



**UNIVERSITY of the
WESTERN CAPE**

FACULTY OF ARTS AND HUMANITIES

DEPARTMENT OF SOCIOLOGY

**NARRATIVES OF MATERNAL MENTAL HEALTH CHALLENGES AND
OPPORTUNITIES AMONG AFRICAN IMMIGRANT WOMEN IN CAPE TOWN**

BY

LYDIA EGHOSASERE IYI

STUDENT NUMBER: 4164921

**FULL DISSERTATION SUBMITTED IN FULFILMENT OF THE REQUIREMENTS
FOR THE DEGREE OF MASTER OF ARTS IN SOCIOLOGY**

SUPERVISOR

PROF EMMANUEL MAYEZA

November 2025

ABSTRACT

Maternal mental health challenges are a critical aspect of women's reproductive health that occurs in the perinatal period—during pregnancy and after giving birth. The condition is characterised by the onset of mental illnesses such as depression, post-traumatic stress disorder, anxiety, and, in some cases, substance abuse disorder. Maternal mental health challenges affect the quality of care that affected mothers provide for their children; it impacts their ability to function properly, cope with the everyday demands of life, and also affects the quality of life of the mothers themselves.

Despite the seriousness and prevalence of maternal mental health conditions among women of reproductive age, as established by many studies before this one, the situation receives little attention in many healthcare settings in Africa. For example, in South Africa, one in three women experiences mild to severe mental health conditions during pregnancy or in the postpartum period. Such women often struggle to access adequate care, support, or the treatment they need to deal with issues that arise in the perinatal period. Poor maternal mental health among women in the perinatal period is linked to risk factors such as poverty, violence, abuse, migration, and substance abuse, among others.

To provide more insight into the maternal mental health challenges in the African context, this study explores the maternal mental health experiences of African immigrant women in Cape Town (South Africa). The study rests on the assumption drawn from previous studies that ideological, structural, and socioeconomic positions of African immigrant women shape the manifestation of these conditions. Therefore, this study aims to explore the maternal mental health experiences of African immigrant women in Cape Town in terms of challenges and opportunities, by adopting a qualitative research methodology. The researcher conducted a semi-structured one-on-one in-depth interview with fifteen African immigrant women in Cape Town.

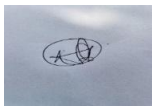
Braun and Clarke's (2013) six-step thematic data analysis technique was adopted, which resulted in the key findings. The findings revealed a high prevalence of common maternal mental health conditions amongst African immigrant women who participated in this study. It also highlights barriers to accessing maternal healthcare services, including limited awareness of maternal mental health intervention programmes in some healthcare facilities visited in Cape Town. Cultural and religious beliefs, stigmatisation, and the notion of resilience also emerged as key findings that act as non-structural barriers to the use of maternal mental

healthcare services by participants in this study. The findings underscore the need to strengthen maternal mental health policies, advocacy, and intervention programmes in perinatal healthcare settings in Cape Town to accommodate the maternal mental health challenges and needs of African immigrant women in South Africa.

Keywords: African immigrant women; mental health; maternal health; maternal mental health; Ronald Andersen's theoretical framework, South Africa

DECLARATION

I, Lydia Eghosasere Iyi, solemnly declare that this dissertation titled “Narratives of Maternal Mental Health Challenges and Opportunities among African Immigrant Women in Cape Town” is my work and has not been previously submitted to any institution of education for the award of a degree. All the work of others used in this study has been duly acknowledged through referencing.



November 2025

L.E Iyi

Date

DEDICATION

I dedicate this work to God, the giver of life and maker of everything; be glorified and praised forever, Amen! I also dedicate this work to all my honourable participants, all the women who suffer from maternal mental health challenges in silence. This work is for you. Your silence echoes louder than a million voices. I feel your pain, I understand your struggles, and I hear your voices through this work. Victory shall be yours at the end. Do not give up.

I further dedicate this work to my dearest mother, Mrs Maria Osatohanmwun Iboyi. You are the inspiration behind this work because I wanted to understand your pain as a pregnant woman suffering from a perinatal mental health condition. I found the answer, Mum, but too sad you are not here to celebrate this victory with me. However, I am confident that you are proud of me.

Finally, I dedicate this work to my beloved father, Mr Sunday Edeye Iboyi. You passed away just barely three months after I started this work. Your passing has left an eternal vacuum in my heart, and I pray God heals this pain.

