possible threats. A lack of balance in research could yield inadequate and potentially damaging outcomes. This will be avoided by examining

the rigour or strength of the procedures to be included in the research design section. The lack of long-term stability inherent in PAR is mostly influenced by participants' subjective experiences. Well-formulated procedures for testing reliability will be put in place to deal with this threat.

Lincoln and Guba (1995: 291) suggest that there can be no objective measures of validity. In this light it becomes crucial to identify ways of establishing trustworthiness. In this context the researcher will address the extent to which one can trust the truthfulness or adequacy of a qualitative PAR.

1.10.7 Trustworthiness

Holloway and Wheeler (1996: 162) state that trustworthiness exists "where the findings of a qualitative study represent reality". Trustworthiness is established by recording and reviewing the research procedures in order to ensure that the phenomena under study are accurately and adequately presented. Trustworthiness, therefore, rests on procedures geared at attaining credibility, transferability, dependability, confirmability, participatory validity and pragmatic validity.

Grbich (1999: 92) postulates that accelerated credibility increases the plausibility of the findings, and thus assists the qualitative researcher to minimise the extent to which his/her viewpoint intrudes on them. In order to provide evidence of procedural rigour in this study, the following features of credibility were applied: prolonged engagement, persistent observation, triangulation of tools, participatory debriefing, diverse case analysis, referential adequacy and member checks.

1.11 ETHICAL CONSIDERATIONS

It is important for qualitative researchers to adhere to the underlying principles of good practice. In this respect, the principles set out in the Belmont Report (see Murphy & Dungwall 2003: 149) were considered. This report is intended to allow flexibility of interpretations in relation to specific projects. The Belmont Report is relevant for qualitative research, particularly in the area of health. It has served as a foundation for:

- Beneficence, through which the researcher has an obligation to ensure the well-being of the research participants. The researcher should strive to maximise possible benefits of research, and thus minimising chances of harm.
- Respect for persons, which includes participants and all other people involved in the research. They should be treated as autonomous agents able to make their own decisions regarding their participation. Those whose autonomy is restricted in any way should be given special protection, and obtain their consent to research participation.
- Justice and fairness should be ensured by the researcher when it comes to distribution of any benefits. Exploitation of any subgroup of participants must be avoided (Murphy & Dungwall 2003: 149).

Stringer and Genat (2004: 45) state that the prime directive of social research is to protect the anonymity of participants. The logical conclusion is that in practice it is best to assume that all information acquired becomes highly confidential. The permission of the participants in this study will thus be requested and they will be asked to sign consent forms. It is in this regard that the permission of the participants will be acquired before sharing information with other audiences.

The researcher's duty of protecting their informed consent will be observed by:

- informing each participant about the purpose and nature of the study before asking whether they would like to participate
- requesting permission to use an audio-recorder
- assuring them of the confidentiality of all privileged information, and
- advising that they might withdraw at any stage and have their information returned to them.

Different institutions require certain institutional protocols to be observed. In the case of this study, different embassies were approached for permission as legal representatives of the participants' countries of origin in South Africa. The researcher sought advice from the Lawyers for Human Rights South Africa in this regard. The human rights of the participants will be protected throughout the period of the

research under the International Bill of Rights and the South African Constitution and its Charters of Rights (Human Rights Watch 2007: 22).

1.12 CONCLUSION

This chapter has served to provide the reader with a format or structure of how the rest of the dissertation would be organised. It was also meant to logically convey clear information about the topic chosen and the study itself. It elucidated the theoretical framework within which this study is located. It also gave an exposition of the methodological approach followed in the study. All these were done in the context of the need to foster women's health agenda.

The essence of was to give the background of the study, its research purpose and objectives; the research design, methodology, and ethical matters. The concepts used in this study were also defined. It introduced the structure of the study, while outlining the context thereof. The next chapter will deal with the literature review conducted in this study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews relevant literature and related scientific accounts from a multi-disciplinary women's health perspective. In dealing with this, a great deal of attention was paid to those relating to accessibility and health service perceptions of foreign women in South Africa. This was important because the literature review offered information on what was already known, provided a conceptual context and helped to identify other research opportunities (Burton 2000: 18).

2.1.1 Significance of Literature Review

In this study literature review served three major purposes: (i) it placed research in a context related to existing research and theory, (ii) it enabled the researcher to ensure that the research contributed to a better understanding of the phenomenon studied and (iii) it also helped the researcher to avoid repeating mistakes made by others (Dane 1999: 29). This review of literature has had the effect of providing the background or basis for the study. Importantly, it supported and interacted with the conceptual framework by introducing, and defining, the key variables that are part of the theme of this study. This became significant to the project, given the interdisciplinary nature of this investigation.

The literature review clarified what was already known in the field. The review also helped the researcher to discover existing gaps and to decide on new research opportunities. This became very influential when deciding on the most appropriate approach to follow. A substantial review of literature on this research theme provided an understanding of the different perspectives on the information that exist in this area of study. Importantly, it showed how the perspectives presented differed in their theoretical positioning, the disciplines they originated from and their sources of origin. The process (of reviewing the literature) was conducted throughout the research process (Patton 2002: 136).

Crush (2007: 54) states that human nature and the evolution of humanity continue to experience the constancy of movement of populations, and the resilience of adaptation to new environments. Migration is, as such, a universal phenomenon which has considerably increased in these modern times due to eased modes of mobility. Human migration is evidently occurring at an increasing level around the globe. Patterns of migration have also drastically changed as regards the influx to the mainly developed world. There is an increased multi-directional global migration trend with proven high cross-border inter-regional migration.

Statistically, exact migration accounts prove to be a great challenge. Displaced people across the world are estimated at twenty eight million (28 million). Twelve million (12 million) of these people are reportedly refugees, fifty-one percent (51%) of which are women (United Nations High Commission for Refugees 2000: 13). These women are most vulnerable as they have had to leave their homes by force. They thus had to abandon everything they knew to go into unknown destinations and ways of life. Throughout the world migrants affect and are affected by cultures and systems of the host nation. The successful settlement of migrants varies according to the bio-psycho-social migration and resettlement factors in the host country.

The literature, amongst other factors, revealed the history of migration as having an impact on the individual's health profile. The impact of human migration on the health of migrants has thus far only been addressed in terms of infectious diseases. This has the effect of emphasizing the risks the refugees pose to the host society. The specific area concerning the impact of migration on women's health and specific gender-related concepts has not yet been adequately treated, especially with regard to the African context (Social Research Council 2008: 18).

Research done in South Africa regarding immigrant women has largely focused on internal migration. Rural women migrate to the urban South Africa accompanying their spouses who are in the country as unskilled labourers. Other women, especially from Swaziland and Lesotho, migrate to South African urban areas seeking unskilled and domestic labour opportunities (Dodson 2002: 7). Such research was necessitated by the need to highlight the extent to which characteristics of migration-related vulnerabilities affected the general and specific health issues of women.

Given this context, it was thus very crucial that the identification of women's health care needs be accurate.

Much of the research done in this area has established that one of the key strategies to deal with these issues (or women's needs) was the introduction of health promotion programmes. It is against this background that preventative health information provision to the community was found to be an important element of this strategy. The method used in bridging the gap between efficacy and effectiveness of such programmes was found to be challenging, especially with regard to reaching underserved groups such as immigrant women. Edelman and Mandel (2002: 72) argue that the necessity to effectively transmit or convey preventative health messages to immigrant women should be a high priority in the agenda of every government's national health plan. The authors maintain that such programme plans should be rolled out with an intention to mainstream women's health care with regard to gender, age and culture.

2.2 INTERNATIONAL CONTEXT

Recent studies reveal that the vulnerability of immigrant women from traditional cultures is exacerbated by their impeded access to adequate health information and services. This is partly due to their multiple roles and unshared responsibilities (Ahmad *et al* 2004: 22). It is further argued that the workload of immigrant women (IW) combined with re-settlement and adjustment challenges, often result in a lack of sufficient time dedicated to preventative health practices and self-care. The expansion of women's roles is another factor associated with compromised health. It is especially the case when women find themselves in the untenable situation in which they are unable to choose their roles, and at the same time have to balance competing demands.

Jirojwong and Manderson (2002) conducted a study on the physical health and preventative health behaviour among Thai women in Australia. The study concluded that Thai immigrant women's health and their use of women's health care services are influenced by immigration factors. These factors included language, social support and health care accessibility. Reports from the Australian immigration office

and the data captured through the compulsory health screening programme showed lower percentages of Thai-born women with physical health problems, as compared to those of native Australian origin, as well as those born in Thailand but lived in Australia for longer periods.

Only a small percentage of immigrant women was reported to be chronic cases of diabetes and hypertension. It was also noted that a higher proportion of overweight women was prone to heart, cystitis and kidney diseases. These women had more problems related to the ears and eyes, than the normal-weight or underweight women. According to screening processes and findings, the women's conditions were likely to have been influenced by migration as no association was found between the length of period lived in Australia and the types of diseases found (Jirojwong & Manderson 2002: 102).

Thai and Australian women were found to have different disease patterns. These included different types of cancers, gynaecological complications and psychological complaints. The use of health services such as pap smear and dental care by Thai women was recorded as lower than that by of native Australian women. Qualitative data on lifestyle adaptations suggested that some Thai immigrant women adopted smoking in Australia to cope with psychological problems. Social support, communication with health care providers and their perception of these services played an important role in influencing immigrant women's use of health care services. For instance, they perceived health protocols or the referral systems from general practitioners to specialists as barriers to their health care seeking effort. Language problems and perceived unfriendliness amongst service providers were also identified as contributing factors to immigrant women's reluctance to seek health intervention (Jirojwong & Manderson 2002: 108).

A study conducted by Ahmad *et al* (2004) explored popular health promotion strategies among Chinese and East Indian immigrant women in Canada. The purpose of this particular study was to explore and understand popular health promotion strategies and factors associated with the successful transfer of health messages among immigrant women. This was done through gathering their opinions, experiences and perceptions. From the input of the focus groups used, it emerged

that compromised mental health and dissatisfaction with health care services were the most important health concerns.

Recorded verbal expressions concerning mental health issues included stress, tension, loneliness, depression, and a feeling of purposelessness. Physical indicators included headaches, back pain, joint pain, hair-loss and fatigue. Chinese women specifically added experiences of stomach ache, insomnia and musculoskeletal problems to their list. Dissatisfaction with the doctor/patient relationship, involving the quality of care, listening skills, poor explanation and limited consultation time was one of the challenges experienced. Immigrant women recognised that with regard to the transfer of health messages, Canadian health promotions were broadly institutional; using seminars, workshops and counselling strategies. In India, women were accustomed to obtaining information through informal strategies such as social networks. Chinese immigrant women on the other hand relied on written material in their home country (Ahmad *et al* 2004: 26).

Both groups tried to continue to rely on these practices (that is, using the same native methods on arrival in the new country of settlement). However, they could not sustain these patterns as they were unavailable among the local communities. Among Chinese women, language was the dominant barrier in understanding health information and accessing health care services. On the other hand, the lack of familiarity with the new environment and systems was also problematic. Inadequate personal time and language challenges were identified as reasons for delayed health-seeking behaviour patterns. Indian women participants in this study did not report any language problems (Ahmad *et al* 2004: 28).

In both research initiatives, the researcher recognises a gap between the expected and the offered or available health care services by immigrant women in the host countries. Ahmad *et al* (2004: 32) describe such disparities as alarming, particularly when the current era of health promotion and service emphasizes the importance of not only targeting but also that of tailoring programmes according to identified and arising needs. Tailoring of such programmes refers to the development of health intervention material according to the cultural milieus and characteristics of the targeted population without which intervention can only produce incomplete results. It

is thus important for all countries to devise specifically tailor-made health programmes to meet the needs of new immigrant arrivals, especially in pluralistic societies such as South Africa.

2.3 FACTORS AFFECTING IMMIGRANTS IN SOUTH AFRICA

The critical theory perspective is the theoretical framework incorporated in this study. It is meant to improve the understanding of immigrant women's everyday struggles globally and more specifically in South Africa. It was applied due to its ability to encourage action, to raise consciousness and foster knowledge towards correction and change (Doodley 1994: 58). Factors directly affecting immigrants' life in general and immigrant women's health in particular were dealt with to give a broad view, with the aim of shaping towards the specific purpose of this study.

2.3.1 The South African Immigration Bill

South Africa has become a major role player in international politics, more especially with regard to the vibrant interventions it makes in stabilising war-torn regions. Its policies on democracy, equity, justice, development and economic strength in Africa have been given a degree of respect by other countries or nations. The seat in the UN Security Council bears testimony to South Africa's contribution in world politics and development (Solomon 2003: 5).

Post 1994, South Africa became known as the land of greener pastures and enormous opportunities by other nationalities in the continent. This explains why South Africa experienced a great immigration influx. The South African government took time to put into place a functional immigration policy. After many negotiations, the South African Immigration Bill was adopted by the National Assembly in May 2002 (Solomon 2003: 13).

This Bill (and consequently the South African Immigration Act 13 of 2002) replaced the apartheid government's Aliens' Control Act 96 of 1991, which was described by the Human Rights Watch (2007: 6) as "an absolute relic of the apartheid era". It conflicted with the internationally accepted human rights norms and the present

South African Constitution. In its design, this Act lacked transparent accountability for administrative decisions. It prohibited employers from entering into any contract or in any way assist illegal immigrants (Crush 2007: 18). The Aliens' Control Act carried provision for the deportation and prosecution of those who employed immigrants.

In terms of the South African Immigration Act, the Department of Home Affairs was mandated to deal with the implementation of immigration law in the country. The management of migration has so far proven to be a challenge that needs to be adjusted along timeframes, as well as regional and historical contexts. It is equally important to uphold the human rights perspectives of the South African Constitution and the Universal Declaration of Human Rights that the country ratified. There are encouraging commitments that will help shape the immigration policy. The Minister of Home Affairs also pronounced her vision to see South African legislation re-written (Maharaj 2004: 21).

According to global trends, the main immigrant types recognised include economic migrants, refugees and asylum seekers. Today South Africa is seen as locked in the middle of one country and many migration systems. Most common migrant categories include contract labour migrants, temporary migrants, asylum seekers, legal migrants, illegal migrants, refugees and victims of trafficking (United Nations 2000: 42).

2.3.1.1 Contract Labour Migrants

This involves migrants who enter into an employment contract with a South African-based employer. Among the specific details contained in the contract will be timeframes through which the validity of the contract is bound to fixed periods as agreed by the two parties and the Department of Home Affairs. Legally, at the end of the contract, the immigrant worker is supposed to return to his/her place of origin (Department of Home Affairs 2007: 12).

2.3.1.2 Temporary Emigration

According to Solomon (2003:6), temporary emigrants consist largely of contract workers and students. He stipulates that the 1990 records estimated that between

hundred and sixty-five thousand to eight hundred and twenty-five thousand (165 000-825 000) people in this category were employed in South African mines, and about a hundred thousand (100 000) in the agricultural sector. These are said to have a strong relationship with illegal immigrants who tend to overstay their contract periods. Illegal immigrants derived from this category in South Africa were estimated at nine hundred thousand (900 000).

2.3.1.3 Asylum Seekers

These are defined as people seeking refuge from the approached government. Asylum seekers are protected by Article 14 of the Universal Declaration of Human Rights of 1948 which gives the right to asylum. Although there is such a provision, international law does however permit extradition of such persons if there is a treaty between the original country and that of asylum. Statistics in this area are admittedly difficult to capture (United Nations 2000: 22).

2.3.1.4 Legal Migrants

Since 1994, numbers in this category have dramatically increased as South Africa saw an influx of Southern African professionals, skilled people and business people. There is a continuing debate around their contribution in the development of Africa and some see them as creating pools of self sustenance as well as opportunities to provide for those left at their countries of origin. They however also have to oblige with the relevant legal requirements before and while living within South African borders (Department of Home Affairs 2007: 41).

2.3.1.5 Illegal Immigrants

These are sometimes referred to as “undocumented” migrants. Individuals under this category may to some degree bear the same characteristics as those of refugees. Solomon (2003: 11) indicates that illegal immigrants also make individual decisions to come to South Africa. Like a refugee, such an individual may reflect the condition faced by people back in his/her home country. However, refugees can only be in a position to go back to their country of origin when the crisis and war or faction-fighting

have been resolved. An illegal immigrant would not depend on the political or military solutions to go back to his/her country of origin and continue or start life again.

2.3.1.6 Refugees

The 1951 United Nations Convention defined refugees as persons who are living outside their country because of well-founded fears of persecution for reasons of race, religion, nationality and/or membership of particular social group or political opinion (Solomon 2003: 17). Following this definition, 13 600 000 world migrants may be classified as refugees, although the number is surely dramatically growing each year. The definition, however, seems to be restrictive as it excludes environmental refugees.

The African Union (AU) formerly (OAU), on the other hand, defines a refugee as a person who, owing to external aggression, occupation, domination or events seriously disturbing public order in either part or the whole of his/her country of origin or nationality is compelled to leave his/ her place of habitual residence in order to seek refuge in another place outside his/her country of origin (Human Rights Watch 2007: 13).

2.3.1.7 Victims of Trafficking

This is a recently growing phenomenon in South Africa, as is world wide, and has become a humanitarian crisis. The International Organisation for Migration (IOM) describes trafficking as a form of migration whereby people, mostly women and girl children, are moved across borders through clandestine schemes. These networks are operated by organised criminals who lure their victims into the developing and developed countries under the false guise of offering them opportunities for a better life (International Organisation for Migration 2004: 2).

When they ultimately find themselves in the harsh reality of the new situation, unaware victims get into involuntary servitude, coercion and deception. Trafficking is said to be a lucrative, multi-million dollar business. Recruited women find themselves engaged in activities such as prostitution, sex slavery and labour exploitation. Victims

of human trafficking in South Africa are protected by provisions of the Sexual Offences Act 32 of 2007, the Children's Act 38 Of 2005 and the fact that South Africa is a signatory to the UN Protocol on Trafficking of Persons.

Dodson (2002: 8) refers to what she calls the three dominant prevailing stereotypes of migration in South Africa. The first is described as the image of a highly formalised system of male migrant labour to the mines. The second is described as the uncontrolled post-apartheid invasion of illegal immigrants seeking a better life. The author describes this as an assumption that all migrants are male. A survey conducted by the South African Migration Project (SAMP) showed that the cross border migrant is frequently and increasingly likely to be a woman.

2.4 MIGRATION AND GENDER PERSPECTIVES

Migration studies globally have neglected the movement of women across borders. These have generally always dealt with it as a residual or peripheral category amongst migration issues. Mainline issues affecting women have thus been treated as "add-ons" and not afforded adequate focus. Dodson (2002: 5) emphasises that relations of power and access to resources determine who moves where, when, how and why. She asserts that men and women have different scales from global to local; and they thus face different opportunities and constraints in determining their patterns of mobility.

Pietila and Vickers (1995: 94) argue that international migration for women also depends on complexities of race, ethnicity and gender. The migration of women from the third world often means a shift in gender roles, relations and status. This emanates from the fact that they move from structures with definite definitions of sex roles to those with more egalitarian sex roles. The pre and post migratory factors of women are under-explored and their links to and impact on the quality of these women's health is thus missed.

Buijs (1993: 44) reports that in the 19th century, South Africa became known as the "lungs of the empire", as it became a popular destination for British middle-class women, recommended by medical doctors as alternative management of the

pulmonary complications that afflicted these women at that time. The evangelisation era, the boom of the mines and the Anglo-Boer war all saw droves of British women migrating to South Africa. They also faced exploitation and abuses that came with low wages, disregarded human rights and invalidism, as well as being exposed to poor health conditions. Until today, South Africa continues to see increasing labour related migration of women. They are motivated by pressing necessities as those characterized by migration pull factors of individual and familial security, provision for dependants, better quality of life and personal development.

There are distinct patterns in immigration factors among African immigrants, which also influence gender imbalances in migration. Limited economic resources accessible to women often delay their travels and risk security involved. Patriarchal dominance and expectations over women require that they seek the consent of males in the family before migrating. There is a practice whereby husbands or males in the family leave home first to “assess” conditions in the envisaged country of settlement or refuge, and then later invite the women and children to follow. The waiting period for the woman and children back home is conservatively dependant on the husband’s readiness to be joined by the family. This period could drag on for different, often personal, reasons which do not necessarily involve the welfare of the family (Cornish 2003: 64).

Dodson (2002: 3) is of the opinion that the experiences of immigrant women in South Africa are not only driven by economic factors such as trading and formal employment, but also social and reproductive reasons. She finds women immigrants to be more law abiding, responsible and resourceful. This analysis may lead to an assumption that in re-drafting the Immigration Bill, the Minister could be especially lenient towards women immigrants.

A study conducted by the South African Migration Project (SAMP) explored factors that encourage or discourage women’s migration to South Africa. The results yielded considerable gender variations regarding immigrant women and male push and pull factors encouraging or discouraging immigration to South Africa (Dodson 2002: 13). In essence immigrant women coming through South African borders generally proved to return home when their visas expired (except for those from war-torn regions).

Female migration, unlike male migration, tends to benefit not only the individual immigrant herself, but also dependants that come with her and those left behind.

There are many other immigrant women, especially amongst refugees and asylum seekers in South Africa, who are often faced with the sole responsibility of establishing homes. It is their responsibility to get the family to be functional in an environment they are unfamiliar with. They often do not any understand English as a medium of communication, have no reliable income, and often live in abject poverty without proper shelter (Solomon 2003: 82).

Maharaj (2004: 54) cites reports of immigrant women who swore that they would not return to South Africa again because their expectations were not met. Other immigrant women maintained that regardless of the number of times they were deported, they would always return to South Africa. The reality of the matter, especially with regard to male and single women immigrants from the African Great Lakes, is that most of them come to South Africa not for long-term settlement. They merely use it as a country of transit to their intended destinations; popularly the Americas and Europe.

2.4.1 Abuse against Immigrant Women

Immigrant women are highly vulnerable to sexual abuse as women in most traditionally patriarchal societies tend to rely on men for daily essential survival means. In such and other related cultures, women are seen as commodities and dependants of men. Their physical and sexual abuse at the hands of males in the family (husbands, brothers and all males in the extended family) has become an accepted part of the dynamics of patriarchal relations. Kemp and Rasbridge (2004: 69) make the point that in most third world countries, abuse is not even reported as a crime against women. The authors further state that refugee and immigrant women bring this attitude to their countries of asylum. Immigrant women, especially those illegal and those awaiting asylum status, do not report abuse for fear of being deported, arrested and detained. They are afraid of being separated from the family and losing custody of the children. A lack of knowledge of, and trust in, the host country's legal system, and sometimes even the fear that the abuser might be

deported aggravates the problem. This is especially so if the woman depends on him for support.

There are many interrelated aspects to the issue of violence against immigrant women. These include sexual harassment, hate crimes (gender, sexuality, race and culture), harassment from state departments and domestic violence. Research shows that women who are battered have more than average health care needs and medical costs than those who are never battered. Worldwide records in the health sector reflect still births, miscarriages and low birth weight as some of the consequences suffered by battered pregnant women in general, including immigrant women (Moleon 2000: 39).

The American immigration law protects abused women from being deported, and in cases where the abuser is the “legal guardian “of the immigrant woman, she may apply for her own petition. The US federal law allows the abused woman the right and assistance to leave the country if she chooses to do so. Women’s units at the UN have taken leadership on this issue, more so that studies show the need for greater resources and co-ordination to eradicate gender violence. Charlotte Bunch of the UN Centre for Women’s Global Leadership at Rutgers State University, New Jersey, was recommended by the UN to investigate more (United Nations 2006: 64).

Violence against women as a phenomenon is not confined to a specific culture, religion, country or group of women in society. Different contestations of such violence and women’s personal accounts are however shaped by factors such as economy, class, race, sexual orientation, age, religion and culture. Issues around violence against women have more to do with the exercise of male power over women than anything else. Abusive men see it as a means of dominance and authority over women, as a punitive and controlling tool, a means of exploitation and role-boundaries definition (Women’s Watch 2007: 22).

During armed conflicts, women experience physical, psychological and sexual violence perpetrated by state and non-state sectors. Common patterns include murder, unlawful killings, torture, punishment, abduction, mutilations, maiming, rape, sexual slavery, arbitrary detention, forced marriage and forced impregnation. In war,

sexual violence against women as a form of torture is meant to inflict injury, intimidate the attacked community, humiliate the opponents and extract information. It is also understood to be a wilful method utilised by opponents to spread HIV/AIDS. Fighters are sometimes given women to rape as a reward for killing opponents. It is estimated that between five thousand (5000) and two-hundred and fifty-thousand (250 000) women were raped during the Rwandan genocide in 1994. According to CNN reports, many women were raped in front of their families, gang raped, kidnapped and taken into opponents' bases as sex slaves during the war in the DRC (Women's Watch 2007: 24).

Life as an immigrant woman means that one must always traverse many layers of oppression and segregation in order to survive. In some cases these layers are not gender specific. Most immigrant women in developing and developed countries have at some stage experienced assault on their dignity and human rights. Not much research has been done on the specific problems of domestic violence among immigrant families. A research conducted in the US among immigrant farm workers indicates that one (1) in five (5) migrant farm worker women reported being physically abused within the previous year and ten percent (10 %) reported forced sexual activity within the previous year (United Nations 2006: 67).

As immigrants in South Africa, women report that those involved in the sex industry are targeted by both South African and immigrant pimps who financially, psychologically and physically abuse them. They force these women to stay in prostitution even when they want to leave. One way of 'forcing' them to stay is by threatening to report them to the police or immigration officers. They apparently beat them up and force them to work even when they are sick. Drug lords use immigrant women in the sex industry for trafficking and delivering drug parcels. They force them to use these substances in the process, by spiking their drinks and then getting them raped in exchange for money, debt settlement or drug deals. Immigrant women in the informal trade industry also report harassment by locals. There were media reports in December 2006 of Somali immigrant women living in Cape Town, who were constantly harassed and assaulted by the local small business owners to such an extent that they had to give up their flourishing business ventures for their own safety (Human Rights Watch 2007). Robbers at South African airports, especially the O.R.

Tambo International airport, target immigrants. They follow them all the way to their local destinations as they are believed to carry cash and expensive clothing when they travel. Women are mainly targeted for their jewellery. It is strongly believed that most immigrant women, especially those from Francophone African countries, prefer to import these from France and Belgium. Immigrant women in the Johannesburg inner-city have fallen prey to local street muggers, who grab jewellery from their necks and ears as they walk or stop at intersections (South African Human Rights Commission 2000: 2).

Between April 2006 and March 2007, fifty four thousand-nine hundred and twenty six (54 926) rapes and attempted rapes and nine thousand-eight hundred and five (9 805) indecent assaults were reported to the South Africa Police Services (SAPS). The national statistics on reported rapes are slightly lower than in 2005, but some provinces have seen a significant increase in the number of incidents. For instance, Eastern Cape has reflected an increase of twenty-one percent (21%) in rape cases and eleven point seven (11.7) in indecent assaults. SAPS have observed that sexual violence is nationally underreported. The effect of this is that it leads to an underestimation of the extent of the problem. Of the cases reported, the South African Law Commission found that only nine percent (9%) involving children end up in conviction. None of these statistics at this stage reflects the specific percentage of immigrant women's reports (Population Reference Bureau 2006: 2).

The Sexual Offences Bill Original Draft (now, the Sexual Offences and Related Matters Amendment Act No. 32 of 2007) obliged the government to provide and bear costs of medical care, treatment and counselling for sexual violence survivors who may have sustained physical injuries or psychological harm. This also covers situations where a woman has been exposed to sexually-transmitted infections as a result of the sexual offences. In terms of this provision access to Post-Exposure Prophylaxis (PEP) services is limited the victims who lay criminal charges or report the incident at a designated health establishment within seventy-two (72) hours (Women's Watch 2007: 22).

According to the Domestic Violence Act (DVA) 116 of 1998, everyone has a responsibility to report abuse and battering to the police (Griffin 1999: 82). It is easy

to assume that since immigrants have the right to security and protection, immigrant women would be covered under the existing protective instruments meant for women and children in South Africa. A noticeable advantage for immigrant women in South Africa is that, since there are no refugee camps, government and non government women's shelters do readily take them in. It is in these facilities that they are sometimes assisted to deal with issues, depending on the type of services the shelter provides.

Some of the health consequences of abuse of immigrant women include poor physical, psychological and reproductive health, which negatively affect their reproductive functioning. As mentioned by other researchers, some adopt alcohol and drugs as coping mechanisms, and others resort to suicide as they are overwhelmed by everything happening around them. Violence against women often results in death, femicide, HIV infection and maternal mortality (Hamilton 1993: 44).

2.4.1.1 Physical Injuries

These include fractures, abdominal and thoracic injuries, chronic conditions and gastro-intestinal disorders (Chinn & Kramer 1999: 64).

2.4.1.2 Reproductive Complications

In most cases involve reproductive complications entail gynaecological disorders, pelvic-inflammatory diseases, STI's and HIV, unwanted pregnancy, poor obstetric outcomes, vaginal bleeding and urinary tract infections (Chinn & Kramer 1999: 64).

2.4.1.3 Gynaecological Disorders

Practitioners in this field report genital mutilation, haemorrhaging, and ulceration of genital area, abscesses and keloid scars, among others (Chinn & Kramer 1999: 65).

2.4.1.4 Psychological Disorders

Stress, anxiety disorders and post traumatic stress disorder (PTSD) are reported. Traumatic syndrome for abused women includes lack of volitional autonomy, fear, anguish, depression and suicide (Chinn & Kramer 1999: 65).

2.4.1.5 Social and Integration Impact

Violence against women prevents women from fully participating in the community and the economy. It further hinders them from realising their potential or expressing themselves socially. Women have limited chances of finding employment, their physical security is often undermined in public spaces, and their political lives and participation are also constrained (Metzopoulos, Ahmed & Souffla 2006: 17).

Women's fear of violence dissuades them from accessing help, accessing information, disclosing abuse and HIV infection. It keeps them from accessing services for prevention, seeking alternative shelter and receiving treatment and counselling. Amongst immigrant women, it is understandable that some may be constrained by cultural values and practices. They generally do not believe that anything can be done in the new country to stop their abuse. This is aggravated by the fact that they, in most cases, are not aware of the legal remedies, policies as well as constitutional rights and procedures that may protect them against their abusers (Barnett 2002: 569).

2.4.2 HIV/AIDS

Throughout the world, the focus of HIV/AIDS has been placed on people living with AIDS in general. Its devastating impact on women specifically has not yet gained due attention. Berry (2007: 32) alludes to the fact that around seventy-six percent (76%) of women living with HIV are in the sub-Saharan Africa; and that among those living with HIV in this region, three in every four are female.

Msimang (2003:16) concurs with most HIV/AIDS research that most women have been infected with HIV through heterosexual sexual encounters. During heterosexual

intercourse, women are twice more likely to get infected with HIV from men than men are by women. Feminists involved in various research projects on this subject have discovered that the major inequalities resulting from patriarchy contribute to most difficulties that women face in the battle against HIV infection.

In countries such as those in the African Great Lakes region, traditional and cultural practices in some areas are still very rigid and undemocratic as regards gender equality. For instance, most women cannot choose their sexual partners. They cannot negotiate for condom use or decide on any other method of contraception, or even to voluntarily test for HIV as a married, engaged or even promised woman (Pietila & Vickers 1995: 29).

As displaced people, immigrant women in most cases find themselves in situations that compromise their health status and are without adequate health facilities.

Collymore (2001: 94) describes the following as factors that highlight the HIV risk of refugee and other displaced women:

2.4.2.1 *Limited Access to Prevention and Health Care Services*

Even where there are HIV and health services in refugee camps, the chaotic nature of the situation does not always enable women to access these and protect themselves.

2.4.2.2 *Presence of Military Forces*

Research has shown links among army personnel, commercial sex and sexually - transmitted infections, including HIV. This is evidenced by the number of rape cases laid against members of the South African National Defence Force (SANDF) when they came back from the peace keeping mission in the DRC. This pattern is also a predominant factor at borders and refugee camps (Collymore 2001: 94).

2.4.2.3 Violence and Sexual Exploitation

According to UNHCR, women and children face high levels of abuse during population movement. Men exert power over women by torturing and forcibly impregnating them as an indication of control and power (United Nations High Commission for Refugees 2000: 60).

2.4.2.4 Sex Work

Women and young girls' exposure to HIV is also raised by their dependency on strangers and acquaintances who offer shelter, food, security and support in a new country. They are, in these situations, inclined to reciprocate with sexual favours (International Organisation for Migration 2004: 5).

2.4.2.5 Population Mixing

Due to high mobility patterns of displaced people, groups move from areas where there are lower rates of HIV infection to those which are heavily populated and thus have a higher risk of HIV infection. These are often exposed to more widespread HIV epidemic and therefore a higher risk of infection (Collymore 2001: 98).

2.4.2.6 Blood Transfusions

It is not always practical in the early stages of an emergency to ensure that transfused blood is not contaminated. There might not always be readily available screening facilities, and thus putting women of child-bearing age more at risk (Collymore 2001: 99).

There is an ongoing debate around the question of whether immigrants bring HIV into the countries they settle in, or whether they contract it in their new countries of settlement. In the case of South Africa, given that the infection rate is the highest in Africa, one would presume that although there might be a tendency for both patterns, the highest infection rates could be of those of people who contracted HIV in the country. Issues of forced sex, sex slavery and survival sex among immigrant women

need to be investigated further as specific gender-group contributory factors highlighting the HIV infection rates of immigrants. Msimang (2003: 111) argues that the reality of the matter is that girls without families to protect them engage in survival sex to feed themselves and their siblings.

The Southern African Development Community (SADC) member states need to fully observe the organisation's Declaration on Gender and Development. This Declaration, amongst others, addresses issues of women and HIV/AIDS. As a binding legal document, this SADC protocol lays down a guide on how to apply the complex women's health issues to all countries who ratified it (United Nations Development Fund for Women 2002: 15).

2.5 SOUTH AFRICA AS A HOST COUNTRY

Throughout the world, members of the civil society have shown traces of subtle hostility against foreigners, regardless of the political will of the host government and leadership in general. South Africa is no exception to this trend. There is an expectation on the part of most African immigrants that the present leadership, most of whom experienced foreign hospitality during their years in exile, would be more understanding and accommodating. It is for this reason that South Africa would be expected to be vehement in teaching those without knowledge and exposure to be more friendly and tolerant (Human Rights Watch 2007: 16).

In countries like Canada, the dislike of foreigners is reduced by the use of the system of adoptive families (Council of Europe 1993: 64). According to this system, a Canadian family takes the responsibility to orientate the newcomers for a government-regulated period. In other countries, refugee orientation programmes are designed to serve the purpose of psychologically preparing new immigrants for what is to be expected, as well as how to gain access to and use available basic services. Unfortunately, in South Africa such programmes do not exist on any significant scale at government level. There are non government organizations (NGOs) which render services to assist in this and related issues on a voluntary basis, mostly not funded by the government to fulfil this task. However, most of these NGOs mainly focus on rendering services to legal refugees.

The lack of intensive and decisive promotion of tolerance and acceptance towards foreigners from the government's side has left South African nationals prejudiced and oblivious to the realities of immigrants and their needs. Consequently, South Africa is a xenophobic nation. This negative prejudice is mainly directed towards immigrants of African origin from other countries within the continent (see Appendix F). There have been detailed reports of assault, discrimination and prejudice against immigrants at the hands of native South Africans to the extent that some people have lost their lives (Crush 2007: 16).

Solomon (2003: 13) makes the point that xenophobia is viewed worldwide as a sentiment generally confined to individuals at the end of the socio-economic and educational spectrum. There is a belief that these people have a lesser world view due to their limited travelling exposure and unawareness of other countries and cultures. Some reports state the struggle for economic resources as another reason. However, the reality is that in South Africa even people socially categorised as elite, politically and economically empowered, well-travelled and exposed to other cultures, including those who have been in exile, evince the same xenophobic behaviour.

The other problem concerning perceptions of the civil society in South Africa with regard to immigrants is that most South African citizens seem not to care about the distinction between legal and illegal immigrants. They discount any good deeds or positive contributions of immigrants within the society, and see them all as illegal aliens or criminals. Interestingly, this phenomenon is predominantly applied to immigrants of African origin. Although there have been a few incidents reported against Chinese and Pakistani immigrants, it is mainly those of African descent from other African countries that bear the brunt. According to research done by Nielson (in Solomon 2003: 18) seventy-five percent (75%) of South Africans felt that immigration laws in the country are not strict enough. Crush (2007: 15) refers to a study conducted by SAMP, which revealed the following:

- South Africans are intolerant of outsiders and African immigrants in particular.
- The majority of South Africans favour more forceful immigration controlling measures.

- Seventeen percent (17%) said that they would financially support sheltering refugees.
- Forty percent (40%) are against immigrants enjoying same access to same educational and health systems.
- Forty-seven percent (47%) said they would personally take action to stop immigrants from moving into their neighbourhood or operating businesses or befriending their children or even working with them.
- Forty-seven percent (47%) agreed to give asylum and protection to refugees.
- Fifty percent (50%) found it necessary to afford immigrants basic rights, security and protection.
- Fifty-four percent (54) % felt that immigrants should not access housing in South Africa.
- A sixty percent (60%) majority of South Africans believe that immigrants weaken the country's economy.
- Seventy percent (70%) believe new refugees are more genuine.
- Seventy-six percent (76%) of South African citizens do not support the ideas of immigration amnesties.
- Eighty-five percent (85%) responded that unauthorized immigrants should not be extended any rights or access to any services in South Africa.

2.5.1 Migrants' Perceptions of their Treatment in South Africa

Immigrants find using the services of government departments such as Home Affairs, Health, Social Welfare and Education to be very threatening and hostile. They prefer approaching faith-based organisations for assistance. They are easily exploited by the business community and, in most cases, agree to low wages because of limited employment opportunities. New immigrants are easy targets of criminals because they are unfamiliar with the environment and local languages. Some immigrants reported cases of being coerced into drug trafficking and other criminal activities, including human trafficking by South Africans. Solomon (2003: 22) reports cases where immigrants were killed by local people for muti (magic potion) purposes.

Given the above picture, this account does not in any way exonerate immigrants from their adverse criminal activities in South Africa. International and local news agents

report evidence of their involvement in various money scams and other criminal activities. These include electronic transfers, cheque forgery, production of counterfeit money and identity documents, as well as drug manufacturing and dealing. They are also notorious for using fraudulent personal documents for conducting “legitimate” business in South Africa and other countries, as well as being involved in human trafficking deals.

Most arrested immigrants claim that they were reported by locals who believe that immigrants take away their jobs and women. In return, these police informants gain monetary rewards of between two hundred and five hundred rand (R200-R500) for each successful arrest. This tactic has, however, led to many wrongful arrests. The state does give such detainees a fair chance to defend themselves and present their cases. If found guilty, they are immediately deported; and if not they are allowed to appeal to stay in the country. The South African Human Research Council (HRSC) states that in many cases those arrested rightly reported that their rights were violated. Some of them did not understand why they were arrested, as their papers were in order. They further reported that at arrest, their identification documents were either destroyed by officials or ignored at presentation. The officials resort to such methods as a way to extort bribes (South African Human Rights Commission 2000: 70).

The Lawyers for Human Rights (LHR) have legally represented refugees and immigrants who needed their services in instances such as the ones referred to above. As a non-governmental organization, the LHR promotes awareness, protection and enforcement of legal and human rights of refugees, and other immigrants in South Africa. Their other programmes include monitoring of legislation and government policies, training of government officials and legal practitioners as well as research on refugee and asylum seekers (South African Human Rights Commission 2000: 82).

South Africa needs stringent human rights-based strategies to eradicate xenophobia. The country, however, must also be able to afford legal, law-abiding immigrants, refugees and asylum seekers generally decent humanitarian conditions. The plight of women and children immigrants must be especially looked at. The civil society needs

to uphold the values of *ubuntu* and to respect basic human rights of all within the boundaries of South Africa as enshrined in the Constitution (Act 108 of 1996). In May 2001, former president Thabo Mbeki appealed to all South Africans to be vigilant against any incident of xenophobia against African immigrants. He stressed that it is fundamentally wrong and unacceptable that South Africans should treat people who come to South Africa as friends as though they are enemies (Cornish 2003: 16).

2.5.2 Realities around the Management of Migration Issues by State Departments and Non-Government Organizations

The Department of Home Affairs has a sub-directorate of Refugee Affairs, which is tasked with the administration of applications by refugees and asylum seekers in the country. This sub-directorate works with the Refugee Appeals Board of South Africa. The Department reported that in 2005 twenty-eight thousand (28 000) applications were received, and in 2006 they acknowledged the presence of thirty thousand (30 000) refugees. The Department of Home Affairs and the United Nations High Commissioner of Refugees recorded eighteen thousand-eight hundred (18 800) applications for asylum between January and March 2006, with more than a hundred thousand (100 000) such applications in that period recorded as pending. The Department of Home Affairs further acknowledged a backlog in the processing of these applications, stating that only a hundred and twelve (112) were approved. About one thousand-one hundred and forty-four (1 144) applications were rejected. There were hundred and seventy-thousand (170 000) recorded deportations in 2005 (Department of Home Affairs 2007: 9).

Of growing concern is the accumulated backlog, inconsistent procedures and administrative obstacles that delay the processing of asylum applications. Due to this disadvantage, asylum seekers get exposed to the risk and threat of unlawful arrests and unwarranted deportations. In order to survive these hardships, they are forced to bribe police and other officials on a regular basis.

Most of them know that their stay in South Africa depends on the validity of their legal papers and are thus diligent in applying for extensions and renewals on time. They however report that they always meet complications in presenting their documents at

the Home Affairs offices. People seeking work permits and study permits are also affected by the same factors. This consequently affects their security, and thus rendering them vulnerable to fraudsters and con-men (Human Rights Watch 2007: 24).

These delays essentially amount to violation of immigrants' human rights as they expose them to risk of brutal harassment at the hands of the police and immigration officials. Some employers take advantage of this situation and use the invalidity of immigrants' legal documents as a convenient excuse to under-pay them. In addition, these employers use this excuse not to register them even when they are legal in the country and/or employed full-time. On the 18th of July 2004, the former Minister of Home Affairs announced that eighty (80) ministry officials were charged with corruption between April and June 2004. About sixty-six (66) officials were dismissed for serious misconduct under the Prevention and Combating of Corrupt Activities Act of 2004. This proves how deep corruption runs at the risk of innocent lives (Institute for Security Studies 2004: 89).

Border police have also been implicated in various forms of corruption involving immigrants. Human traffickers bribe the border police to help them move the victims of trafficking (VOT's) to avoid detection (International Organization for Migration 2004: 2). Some incidents of corruption amongst police officials are attributed to low salaries. The police see the money gained through corruption as a supplement for their meagre income. The existence of bribery has led to compromised police check procedures in our borders. This situation is one of the contributing factors to the increasingly porous borders.

2.5.3 Traces of Human Trafficking in South Africa

According to the United Nations Protocol to Prevent, Suppress and Punish Trafficking of Persons (International Organization for Migration 2004: 2), trafficking of persons shall mean the recruitment, transportation, transfer, harbouring or receipt of persons by means of threat, use of force or other forms of coercion, of abduction, of fraud, of deception, of abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control

over another person for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation. It includes forced labour services, slavery or practices similar to slavery, servitude or the removal of organs.

According to International Organization for Migration (2004: 7), the National Trafficking Task Team has been established at governmental level to deal with human trafficking issues in South Africa. This body consists of the National Prosecuting Authority (NPA), Department of Home Affairs, Department of Justice, Department of Social Services and Population Development, Department of Labour, Organised Crime and Border Police Units of the South African Police Services (SAPS), United Nations Office for Drugs and Crime, Molo Songololo and the International Organization for Migration (IOM).

South Africa is regarded as a country of destination, a country of transit for some and also a point of origin for traffickers from other African countries, Asia and Europe (International Organization for Migration 2004: 8). Domestic and organised crime syndicates find women as easy targets, because they frequently traffic them across borders for the sex industry. There are, however, young men mainly targeted for agricultural work and drug trafficking. Women are often kept at isolated hide-outs at arrival to avoid detection. Most women who are found to be victims of human trafficking are lured into scams through guises of employment, marriage and education. These syndicates aim at women from poor families who would easily surrender to the pressure emanating from being deceived to see these coercions as opportunities to make a living for themselves and their poor families.

Prostitution is a large aspect to contend with when dealing with trafficking of women. Some victims of trafficking in time come to perceive prostitution as a strategy to overcome economic and social challenges. They see it as a way to ultimately reclaiming their freedom from the pimps and continue working in the industry to rebuild their own lives and cater for their dependants. For other immigrant women, it is the “easiest” way to start a life in a strange country where there are not many opportunities for immigrant women to support themselves and their children. On the other hand, prostitution is a very profitable industry with potential to form large

organizations and coalitions that would operate as formal business. The predominance of patriarchal sexuality, its availability, demand and growing market continue to benefit syndicates of men at the expense of desperate women (Women's Watch 2007: 5).

The Human Rights Watch (2007: 12) states that the South African government's failure to protect the constitutional rights of migrants also frequently violates the government's obligation under the International Covenant of Civil and Political Rights (ICCPR). South African nationals need to be constantly reminded that migrants also have rights as soon as they are at the hospitality of South Africa. They have rights to save environment, adequate housing, health care, sufficient food, water, social security, education and their own language and cultural life.

2.6 SOUTH AFRICAN HEALTH CARE SERVICES

It is understood that South Africa is a complex society which is characterised by socio-economic stratification and vast cultural diversity issues. It is this complex nature of the society that could potentially create delaying factors in the efficient transformation of the health system. The health status of a nation is determined by two major contributing factors, namely (i) the developmental stage of a nation, and (ii) its level of influence globally. South Africa is categorised as a middle income country with opposing extremes of wealth and poverty (Global Health Watch 2005: 55).

In 1990, the then government was already planning for "Health for All by the Year 2000", thereby positioning the means to intensify the extension of Primary Health Care to all people. It became apparent that the specific health needs of women also had to gain significant attention. The present National Health Department faces challenges inherited from the previous health system. Some of these challenges have, nevertheless, been successfully dealt with in a progressive manner. South Africa, like many countries around the world, adopted the Primary Health Care strategy which in its design promotes and empowers people to improve their quality of life. This strategy insists on making health care accessible to all. It employs an inter-sectoral approach that emphasises prevention and the importance of community participation (Department of Health [Sa]: 8).

A report by UNHCR (United Nations High Commission for Refugees 2000: 17) states that given the new health accessibility policies, refugees in South Africa are afforded the right to basic medical services at primary health care level. A survey conducted in 2003, however, revealed that seventeen percent (17%) of refugees were reported to have been refused medical attention at emergency services (Cornish 2003: 18). Although the government is not restricting any refugees from accessing these services, the Poverty Reduction Strategy Paper (see Economic Commissions of Africa 2003) does not include or refer to any assistance to refugees in this regard. The Women's Health Rights and the Platform of Action in the Report on the Beijing Conference on Women emphasise that refugee women must know about their rights and know how to get protection if their rights are violated (Department of Social Services and Population Development 1995: 98). The question remains: how many refugees would know about these rights if nobody informs and empowers them with regard to these issues?

In many countries, the first point of contact with health care for refugees is usually the emergency care at a temporary border camp or refugee camp. This is usually where primary care and hospital facilities are set up to treat asylum seekers with injuries, severe malnutrition, acute illness and other urgent health problems. Hypertension, diabetes and chronic parasitism are low priorities in many refugee camps (Kemp & Rasbridge 2004: 25). The authors remark that only after basic requirements such as shelter and employment have been met, do refugees and almost all immigrants seek health care intervention.