ACKNOWLEDGMENTS

I thank God for the grace to complete this work. Indeed “I will lift up my eyes to the hills, from whence comes my help? My help comes from the Lord, who made heaven and the earth” (Psalm 121:1-2). You have been my strength and my light, my God in whom I will trust. Thank you for the inspiration, strength, and direction throughout this work.

In the course of writing this dissertation, I received the invaluable support of very many people in various ways that time and space will not permit me to mention all of them here, but I want you all to know that I am grateful.

My profound gratitude goes to my research supervisor, Prof Emmanuel Mayeza. I am grateful for all your support, timely feedback, professionalism, and patience. Your contributions are invaluable. I truly appreciate it. And thank you for nominating me as a recipient of the UWC DVC for Research and Innovation Bursary. This funding was helpful to me in completing this study.

To Dr Chinwe Obuaku-Igwe, thank you for your assistance in the earlier stages of this study.

I thank my colleagues in the Department of Sociology, especially Dr Susan Hollard-Muter, who often sent me materials she considered useful to my topic. I am grateful for your kindness.

To Dr Lionel Thaver, I say a big thank you. Working with you as a tutor for over two years was incredibly enriching for my professional and career development. I learned a lot from you, and I wish you happiness and peace in your retirement. My prayer for you is that God grants you good health to enjoy the fruits of your labour. You deserve it.

To Sharyn Spicer, Celse Sabakwiye, Remoneilwe Mogatosi, Trevor Makhetha, Vanessa Mpatlanyane and Shireen Parsley, I say thank you all for your encouragement in one way or another as colleagues in the Department of Sociology. This journey has been an incredible experience with each one of you playing an important role. To my very special women, Mrs Bernadette Epie Munge and Mrs. Liezl Moodie, I say a big thank you for always willing to share your time with me and directing me to learning opportunities within and outside the university. Your suggestions and input in this work are much appreciated, God bless you.

To my classmates who began this journey with me (Laureen Tamsyn Richards, Babalwa Ganya, Vanessa Hlaka, and Laura Bari Yembe), I thank God for giving us the strength to come this far, and I wish you all fulfillment in all your life endeavours. To Laura, this journey has established a special bond between us. I appreciate your support, care, and contribution toward my work. I have fond memories of the moments we share in the postgraduate labs, the library, working for hours, and discussing research. Thank you for always being willing to listen to my groanings and encouraging each other to get to the finish line. You are the epitome of strength and beauty. I pray that the good Lord blesses all your sacrifices and hard work.

I would also like to thank all my colleagues at the library. Seeing you all every time I go to the library gave me the courage and resilience to complete this work; you all inspired me in one way or another. Thank you for staying true to the cause. To the librarians, my cleaner friends, and security guards, thank you all for motivating me in your own unique ways. I would like to thank the Postgraduate Research Office for providing me with the opportunity to attend the thesis completion retreat in June 2024. The experiences were incomparable. The retreat helped me overcome my brain freeze and gave me the motivation to complete this work.

I would like to express my deep gratitude to the following persons who were a constant source of motivation, encouragement, and inspiration to this work: Dr Olusola Adeniyi and his team of postgraduate research coaches; God's Love Chifon, Godwin Adeoye, Letitia Butler and Ndivhuho Beauty Takalani. Thank you for your guidance throughout the data analysis stages of this work. To Mrs Lousia Van Romburg and Mrs Monique Manuel at the Centre for Student Support Services, I say a big thank you for your time and genuine commitment to seeing that I maintained a positive mindset throughout the period of working on this dissertation. To my campus family at the Health and Wellness Unit, Prof Rashid Ahmed, Mrs Michelle Jaftha and my fellow peer educators, thank you for providing a safe space for me. I am grateful.

Special thanks to Dr Kinsley Ekene Amaechi, Dr Friday Alaji, Dr Ajele Kenni Wojujutari, Knowledge Mabhena, and Dr Femi Adeagbo, for your mentorship and guidance.

I am eternally grateful to my special friend and colleague Sivenathi Ngadlela for willingly offering me her laptop for three months after my laptop broke down at a very crucial stage of this work. Indeed, your action is a true reflection of the African principle of ‘Ubuntu, Abantu’. My prayer every day for you is for God to bless you in a very special way and that the universe will provide your needs every day (*Ndiyabulela Netshomi*).

I am very grateful to the following families who served as my support system on this journey: the Diala family, the Oriakhogba family, the Omoruyi family, and the Aderibigbe’s family. Words will not be enough to express how grateful I am for your encouragement, support and care throughout this journey, but I know that God will reward you for your kindness.

To my siblings, Ovie Kelly Iboyi, Praise Iboyi, Osahenoma, and Hannah, thank you all for your support and encouragement, I could never have asked for better siblings. I love you all.