As for many immigrants, their understanding of health education, information and procedures on how to gain access to health care services is partly influenced by language skills. Jirijwong and Manderson (2002: 65) refer to language or communication difficulties that immigrants face. Noted as a contributing factor, is the reported negative or dismissive attitude towards immigrants by health care service providers. This makes migrants reluctant to ask for explanations on diagnosis, treatment, prescription and dosages.

2.7 WOMEN'S HEALTH PROGRAMME IN SOUTH AFRICA

Women's health is no longer seen as merely synonymous with reproductive health. It rather incorporates health promotion, management, maintenance and restoration across the woman's lifespan. It embraces perceptions and views of all women; that is, it acknowledges minority women, rural women, elderly women, homeless women, women with physical challenges and lesbians as equally important. In mainstreaming women's health care, women struggling with addictions, those incarcerated and even immigrant women's holistic wellness cannot therefore be treated as homogeneous. Over the years, women from different cultural backgrounds have been rendered invisible and discriminated against in health systems (National Women's Health Resource Centre 2004: 109).

Pender (1996: 100) recommends activities that might be used in order to reflect that the health care services consumer is in control. These include:

- being actively involved in the health care problem solving process
- making rational and informed choices with regard to health issues
- developing competencies and skills that foster creativity and adaptation amid changing circumstances affecting the status of health
- striving for mastery of environmental conditions that impact on health and wellbeing
- advocating for the development of health financing plans that provide for a range of self care and educational services for all ages.

The general assumption amongst women's rights and women's wellness activists in South Africa is that women's health has not reached a stage where it could be rated as a national health priority. It is important to note, for instance, that there are no reliable statistics on women who use these services in the country. Wilson and Ramphela (in Lessing 1994: 80) point out that the demographic factors such as social class, age distribution, level of education and geographical positioning all influence health care needs, health care provision and service accessibility. They further make the point that women are the most disadvantaged when it comes to the above-mentioned factors.

During the United Nations Decade for Women, which was dedicated to the period, 1975 to 1985, World Health Organization's (WHO's) international attention focused sharply on the development of women. At the closure of the decade, a directive was issued, calling for special attention to women's health issues (Lessing 1994: 39). In South Africa, women's health programmes were created under the auspices of the National Department of Health in 1994. They were launched as part of the department's initiative to prioritise women's health and raise awareness to the importance of women's issues in different social sectors. They were meant to ensure that women and girl children are accorded the respect, dignity, security and wellbeing they deserve.

According to the National Department of Health (2000: 21), the Gauteng Provincial Department of Health launched a Women's Health Programme. This programme covers different areas that affect the quality of women's lives and wellbeing in the country. Those areas classified as of high priority in the province were identified and addressed. The said areas were:

- Victims of violence
- Termination of pregnancy
- Contraceptive services
- Cervical cancer screening
- Breast cancer screening
- Antenatal care
- Voluntary counselling and testing
- Genetic services
- Mother and baby friendly initiatives
- Nutrition and development projects
- Youth friendly services.

2.7.1 Victims of Violence

The main goal of this programme is to reduce the negative impact of trauma and violence. This is inspired by the consideration that violence prevention remains as the WHO's health priority globally (Metzopoulis *et al* 2006: 37). Emphasis is put on

policies, protocols and procedures which should be put in place for care and treatment of victims of rape and all sexual offences. All health facilities are equipped with the necessary resources to enable adequate management of the psychological and physical care of such patients. Trauma centres have been established for counselling, support, treatment and referral of all victims of violent incidents. Such incidents include domestic violence, sexual violence and child abuse. A programme on post-exposure prophylaxis against HIV infection, especially for victims of sexual offences, is offered. Health promotion education initiatives empower victims of rape to report to the nearest clinic within seventy-two (72) hours of the incident in order to commence with treatment against HIV infection.

2.7.2 Termination of Pregnancy

The Choice on Termination of Pregnancy Act 92 Of 1996 gives women the right to choose whether to keep or terminate their pregnancy. It is aimed at reducing maternal deaths caused by illegal abortions by providing accessible and efficient user-friendly termination of pregnancy services. Women are advised to report at the primary health care facilities early in the pregnancy between one (1) and three (3) months) if they wish to terminate. Notwithstanding these provisions, the routine emphasis of safer methods of contraception continues, because termination is not a method of contraception (Department of Health 2000: 21).

2.7.3 Contraceptive Services

The contraception policy was developed to reduce the rate of unwanted pregnancies. Its main objectives are to:

- promote expanded choices of contraceptive methods as a basic right of female clients
- allow women clients to decide on the number and spacing of their children
- promote contraception through information, education and communication
- promote accessibility and availability of contraceptive services
- create awareness to health service providers as well as clients about male and female sterilisation as an alternative method of contraception.

Contraceptive services have been improved by the addition of education for women about possible problems that could be associated with pregnancy, particularly unplanned pregnancy. Sexually active teenagers and women older than 30 years are actively encouraged to use contraceptive services. The Sterilization Act 44 of 1998 has given women the ability to decide if they do not want to have any further pregnancies, thereby enabling them to control their own reproductive span. The effect of the provisions of this Act is that women are empowered to decide on their reproductive issues without their husbands' consent. Vasectomy and condom use are also promoted (Department of Health 2000: 22).

2.7.4 Cervical Cancer Screening

This type of service has been put into place to detect early presence of cervical cancer in women. The essence of early detection is that immediate intervention can be made, and thus improve the quality of lives among identified patients. Cervical cancer is recorded as one of the most common causes of death among women. The cervical screening policy targets ninety percent (90%) of women between ages thirty and fifty five (Barnett 2002: 8). The cervical cancer screening serves to:

- reduce the incidents of cancer of the cervix by early detection and treatment before it spreads to the rest of the body
- reduce the number of deaths associated with cervical cancer
- reduce excessive expenditure of scarce health resources currently spent on the treatment of cancer of the cervix (Department of Health 2000: 22).

2.7.5 Breast Cancer Screening

Breast cancer has become one of the deadly concerns of women world wide. There is an urgent need for concerted effort to increase awareness of breast cancer amongst women. This programme aims at:

- creating awareness of breast cancer amongst the general public
- providing women with skills for breast self-examination

- encouraging women to seek professional help as soon as any abnormalities are detected.

Breast self-examination is a screening method that enables women to become familiar with the feel of their breasts. The significance of this method is that it can identify changes earlier and thus enable early medical intervention. Studies have shown that between eighty to ninety percent (80-90%) of cases of breast cancer are self diagnosed (Department of Health 2000: 23).

2.7.6 Antenatal Care

The policy to care for women during pregnancy is to ensure the possible best outcomes for pregnant women and their unborn babies. This is achievable through the best physical and psychological preparation of the mother before the delivery of her baby. Due to the HIV/AIDS epidemic, this service now includes other care services such as Prevention of Mother to Child Transmission (PMTCT) and Voluntary Counselling and Testing (VCT). These services present an opportunity for HIV/AIDS testing ideally before pregnancy, but especially during pregnancy. Counselling on available options include adoption, termination of pregnancy and infant feeding choices (Department of Health 2000: 24).

2.7.7 Voluntary Counselling and Testing (VCT)

According to the Women's Health Directorate, this programme is implemented to encourage sexually active people, especially those planning to have children to ascertain their HIV/AIDS status. Awareness is raised on the benefits of such a choice. These benefits include:

- making informed decision regarding the knowledge of their HIV/AIDS status as ensuring that you do not infect others, and practicing a healthy life-style and eating habits
- if found to be HIV negative, protecting that status by engaging in safe sex life-style
- making informed decisions on whether to keep the pregnancy or terminate it
- being fully aware of the risks and benefits involved

- counsellors and other workers offering support at VCT sites, as they should, treat clients with respect and confidentiality (Department of Health 2000: 25).

2.7.8 Genetic Services

Women are advised to attend antenatal care clinics early in their pregnancy to enable the early detection of any genetic disorders or congenital conditions such as Down's syndrome or Albinism. In this sense they will be able to receive counselling regarding special care involved in raising children born with such conditions (Department of Health 2000: 26). The objectives of these services are to:

- ensure that appropriate services are available at all levels for children with genetic challenges
- provide expert advice, help and support for affected families
- initiate primary prevention programmes.

2.7.9 Mother and Baby Friendly Initiative (MBFI)

MBFI has been implemented to encourage women to exclusively breastfeed their children up to the age of six (6) months before introducing solids; and to continue until the child is two (2) years old. If the mother is HIV positive, she needs the advice of a health worker before taking a decision on the feeding choice. The project aims to increase the rate of exclusive breast feeding of children up to six (6) months at least by ten percent (10%). The benefits of such advised feeding method are also promoted (Department of Health 2000: 26).

2.7.10 Nutrition Development Project

This project specifically targets women and children, especially those unemployed and/or poor. Its main aims are to:

- promote self reliance and improve household food security, and to promote nutrition education
- focus on the relationship between nutrition and growth or development

- allow growth monitoring and promotion
- promote healthy growth of children under the age of six (6)
- empower women on how to look after their children so that they develop as healthy individuals.

2.7.11 Youth Friendly Services

These are designed to promote responsible and healthy reproductive and sexual behaviours, or sexual abstinence, among adolescents and youth. This entails the reduction of the number of incidents of teenage pregnancy, abortion and sexually transmitted infections, including HIV/AIDS. A life skills provision strategy is employed to implement this. The training content includes sex and gender sensitive education. Some of the services offered in this regard are:

- free distribution of contraceptives, including condoms, to all those who are sexually active
- a youth helpline for peer counselling and the development of peer education programmes (Department of Health 2000: 30).

Although such elaborative women's health programme should be appreciated, there are still persistent patterns that continue to undermine the quality of women's health. These affect the progress towards attaining and maintaining acceptable levels of good holistic health care. Policy makers and public health experts still narrow the conceptualisation of women's health in terms of maternal and child health care. There are concerning realities as the high prevalence of HIV/AIDS among women and related high mortality rates undermine most initiatives meant to stabilize the system in South Africa.

2.8 SPECIFICS OF IMMIGRANTS' HEALTH

From the global health perspective, immigrants and refugees of all kinds bring with them diverse epidemiological profiles based on the different environments and endemics of diseases in their areas of origin. Some researchers argue that the illness patterns presented by immigrants are the direct result of their migration experiences.

Kemp and Rasbridge (2004: 5-16) are of the opinion that apart from the epidemiology, the study of health among refugees and other immigrants is a study on culture. They explain that while illness and disease may be universal, the definition of health, interpretation of symptoms, remedies and treatments to promote and restore health are very much culturally defined.

There is subsequently no universal standard of care or screening procedure for the newly arrived refugees. As previously mentioned, in some countries, people come into contact with medical services at entry points of the country they seek asylum from or at transit points where medical check-up is a compulsory part of the orientation programme. This applies mostly to European countries. In America such services are provided by case workers assigned such duties on behalf of the state as refugees are expected to do health screening before entering the American borders. Countries that utilise the refugee transit centres have proven to have better immigrant health outcomes as they can immediately identify communicable diseases that pose public health risks. They can also eliminate health-related barriers towards enhancing adaptation. In some countries, official documentation on immunization, physical report, declaration of mental disorders and addiction reports are required (Global Health Watch 2005: 98).

There are general and specific guides used during the health screening of immigrants and refugees in terms of the global health risks. The specific guides are those specific processes followed by countries for health screening of refugees and other immigrants. According to Global Health Watch (2005: 101) global communicable diseases of public health significance to be tested for in most countries include:

- Tuberculosis
- Human Immuno Deficiency Virus
- Syphilis
- Chancroid
- Gonorrhoea
- Granuloma inguinale
- Hansen's disease.

According to Kemp and Rasbridge (2004: 20), the global guidelines of conditions immigrants have to test for include:

- Malnutrition
- Intestinal parasites
- Hepatitis B
- Tuberculosis
- Dental caries
- Malaria
- Sexually Transmitted Infections
- Human Immuno Deficiency Virus
- Diarrhoeal diseases
- Post Traumatic Stress Disorders
- Rheumatic heart disease.

Domestic or preliminary screening would be efficient if it was conducted at the country of origin, before departure for the new country (of asylum). In other countries this involves submitting a short history and report of vital signs of the condition, test results of sexually transmitted infections as well as proof of TB treatment at entry. These tests are commonly conducted by the local health department agencies such as clinics within the community (Global Health Watch 2005: 101).

According to the admission requirements of the South African Department of Home Affairs, the admissions officer may require the immigrant to submit to a medical examination. This should be certified by a qualified health practitioner designated by the director general of the department if there is reason to suspect that the applicant is infected or is a carrier of any of the diseases or viruses contemplated in Regulation 24 (1). In terms of the Study Permit Requirements, section 10 (d) specifically demands submission of a medical and a radiological report, section 10 (f) thereof stipulates the requirement of yellow vaccination certificate, and section 10 (h) requires proof of a medical scheme in terms of the Medical Schemes Act No 131 of 1998. The operational definition of a medical report in this regard refers to a written report by a medical practitioner with reference to the applicant's general state of health. The medical report should detail any medical condition that the applicant

suffers from. Such a report shall not be older than six (6) months at the time of its submission (Department of Home Affairs 2007: 4).

With regard to immigrant women's health, a Treaty Permit demands the same requirements as a Study Permit, but specifically stipulates an exemption for pregnant women from taking the radiological examination (Department of Home Affairs 2007: 6). Although "health" as a concept is relative; however, research points to the fact that the health of immigrants, especially the newly arrived refugees, is less optimal. This applies significantly to refugees from countries characterized by high records of disease prevalence and short life expectancy.

Kemp and Rasbridge (2004: 28) assert that the health issues of immigrants are much complex in that their original health profiles may change along a hypothetical continuum. They may range from an acute phase, where illnesses mostly result as antecedent factors for resettlement, through to the chronic level, where the quality of health conditions is largely due to long-term resettlement issues.

Table 2.1: Representation of the Refugee Health Hypothetical Continuum

Level I: Acute Phase	Level II: Transition	Level III: Chronic
<ul style="list-style-type: none"> - Mainly to do with new arrivals - High communicable nature of illnesses - Public health threat - Characterised by past stressors such as war, flight - Evident psychological distress as poor social support - Records: parasitism, montoux (test) skin positive, hepatitis B, C and D. 	<ul style="list-style-type: none"> - Experienced three to six years after arrival - Some integration has taken place - Health concerns focused on children and later shifted to adults - Emergence of significant health problems as hypertension, diabetes and goitre - There is denial of psychological distress. 	<ul style="list-style-type: none"> - Occurs ten or more years after settlement - Experienced by those who have not been assimilated - Refugees live in isolated enclaves, little social support, poor socio-economic conditions, less access to health and therefore poor health.

Adapted from: Kemp 2004: 10

2.8.1 Psychological Impact of Immigration

Mental health is another area that needs to be dealt with when treating health matters of immigrants. Post Traumatic Disorder (PTSD) and depression are common (Kemp & Rasbridge 2004: 13). This is noticeable in the habits that form as attempts to deal with the problems faced. Examples of such habits are withdrawals, heavy alcohol drinking and smoking. A lack of economic stability, basic human needs and access to social support accelerates the impact of stress on individuals.

Mental health status, however, varies according to one's circumstances and personal experiences of immigration. The reasons for leaving home, how one left (for example, were there proper preparations?), the mode of transport used, conditions of the travel, length of travel, circumstances at transit zones and reception at the new country are important. Kemp and Rasbridge (2004: 20) remark that immigrants often experience "sadness from losing their sense of place". The understanding of trauma and its outcomes requires the comprehension of the social and cultural dimensions of the phenomenon. Immigrants' compromised mental health occurs as a major health concern after immigration. Related mental health problems observed and reported include tension, stress, depression, loneliness, and withdrawal. Physically, these people experience back-pains, long-lasting frequent headaches, joint pains, fatigue, insomnia, anxiety, panic attacks and a lack of appetite.

In some cases, immigrants do have histories of previous mental health problems that have been brought to a manageable status for a while. These are often triggered by the enormous pressure and stress experienced either during pre-immigration period, at refugee camps or in the settlement phase. Stewart and Do (2003: 249) refer to longstanding evidence to indicate that immigrants from lower socio-economic backgrounds have higher rates of mental health problems than those from higher socio-economic groups.

Locally, specific discourses of suffering framed by cultural beliefs, social practices, and historical experiences were also depicted. In this case, affected immigrants' recovery depends on their coping strategies and survival tactics which fundamentally

shape their socio-historical experiences and limit possibilities contained in the recovery environment (Stewart & Do 2003: 252).

As already mentioned, it is important to understand the health of immigrants by also recognising the health and medical systems they come from. This should be in addition to the many non-western approaches practiced across the globe. Many people from countries in the sub-Saharan Africa rely on ethno-medicines. These are beliefs and practices relating to diseases which are products of indigenous cultural development and are not explicitly derived from conceptual frameworks of modern medicine (National Centre for Complementary Alternative Medicine 2002: 214). The National Centre for Complementary Alternative Medicine (NCCAM) classifies these therapies into the following five (5) major categories:

2.8.1.1 *Mind-Body Interventions*

These use a variety of techniques designed to enhance the mind's capacity to influence the bodily functioning. Examples include meditation, dance and prayer.

2.8.1.2 *Biologically-based therapies*

They use substances found in nature such as herbs and food. Lately, there are claims of some animal parts usable for cure. However, they still need to be scientifically proven fit for human consumption.

2.8.1.3 *Manipulative and body-based methods*

They are based on the manipulation and/or movement of one or more parts of the body. Examples here include chiropractic manipulation and massage.

2.8.1.4 *Energy therapies*

These use what are believed to be energy fields of our bodies, and are conducted by the practitioner.

2.8.1.5 *Alternative Medical Systems*

Alternative medical systems are built upon complete systems of theory and practice which have evolved earlier and have developed apart from western conventional medicines. Relevant examples of these systems would include (i) traditional Chinese medicine and (ii) Indian systems of Ayurveda. Most traditional societies interpret mental illnesses as afflictions. They use different local terms to identify these illnesses, conditions and other disorders. In most cases are linked to spiritual or super-natural causes. It is in this respect that they are understood not to be medically treatable or curable by western means. Immigrants in a new country would only consider consultation with a psychologist or psychiatrist when their preferred methods have failed. Some would consider consultation if advised to do so by someone trusted from their home country. Frequently, mental health cases commonly experienced by immigrants are treatable and manageable if the right intervention is sought on time (National Centre for Complimentary Alternative Medicine 2002: 216).

2.9 THE ROLE OF THE UNITED NATIONS HIGH COMMISSIONER OF REFUGEES IN SOUTH AFRICA

The United Nations High Commissioner of Refugees (UNHCR) was established by the UN in 1951. Their main function is to provide international protection to refugees and to provide durable solutions to their problems. The UNHCR was mandated to deal with refugee problems around the world through the 1951 Convention, which was amended in 1967. The OAU (now AU) Convention of 1969 was produced as a cornerstone of the UNHCR operations in Africa, addressing many refugees' struggles in many African countries (United Nations High Commission for Refugees 2000: 12). In Africa, their main function today is to protect and organise material assistance for refugees in their host countries.

As part of its mandate, the UNHCR has to care for all refugees, especially women whom it regards as the majority and the most vulnerable. It is recorded that eighty percent (80%) of them travel with children. The intention of the UNHCR is to protect and help refugee women integrate with the host communities. It has a consolidated

responsibility to protect and promote the rights of refugees and asylum seekers. It is the responsibility of the UNHCR to see to it that immigrants are not returned to their countries of origin unlawfully. It has to encourage countries to respect, follow and implement international laws that they are signatories to and all applicable regulations regarding refugees. This body also helps to re-unite families who were separated when in flight during crisis (United Nations High Commission for Refugees 2000: 18).

Some of the strategies that the UNHCR applies in order to ensure that refugees lead normal lives include voluntary repatriation, whereby refugees wishing to go back home are assisted to do so provided their safety is ascertained. They support local integration whereby refugees and asylum seekers are assisted to adjust to life in the new country with the agreement and support of the host country. Resettlement is another option through which refugees who face security risk at their own countries can be resettled in the country they are seeking asylum from (United Nations High Commission for Refugees 2000: 20).

In November 1989, the UN passed a resolution which stated that all UN members must adopt all necessary measures to ensure appropriate and post natal health care to mothers (United Nations Development Fund for Women 2002: 62). After 1994, through the encouragement of the UNHCR, South Africa ratified a few international instruments relating to refugees. These included the 1951 Convention of the Status of Refugees, the 1967 Protocol and the 1969 OAU (now AU) Convention Governing the Specific Aspects of Refugee Problems in Africa. This commitment obliged South Africa to abide by and implement international law and set standards protecting refugees internationally.

April 2000 saw the coming into effect of the Refugee Act 130 of 1998, which ensures refugees' and asylum seekers' protection in South Africa by law. According to the Constitution of South Africa, refugees within the country are to enjoy almost all the rights granted to the citizens (United Nations High Commission for Refugees 2008: 9). The UNHCR in South Africa therefore lobbies and advocates for the rights of refugees in South Africa, for an improved quality of life, assisting the government in protection, and effective handling of asylum seekers' applications.

The UNHCR in South Africa is also committed to providing training on refugee laws to government immigration officials, the police and legal counsellors. It also works with NGO's involved in this area. The UNHCR was involved in the Roll Back Xenophobia Project, a campaign that produced reading materials containing information about refugees and their rights. The aim of the project was to curb xenophobia among native citizens. This initiative was also aimed at forging partnerships between refugees and the locals in order to encourage mutual understanding (United Nations High Commission for Refugees 2008: 13). The UNHCR continues to work towards fostering respect for immigrants among South Africans and protecting the human dignity of non-South Africans. The impact of this initiative on easing the plight of refugees in South Africa may be said to be visible, commendable and even successful. The desire on the part of the UNHCR to encourage the South African government to consider this issue seriously, and influence the political will has so far proven to have worked positively.

However, the need to change the attitudes of South African nationals still remains a huge challenge. They should work to shift their minds towards understanding, empathy and acceptance of the reality that there will always be immigrants and that the refugees amongst us need to be provided for. In the June 2006 statistics, South Africa was reported to be hosting twenty-nine thousand (29 000) recognised refugees and hundred and ten thousand (110 000) asylum seekers (Relief Web 2007: 9).

It is crucial for South Africans to realize that the massive escalation in the number of immigrants in South Africa since 1994 is directly attributed to the political changes that have occurred in the country. In addition, South Africa's participation and contribution in the global context are other contributing factors. The rest of Africa's hope was revived by the democratic dispensation achieved by South Africa as a country. They rightfully claimed this achievement as their own victory as many African countries had contributed in many ways to the liberation of the people of South Africa from apartheid. Problems around illegal immigration have to be treated within the regional historical context. Political instabilities, economic crises, poverty, drained resources, lawlessness and many other such debilitating factors in the region today have to be well-managed (Solomon 2003: 37).

With the new government, the “Law and Order” type of management of South African migration system became irrelevant. It became more important to introduce a human rights-sensitive approach that would acknowledge the existence of immigrants among the nationals. The evident existence of xenophobia in the country challenges the government to intensely devise strategies that would affirm the security of its nationals and also protect the basic human rights of immigrants. South Africa has a legal obligation to safeguard the wellbeing of all the people living within its borders in terms of the UN Declarations and Conventions it has ratified (Populations Reference Bureau 2006: 2).

One of the ways to lead immigrants towards holistic wellbeing and productive functioning is to put in place programmes meant to restore their health. It is, therefore, important for the South African government to identify the health problems of immigrants in order to be able to create mechanisms to deal with them. This will make it easier for them to provide relevant strategies and resources according to identified needs. The provision of immigrant women’s health needs as a gender-specific requirement should be integrated with the already existing programme of the National Health Department’s Women’s Health Care in order to gain effective outputs.

2.9 CONCLUSION

The process of literature review involved clarifying what is already known in the field regarding the research theme. The review dealt with factors affecting the lives of immigrant women in South Africa such as the implications of the South African Immigration Bill, the gender perspective and the abuse of women immigrants, amongst others. The role of South Africa as a host nation or country was looked at, including issues of xenophobia. The women’ health programme offered by the Women’s Health Directorate in the National Department of Health was also discussed.

This chapter reviewed some of the work already done concerning the literature in the area under investigation. It also considered the various health programmes offered

by South Africa as regards women immigrants. The next chapter will focus on the theoretical framework designed for this study.

CHAPTER 3

THEORETICAL FRAMEWORK

3.1 INTRODUCTION

In research, conceptual frameworks and models are mostly employed in grammatical representations of theories or concepts to guide the research. Theoretical frameworks are better suited for studies based on a specific identified theory. They are developed from theories, quantitative or qualitative, and the author's personal experiences and values (Grinnell 1998:227). In qualitative studies such as this, concepts and theories are used to assist in testing the existing paradigms in the specific area of study, and to determine where this particular study fits within the existing body of knowledge. This chapter will thus discuss some of the models and theories in order to locate this study within a theoretical framework.

3.1.1 Health-Seeking Model

The increase in global migration over the years has produced sound research in the general area of migration and in some specific related to this area. Some of these issues were discussed in the previous chapter. A number of theories have emerged in an attempt to explain some dimensions involved in immigrant or refugee service-rendering, including social and health services (Green & Thorgood 2004: 38).

Health-related decision making and health-seeking initiatives are key themes in health-seeking models. Family structure, age, gender, health belief and practice are best used as parts of the matrix of an understanding that includes all determinants of decision-making. This includes help-seeking initiatives related to illness, disease, prevention and health promotion (Kemp & Rasbridge 2004: 84). Some of the related factors are:

- Attitudes, belief and personal characteristics, including socio- economic status of the individual.
- The individual's culture and social networks, especially the family.

- Past and present personal and social network experiences in health and illness.
- Characteristics and competency of health care systems and individuals within the systems as they interact with the individuals and populations.

According to this model, the health of migrants is highly influenced by the reasons and conditions of migration. The migrants' experiences of social and cultural changes concomitant with migration also play a part in this regard. Their proven low use of health facilities and delays in seeking medical treatment and other health-seeking behaviour are likely to be influenced by their beliefs and cultures. Their decision to use health services in the new country is found to be based on the nature of the illness, the effectiveness of the treatment and costs involved (Kemp & Rasbridge 2004: 90).

Previous experiences with the health care providers are influential in decision-making. Communication barriers as identified in almost all studies in this area also contribute to immigrant women's lack of understanding of health information and the proper use of services.

3.1.2 Community Preventative Health Model

This model holds the premise that the provision of preventative health information to the community is a priority for health promotion programmes. It emphasises that the immigrant women's perception of the need for self-awareness about health problems should motivate them to seek more information (Edelman & Mandel 2002: 104).

In dealing with underserved groups such as immigrant women, bridging the gap between efficacy and effectiveness in health promotion initiatives could be a challenge, especially when aiming at reaching this specific group. Some immigrants avoid medical visits because of the self perception that they are healthy. Ahmad *et al* (2004: 53) argue that the "healthy immigrant effect" is naturally lost over time. The need to convey continuous effective preventative health messages to immigrant populations is crucial, especially at the intersection of gender, ethnicity and culture. Immigrant women do not easily yield to standard health preventative or promotion

messages or information, because of their focus on newly-found multiple roles in the new context.

It is the researcher's view that there is an evident lack of recorded in-depth scientific accounts on the health issues of immigrant women in South Africa. This may be interpreted as suggesting that not much is known by host countries about the experiences and perceptions of immigrant women. The impression is that not much is known regarding the effective means of promoting their health, interpretation of health information and, therefore, the use of preventive health care services.

3.1.3 Integration Theory

In this context, integration is understood as meaning that immigrants can gain access to mainstream services. However, these services are not aligned or restructured towards removing elements that may be barriers for non-natives. Observers of this theory assert that the conditions of refugees exacerbate poverty and ill health among female refugee-headed households. They emphasise that adequate promotion of the health of these women would also enhance the welfare of their families (Appleyard 1997: 165).

All methods of integration assume some form of assimilation of the immigrant into the mainstream structures and dominant cultures. It is important to note that these structures and cultures generally remain unchanged. Popular integration assistance takes the form of counselling, health education and the need for income-generating facilities as well as effective services (Appleyard 1997: 169). The author stresses that integration programmes continue to be a burden on most developing countries' governments. The inaccessibility of these programmes to refugee women relegates immigrant women to a poor dependant status. Aspects associated with the inaccessibility of such programmes include their irrelevance to immigrant women's immediate problems, design inadequacy and, sometimes, inappropriateness.

In most countries, including South Africa, governments provide health services to immigrants and refugees as part of the generalised national programmes. In some countries, however, there is a formal facilitation plan for the integration of refugees.

Canada is a suitable example in this regard. Special refugee counselling programmes are established to provide mainstreamed guidance to health, social welfare, employment and education. In the strategic manner of implementing this theory, when immigrant women face challenges, they are expected to contact counsellors who would determine the nature of the case and recommend appropriate action. Counselling then becomes a continuing process until the woman is fully integrated into the host community and systems (Council of Europe 1995: 68). It is in this regard that South Africa falls short in its effort to integrate immigrants into local communities.

3.1.4 Cultural Competence Framework

Cultural competence is defined as the ability to perform and obtain clinical outcomes in cross-cultural encounters (Kemp & Rasbridge 2004: 102). According to this framework, cultural competence in the health care sector is of profound importance on several levels. It refers to the sensitivity to the customs of others, and conveying respect. With sincere human/client respect, compliance to medical instructions and a medicinal regimen is found to automatically follow.

This theoretical framework identifies two related sets of competencies: (i) generic competence and (ii) specific competence. Generic competence is localised knowledge and skills applicable to a patient or community across the cultural barrier. This type is gained through involvement in cross-cultural encounters, seeking and learning general knowledge and skills related to cross-cultural health care and maintaining basic attitudes of acknowledgement and openness to other cultures. Kemp and Rasbridge (2004: 99) describe specific cultural competence as knowledge and skills possessed, and are applicable to patients and communities from specific cultural backgrounds. This type of competency can be gained by the local service provider through learning about other cultures from the participant/observer environment. Observation and learning from literature and personal or other professional exposure also help to expand the knowledge base regarding specific cultures.

Mikhail and Petro-Noustas (2001: 112) further argue that though the use of interpreters is necessary, it is still important for the immigrant's interaction and physical expression to be observed in order to assist in enhancing therapeutic relationships. Although most health care providers think in terms of individual competency, it is equally important for institutions to work towards cultural competence. Research has proven that increased rapport with patients contributed positively towards such an endeavour. Intentionally or unintentionally driving the vulnerable immigrant women population underground because they are made to feel they do not fit in only results in a serious public health problem. This could increase the risks of treatment avoidance, delayed and thus late treatment, mis-diagnosis and a series of complex health problems.

3.1.5 Acculturation Theory

The Social Research Council of the United States of America (SRC)'s describes acculturation as "cultural change that is initiated by the conjunction of two or more autonomous cultural systems" (2008:6).

Acculturative change may be the consequence of direct cultural transmission. It may be derived from non-cultural causes such as ecological or demographic modifications induced by an impinging culture or it may be a reactive adaptation of traditional modes of life. Its dynamics can be seen as the selective adaptation of value systems, the process of integration and consequences and the operation of role determinants and personality factors (Tseng-Wen-Shung 2001: 105).

According to acculturation situations, cultural contact does not result from a dominant culture impinging upon an indigenous culture. There are acculturative changes which result from a process of migration from one culture to another. Acculturation changes may even take place among temporary residents, and importantly, it is different from assimilation. Assimilation is the complete loss of original ethnic identity of an individual or community/group, leading to absorption into the dominant culture (Social Research Council 2008: 8).

Tseng-Wen-Shung (2001: 107) sees acculturation as a gradual process symbolized by concrete objects such as tools, utensils and ornaments. These are generally the first things adopted by newcomers to any culture. In the health sector, high-tech equipment such as X-rays and digital thermometers would be examples of concrete objects used every day by medical professionals, which most immigrants from under-developed societies would come into contact with for the first time in their host country.

The transfer of elements such as behaviour takes longer to change after exposure. Tseng-Wen-Shung (2001: 108) states that acculturation is not a conscious process, and further points out that immigrants living in South Africa are often unaware of it. It is the degree to which they have adopted South African ways of life until they return to their original homes after having lived in South Africa for several years. It is important to note that acculturation is not necessarily a co-existence of positive personal adjustment or vice-versa, even though it is in essence, a process of learning and adjusting for the individuals involved.

3.1.6 Social Cohesion Theoretical Framework

Mulemfo (2007: 1) defines social cohesion as a process through which people from different demographic backgrounds join hands in creating an environment of healthy interpersonal relationships through acceptance, understanding, respect, trust and dialogue. Immigrant associations may play a significant role in facilitating the initial adjustment. They may exert influence through acting in a representative capacity in negotiations with government authorities. Social cohesion of an immigrant group such as immigrant women will depend on a number of factors amongst which, their population size is significant. Other factors include (i) institutional competence and the functionality of existing structures, and (ii) the response and commitment of the governments and relevant departments. Concerned NGOs and international organisations catering for the special needs of immigrant women have to be able to work together to uplift immigrants' quality of life.

Of significance in this approach is the number of immigrants. Their interests and the effectiveness of their organisations in mobilising support for action are also important.

Governments and humanitarian aid organisations argue that it is economically and logistically not viable to design and provide special programmes and services to small numbers of beneficiaries in already set communities. However, prejudice from host societies may be a disadvantaging factor in the sense of exposing immigrants to explicit discrimination in service provision (Mulemfo 2007: 3).

3.1.7 Feminist Analysis

Feminism posits that women preface some form of oppression, devaluation and exploitation. Differences such as race, ethnicity, class, culture, sexual orientation, physical abilities, age, religion and one's own nation placing in the international statistics, contribute towards the creation of conditions of oppression. Thus, immigrant women from third world countries face challenges of "invalidity" in developed countries (Hamilton 1993: 91).

Griffin (1999: 62) states that feminism is by nature a social justice course. It complementarily shares underlying ethical commitments with the Participatory Action Research (PAR) method. This study looks at the analysis of the gendered exclusion towards gender liberation and women empowerment. It builds *praxis* with the belief that the status quo must be overturned for the realization of more liberating conditions. Feminism is committed to expose the courses that sustain the forces of oppression.

Women in general, and feminists in particular, stress that they have always struggled to gain recognition for issues affecting their lives. They always have to work hard to persuade the larger segments of society to understand that the rights of women are repeatedly trampled upon and women are continuously sidelined and eventually silenced. Feminists are vigorously fighting for a democratic social change. Their approaches stress the value of diversity. In focusing on the conditions of under-representation of women such as immigrant women, they reveal the class factors which are the centres of most social theory and social policy. Through academic feminism or activism, routine dealings with oppression and silencing have developed a powerful commitment to listen to and hear the voices of the silenced (Peck 1996: 274).

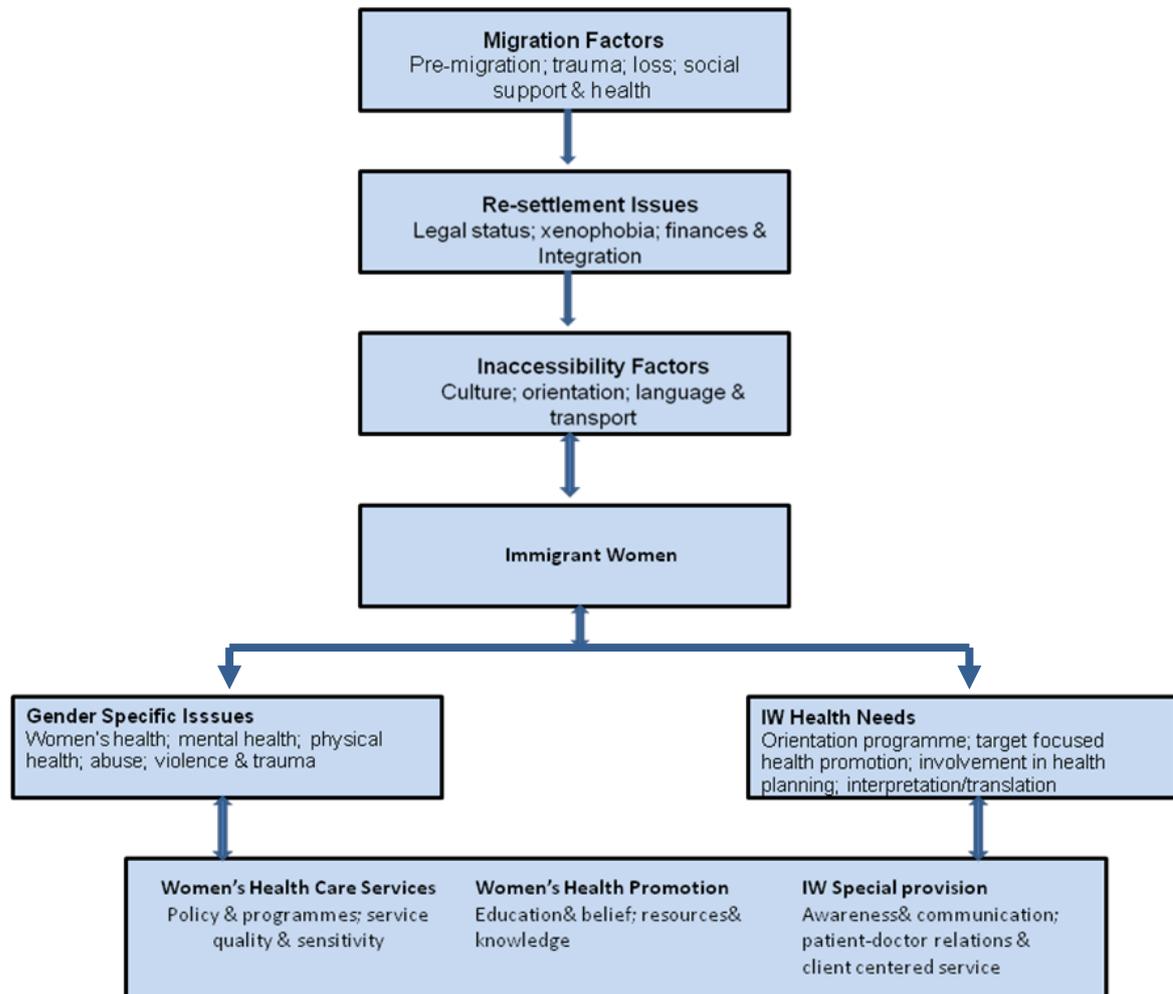
Maguire (1996: 81) articulates her views on the combination of feminist agendas in PAR and the personal experiential dimension inherent in the process. She uses the issues of feminism while focusing on the social problems she is trying to solve. Maguire argues that the very notion of PAR is absurd to imagine without the systematic incorporation of feminist perspectives. She stresses that critical social theory (which encompasses women's holistic health for this study) should press for the politics of empowerment.

3.2 DISCUSSION OF THE THEORETICAL FRAMEWORK

In formulating a theoretical framework, a researcher is allowed to include his/her own experiences and value assumptions as a further basis from which to discuss variables. According to Grinnel (1998: 436), such data might enhance the understanding of why certain variables are emphasised and defined while others are omitted.

The schematic theoretical representation below identifies significant variables in this study, and shows the relationship between these variables in relation to the research topic.

Figure 3.1 Schematic representation of the theoretical framework



3.2.1 Migration Factors

In the different spheres of social and cultural activity, immigrant women are always disregarded. Reasons concerned with why these people had to leave their homes and what most women had to experience on the way affect all immigrants negatively. Reduced social support and the loss of their belongings are some of the general aspects affecting them. Trauma experiences and abuse suffered could directly affect the quality of their health (Peberdy 2005: 87).

3.2.2 Resettlement Issues

Immigrant women have to face the challenges of their new reality and fight to get their legality status in a foreign country (Council of Europe 1995: 52). For instance, they have to deal with prejudice and xenophobia, as well as conduct their affairs in a foreign language under circumstances of no social or adequate financial support. Public authorities who are tasked to implement integration policies are openly critical of the situation. They claim that they have not been provided with the resources to adequately carry out their assignment.

3.2.3 Inaccessibility Factors

Matters relating to methods practiced over a long period are seen as cultural barriers. These include a lack of progressively structured orientation programmes, which could contribute towards solving the language issues. Challenges around gaining access to women's health services and their own specific health needs are some of the factors identified in the framework (De Vos 1998: 102).

3.2.4 Gender-Specific Issues

Women's health care services are meant to pay specialised attention to women's health needs holistically. However, due to entrenched patriarchal systems in every structure, they should be designed not to only look at the bio-chemical functioning of women's bodies. They need to also attend to psycho-emotions, post-traumatic disorders and presumed social roles, especially those of immigrant women (Hamilton 1993: 133).

3.2.5 Women's Health Care Needs

A consideration of these factors encourages a collective self-reflective process. This situation will enable immigrant women, who are participants in this study, to directly identify health needs that could be addressed through the proactive involvement of all relevant government participants to address issues related to purposeful involvement of immigrant women. This process will include them in planning their

intended health programmes. Translation and interpretation services are to be thought of as basic needs to enable both the service provider and the service recipient to relate on a trusted and service-friendly basis (Manderson & Alldey 2003: 59).

3.2.6 Women's Health Care Services

The governments, health policymakers and women's health programme designers in their respective roles need to be cautious in producing umbrella operational means that do not cater for specific groups such as immigrant women. Alexander and La Rosa (2000: 74) point out that it is important to bear in mind that women's health needs are not homogeneous. The authors further advise that when dealing with such needs one has to be practical. It is therefore important to ensure that special provisions are accommodated by all service rendering participants.

3.2.7 Women's Health Promotion

The World Health Organization (2004: 35) defines health promotion as the process of enabling people to increase control over, and to improve, their health. Health promotion is seen as a science and art of helping people change their lifestyle to move towards a state of optimal health. Health promotion can therefore be understood to encompass educational programmes, preventative health services, women-friendly health policies and gender-sensitive community involvement.

It is important for designers and beneficiaries of women's health promotion programmes to operate from an informed point. This is where the use of Participatory Action Research becomes important. PAR enables greater participation and, for instance, openly discusses what looking at a graphic pamphlet addressing feminine health issues in a foreign language means to an immigrant women who is not proficient in the new country's commonly-used language (Payne 1999: 42).

3.2.8 IW Special Provision

This provision largely impresses an educative form of scrutiny into the women's health services rendered by South African service providers to non-South Africans. The aim is to raise awareness of particular challenges and needs of specific communities within the society. The raising of awareness of specific needs, better communication skills and intentionally improved client/doctor relations, as well as concerted effort to provide specific programmes are some of the particles that give measure to the quality of service rendered (Pietila & Vickers 1995: 107).

3.3 APPLIED THEORETICAL FRAMEWORK

Habermas (1990: 98) makes a powerful connection between truth and justice. As a third-generation critical theorist, he observes that the truth can only emerge in settings where all social assertions are equally open to critical scrutiny. Applied to social science, critical theory helps people to understand the ways in which they are shaped by assumptions they take for granted to find ways to transform for the better. Examples of such assumptions are habits, customs, ideology and traditions.

Critical theory has its roots in Marxism and is suitable for use in interdisciplinary studies. It emphasises the role of interpretation in human life through which the subjective experience is seen as reality. This theory acknowledges that everyone has a social location made up of attributes such as gender, race and social class. It is particularly useful as a framework for viewing issues of social policy and systems, as well as discriminatory practices. The theory differs from traditional theory in that it seeks to liberate people from circumstances that oppress or undermine them. Its use is always aimed at explaining and transforming these circumstances. In essence, critical theory provides the descriptive and normative bases for social impurity, and aims at decreasing domination and increasing freedom in all forms. It has the ability to interrogate the ideology of the society and critiquing it by comparing it with the social reality of the very society (Critical Theories & Marxism 2007). In terms of this theory, the task of the researcher has three important dimensions:

- To understand the ideologically distorted subjective situation.

- To explore the forces that caused that situation.
- To show that these forces can be overcome through awareness on the part of the disadvantaged or oppressed individuals or groups in question.

In using critical theory, this study adheres to the pre-set criteria for the optimal use of the theory as listed in Habermas (1990: 105):

3.3.1 Explanatory Aspect

- This has been addressed in the sense that the researcher would explain the existing situation of immigrant women trying to gain access to and use women's health services in South African health facilities (that is, their reception and general treatment by authorities and civil society).

3.3.2 Practical Aspect

The practical element was satisfied thus:

- Group discussions were held with immigrant women themselves and women's health professionals to identify existing limitations and needs.
- Follow-up interviews were conducted with individual participants.
- Health promoters were invited to inform immigrant women about available services, access and related service system (Habermas 1990: 108).

3.3.3 Normative Aspect

This aspect was addressed through:

- Seeking ways to assist in transforming the existing methods.
- The involvement of health professionals aimed at raising their awareness and hoping this has a positive ripple effect.
- Participant immigrant women's will to pass on acquired information and is meant to work towards mind a shift among the wider immigrant women community (Habermas 1990: 108).

This theory is not verified by experimental tests. However, through action on the part of the participants with the assistance of the researcher, it has been found, upon reflection, that a good account of their suffering or challenges has effectively pointed to their relief. Another given advantage of using critical theory is that it allows self-reflection on the part of both the research participants and the researcher. When used in an interdisciplinary atmosphere, critical theory can open up new hybrid spaces, allow more research opportunities and negotiation between traditional disciplines and investigation of complex contemporary issues (Greenwood & Levin 2007: 58).

3.4 CONCLUSION

Theories discussed in this chapter originated from a variety of disciplines including sociology, gender studies, and anthropology, demography and health sciences. The fact that these theories by nature have evolved separately as founded in different disciplines, complicates their comparison and analysis. A major criticism of such a pool of theories is that no single theory offers direct and complete explanation for immigrant women's health phenomena.

Of most importance to this study is the acknowledgement that the very interdisciplinary character of this study is not only inherent to this type of work, but also crucial. In essence, all reviewed theories converge on the point that immigrants' adaptation is a complex behavioural process that can be influenced by (i) the transitional experiences (in moving from one country to the other), (ii) characteristics of migrants themselves and (iii) conditions in the host countries. Immigrants' adaptation as a multi-dimensional process has the following characteristics: the well-being of immigrant women interacts with other situational factors such as social integration, personal satisfaction and the degree of self-identification with the new country.

The use of critical theory distinctly increases our awareness of the political nature of the social phenomenon of discrimination against immigrant women, inaccessibility to women's health care services and their specific health needs. It also enables the researcher to develop the ability to reflect critically upon applicable realities taken for

granted by those not marginalised. This chapter has depicted the theoretical framework on which this study is based. The research methodology adopted for this study will be presented in the next chapter.

CHAPTER 4

RESEARCH DESIGN

4.1 INTRODUCTION

This chapter deals with the research design adopted in the study. Participatory Action Research (PAR) has been applied as a research method because its main concern is to direct efforts towards improving the existing situation. PAR extends understanding of the existing problems, produces increased knowledge and formulates action towards resolving identified problematic issues. In its nature, PAR harnesses a variety of different techniques to qualitatively interpret progress made through the research process. PAR does not seek to qualify and measure the effects by laboratory-influenced methods, but rather, strongly acknowledges the value of human research activity. It is understood as a collaborative approach to enquiry that provides people with the means to take systematic action to resolve specific problems (Morton- Cooper 2000: 12).

4.1.1 Utilisation of Participatory Action Research

The critically reflexive forms inherent in PAR challenge the status quo in culture-bound structures, practices and opinions. It is thus based on action and participative-collaborative forms of data collection. Its focus is not only about developing praxis or practice, but also about critiquing and influencing shifts in paradigms and views. PAR is therefore problem-sensing and problem-focused with the aim of realising the ideal. Its top-down hierarchical model of research defines it as a way of integrating practice with research in a single act as the researcher progresses (Heron & Reason 2001: 65).

Participatory Action Research (PAR) was adopted in this study, because it offers gender researchers a greater awareness of a variety of interventions and group process techniques developed in the collaborative inquiry. It helps to harness commitment to activism. In the case of this study it is aimed to harness women's development theory towards social change (Morton-Cooper 2000: 41).

PAR aims at producing knowledge and action directly useful to the situation of the study participants. It is particularly relevant for this study because it has an awareness-raising quality that gives it the ability to empower people or participants for their own benefit. As a strategy, it uses all tools that researchers may find helpful. It is a pragmatic combination of analysis and techniques for linking elements of participation and research in concrete situations. Greenwood and Levin (2007: 92) assert that "we do not need fewer and purer tools, but more diverse approaches to meet the challenges of inequality and oppression".

PAR is important in developing an alternative system of knowledge production. This should, however, be based on the people's role of setting the agenda, participating in data-gathering and analysis, as well as controlling the use of the outcomes. It would emphasize the emergent processes of collaboration and dialogue which empower, motivate and increase self-esteem, and develop community solidarity (Reason & Bradbury 2001: 79).

This method (PAR) can identify common themes in participants' experiences through dialogue, and allows them space to validate each other while, at the same time, creating shared meaning. It is through the shared meaning that participants find their sense of identity legitimized. Stringer and Genat (2004: 15) maintain that PAR derives from a research tradition that emphasizes dynamic approaches to investigations that are reflective, participatory, cyclical, focused (on understanding), as well as change and community oriented.

Heron and Reason (2001: 68) point out that Participatory Action Research is grounded on four ways of knowing: experiential, presentational, propositional and practical.

4.1.1.1 *Experiential knowing*

This means the researcher's direct encounter with some entity, person, place, process, thing or energy. The encounter generally occurs through participation, feeling and imagining the presence of that entity.

4.1.1.2 Presentational knowing

This is grounded on images from experiential knowing, and described as an intuitive grasp of the significance of the experience of one's own world. It is symbolized in graphic, musical, vocal, and verbal art forms.

4.1.1.3 Propositional knowing

It is in conceptual terms, a description of reality through statements and various propositions based on presentational forms.

4.1.1.4 Practical knowing

Practical knowing demonstrates a skill of competency and the ability to act in purposive deeds. It is based on the other three forms of knowing, and culminates in the practical skills from action (Heron & Reason 2001: 68).

The intention of PAR is to generate effective solutions to practical problems by engaging the hearts or spirit of the participants. This is done so that the participants can take ownership for their well-being and engage it enthusiastically and creatively. Participants' contributions, experiences and views are valued throughout this process, while de-mystifying the researcher as the sole expert. In this regard, Reason and Bradbury (2001: 11) state that PAR seeks to bring together action and reflection, theory and practice, in participation with others. This happens in the pursuit of practical solutions to issues which are of pressing concern to a group of people.

At the first formal meeting with participants, a guiding frame or plan of research design was constructed as a first step. This frame or plan is a draft picture of the project. It is important at this stage to allow the participants to become involved, and to create space for their interaction, participation, contribution, understanding and ownership. Stringer and Genat (2004: 22) are of the view that this also helps to hold the researcher accountable for the commitments made to the research process as well as to research participants from the early stages of the study. A significant aspect of the plan is that it also helps in refining the details of the activities involved.

In the case of this study, the major steps agreed upon and adopted from Stringer and Genat (2004: 22) were:

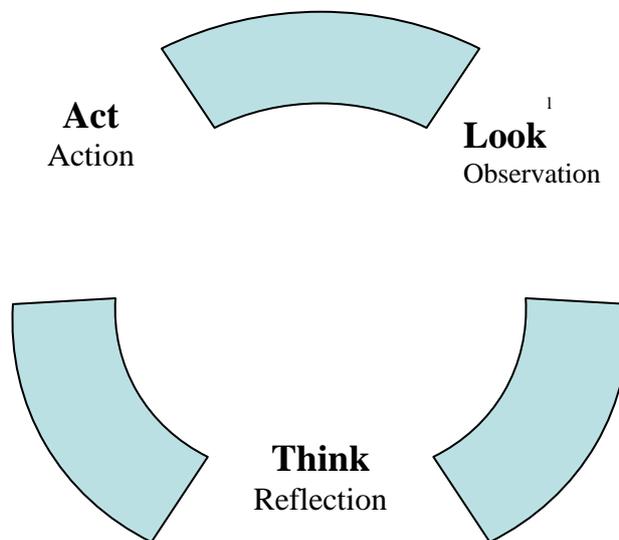
- Building a preliminary picture: this step involves identifying the research problem and the relevant people affected.
- Focusing: the statement of research problem, the research question and objectives are refined at this stage.
- Framing: this stage is focused on establishing the scope of enquiry.
- Sampling: explains the procedure involved in identifying and selecting research participants.
- Sources of information: the participants, stakeholders, sites, settings, records and other relevant sources to be used in the study are identified at this stage.
- Form of information: the type of information to inform the enquiry, interview transcripts, observational records, reviews, summaries and research reports are to be collected and included in the study.
- Data gathering: all materials used in the above mentioned step and all usable equipment are to be listed.
- Data analysis: requires going through and distilling information to identify key features, concepts and meanings through categorization and coding.
- Ethics: all involved should be participating at free will; the researcher should ensure that participants are not exposed to any harm throughout the process and that all steps are explained formally.
- Validity: this refers to the description and explanation of procedures used to enhance the strength of the study. Smith & Hunt (1997:303) describe validity as the degree to which an instrument measures what it is supposed to measure.

4.2 BUILDING THE RESEARCHER'S PICTURE

One of the unique characteristics of PAR is the cyclic nature of its implementation. It constitutes repeated cycles of observation, reflection and action; also known as the Look-Think-Act sequence. The first cycle requires of the researcher to observe (look) for/at relevant settings. In the second cycle, reflection (think) is applied on the observations made at the settings to clarify the exact nature of the research problem.

Thirdly, a plan (act) is outlined, agreed upon and implemented with the selected participants. In the next phase of the cycle, they all “look” again, reviewing the actions they have taken; then they “think” with the intention of evaluating the effectiveness of actions taken, and “act” is exercised as the last phase of this cycle to modify the outcomes as needed, adjusting and extending as necessary (Stringer & Genat 2004: 42). It is through this process that the researcher and participants see and experience the repeated refinement of the study details as represented below:

Figure 4.1 Look-Think-Act Cycle in Action Research



Source: (Stringer & Genat 2004: 42)

4.2.1 Look Stage

This stage builds a preliminary picture of the total situation. The main purpose is to describe who is involved, what, how, where and when are events and activities occurring. Information is at this stage acquired by observing, interacting and communicating informally with participants. In the context of this study, it is observed that immigrant women from the Great Lakes have difficulties in gaining access to health care facilities. The researcher looks at how they are affected by challenges experienced by all users of the health service sector. Investigations on challenges posed by the new environment, language, culture and the consequences of

immigration in general and those which are gender specific are also undertaken (Stringer & Genat 2004: 43).

4.2.2 Think Stage

This is the stage that demands of the researcher to reflect on the emerging picture as the process ensues. In this respect, the analysis of the situation enables the researcher to develop a clearer understanding of occurrences. It gives understanding as to how events take place and notices how the participants are affected by or how they affect the issue (Stringer & Genat 2004: 44).

In practice, the researcher checks the information gained from participants, engages in discussions around the situation and their health status before they left their country or countries of origin. Occurrences that would have influenced the state of health during transit are highlighted, and those encountered at settlement in S.A. are also looked at. Identification and understanding of common patterns and appearances of uniqueness are also pointed out. Matters relating to the understanding of system usage, issues of access, service quality and how these affect immigrant women were fully treated (Stringer & Genat 2004: 44).

4.2.3 Act Stage

This stage brings forth the actions emerging from reflection, and requires plans for the next step and the application of appropriate activity. The cycle appears yet again throughout the levels of the study.

At this level the strategies to resolve the problems are to emerge from the outcomes of the reflection stage. All parties involved participate and negotiate throughout the process to deal with change. As regards this study, the parties would deal with issues around how to help immigrant women access, understand and use women's health care services and facilities, as well as to identify their exact challenges. The awareness and existence of these is brought to the attention of service providers, policymakers and host communities. It is used to encourage self-help and

empowerment exercises among immigrant women to make living in a new country adaptable (Stringer & Genat 2004: 46).

4.3 FOCUSING THE STUDY

The challenge at this level of the study is identifying where the study should actually begin. This aspect is compounded by the fact that the immigrant community this study deals with has problems which are very intricately connected. In most studies that deal with immigrants' health issues, their health problems are often associated with poor diet, inadequate living conditions and their own cultural arrangements. Matters of defining clear cause and effect in this relationship are not left as evident or given as simplistic (Stringer & Genat 2004: 67).

The "how" question helps the researcher to move towards the objective of the study. It is important for the researcher to understand how the research participants understand the problematic issue from their own perspective. The researcher thus needs to understand how immigrant women, as participants, interpret events. This should include their interpretation of pre-participation and post-participation information. The "how" question looks at how immigrant women can assist the health care practitioners to render better health care services from an informed position, with an understanding of their (immigrant women's) health care needs (Stringer & Genat 2004: 67).

Developing a clear, precise and focused research question is critical for it assists the parties involved to consider essential reference during their enquiry as they evaluate all emerging data. The Look-Think-Act cycle is a profound strength of PAR mainly because it allows the researcher to identify the problem, refine or reframe the research question with absolute consideration, and to respect the context of the participants (Stringer & Genat 2004: 69). In dealing with immigrant women, issues around intrusion of their privacy, personal and family lives, personal health history, living conditions and language skills are to be treated with sensitivity as these are crucial in focusing the study. These factors contribute to the observation and reflection on the part of the researcher. The result of this is that the engagement and interactive thinking of the researcher and the participants are enhanced. The Issue

Problem Question Objective (IPQO) was useful in clearly stating the basis of this study.

Table 4.1: IPQO process in focusing the research study

Issue	Issue/topic to be studied: defining which issues exactly cause concern	Immigrant women face challenges in accessing health care services in S.A. as well as understanding health promotion messages and thus avoid using these services.
Problem	Research problem: stating the issue as a problem	Health care service providers are unaware of IW's specific health care needs.
Question	Research question: reframing the problem in question form, asking, in fact, "what is happening?"	How do IW in S.A. understand health care services and related programmes available.
Objective	Research objective: Describing what we hope to achieve by the study	To know specific health care needs of IW in S.A; to empower them to access, use and trust these services; to raise the awareness of professional women's health care practitioners.

Source: Adapted from (Stringer & Genat 2004)

4.4 FRAMING THE STUDY

Albertse (2007: 37) states that through the process of framing, the researcher starts to consider the breadth of the study; thereby deciding which issues are important to be incorporated as data emerges. It is important to trim the scope of issues to a realistically manageable size. The researcher has to be conscious of this at the beginning of, as well as during the research process in order to avoid complicating or restricting the study. The researcher needs to continue asking questions and deciding on matters of “who, where, when and what” in order to develop a functioning strategy of managing the process. The following table was used to help frame the study:

Table 4.2: Study Framing Table

Who	Identify most relevant participants who are affected by the issue under study and who can benefit from participation and contribute towards positive outcomes.	Immigrant women from the African Great Lakes region living in South Africa can benefit from participating in the study and overcome their health services access challenges.
Where	Agree on the place of research, where it is likely to take place and which other places could be used or visited (homes, private clinics and public hospitals, church hall).	Immigrant women participants in this study will meet at the agreed venue, the church in the inner city for focus group meetings. Follow-up individual interviews will be conducted at venues convenient to them.
When	Think of and plan around the expected duration of the study and when is it likely to begin and finish. Determination of suitable length and specific time frames for focus group sessions and individual interviews needs to be taken care of.	Scheduled time-tables for focus group meetings and individual interviews will be adhered to. If necessity to change the planned schedules arises, alternative times can be arranged to suit all involved.

The researcher had an opportunity to present a pre-proposal paper on this work at one of the “high noon” sessions of the Institute for Gender Studies-Unisa. This translated into an exercise which could be understood as the stage wherein the conception and definition of the project took place. The participants or attendees of

that session, who were mostly academics and research specialists, helped to frame this study through feedback and critical questions concerning the study plan and the intended methods.

Any important new information was shared with the research participants as the review of literature continued throughout the study. The Look-Think-Act cycle was also continuously repeated as part of the reflection exercise, because it provided new possibilities for better insight, as well as conceptualization and interpretation of the research issues (Rubin & Babbie 1997: 257).

4.5 SAMPLING

Sampling is the selection of a smaller group of people to participate in a study. It serves to provide more information concerning the theme on which the research is grounded. Sampling has the purpose of ensuring that particular assumptions and understandings of people involved in a specific research context are considered in finding effective solutions to the issue under study (Polit & Hungler 1995: 64).

As this study is exploratory, purposive sampling was applied. Data was collected from a few members of the target population, which is a procedure directed towards obtaining a certain type of element. Information known to the researcher and those involved in the research was used to choose people who would best know and understand what the researcher is trying to address (Rubin & Babbie 1997: 266). This type of sampling was chosen to ensure that the diverse relevant perspectives of people likely to affect and be affected by the study are included.

When selecting participants for this study, Stringer & Genat's (2004: 92) guide on selecting participants for research purposes was adopted. They suggest covering a variety of purposes, including:

- Maximal variation: sampling through which people who represent diverse perspectives on any social context are included.
- Extreme case sampling: this method includes extremely troublesome or enlightening representation of people.

- Typical sampling: this involves participants who are regarded as typical of the people in the setting.
- Concept sampling: participants who possess particular knowledge related to the issue under study.

Grinnell (1998: 440) is of the opinion that describing the study's sample and sampling strategy involves specifying the unit of analysis, precise procedure and estimated number of people involved. At the sampling level, the researcher has the responsibility to select a sample of participants who represent a variation of perspectives and experiences across all groups and subgroups affected by the issue under study.

In this study, the sample includes a representative group of immigrant women from the Congo, Democratic Republic of Congo (DRC), Burundi, Rwanda, Tanzania, Kenya and Uganda as the primary stakeholder group. The affecting party in the sample includes women's health professional practitioners (including health promoters and nurses).

Our critical reference group members or primary research participants comprising immigrant women was screened for factors related to a significant variation in experience and perspective, including gender, class and ethnicity. This helped to ensure a fair and adequate representation of social settings. Participants became eager to assist the researcher to identify some of the women they thought should also be invited to participate due to their varying significant experiences relating to the research topic. In this regard, the researcher used the knowledge of the immigrant community to hand-pick the key people who in the researcher's judgement best represent the range of those persons who are in the best position to know the health care needs of immigrant women.

In terms of traditional focus groups, a sample should, by rule, consist of twelve (12) participants. However, other researchers argue that eight (8) should be the limit (Albertse 2007: 7). The exercise of keeping it natural and not shunning women who felt they needed to contribute to the study brought a clearer definition of involved participants and also allowed the sample to become more, inclusive, diverse and yet

manageable. A total of twelve (12) immigrant women ultimately participated in this study.

Table 4.3: Representation of the sample

	Immigrant Women Participants						
No. participants per C/O	Congo	DRC	Burundi	Rwanda	Tanzania	Kenya	Uga
	2	2	1	2	1	2	2
No. participants per age group	19-23	24-28	29-33	34-38	39-43	44-48	49-53
	2	1	3	2	2	1	1
No. years in S.A.	0-1	2-6	7-11	12-16	17-21+	-	-
	2	6	1	2	1	-	-
No. visits to GHCS facilities	1	2	3	4	5	6	7+
	2	3	2	4	1	-	-
No. visits to SHCS facilities	1	2	3	4	5	6	7+
	2	2	4	3	1	-	-
No. usage of PRWHCS facilities	1	2	3	4	5	6	7+
	3	1	1	-	-	-	-
No. usage of PUWHCS facilities	1	2	3	4	5	6	7+
	6	1	3	2	-	-	-
No. hospitalizations in WHCS	1	2	3	4	5	6	7+
	5	3	1	-	-	-	-
No. times used any other WHCS except in S.A and C/O	1	2	3	4	5	6	7+
	3	1	-	-	-	-	-

In PAR, the researcher is required to primarily select the participants in the study and then attempt to locate the setting in which these people can be found. It is critical that the setting be conducive for the research exercise and enable responsibilities to be undertaken. The setting has the power to influence the quality of data that can possibly be generated (Polit & Hungler 1995: 293). The researcher and the participants in this study agreed that for all focus group meetings, a church hall in the inner city of Pretoria would be used (non-Christians among the immigrant women voluntarily agreed to the venue). The chosen venue was convenient for every participant's reach as most lived in the metropolitan city and some in the surrounding suburbs.

With regard to individual interviews, it was agreed with the larger focus group and particular individuals, that one-to-one interviews would be conducted at the particular participant's residence at her and her family's convenience. The questions of privacy and confidentiality were discussed in depth. The researcher took particular cognisance of the fact that their residences are their and their family's security and comfort spaces. Adherence to set and agreed time schedules and work plans were as important here as in every step.

Flexibility in terms of possible re-scheduling of appointments was allowed, because it was important to guard against chopping or running through the interviews and focus group meetings. Drawn schedules were reviewed at every focus group meeting to secure a plan of action for the next meeting. This was also done to ensure that all were at the same level of understanding as regards the discussions taking place at particular instances. It also helped to show how that fitted into the general progress of the study. Telephone interviews were also conducted at the times agreed upon for the length of time scheduled. If there was an anticipation of a few minutes overlap, permission to continue would be asked from the interviewee concerned (Kvale 1996: 75).

4.6 PILOT STUDY DESCRIPTION

Six immigrant women were initially approached to participate in the pilot study. The researcher then went through the guided questionnaire with the group. Three two-hour focus group meetings were held according to agreed time schedules and

separate individual interview sessions were also conducted with three of the pilot study participants. Significant data was gathered from this exercise. It helped to shape or refine the final questionnaire guide into a purposeful, user-friendly and functional tool. It was during discussions that limitations such as gaps, repetitions and overlaps were identified and addressed. Technical issues such as the sequence of questions and some expressions used by the researcher in the language were re-worked. This was done because such issues have the potential of influencing the quality of the data, depending on how they are understood or misunderstood. In interviews, observed matters of cultural influence in terms of disclosing personal information came out strongly and thus the tone of posing questions had to change, building in a free but logical flow of information (Burton 2000: 61).

A pilot study is a preliminary investigation of a larger in-depth survey of the same subject matter. Morton-Cooper (2000: 39) states that a pilot study should help to identify any weakness in the proposal for the main study. The understanding is that a pilot study can be used for strengthening claims made in the proposal. It should forward justification for resources spent on the study and give evidence for intellectual capacity to bring the study to a scientific completion. It is through the pilot study that participants get to understand the scope and purpose of the study.

If taken seriously, a pilot study should help the researcher to gain valuable background information on the subject studied and increase the knowledge related to the subject under study. It assists the researcher to have an idea of who could be potentially important to participate in the study (Morton-Cooper 2000: 40). A pilot study allows the researcher to gain access to other researchers and practitioners in the field, thereby enhancing a sense of determining feasibility and considerable strategies. Importantly, it gives possible participants exposure to the content and preview of what is involved in the study.

A pilot study offers the researcher the opportunity to face confrontational but crucial questions before engaging in the larger study with the larger group of long-term participants. These questions include asking whether the research question is of importance to research at all, and whether it adds any value to the existing body of knowledge, and whether the intentions of conducting such a study are ethical and

clean. A key aspect of PAR is to find out whether there is a way to give back and empower the participants and their communities in turn. The most crucial point to consider is whether the study is feasible (Greenwood & Levin 2007: 37).

In conducting the pilot study, potential problems more to do with researcher/participant interaction were also depicted and attended to. This meant eliminating some elements which could thwart the reliability of the results. For example, excluding women who had lived less than a month in South Africa. Contact with other relevant participants such as NGOs, government departments and other research institutions proved important in terms of producing fact-checked data. The excitement and interest of all involved in the pilot study made it easy to identify other participants for the in-depth study. Triangulation of instruments became important as the pool of data sources increased. Referential adequacy, which refers to the drawing of research terminology in a study, was drawn with due consideration of participants' language skills and understanding of concepts, and thus increasing the probability of the utility of the study (Burton 2000: 74).

The data derived from the pilot study necessitated an in-depth study on the matter of not only gynaecology, but also specific women's health needs of immigrant women from the Great Lakes living in South Africa. These had to be attended in a holistic manner. The preliminary results pointed out the challenges posed by the lack of knowledge of local systems on the part of the immigrant women. This was especially the case as regards women's health services and difficulties that are faced in gaining access to these services. The pilot study indicated short term and long term consequences of this reality as regards their health state, holistic wellness and everyday functioning. These results revealed a great deal of unawareness and misunderstanding of the specific needs of immigrant women in South Africa by professional women's health care service providers.

Part of the results of the pilot study also brought out the realisation that most immigrant women who had used these services before, and thought they knew the system, realised only after the exercise that they actually went through the system as directed, without necessarily understanding how everything worked. It was found out that some did not even clearly understand why they had to undergo some medical

procedures they were advised to. In essence, transition or change on the part of participants began at this preliminary stage already (that is, the pilot study). In other words, the participants started expressing experiences of awareness during the pilot study process.

4.7 VALIDITY

Validity in PAR is established according to the degree to which an audience may accept it as trustworthy. It is aimed at ascertaining the worth of research according to its usefulness. In respect of this research, this issue was purposefully considered in order to help the researcher accomplish the professional task of ensuring that the research was balanced. Stringer and Genat (2004: 73) interpret validity as an attempt to call a text to authority and truth, established through recourse of a set of rules concerning knowledge, its production and representation. The authors assert that if the rules are followed, validity will be established; that without validity there is no truth, and without truth there can be no trust in the text's claim to validity. This means that validity sets good research apart from bad research; and it separates scientifically acceptable research from that which is unacceptable.

Following the recommendation by Stringer & Genat (2004: 75), this study was tested for the following elements:

4.7.1 External validity

It involved the estimation of the probability that the results obtained from the sample could differ from what is expected.

4.7.2 Internal validity

This looks at the extent to which the results could be attributed to the dependant variable included in the study (Stringer & Genat 2004: 75).

4.7.3 Instrument check

Instruments used were thoroughly checked to ensure that they properly measure what they are designed and meant to measure (Stringer & Genat 2004: 76).

4.7.4 Insider verifying

This was applied through follow-up interviews with some participants to double-check consistency of provided data in focus groups and its interpretation (Stringer & Genat 2004: 76).

4.7.5 Methodological Tri-angulation

This approach was used as different data collection techniques and instruments were utilised to enhance validity and strength so as to overcome the bias inherent in data gathered from single perspective (Stringer & Genat 2004: 77).

4.7.6 Self-validation

The researcher applied critical thinking in the quest to develop intuitive understanding of practices involved and to clearly communicate these to interested parties (Stringer & Genat 2004: 77).

4.7.7 Participant validation

This act refers to the direct outcome of the dialogue between the researcher and the participants, as derived from the focus group and support group meetings. This allows participants to compare their known feelings and findings regarding their participation as a group, against those they hold as individuals. The process helped to overcome the problems of the researcher interpreting events and issues only through her own lens and understanding (Stringer & Genat 2004: 78).

4.7.8 Confirmability

This element was applied to confirm that the research adequately represented the perspective presented in the study. It was thus used to enhance the trustworthiness of the study by conducting a trial with participants. Through this trial, recorded information gained from the research was reviewed. This process involved notes from meetings with the group and individuals, audio-recorded data, observation notes and plan schedules (Stringer & Genat 2004: 79).

4.8 ETHICS

Every study involving human respondents raises a unique set of ethical issues. Ethical concerns were at all times adhered to and all participants and the researcher held each other accountable to ethical conduct throughout the research. As according to the requirements of scientific research, protocol requirements were adequately engaged in this study. Basic research ethics establishment which covers confidentiality, permission and informed consent were always fully observed (Hulley & Cummings 1998: 151).

4.8.1 Confidentiality

The code of confidentiality, care and sensitivity was always discussed and consciously observed in all encounters, in both formal and informal situations with the participants. This was especially the case in situations where people would open up their lives and disclose private matters. The same occurred in one-to-one interviews, as mentioned subsection 1.10.3.2 above. Some participants requested that they remain anonymous. In this regard the researcher ensured that nobody should be able to identify them with the information they supplied in the study. De Vos (1998: 28) states that all information that could lead to identification of respondents should be terminated after use. This was applied in this study.

4.8.2 Anonymity

Protection of anonymity was also ensured and exercised where matters that might have come out from individual sessions needed to be discussed in the larger focus group meetings. Anonymity of a person makes it impossible to link the data to the participant and thus protects the right to anonymity. Permission would always be asked from the relevant individual/source of information before the matter was brought up in the larger group (Polit & Hungler 1995: 112).

4.8.3 Privacy

In the effort to guard participants' privacy, only data pertaining to the aims of the study was collected. Participants were assured that their thoughts, behaviour and personal experiences would remain private and not used in any way that might embarrass them or their families (Polit & Hungler 1995: 150).

4.8.4 Termination

The participants were re-assured of their right to withdraw from the study at any time should they so wish, regardless of their initial consent participate (Hulley & Cummings 1998: 95).

4.9 CONCLUSION

Research design links the components just prior to it, the operational definitions, population, sample, as well as the data collection issues. It was significant to discuss the research components and study participants with a relevant plan in mind regarding: who exactly would be studied, when and where observations or data would be gathered. This and the pilot study exercise were done in order to review the progression of the initial plan and to realistically assess the probability of putting a contingency plan in place.

The aim of this chapter was to select a research design to obtain preliminary answers to general and specific questions pertinent to this study. An exploratory method using

PAR was found to be the most suitable. The techniques required to apply such a method were adhered to as was the effort of focusing and framing the study. Sampling and running a pilot study were significant steps towards the completion of the study. The validity of the research results was also tested. The discussion of data analysis and interpretation follows in the next chapter.

CHAPTER 5

DATA GATHERING, ANALYSIS AND INTERPRETATION

5.1 INTRODUCTION

The purpose of this chapter is to describe how the researcher made sense of the data collected. This process included an analysis of the descriptions and explanations of the records. The chapter further discusses the methods used in data gathering, as well as the strategies used to analyse the said data. This is followed by the presentation of how the analysed data was interpreted.

A variety of data sources was used in the process of gathering information to generate the contents of this study. In the previous chapter, it was mentioned that in PAR, the participants' experiences and perspectives are complemented by observations and reviews of artefacts and literature. Such a process requires the researcher and the participants to develop a relationship of trust to enable easy interchange of both information and interpretation of experiences (Streubert & Carpenter 1995: 90).

Interviews are some of the earliest and still most common procedures in human research and are perceived as a principal means of understanding people's experiences and perspectives (Doodley 1994: 79). In this study, both focus group and individual interviews were conducted to allow immigrant women to describe and interpret their experiences. Other instrumentation techniques included policy and documentary analysis, narratives capturing, artefacts and literature reviews, as well as observations to enrich and add depth and rigour to the research process. Triangulation of instruments was opted for to also ethically accommodate all participants, considering their cultural ways and trying not to upset the arrangements of their everyday lives and those of their loved ones. It was crucial for the researcher to ensure that a full account of immigrant women's views and experiences is properly presented and all information well managed.

5.1.1 Focus Group

A focus group is a group interview involving a number of people in a research process. It is a group discussion made up of members who have something in common, usually focused on a particular topic. It is limited in both time and tasks. This type of interview is normally led by a facilitator, who in this context is the researcher. Focus groups are used to find out what a group or groups of people think. Attention is given to how they discuss ideas together. The process allows the sharing of opinions from participants' personal experiences, and raising awareness of important issues as they arise. These group discussions are structured to allow group members to discuss issues before moving on to task and action (Greenwood & Levin 2007: 18).

In the context of this research, focus group sessions were effectively planned and facilitated according to following specific steps (see Stringer & Genat 2004: 36):

5.1.1.1 *Setting of ground rules*

This was done to allow all participants to express their own opinions and to be objectively accepted.

5.1.1.2 *Provision of clear guidance*

Focused questions were mediated as they were posed, and all discussions were monitored for focus and clarity.

5.1.1.3 *Group facilitation*

The researcher ensured that all focus group members had equal chance to talk and contribute. This meant that the quiet ones were encouraged to share their opinions as the discussions unfolded.

5.1.1.4 Group discussions recording

The researcher recorded all the proceedings, and the contributions were captured in the participants' own terms. All discussions that emanated from the group meetings were summarized as part of focus group session's proceedings.

5.1.1.5 Feedback and clarification

All participants were gathered for feedback discussions. In these discussions individuals were allowed to expand and clarify their own points presented at focus group discussions. This also involved the recording of new information.

5.1.1.6 Combined information analysis

This was done to identify common features in the group discussions. However, divergent issues were also identified and ranked in order of priority.

5.1.1.7 Plan of action

All participants were involved in discussing and deciding the next step. This entailed the following aspects: (i) action to be taken, (ii) allocation of people responsible for each task, and (iii) the time- frames involved. Progress review meetings were also scheduled.

When using focus groups, three (3) stages of implementation were followed. The steps were: the beginning, the middle and the end.

- The beginning
The researcher allowed the participants to talk and relate their experiences and ideas freely and willingly. However, she advised everyone of their right to privacy. The immigrant women shared information about their general experiences of life in South Africa as a host country. The information included their perceptions of the quality of life and their immediate needs, as well as the sources of these basic needs (Burton 2000: 134).

- **The middle**
The researcher helped participants to focus through the use of more follow-up questions on specific issues. They were asked questions on their health histories and their understanding of women's health care services in South Africa. Further questions enquired on their level of knowledge on issues such as: (i) their specific types of usage of these services, (ii) processes involved, (iii) post-service perceptions, and (iv) identification of the gaps in services rendered (Burton 2000: 135).
- **The end**
This involved completing the group task. In this regard the participants looked at specific needs identified to better the services in women's health care. They re-assessed professional women's health care practitioners' recommendations and those of immigrant women themselves. A workshop on women's health promotion was conducted to give more practical information to the immigrant women. This presented an opportunity for specific questions to be addressed. Concerns around service rendering were directly raised with health practitioners, who recorded these for further discussions amongst themselves.

5.2 INDIVIDUAL INTERVIEWS

Qualitative research interviews involve everyday life experiences of the research participants. Interviews are guided conversations providing means whereby the researcher is able to hear perceptions and views of others, and incorporate these into the process of enquiry. Interviews can, symbolically, recognise the legitimacy of the interviewee's point of view. They offer those interviewed the opportunity to revisit and reflect on events in their lives, thereby extending their understanding of their own experiences (Kvale 1996: 25).

There are protocols involved in order to engage in a comfortable, ethical and productive interview. These include establishing a relationship of trust, and providing interviewees with the opportunity to determine the time and place of interview. It is also important to allow them to know the focus of interest and the real interest in their own perspective. Grbich (1999: 93) describes a guided interview as having broad

objectives reflected in guiding questions. He further states that it encourages informants to describe their views and experiences on particular themes, and allows the interviewer the freedom to explore issues that arise. It is in this sense that guided interviews were used in order to be in congruence with the research design.

Stringer and Genat (2004: 52) developed a questioning schema. Two phases of the schema were adopted for this study:

5.2.1 Phase 1: Grand Tour Questions

This fundamental point of enquiry in this phase allowed the interviewees to describe, frame and interpret events and phenomena in their own terms. The researcher as the interviewer however, had the responsibility to contextualise the issue or point of enquiry as it is meant to elicit extended discourse. Specific grand tour questions were utilised in this study because individual interviews were always conducted after focus group meetings. The interview questions would thus focus on occurrences, observation and information that arose from focus group discussions.

5.2.2 Phase 2: Mini Tours

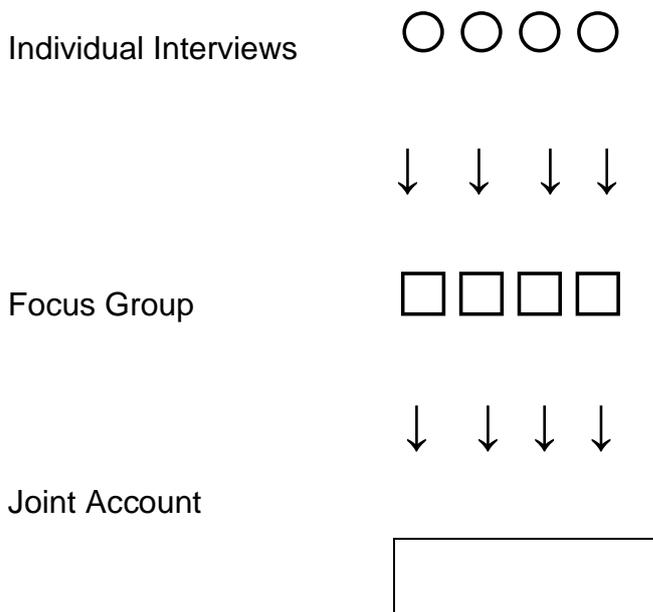
These are actually prompt questions asked to extend the description or explanation given, and thus get more information around the specific question. This allowed the interviewee to look deeper into the experience. The interviewer used the language, terms and concepts of the interviewees in order for them to extend their own responses in their own terms.

The “mini tours” phase depends largely on information disclosed in the initial response. In using the direct prompt questions, or extension questions, the researcher skilfully framed these to encourage the interviewees to expand on their facts without swaying their (the interviewees’) original point or perspective (Stringer & Genat 2004: 52).

Polit and Hungler (1995: 362) suggest that credibility in research can be enhanced by spending more time with the informants. As part of the process of enhancing the

credibility of this research, it became essential to repeat some interviews. This allowed a re-search of issues under discussion and re-tested the probability of the correctness borne in the outcomes of the initial interviews. It enabled the participants to reflect on issues, as well as to review and extend information acquired in the previous individual interviews and related focus group meetings as illustrated below:

Figure 5.1: Diagrammatical illustration of individual interviews and focus group in data gathering process



Source: Adapted from (Stringer and Genat 2004)

This process allows the participants to deal with unquestioned assumptions both individually and as a group. The significance of this is that it offers greater clarity of understanding and working through complexities. It enhanced the development of solutions through a combined effort, and also created a form of unified working pace for all.

5.3 DATA RECORDING

5.3.1 Field Notes

Doodley (1994: 262) maintains that field notes constitute important repository of data that guide more enquiries and provide material from which research outcomes

emerge. It is through field notes and on-going recording of observations that the researcher is able to compile a detailed description of events and actual places as observed at the time of occurrence. Field notes were recorded in this research during the focus group meetings at the hall, at individual interviews in participants' houses and at the workshop. It is important to highlight that the atmosphere and circumstances do not always allow immediate recording of events. However, at the earliest convenience presented, the researcher managed to write down the notes.

5.3.2 Tape Recordings

Tape recordings were used to provide a detailed recording of all that was said in both individual interviews and focus group meetings. A tape recorder was always used with the permission of the participants/interviewees. This also assisted the researcher in checking the veracity of observations and analysis. It provided the means to ensure that language and concepts are thoroughly captured. An added advantage is that, with proper use, a tape recorder can be played over and over again for verification (Merriam 2002: 36).

5.3.3 Documents Review

Policy documents specifically dealing with issues of immigration, women's health, South African Health system and programmes, relevant ratified international declarations and relevant media reports or statements were consulted. This was essentially done to complement and extend the understanding of the issues concerned. The researcher was mindful of the proliferation of documents on these issues, and thus maintained focus by only using relevant documents. This helped to guard against the compilers' or organisations' inscription and/or imposition of their own perspectives and values, as well as bias in the final compilation of the data and results (Lincoln & Guba, 1995: 89).

5.3.4 Web Searches

The data recording process also included searching the various websites, more especially those related to immigrant and health issues, women's health programmes and policy implications. The searches included websites of different international

organisations such as the WHO, UN, UNHCR, IOM, and those of local governmental departments such as foreign affairs, home affairs, health, social services and population development. The researcher ensured that even websites of local research organisations, relevant parastatal centres and non-governmental organisations were also visited.

5.4 DATA ANALYSIS AND INTERPRETATION

The process of qualitative data analysis involves piecing data together. It makes the invisible clear, differentiates between the significant and insignificant, and provides logical links between facts that might initially seem unrelated. It identifies categories and their interrelationships, and critically analyses the consequences and antecedents. Morse (1995: 25) describes it as a creative process requiring ingenuity and flexibility.

The main reason for conducting data analysis in PAR is to distil the data gathered in a manner that can assist the researcher and participants to understand, interpret and attach meaning to the information and observations derived from utilised sources. It is thus crucial, in this context, to capture direct experiences and perspectives of participants. It is equally important to make sure that all of their views and explanations are accurately represented; and also to ensure that it makes sense to them (Greenwood & Levin 2007: 115).

Merriam (1998: 38) identifies the following strategies of data analysis:

- **Ethnographic Analysis:** researches on culture and society. In this type of analysis, researchers often use categories such as economy, social demographics, life situations and the environment in analysing related data.
- **Narrative Analysis:** focuses on the manner in which people experience the world. It gathers and presents data in terms of stories about people and stories told by people.
- **Phenomenological Analysis:** examines the essence of experience, including critical bracketing of the researcher's assumptions.

Ethnographic Analysis evidently became the most dominant strategy in this study because of its proper data collection ability and reliable analysis. The researcher had to be acquainted with the ethnographic factors affecting the study participants' lives in the present and the past (Albertse 2007: 18).

The use of Narrative Analysis became an essential part of analysing data in this study. Due to the nature of this study, parts of the data collected are in a form of told stories from interviews, results of discussions and interactions from focus group meetings. The researcher's recollection of events as they unfolded was also of significance, when bringing these experiences to life for the reader (Lincoln & Guba 1995: 89).

An analysis of the essence of experience, which includes critical bracketing of the researcher's own assumptions, was applied. This was, however, done with caution and awareness of personal assumptions and reality. The researcher found it important to adequately relate the participants' experiences and to stay receptive of the emerging forms of information and arising insights as the study unfolded (Patton 2002: 63).

The data analysis strategies adopted for this study were chosen because of their suitability to show the readers how the participants make sense of their lives, especially as regards their health issues in South Africa. The participants uncover how the immigrant women utilize new understandings to significantly better the quality of their lives, and to be able to participate pro-actively in the management of their health. It therefore became the responsibility of the researcher to adequately and respectfully capture the participants' emotions, as well as their verbal and physical expressions. This process gained the researcher and the participants the advantage of developing an empathetic understanding of each other's life experiences (Rubin & Babbie 1997: 141).

This study utilised the editing, categorizing and coding method of data analysis, commonly used in qualitative research. According to Polit and Hungler (1995: 432), coding is the process of transforming raw data into a standardised form for data processing and analysis.

5.4.1 Transcribing the Interviews

The researcher replayed the tapes, attentively listening to the participants' tone of voice and responses. As part of the process, the researcher's own notes were re-read and the interview was transcribed verbatim in order to analyse raw data. The French expressions (recorded and noted as expressed in French while discussions were mainly in English but permitted French self expression) were first transcribed and then translated into English for data analysis purposes. The "QSR NUD*IST Power Point 4.0." computer programme was used to process the data. To ensure transcription accuracy, all tapes were replayed and notes written in full to allow a clear description of observations (Patton 2002: 80).

5.4.2 Editing and Cleaning of Raw Data

This is the most time consuming step in data analysis. The researcher started cleaning and entering data already while conducting individual interviews and collecting data from focus groups. This involved entering, cleaning and pre-coding the results to check for misunderstood questions, misguided discussions or any misunderstandings that might be traced. In this vein, Albertse (2007: 22) postulates that the objectives of editing are to ensure accuracy, consistency and to detect inappropriate answers. The researcher fulfilled this task to make sure that she was familiar with, and actually knew the raw data and the meanings attached to each category.

5.4.3 Data Sets Reviewing

This process involves the researcher reading through all the data with the purpose of helping her to become familiar with it (that is, the data). This allowed the researcher to be comfortable with the information so that she could safeguard the developing links between items and elements as they emerged. In order to focus the data analysis, the research questions formulated at the study design phase, and interpretations drawn through data collection phase, were used. These aspects ensured that both the researcher and the participating immigrant women keep the analysis relevant to the purpose of this study. Through-out this exercise, the

researcher was constantly mindful of the fact that immigrant women's experiences and perspectives differ due to their variety in age, ethnicity, belief and background. The data sets were thus formulated to highlight these differences (Albertse 2007: 25).

5.4.4 Categorisation and Coding

The different types of phenomena emerging from the data were sorted into categories. These categories were then defined so as to create order and improve the organisation of data. Some researchers call this process data reduction. A significant aspect of categorisation is that it offers an understanding of meaning and communication of matters. The process entails the transcription of tape recordings, and documents key occurrences, key words and phrases that can provide meaning to the people under study. As a result, associated units of meaning were packed into the same category, as identified according to their type (Patton 2002: 89).

5.4.4.1 Coding

This process involved grouping of information contained in the categories according to the similarities in their phenomena. As this process was implemented, it became important to ensure that relevant and accurate codes were allocated to the meanings intended by the participants. Descriptive codes, interpretive codes, pattern codes, reflective codes and marginal remarks were some of the labels assigned.

Simultaneously, themes were also identified through word analysis, checking for word repeats and identifying important words with specific meanings. Intentional Analysis was applied, in which respect metaphors and connectors were identified. Secondary analysis, whereby other sets of information were consulted to question and review field notes was ran after editing and manipulation of data. This might sound like a repetition of processing, but it was done to compare data results and ensure that same outputs resulted. This act was aimed at enhancing reliability (Patton 2002: 91).

5.5 NON- INTERVIEW DATA ANALYSIS

This step became important in the study as immigrant women would have culturally-bound expressions and body language unfamiliar to the South African culture or traditional western ways. As described by Burton (2000: 104), the same information was analysed to mainly clarify and enhance data related to the researcher's observations of immigrant women's participation in the focus group meetings, individual interviews and the workshop. Field notes included their oral and visual expressions, narratives and discourses which were also analysed.

5.6 COLLABORATIVE DATA ANALYSIS

This is a peer review process and was opted for because it encourages group cohesiveness. It also has the ability to achieve or bring out deeper understanding. Collaborative data analysis reflects clarity and offers solutions towards the research problem. This enquiry process is ideal for capturing this in the cycles of reflection. It is in these cycles that what is of value and how it contributes to the participants' flourishing as human-beings are core themes. Although the researcher is to an extent also a research instrument with a filtering role, it is his/her hope to also "hear" the meanings behind the words of the story tellers or narrators. Participants are thus a key factor in this exercise as they went through re-checking and sharing accounts from interviews, focus group meetings and their own observations and interpretations collaboratively. This served to verify and set consistency for the research results (Heron & Reason 2001: 43).

The Look-Think-Act practice and the frequent definition of the research question helped the researcher and the participants to stay focused on the study. All involved were vigilant about gathering data that addressed the problem and analysing the results according to the rules of logic in scientific research. The specific interventions used were all concrete, observable and measurable. It was thus it was possible to both monitor the progress and modify the interventions accordingly. Logical pitfalls in qualitative data analysis were avoided. These are described by Rubin and Babbie (1997: 78) as follows:

- Provincialism: researcher and participants interpreting the world in terms of their own particular histories and current situations, and thus influencing their observations to suit their own point of view.
- Going native: researcher over-identifying with the culture observed, and losing his/her own self identity and sense of analysis.
- Emotional reactions: they point to the strong personal involvement and emotional reactions of the researcher to research observations; this might risk the reality of the context.
- Hasty conclusion: researcher's susceptibility to draw hasty conclusions, weight of evidence interpretation of data may not be well evaluated.
- Questionable cause: researcher ensures that the cause identified is the real and actual cause; to double check if there are no other most possible and relevant causes missed.
- Suppressed evidence: researcher to make sure that the information/data dismissed as irrelevant is just not avoided but does not realistically feature in the conclusions.
- False dilemma: ascertaining that research conclusions selected from a certain representation position do not totally rule out all other alternatives.

5.7 CONCLUSION

Interaction with the respondents or participants in the case of this study presented the researcher with the opportunity to observe and interview those involved in the study. Data recording and final compilation were lengthy but crucial for the final analysis. Qualitative method was utilised due to its ability to describe everyday life from research participants' point of view.

In this chapter, the research design, methodology and analysis of this study were discussed. It is in this chapter that the logical pitfalls avoided in the processing of the data were disclosed. The next chapter presents a discussion of the details of the research findings and the conclusion.

CHAPTER 6

FINDINGS, SUMMARY AND CONCLUSION

6.1 INTRODUCTION

This chapter will deal with the research findings or results of this study. This will be followed by a summary and conclusion. Grinnell (1998: 452) asserts that not all findings of a study need to be reported in an article-length report, but all important results that bear on the problem area of the study should be shared.

6.2 FINDINGS

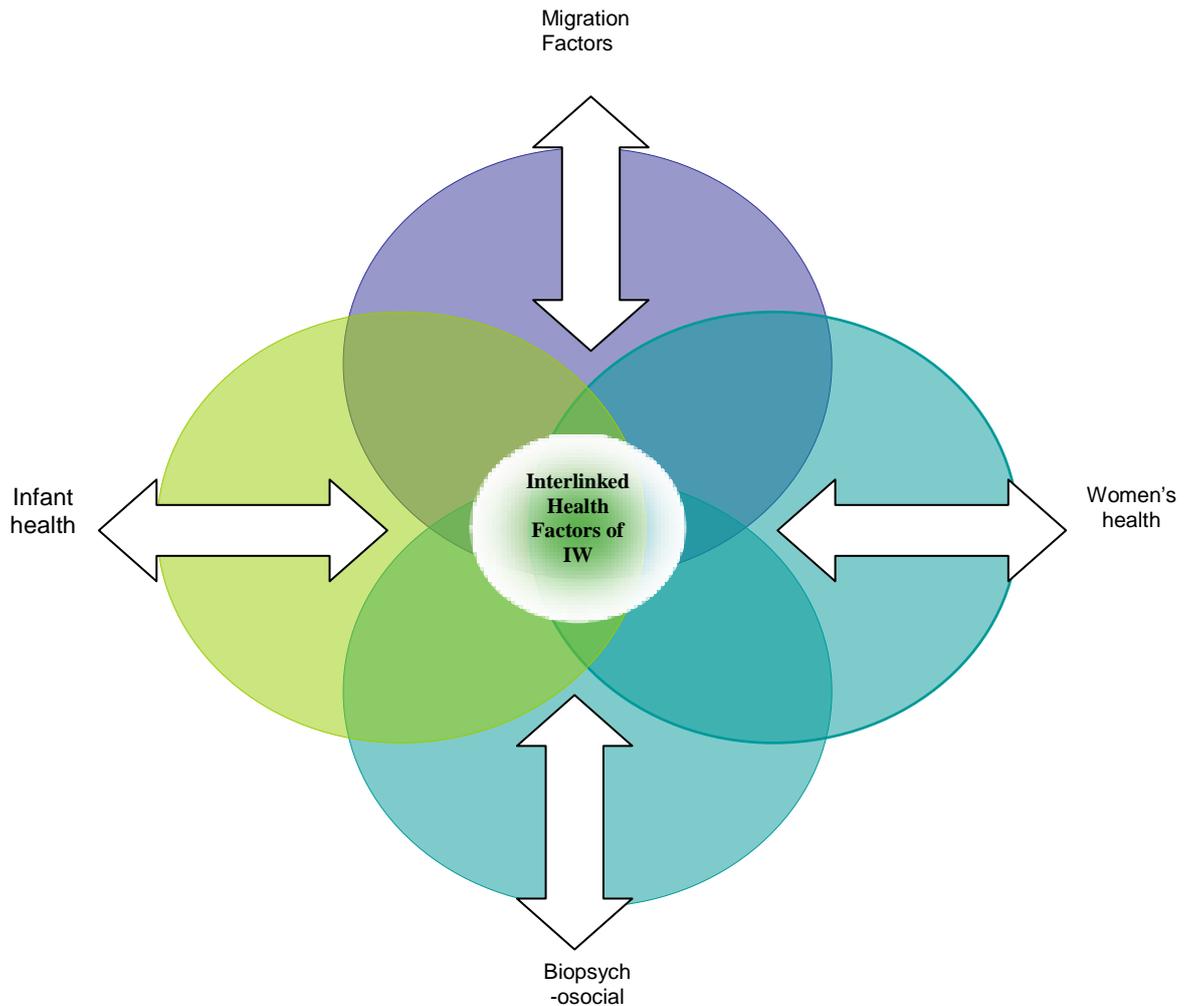
The essential purpose of writing this section of the research report is to present findings that have been anticipated by the statement of the research problem (Grinnell 1998: 452). A number of research initiatives have proven that it is still difficult for women in developing countries to make informed choices regarding their health needs. The reality of the women's health situation is that attaining a healthy life is twice more difficult for women who have resettled in new geographical areas, and thus facing new cultures and contexts.

Data derived from the questionnaire guide used in the focus group, semi-structured individual interviews, telephone interviews with professional health practitioners, field notes and observation recordings evinced a common pattern or similarities in terms of women's health indicators. Geographic location, socio-economic positioning and acculturation were presented as ethnic disparities as regards the issue of in women's health.

The interview guide used with the focus group (see Appendix C) covered four themes that entailed factors related to the health of resettling immigrant women. Analysed data produced interlinked patterns formed out of the main themes: (i) migration factors, (ii) women's health, (iii) bio-psychosocial factors and (iv) infant health. These related specifically to the results of this study. Information gathered from health

indicators reflected these four main themes and their respective related factors as presented below:

Figure 6.1 Diagrammatic Representation of Inter-linked Health Factors Deduced from Immigrant Women's Health Indicators



6.2.1 Health Factors Deduced from Immigrant Women's Health Indicators

6.2.1.1 Migration Factors

- PTSD (Post Traumatic Stress Disorder)
- anxiety
- somatisation

- depression
- sex and gender-based violence (SGBV)
- stress
- abuse
- marginalization.

The health status of immigrants, especially immigrant women, varies from one locale to the other. In most cases the health status of newly arrived immigrants is poorer than that of the local population or those who have stayed for longer periods in the host country. In this research, as in the study conducted by the NWHRC (National Women's Health Resource Centre 2004: 88), we have found that access to women's health care is limited.

The status of immigrant women's health is greatly influenced by the circumstances of migration. In women whose lives have been abruptly disrupted by unplanned migration, the above stipulated characters of migration factors are experienced but not exclusive to this group. As these are more psycho-emotionally involved, they are rarely medically or professionally treated by immigrant women. The participants in this study disclosed that immigrant women seldom, and almost never, seek professional help or consultation when exposed to these health conditions.

6.2.1.2 *Bio-psychosocial Factors*

- isolation
- loss of support systems
- prejudice
- language challenges
- loss of income/unstable economic conditions
- lack of shelter
- conversion of qualifications
- difficulties with employment
- transport
- new culture (e.g. food).

The lack of resources is generally a frustrating element for anyone. It is observed to be more so for immigrant women, who find themselves in an unfamiliar geographical and cultural environment (Doyal 1995: 132). The results have indicated a link between the status of immigrant women's health within the new host country and the high levels of stress impacting negatively on the quality of women's health. The identified bio-psychosocial factors listed above thus appear prominent as direct stress factors affecting their everyday life and functioning. Another factor under this theme was the observed active participation of immigrant women in some spiritual support initiatives or structures such as prayer or meditation gatherings for extraordinarily long hours throughout the week.

According to deduced descriptive data, these structures serve as their sources of social support relationships. The participants themselves however, concluded that they do not always find tangible solutions to their pressing challenges from these structures. With regard to this specific phenomenon, Cheetham and Griffiths (1992: 24) point out that such "fanatical religious involvement" can sometimes induce stress and become negative as well. They further state that these relationships mostly remain superficial and highly spiritually-oriented. They (the relationships) are seen as merely the sessions for sharing and repeatedly allowing debilitating discussions around these stress factors. The structures are found not to address important resource needs or supply issues which are more urgent for most immigrant women.

6.2.1.3 Women's Health Factors

- sexual and gender-based violence (SGBV)
- reproductive complications
- difficult pregnancy and labour
- urinary tract infections
- sexually transmitted infections (STI)
- menstruation pains
- prolonged menstrual cycles
- low pregnancy weight gain
- short pregnancy inter-spacing
- sexual dysfunctions

- female genital mutilation (FGM)
- cervical and breast cancer
- mental health challenges
- chronic health.

Most social researchers agree that minority communities throughout the world face challenges of ethnic disparities that highly affect their access to health service. In respect of this study, analysed data showed that immigrant women from the African Great Lakes living in South Africa found it difficult to use the women's health services because the systems and services were unfamiliar. Other participants stated that they experienced symptoms of some of the above listed characteristics of women's health factors before leaving their countries of origin. They reported that they had never consulted for further medical investigation.

Some immigrant women believe that they developed these in transit to their destination, South Africa; while others are certain that they developed these conditions while already in the country. The participants indicated that there is a tendency to keep unfamiliar health symptoms secret, because of fear that it might be more serious than its physical presentation. There is also fear, shame and embarrassment associated with physical examination procedures. The researcher, however, observed, that the level of education, socio-economic class and lifestyle, and belief had greater influence on how immigrant women understand and react towards their women's health conditions and the methods of treatment opted for (Cheetham & Griffiths 1992: 28).

6.2.1.4 Infant Health Factors

- low birth weight
- lack of mother/child interaction
- malnutrition symptoms
- vaccine preventable infections
- inadequate health care history.

Most women's health studies bundle women's health and child health together. In most developed countries, these are treated as different but related disciplines, which are, fortunately, the health care model followed by South Africa. There is on-going research by the National Department of Health (in South Africa) on the causes of maternal deaths in South African state hospitals. Public health education based on the findings of such a study, however, still need to be implemented (World Health Organization 1998: 17). Participants in this research were agreeable with the research findings that among immigrant women giving birth in South Africa, most record low birth weight of babies born.

The participants' responses indicated that although most immigrant women use hospital facilities to give birth, they never go to back for post-natal treatment or consultation. The only occasion on which they return is when the baby is sick. They rely on traditional methods practiced back home by their communities of origin such as herbs and hot bath cleansing for new mothers.

Vaccinations and nutritionally-efficient baby feeding are areas that need attention as babies are in most cases fed solid food much earlier than paediatricians recommends. Most young mothers prefer breastfeeding for short periods for their own perceived aesthetic benefits rather than for proven health benefits of their babies. Among the participants, those who indicated that they have used post-natal services confessed that they had to be informed and convinced first. They conceded that they actually understood the seriousness of health risks associated with neglecting these treatments much later.

An analysis of the themes of these results immediately reflected that the health deficits in immigrant women were directly understood as the consequences of their act of migration. Immigrant women's potential health risks obtained from their personal histories also highlighted potential women's health threats and therefore possible mortality causal factors.

The continued impact of stress yielded certain results as seen under the discussion of bio-psychosocial factors (see 6.2.1.2 above). They were identified in reports of physical reactions as related to gastro-intestinal disorders, respiratory and cardiac

complications. From this set of factors, social support systems and spiritual health also became essential components that influenced their lifestyles and coping mechanisms.

The quality of their children's and their own nutritional health standards revealed guidance-seeking dietary patterns as regards weight, psychosocial activity and physical health. Critical evidence showed the link between a lack of access to resources (or their unavailability) and these stress factors as common to immigrant women's everyday lives. These affect the general quality of their lives.

Information gathered from discussions with obstetric practitioners confirmed that a significant number of immigrant women do, in fact, give birth to babies with lower birth weight rates. The specific reasons were, however, not scientifically established. Therefore, speculation in this regard remains at an assumption level, but related to the harsh conditions that most immigrant women find themselves exposed to during pregnancy.

Target group-focused health promotion/education and health outreaches are reiterated as essential parts of women's health programmes in which all countries must invest (Chinn & Kramer 1999: 65).

6.2.2 Health Concepts and Beliefs

Pender (1996: 133) argues that assessing women's health beliefs is a more reliable indicator of motivation to change behaviour that negatively impacts on health promotion. In this study, the health beliefs of immigrant women were determined in the preliminary discussions with them, revealing health specific conceptualisations, activities and behaviour. Immigrant women were concerned that they were "not feeling very well". They believed that their state of health had generally changed. Not all of them could say with certainty where the malaise originated from. However, the general consensus was that since they had left their countries of origin, they felt different mentally and/or physically. This also included even with those who had to flee their countries for safety reasons.

Immigrant women found the quality of life in South Africa better than that in their countries of origin. They frequently referred to easy and constant access to water and electricity as examples in this regard. Nevertheless, they pointed out that they still get nostalgic. Some related this feeling to a sense of loss or detachment they continued to feel. It was evident that they had accepted the fact that they had to start life all over again. However, they sometimes find it difficult in their minds and emotions to let go of their past, no matter what their past and present conditions were. Some of the expressions used were:

I have lost everything and everybody I knew, everything I made, everything I was given, everything I owned and the way I lived.

Another feature that appeared repeatedly in the focus group was the belief that people should only go for medical consultation when all self medication and home remedies fail. They believe that doctors are meant to handle only “serious cases”. There is a common sentiment among immigrant women that “as an adult, and a strong woman, one cannot always run to the doctor for every pain”. Enduring pain is seen as an indication of strong character. As a result, women decide that pain is bearable and force their bodies to bear it (the pain).

In another interpretation of a health belief oriented model, a participant stated that in her religious view, sickness is part of a spiritual journey towards strengthening one’s faith. The belief is that it is worthy to persevere through pain because there is some form of divine reward after recovery (Women’s Health 2006: 14).

From the perspective of a women’s health advocate, this kind of health belief encourages women to delay medical consultation as, in their own understanding, they do not want to intercept the patiently awaited flow of blessing. On the other hand, the reality is that the illness is likely to progress into detrimental stages.

The women’s health nursing paradigm stresses that the notion of keeping the family functional is a responsibility taken at the cost of most women’s health (Hamilton 1993: 72). Women think that they cannot afford to stay sick while their families need their assistance. They unanimously agree that life has to run smoothly for their husbands and children all the time, unless they (women) are confined to a hospital

bed. The researcher found, in this understanding, the Individualism-Collectivism framework at play. Immigrant women could not separate their own health concerns from those of their family members, although in most cases they would put theirs last as less attention-deserving (Peck 1996: 137).

The view of women's health practitioners contacted through this study is that sometimes immigrant women patients expect more than what is contextually practical. They look to a medical doctor to help resolve their private social or family issues. These medical practitioners do accept that some of their colleagues practising from the family medicine perspective do try to allow some discussion on patients' personal concerns. However, given the load of work in the context of the South African medical practice, this is not always practical. Around this issue, participants' responses were that they find most local doctors very cold towards them as patients, and not affording them adequate time to discuss "issues" during consultation.

Older women (most of whom grew up in rural areas) expressed the concern that they find it difficult to be examined by male doctors, especially when the doctors are younger in age than they (the women) are. In addition, some results on this matter carried religious connotations (Stewart & Do 2003: 68). Some participants found this act to be a bigger problem as it carried deep moral and religious implications for them. They sometimes understood it as "explicit self exposure to strangers". This occurred especially if the medical professional was of a masculine gender.

6.2.3 Knowledge and Understanding of the Health System

Immigrant women appreciated the free antenatal care services extended to them as legal foreigners in South Africa (Department of Health 2000: 14), because any kind of medical treatment in their countries of origin is expensive. Some immigrant women reported that they had witnessed family members dying back home, because they could not afford medical treatment. They were however frustrated and thus dissatisfied with the "complicated protocol" as they termed it. A participant explained her experience as follows:

When I reached the hospital to ask when I could come to give birth to my baby, the nurse asked me for my card and booking confirmation. I did not understand what she was talking about. When I softly explained that I was a foreigner and did not have what she wanted, she started speaking loudly that I needed to go to the primary health care service point first. Another nurse came and explained the process nicely to me.

Some participants mentioned the fact that they found the system inconvenient in some instances. One participant told about her going to a clinic in another area where she was visiting for a weekend to get her blood pressure medication and contraceptives, only to be referred back to the clinic where she lives in Pretoria.

There was also a discussion about why one would need a referral letter from a general practitioner in order to be treated by a specialist. They saw it as double usage of resources and, according to their understanding both doctors initially perform the same physical examination. Some of the indicated problems in this area are long queues and waiting periods before being assisted at public medical facilities. This problem was compounded by a shortage of medical staff, especially doctors.

6.2.4 Transportation

The participants complained that the referral system means more travelling costs for them. The refugee women in the group especially stressed that financial support is hard to come by. Some women pointed this as the reason for not going through to the next consultation as scheduled, or for not completing the prescribed series of treatment. They said that they sometimes had long periods of interruption in between treatments, and thus the progress towards recovery is delayed.

The women discussed how they did not like using public transport for fear of being targeted as aliens by the locals, irrespective of the fact that they were legal in the country. Other tendencies involve the hostility of minibus taxi drivers and the unpredictable price hiking and fixing of meter taxis by drivers once they discover that the client is a foreigner. This makes it uncomfortable for them to use public transport as they are often taken advantage of (Perbedy 2005: 13). When discussing alternative transport methods, some pointed out that they felt like they were burdensome when they had to ask friends with cars to help them to medical

consultation appointments. In most instances they end up missing these appointments.

6.2.5 Communication

Language challenges were identified as major barriers in the usage of women's health care services. The lack of proficiency in South African languages, especially among immigrant women from a Francophone background, hinders effective communication. As a result, most of them have to rely on the services of others for translation. In some European countries the government employs translators and interpreters to serve in government departments. This system has already been successfully implemented in the Department of Justice in the South African courts. However, in most South African public service departments, immigrants have to see to their own means regarding interpretation (Council of Europe 1995: 34). According to the participants, this service, on the other hand, has been found to cause problems with reference to privacy issues. A participant said:

Like I wanted to ask the doctor if my husband and I could continue to have sex while I was pregnant, but I could not do that in the presence of my younger sister-in-law who was translating for me.

Immigrant women refrain from asking the medical practitioners important questions through an interpreter as they sometimes find it uncomfortable and embarrassing. Immigrant women from the Anglophone background experience less linguistic problems, but they are still confronted with cross-cultural communication issues. The level of understanding of the use of resources, administration channels and/or medical instructions due to immigrant women's lack of exposure to the South African type of health care system remain difficulties.

6.2.5.1 Translation

Issues regarding the accuracy of translation and interpretation are of concern to immigrant women. A participant stated that she preferred to take along her husband because she could trust him more. In this sense she did not have to worry about the accuracy and confidentiality of information.

Interviews regarding communication indicated that written communication was found to be more problematic. Even those who could converse in English admitted that handling and fully understanding documentation with technical English terms such as contained in the medical administration forms remain a challenge.

Lengthy medical care, especially when it requires a lengthy course of tablets, self-administered injections or instruction notes can be confusing, and might put the health of a patient at risk if not properly administered. This ultimately becomes one of those instances where they really need the assistance of family or friends, and sometimes even neighbours or strangers.

6.2.5.2 Doctor- Client Relations

Matters of doctor/patient information have shown to have a great impact on how immigrant women perceived health care services (Pender 1996: 62). A discussion ensued during which the question of the age of doctors and their unfriendliness was highlighted. They were described as “cold” partly because their treatment was found to be straight to the point and strictly professional. The manner in which disease prognosis is delivered was criticised as too blunt and restricted to medical professionalism, and showed empathy.

A participant from an Anglophone background recalled:

When I was diagnosed with cervical cancer, a male doctor just stood beside my bed in the ward (in a public hospital), to tell me the bad news. He was flipping through my medical record file without looking at me. He turned to leave; when he reached the door, he looked at me and asked if I had heard him?

With tears welling up in her eyes, she explained that the doctor’s non-caring attitude and cold body language at that moment shocked her. Her other issue was that the doctor was not concerned as to whether she understood the meaning of the message, especially its implications to health.

Another immigrant woman expressed her gratitude to a doctor who, upon her admission for a caesarean procedure at a private hospital, arranged for a French-

speaking nursing sister in the hospital to be present. She was thankful that throughout her stay in the hospital, the nursing sister voluntarily kept her informed and reassured her family about her recovery. She claimed that this kind of support helped her to clearly understand and cope with the treatment and assisted her to start building a sense of trust during the process of recovery.

The other dimension of the doctor/patient relationship is the authority placed on the persona of a medical practitioner, especially when the medical practitioner is male. Medical practitioners are seen as most enlightened, fault free, and possessing the intellectual ability to correct what is wrong. This meaning does not only apply to their bio-medical abilities, but also with regard to the community's social and spiritual functioning. This phenomenon originates from the migrants' home countries. Reichler (1998: 52) states that immigrants have a very high regard for medical practitioners, and totally trust all information and instructions given to them without asking any questions about the diagnosis or causes of illness. This is the case even though they sometimes do not even fully understand the reasons for a particular treatment. It is thus rare to find immigrant women consulting with a different medical practitioner for a second opinion on the preliminary prognosis.

The other reason why most immigrant women patients rarely consult for second professional opinion is because they believe no doctor can be wrong. Participants in this study agreed that asking many questions regarding the prognosis or diagnosis may mean that a patient does not trust the medical practitioner, and fear that this might be seen as a waste of the medical practitioner's important time.

6.2.5.3 *Health promotion initiatives*

The World Health Organization (2002: 5) defines health promotion as the process whereby people enable others to increase control over their lives and improve their own health. Edelman and Mandel (2002: 18) depict characteristics of health promotion as follows:

- focusing on improving the general health promotion of individuals, families and communities

- practical and effective mode of care delivery
- potential to enhance the quality of life from birth to death
- individuals to take personal health responsibility
- activities to be health effective
- values and habits that will make a difference to an individual's health life.

Health promotion is motivated to specifically increase the well-being and actualize the health potential of individuals. Pender (1996: 7) asserts that promotion requires action in order to enhance the quality of flow of life in the human environment through an interactive process.

Women find health promotion effort to be a significant part of women's health provision. The availability of health promoters in baby and mother clinics in South African primary health care facilities are good educative strategies.

Promotional material produced in South Africa is mainly in English, and some in other local languages. Women speaking the Swahili language reported that they can try and read a few Zulu words on posters as they mostly bear the same meaning (as those in Swahili); however, in most cases, it is difficult. They agreed that the graphic expressions on the posters sometimes give them an idea of what the specific poster is about, but the significance of the real message is not always correctly captured.

Immigrant women gave an example of a poster that was apparently put up in most mother and baby clinics at a specific period. The poster was about pap smear promotion. They explained that when the health promoter kept on mentioning the word pap-smear they thought she was referring to some form of nutritional product or method. It was only at a later stage that they learned what it actually was about through friends. They had simply never heard of the word before and most confessed to have never had an opportunity to undergo such a test. Of those who already took the test in the focus group, most reported that they had it for the first time in South Africa after being referred by a medical professional.

Reproductive health promotion was appreciated as a strength in women's health care service. The fact that there is such a wide variety of free contraceptive products for all

women was well received. However, the matter of fully understanding how each product works in simple terms in order for them to make an informed choice was of concern. They found it difficult to trust these products as preventative measures and had questions on whether these would not cause infertility and reproductive complications later in life. The right to abortion and what one participant described as “loose display of condoms everywhere” were found to be controversial. These were seen by the participants to be encouraging sexual promiscuity and high rates of pregnancy among young women in South Africa.

The limitation in terms of language proficiency was described as a huge barrier that hindered women from fully understanding health risk factors and communicated health hazards. The drawback was, therefore, that health promotion initiatives targeting women do not reach all of them. The cultural and linguistic challenges have psychological, social and physical negative impact on these immigrant women in South Africa. This especially impacts on those who are non-English speaking.

6.2.6 Health Behaviour and Life-Style

The research participants in this study were very dynamic in terms of economic class, religious belief, educational background and social status. Some of the participants were professionals with very good qualifications. Others were successful entrepreneurs back in their home countries and were rebuilding their businesses in South Africa, while others have established small businesses. A few of these women were spouses of businessmen, medical and engineering professionals, as well as executive corporate employees or religious leaders. In the case of this group, their income affords them better living conditions and generally a good quality lifestyle.

It was among this group that one found exposure to health information, either through asking for more explanation when they received pamphlets or saw posters they did not understand. They could afford access to private medical care and were aware of the importance of taking pap-smear tests or mammograms. Transportation problems did not affect them much as they or their spouses or relatives/friends owned cars.

The larger group among the participants was that of immigrant women who registered as legal refugees; some with study permits, work permits and others

accompanying their spouses. They were found to live reasonably decent, humble lives. Most of them had basic necessities and were trying hard to make a living through hairdressing, dressmaking or managing stalls at flea markets. As single parents in this country, the majority of these women had to make ends meet in order to ensure that their children were provided for.

Their awareness of women's health care is moderate, but their factual knowledge is low. They are overwhelmed with the challenges of everyday survival. Although general self-care is well practised, they see specific women's health self care as "a luxury" they can only attend to after all important family matters are dealt with. On account of their financial constraints, they do not always follow up on medical care or commit to medical consultations. The researcher's observation is that this group is not merely ignorant of women's health care matters, but also preoccupied with survival necessities of their families.

As in the study conducted by Ahmad *et al* (2004: 28), the participants developed other methods of obtaining women's health information. In this respect they continue to rely on family, friends and social networks, especially those networks with religious affiliations. Television advertisements are also considered to have an impact. Workshops, radio and newspapers are the least women's health information sources immigrants rely on (Edelman & Mandel 2002: 19).

6.2.7 Self-Concept

According to Smeltzer and Bare (2000: 97), self-concept refers to one's view of oneself. It is an image that is developed over many years. It comprises attitudes about oneself, perceptions of personal abilities, body image and identity, and a general sense of self-worth.

Isolation, prejudice and elements of xenophobia affect immigrant women's self-perception, their sense of self-worth and their self-esteem. They all stated that they experienced strong feelings of not being wanted, feelings of not belonging, being different and sometimes made to feel not good enough. Some women pointed out that made them isolate themselves. They thus withdraw from circumstances that

would expose them as foreigners. The result of this is that they keep amongst their own people, people from the same region or other immigrants.

The participants were emotional about the fact that South Africans, including local service providers such as women's health professionals, do not always understand that they love their home countries. They stated that they were endeared to their own ways of life, but that it was mostly political and economic factors that forced them out of their countries of birth. As one participant put it, the immigrant women are concerned that "South Africans think that we are useless resource suckers, fishing for hand-outs".

They find the hostile and intolerant attitude of the women's health care service providers and their fellow local patients to be disruptive to their adequate day-to-day well-being. Even though they might not fully understand the local languages, the aggression expressed by the local people through body-language clearly communicates this hostility. This kind of environment destabilises their sense of security and safety, and enhances the feeling that they are vulnerable. A participant captured this sentiment thus:

Sometimes they make you feel like you are not important. The doctors and nurses speak over you as if you are not there; for that moment you actually start believing that you are invisible and that you can never understand what they say or decide about you and your health.

Descriptive data in this study indicated that this happens mostly when they (immigrant women) are treated by male doctors. The question of gender imbalances in male doctor/female patient relations, combined with those of insensitive service provision have already been discussed at length. In this vein, the participants emphasised that they did not want to be treated as if they were special fragile cases who could not do anything for themselves. They indicated that they tried hard to retain their self-respect, their dignity and sense of independence. Spiritual focus and issues of faith frequently came up as their sources of courage and coping mechanisms.

6.3 IDENTIFIED HEALTH NEEDS OF IMMIGRANT WOMEN

Immigrant women in South Africa appreciate the wide range of women's health care facilities, services and bio-technology offered by the country. However, it is evident that there is an existing gap between the expected and available methods of service delivery. A number of needs were identified with great involvement of participants in this study. Recognition, acknowledgement and an effort to put in place mechanisms to meet these identified needs will directly improve the quality of health care service rendered to these and other immigrant women in South Africa. Such an act will ensure the realisation of the "Health for All" and the "Batho Pele" public service provision principles that this country attributes to its human rights-based constitution (Barron 2000: 20).

6.3.1 Immigrants' Orientation Programme

The immigrant women made the point that when they arrived in South Africa they expected to undergo a formal orientation programme, whereby they would be made aware of how things work in their new country of settlement. Their view at present is that the government misses the opportunity of gathering factual data about the health needs of immigrants in general at the stage of entry into the country. It is as a result of this that they mostly get lost in the system, and therefore encounter many problems due to a lack of awareness and knowledge.

The Minister of Home Affairs, Ms. Nosiviwe Mapisa-Nqakula committed her department to a service process that was designed to make the lives of immigrants easier, whereby special identification cards would be issued to all legal refugees. Her view was that the advantages of possessing such a card include the right to health care, the right to study, work, find accommodation and be able to enjoy the security of using commercial financial institutions such as banks (Radio interview: Minister of Home Affairs and J. Maggs, 5FM 2007).

In the same interview, the minister was asked about the role of the department in relation to structured orientation alternatives to refugees and related controversies. In her response, she explained that her department was busy conducting an in-depth

survey to determine the potential of establishing one-stop service centres. Through these service points, she said people will be rendered humane services at arrival. This would also improve the treatment of immigrants by all concerned officials and the public.

6.3.2 Women's Health Services Access Brochure

There was a discussion on the need for a women's health resources list to be included in the package for new immigrants at arrival in the country. This is anticipated to be a helpful tool to direct them as to where exactly to go for medical help, and how to go about the right channels in accessing these resources. Participants agreed that such a compilation should include services rendered by other departments and non-governmental organizations.

6.3.3 Multi-lingual Women's Health Promotion Brochures

The immigrant women clarified the point that they understood the enormous financial implications of a request for full translation of brochures and posters to other foreign languages. They acknowledged that it seemed an impossible expectation at this stage in South Africa, as the country is still battling to produce material translated in all the local languages. They, however, pointed out that they do have a need for women's health promotional material designers to, at least, translate the headings and captions into other main foreign languages predominantly spoken by immigrants in South Africa. Examples of such languages include Portuguese and French.

The immigrant women believe this would give the readers a sense of what the promotion is about. Their view is that this will further stimulate curiosity and encourage immigrant women to ask more relevant questions during the promotion, and thus allow them to participate and spread information from an informed position.

6.3.4 Non-Institutional Women's Health Promotion Initiatives

Informal women's health promotion initiative is an identified need that the government has to consider as an option. It has to be adopted as an alternative approach which

gives special attention to immigrant women as a peculiar group. This will enable them to access health information. This approach is further discussed below (see 6.4.).

6.3.5 Tailor-made Women's Health Services

The existing International Declarations influencing women's health status in the world bind governments, including South Africa, which are signatories to those agreements and conditions at all times. The challenge is that countries are also expected to also invest in tailoring their services. In this way, they can ensure that they meet specific needs of the general and specific women's groups in areas such as programme financing, implementation, education and service rendering.

6.3.6 Women's Health Practitioner's Awareness Raising

There is a need for medical practitioners in the women's health care sector to be informed about the specific needs of immigrant women. In this respect they can avail themselves of these requirements when dealing with this target group. It will also help the system to be more user-friendly. Women's health care providers, both nursing staff and professional doctors, will thus be in a position to treat these patients from a specific knowledge-based approach. This is another area that emphasises and calls for multi-sectoral programme implementation. The Immigration Office's health profile drawn during the health screening procedure when the immigrant women entered the country might come useful in shedding light on the patient's medical status and acquired history (United Nations Population Fund 2004: 97).

Continued training or in-service training of medical professionals on cross-cultural matters is also important in that their information on different clustered cultural backgrounds, norms and expectations are mirrored in the pluralistic new South Africa. Although medical professionals are involved with the science of healing, they should not ignore human relations as they are fundamental elements of their profession. It is widely believed that in addition to family support, good doctor/patient relations are beneficial in enhancing the recovery of patients.

6.4 RESEARCH PARTICIPANTS' RECOMMENDATIONS

Participants who have food or goods stalls in a popular and easily accessible flea market known and frequented by most immigrant women living in the Tshwane Municipal area, stated that they and other women trading in the same informal industry would not mind posting women's health promotional material at their stalls. They reported that there is a constant flow of immigrant women from the African Great Lakes purchasing food and different products (from their region) at these stalls on a daily basis. A few women who owned hair salons and those whose spouses owned barber shops and internet cafés also volunteered free space for advertisement at their businesses.

There was also a suggestion that health promoters should approach the women who have some form of English language understanding, with a view to enlist their services to educate fellow women on women's basic health information. They would even be willing to interpret at women's health talks.

Immigrant communities' local newspapers and circulated newsletters were mentioned as possible mediums to advertise and publish women's health information, events and promotions.

Women's health promoters were openly invited to women's religious weekly meetings to target those halls, churches, mosques and synagogues where there are immigrant women community gatherings. In any case, the women experienced these meetings as already serving as opportunities for shared support and awareness-raising amongst immigrant women with similar challenges.

These recommendations from this specific group of women's health care service beneficiaries clearly demonstrated their pro-active approach to the problems they were faced with. Their will and urge to use what is at their disposal and within their legal capacity to contribute towards helping themselves is perceived as part of their individual and collective strength.

6.5 RESEARCHER'S RECOMMENDATIONS

The researcher realised that the immigrant women own perceptions of health services access barriers also stemmed from their view of the health system as too advanced and therefore too complicated to understand and too difficult to utilise.

They do not easily understand the holistic approach to women's health care. This is because in their perception, the non-physical health matters are minor. It is on this account that they do not adequately attend to these ailments. However, like other research works done in this subject area, this study reveals that immigration factors play a major negative role on immigrant women's mental health. Data deduced from discussions about this feature showed that their physical ability to go about and do what they have to is seen as more important. The management of the equilibrium between the two aspects (that is, mental and physical) is "not always possibly attainable" in their new circumstances, and thus easily dismissed as not important (Reichler 1998: 22).

6.5.1 Holistic Approach

It became important to explain that this approach (holistic approach) carries the same principles as their (immigrant women's) traditional view of the high value placed in protecting the body, mind, emotions and spiritual harmony in human beings. This is a perspective they could easily assimilate into their belief and ways of living as it resonates with their own life worlds. Ahmad *et al* (2004: 59) point out that the bio-medical approach, however, views the human body as a series of body parts, and health as the absence of disease or abnormality. This can be interpreted as a way of compartmentalizing the mind and body health. We must all move away from this perspective.

At its present progress towards women's development, women's health care service profile cannot afford to live up to this boxed image either in any part of the world. Research, popular culture and future-focused health trends emphasise a call for a holistic health care approach, which entails inclusive and totalized, but dynamic women's health care (World Health Organization 1998: 36). We therefore need to

keep in step with international developments in upgrading services, research and practice of women's health care, its review and monitoring, as well as its financing.

6.5.2 Specific Provisions

The South African National Health Department, especially the women's health directorate, needs to recognise that central to the realisation of the human rights of women is an understanding that they should not experience any form of discrimination. All other service providers need to ensure that women are protected from all forms of human rights violations that often victimise them only on the basis of gender. They significantly need to agree that there is a multiplicity of factors at play. These include race, ethnicity, age, class and sexual orientation.

These spheres of experience originate from different structures which, at most, overlap in application. Policymakers, programme planners and service providers need to ensure that the cross application inherent in the women's health care service system does not neglect, further marginalize or offer immigrant women in the country a compromised quality of services. Matters of gender specifics and sub-group specifics need to be taken into consideration in programme planning and implementation (United Nations 2000: 31).

6.5.3 Participation and Decision Making

Women's equal participation in all spheres of life is of a pivotal role in the general process of own courses. They have shown that they can be good leaders as rightful participants in different forums previously dominated by men and that they can unite against the barriers imposed by culture (Norsigian 1993: 19). It is therefore critical that women should have a say in the services meant to cater for their specific health needs. By participating in policy making, programme design, implementation monitoring and evaluations, women (including immigrant women) will be health participants and owners. They will be empowered to make decisions on a broader scope of women's health care issues, ensuring that all render and receive decent health services.

6.5.4 Free Access to Mother/Baby Health Care Services

The government and the Department of Health are duly praised for their free provision of these health care services to women, mothers and babies, including legal immigrant women. This service allows a continuum of health care, building in a holistic patient focus in an integrated health system from primary to tertiary levels (Health Services 2007: 45). What is exciting about this system, from a women's health researcher and gender practitioner's point of view, is its integration from primary to tertiary level.

The challenge remains for the women's health care workers in both the public and the private sector to familiarize themselves with the expectations and know the needs of IW as their patients/clients and a group with special needs. They should try to create an environment of care and trust so that the service users are able to open up and communicate honestly and freely.

6.6 LIMITATIONS OF THE STUDY

This study was challenged firstly, by the fact that the target group in its situational composition is highly mobile. As mentioned earlier, being mainly women bread winners and accompanying their spouses, they are always in search of a better life. They thus relocate from city to city, sometimes spontaneously responding to the pull factors that present as opportunities. Continuation was sometimes a problem, but the researcher improvised through telephone interviews. This helped to create a sense of continuity, participation and an opportunity for proper conclusion of the themes that were under discussion at a point of interruption.

Secondly, the language issue was sometimes time-consuming as the participants comprised English and French speakers. Amongst the French speakers, some were more eloquent in Lingala (one of the native languages most spoken in Central Africa and popularly used in both Congos). Although the focus group meetings were mainly conducted in English, expressions in French and Lingala had to be translated/interpreted for English-speaking participants. The same would apply when unfamiliar

English words were used. The participants, however, enjoyed this exercise as it presented learning opportunities for them.

The third limitation identified was researcher's bias. As the researcher has direct personal links with the Congolese community, this could have increased bias. To prevent this from interfering with the scientific quality of this study, the researcher intentionally implemented reflexivity, intuiting and bracketing through out all stages of the study. Member checks were enabled as well as reviews of interviews, transcriptions and analysis and coding by another experienced researcher and practitioner in the related field of study (Tseng-Wen-Shung 2001: 88).

This study dealt with issues which were context-bound to immigrant women from the African Great Lakes living in the Tshwane metropolitan area, in the Province of Gauteng, South Africa, as a specific group. It thus explored and described their specific experiences. The researcher, therefore, does not claim that the findings of this study will be applicable generally or to all contexts. If the reader for any reason considers transferability of these findings, the context in which this study was conducted should be contemplated.

6.7 RECOMMENDATIONS FOR FURTHER RESEARCH

Other researchers and health professionals consulted throughout this study reaffirmed that there is a need for a more comprehensive research in other provinces or cities in South Africa. They highlighted the need to do such a research with immigrant women from other African regions and even other continents. Such findings might contribute to the development of relevant models or the establishment of implementable and measurable policies. These can be utilized in the improvement of the quality of women's health care throughout Africa and the world. Importantly, such results could provide governments and relevant stakeholders with factual insight regarding the needs of immigrant women, in order for them to be able to provide more comprehensive support and good quality services.

The experience from this study brought the researcher to the realisation that women's health research needs to be multi-disciplinary and cross-sectional. This will

assist in bringing out realistic and reliable results that can be used to plan for adequate remedial strategies.

More resources should be invested in scientific research on holistic women's health care services, systems, programming and actual service-rendering strategies and educational methods. This will help in further scientific investigation on the issue of women's care services. A comparative in-depth study on methods used to service health care needs of immigrant women in first-world countries and developing countries could help bridge the gaps and better the quality of immigrant women's lives. This approach could help to elevate the needs of immigrant women in various host countries, and thus qualify immigrant women's holistic health as a priority.

6.8 CONCLUSION

Women's health as a gender subject needs to be expanded in curricula to include not only chronic, mortality and morbidity issues. Attention should also be given to the psychological changes that occur and the preparedness required in a woman's life cycle. Specific role assumptions and self-actualisation skills are critical for the optimal health development of a woman. This appears to be especially so for immigrant women, given their conditions and everyday life challenges. Optimal well-being and wholeness can, however, never be accomplished if gender-specific medical practice does not include all the tenets of health that encompass the attainment of such envisaged optimal well-being.

Regarding this research in general, it is the researcher's hope that this exercise contributes to the deeper understanding of the socio-political plight of immigrant women. In addition, it is hoped the research will draw attention to the frustration caused by the economic conditions and legal status on the part of immigrant women. In this regard special attention needs to be given to their women's health challenges and needs. The research, it is hoped, should contribute in the spread the spirit of social justice, gender equality as well as uphold and protect the human rights of all immigrants, especially immigrant women and children in the effort of combating xenophobia. It is the researcher's earnest wish that this research report will have a positive transformative impact on South Africans who will have access to it.

This is a concluding chapter of the overall study on the health needs of immigrant women from the African Great Lakes living in South Africa. The chapter covered the research findings, part of which identified the health needs of immigrant women. The recommendations were raised by both the research participants and the researcher according to the themes recorded from the data analysis. Specific limitations of this study were cited, and possible future research themes recommended.

The researcher wishes for the recommendations from this study to constructively serve as a basis for future research projects. These recommendations could inform policy in different participating ministries, as well as in channelling significant attitude changes in individuals and, subsequently, institutional women's health service providers.

It is hoped that through this project the research participants became empowered. As suggested in the outline on Participatory Action Research (see 4.1.1), empowering participants is one of the key objectives of such research projects. The participants reported that their involvement in the research process has had a positive contribution or impact on their lives, and that they will continue to share the experience with others.

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RADIO INTERVIEW

(5FM, 2007. Jeremy Maggs Show. 27 June 2007, 10:00)

APPENDIXES

APPENDIX A: ETHICAL CLEARANCE CERTIFICATE

27/10/2009 03:05 012-429-8998

HEALTH STUDIES

PAGE 01/01

**UNIVERSITY OF SOUTH AFRICA
Health Studies Research & Ethics Committee
(HSREC)
College of Human Sciences**

CLEARANCE CERTIFICATE

Date of meeting: **21 July 2008** Project No: **3310-268-6**
Project Title: **The health needs of immigrant women from the African great lakes living in South Africa**

Researcher: **Mulemfo DML**

Supervisor/Promoter: **Prof O Makhubela-Nkondo**

Joint Supervisor/Joint Promoter: **Prof CL Obi**

Department: **Health Studies**

Degree: **MA Cur**

DECISION OF COMMITTEE

Approved

Conditionally Approved

Date: **23 August 2008**

VJ Ehlers

**Prof VJ EHLERS
RESEARCH COORDINATOR: DEPARTMENT OF HEALTH STUDIES**

M Bezuidenhout

**Prof MC Bezuidenhout
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

APPENDIX B: INFORMED CONSENT FORM**AGREEMENT TO PARTICIPATE**

Research Study : Health Needs of Immigrant Women from the African Great Lakes Living in South Africa

Researcher : Desirée Mulemfo **Contact No** : 0714024120/012 8039516

Background

Lack of effective health screening procedures and orientation programmes for immigrants entering South African borders exasperates women's health problems of immigrant women. Immigrant women have different health concerns and women's health needs. Most research has shown that immigrant women have challenges in accessing women's health care facilities, and that immigrant women are the most vulnerable group socio-economically and get less treatment for their health problems.

Main Goals

1. Explore factors hindering immigrant women from accessing women's health care services.
2. Identify women's health needs of immigrant women.

Gathered Data Usage

1. Expose factors relating to the two above mentioned main goals.
2. Raise awareness of professionals in the women's health care sector and policy makers
3. Empower immigrant women with information and skills to easily access and adequately utilise women's health care facilities.

Data Collection Methods

- Individual interviews.
- Focus groups.
- Semi structured interviews.
- Other aids include tape recorder, field notes, observation notes, narratives.

Information Handling

1. All written reports are accessible to participants
2. No information gathered will be shared with third party without participant's permission.
3. Information gathered is the property of the participant and may be collected when the participant withdraws from the research.

Ethical Procedures are Established by

1. Confidentiality
2. Permission
3. Informed consent

If at any stage you wish to withdraw from the study, you are free to do so.
If you wish to contact the researcher at any time, you may.

I.....have read and I understand the information hereby contained. I agree to participate in this research with the mutual understanding that I may withdraw at any time without prejudice. I agree that the research data generated may be published without use of my name or any identification.

Signed..... **Date**..... (Participant)

Signed..... **Date**.....(Researcher)

APPENDIX C: FOCUS GROUP INTERVIEW GUIDE

INTERVIEW GUIDE

Migration Factors

- Forced to leave country of origin
- Decision to migrate
- Country of origin
- Countries of transit
- New country visited before migrating
- War in country of origin
- Refugee camp experience
- History of torture/abuse
- Trafficking experience
- Family separation
- Relocation to new country
- Detention Centre experience
- Contact with country of origin
- Length of time in new country
- New language proficiency
- Discrimination experiences
- Acculturation experiences
- Socio-economic factors
- Legal status in new country
- General access to services

Bio-psychosocial Factors

- Age
- Education
- Religion
- Diet
- Nutritional status
- Infectious diseases
- Injuries/wounds
- Chronic illness
- Disabilities
- Social support
- Economic status
- Life-skills

Women's Health

- Family planning
- Post abortion care
- STI/HIV prevention
- Female genital mutilation
- Sex and gender based violence
- Pregnancy and child birth history
- Recent/ current pregnancy
- Anti-natal health care
- Menopause
- Depression
- Post partum health care
- Activity after birth (work, school)
- General health care
- Vaccinations
- Life-style
- Health behaviour
- Health belief information
- Health information
- Women's health care
- Women's health care promotion

Infant Health

- Gestational age at birth
- Birth weight
- Gender
- Feeding
- Breast feeding
- Growth and development
- Infections
- Congenital conditions
- Vaccinations
- General health
- Child care information and skills
- Infant mortality issues

APPENDIX D: INTERVIEW SCHEDULE FOR INDIVIDUAL IMMIGRANT WOMEN**INTERVIEW SCHEDULE**

The themes are organised in the order of a typical interview; however, they are suggestive rather than obligatory. Wherever possible the questions have been worded with gender, cultural, ethnic and other sensitivities in mind and the wording is thus generic so as to be modifiable for the targeted respondents.

Date.....Age.....

Location.....Audio tape (YES).....(NO).....

Demographics

Where were you born and raised?

Your spouse?

Your children?

How many years have you been in South Africa?

Your spouse?

Your children?

What is your educational background?

Your spouse's?

Do you have school going children?

Are you presently employed?

Your spouse?

Are you involved in any form of business venture?

How many languages do you speak?

Do you speak and understand English?

Do you speak or understand any local African language?

Social life

Do you have good support systems?

Do you have any friends/relatives from your home country (in S.A)?

Do you have native South African friends?

Do you frequently socialise within your community?

Do you regularly attend local/any religious meetings?

Do you belong to any social club/movement in South Africa?

Do you know your neighbours?

Do you interact with your neighbours?

Do you participate in neighbourhood events?

Do you find similarities between your present community and that back home?

Do you eat local food?

Do you sometimes dress like the local people?

What are the things that make you feel good about living in South Africa?

Do you find life “easier” in South Africa?

Do you benefit from any opportunities provided by South African systems?

Health Matters

What does good health mean to you?

Have you recently consulted with any medical practitioner?

Have you recently been hospitalised?

Are you presently taking any prescribed medication?

Do you ever self medicate?

Do you ever use alternative medicines?

What do you understand by mental health and emotional health?

How important is your spiritual health?

How do you maintain good holistic health?

Can you think of some general kinds of things in your life that affect your health?

Are your basic every day needs met?

Are you satisfied with the quality of your family life?

What are some of the things you like about South African health care system?

What don't you like?

What could be improved?

Describe your experiences concerning visits to the local clinic and public hospital?

Were your visits to private hospitals and other private health facilities different?

Were these visits different from the medical consultations back home?

How comfortable are you with the interaction with your doctor?

How do you feel about physical examinations?

Does it matter to you whether the doctor is male or female?

What if anything, would stop you from going for health care if you feel you need it?

Do you find others, including medical staff, helpful at health care facilities?

Do you think that your doctor and other professional practitioners understand your needs?

APPENDIX E: MAP OF SOUTH AFRICA



APPENDIX F: MAP OF AFRICA



APPENDIX G: MAP OF THE AFRICA GREAT LAKES REGION



APPENDIX H: NEWSPAPER CLIP: 2008 XENOPHOBIA IN SOUTH AFRICA



Left: Locals torched homes belonging to foreigners in Brazzaville.



Right: Displaced foreigners were transported to the Atteridgeville police station by the police.

Immigrants say they are tired of running, and ready to fight back

PATRICK HLAHLA

Scores of foreigners have fled their homes after their shacks were set alight by marauding groups west of Atteridgeville.

Fighting in the sprawling informal settlements of Brazzaville, Jeffsville, Phomolong and Siyahlala broke again out early yesterday morning.

Several shacks and businesses were set alight and a number of foreigners were injured when they were attacked by the marauding groups, consisting mostly of youths.

Paramedics struggled to reach some of the injured as roads in the informal settlements were inaccessible and many of victims had fled into the mountains.

Displaced foreigners were transported to the Atteridgeville police station by both the Tshwane Metro Police and the SAPS.

Yesterday's attacks took place while local ANC councillors, the police and other stakeholders met at the local police station in a bid to find a solution to the problem and to find alternative accommodation for the foreigners who are currently being housed in a school in the township.

Shop owner Samuel Jaime called the attackers "criminals", saying the gangs had looted the foreigners' stores and shacks.

"I was attacked last week Tuesday by criminals who looted my shop before setting my shack alight.



□ A policeman stands next to a burning shack.

"These people came again today (yesterday) to finish me off," Jaime said.

He said he was forced to leave his family behind when he fled to the police station.

"I think next time, I will stand and fight back. I am tired of people targeting my family," said Jaime.

He said most of the people in the area were jealous of the success of some of the foreigners in Brazzaville.

"We know who is behind these attacks and we are prepared to fight them.

"We have gone to the local police station for assistance and they have refused to assist us," he said.

Jaime said some of the locals did not like it when foreigners owned shops and possessed cars.

"They ask questions and come up with stories that we are criminals, which we are not," Jaime said.

Another foreigner, who did not wish to be named, said they were prepared to defend themselves.

"These groups of youngsters and a few adults are attacking us for no apparent reason.

"We are legally in the country and we have identity documents to prove that but these people do not want to know," he said.

The man said he knew "how to fight", adding that he was prepared to

tackle those behind the violent attacks.

"We know who they are and we can attack them if we want," he said.

He claimed that he had shown them his ID to prove that he was legally in South Africa and employed but they did not want to listen.

Dikeledi Lehobye, the mayoral committee member responsible for community safety said the situation was "worrying".

Lehobye said of concern to them was the fact that there were some criminals who were behind the attacks.

"This is worrying because clearly there is no element of xenophobia.

"People are looting shacks and shops and this is a criminal act," Lehobye said.

She said there was a need for increased police patrols in the affected areas.

"The situation is volatile and we need more police patrols to bring the situation under control," she said.

Lehobye said the municipality was working together with all stakeholders in the township to find a solution to the problem.

Atteridgeville police spokesperson Captain Thomas Mufamadi said four suspects have been arrested in connection with the yesterday's incident.

Mufamadi said all displaced people would be housed at a school in the township. According to Mufamadi the situation was quiet late yesterday afternoon.

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