To my in-laws, thank you for your love and for believing in me and supporting my dreams. This would not have been possible without you. May God continue to bless you all in Christ name, Amen! To my dearest husband Prof. John-Mark Iyi, you have been my rock and biggest support system. This work would not have been possible without you by my side. Thank you for all your sacrifices, unwavering love, inspiration and encouragement. Thank you for fulfilling your promise to me. This is for you my most beloved husband and friend. You made life very easy for me and you gave me the confidence that I can achieve anything I set my mind to. Thank you for holding my hand through it all and for believing in me. I want to do life with you forever. I love you dear.

To my beautiful children, Nosamudiana, Efosa, Esenosarumen, Esenosariemen, Osayande, and my most handsome nephew, Omovigho Iboyi, thank you all for being my biggest fans and I am very thankful to God for placing you all in my life. My adorable daughter “Nosa” deserves special thanks for demonstrating a level of understanding and encouragement rare for her age. Your gentle words “mummy have you completed your thesis?” served as a constant reminder and was often a strong motivation for me to do this and make you proud and I am glad we did it my baby.

LIST OF ACRONYMS AND ABBREVIATIONS

- AIW African immigrant women
- AIDs Acquired immunodeficiency syndrome
- BMHSU Behavioural Model of Health Services Utilisation
- CPMH Centre for Public Mental Health
- DHA Department of Home Affairs
- DSM-IV Diagnostic and Statistical Manual of Mental Disorders
- EPDS Edinburgh Postnatal Depression Scale
- GAD Generalized Anxiety Disorder
- HIV/AIDS Human immunodeficiency virus
- LMIC Low- and middle-income country
- MMH Maternal mental health
- MMHG Maternal mental health guidelines
- MM Maternal mortality
- MMFR Maternal mortality in facility ratio
- SADC Southern African Development Community
- SDG Sustainable Development Goal
- SA South Africa
- TOP Termination of Pregnancy
- USA United States of America
- UNDESA United Nations Department of Economic and Social Affairs

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TITLE PAGE

**NARRATIVES OF MATERNAL MENTAL HEALTH CHALLENGES AND
OPPORTUNITIES AMONG AFRICAN IMMIGRANT WOMEN IN CAPE TOWN**

CHAPTER 1

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction

Owing to economic, political, educational, and social reasons, many developed countries are witnessing an increase in transnational migration of people into their countries. While some of this influx may be voluntary on the part of the immigrants, other forms of migration are involuntary. For example, looking at the trend in the resettlement of refugees, one can argue that many of the persons in this category of migrants are victims of armed conflicts, political unrest or persecution, forced displacement, natural disasters, and climate-induced displacement from their home countries. Meanwhile, for voluntary migration, people often consider push and pull factors. For example, harsh economic conditions, lack of employment, low wages, lack of access to education, and general state of insecurity are some of the push factors that motivate people to migrate from their home countries. On the other hand, countries offering better economic opportunities present pull factors that attract these individuals. For example, in the last decade, there has been mass migration of healthcare workers from many African countries to the Global North (notably, the United States of America, Canada, Australia, New Zealand, and the United Kingdom). Most of these migrants are of African descent (Omenka et al. 2020). In Africa, South Africa has often served as a top destination for both voluntary and involuntary migrants (Alfaro-Velcamp and Shaw, 2016). Attracted by South Africa's economic and political stability, immigrants from neighbouring African countries particularly within the Southern African Development Community (SADC) region as well as immigrants from other parts of Africa, Europe and America regard South Africa as a favoured destination (Ferdinand Mukumbang et al. 2020; Victor Mlambo, 2017).

According to Abha Jaiswal et al. (2024, p.3), Mukumbang, (2020, p.2), as of 2019, South Africa has about 4.2 million migrants, with about 43.1% of them being women. This is a significant increase in the number of immigrant women living in South Africa since the dawn of democracy in 1994. This increased influx in migration and the population of female migrants has increased the demand and pressure on the South African healthcare system, making it difficult for the state to meet up with its population's healthcare needs and thereby

exacerbating the maternal mental health situation of African immigrant women in the country (Jonathan and Godfrey, 2014).

The focus of the current study is to explore the maternal mental health experiences, challenges and opportunities for African immigrant women in Cape Town, South Africa. The purpose is to demonstrate how structural and non-structural factors impact African immigrant women's experiences of maternal mental health in Cape Town, South Africa.

What follows in this introductory chapter is a brief summary of the theoretical and empirical background from which the current research has studied African immigrant women's experience of maternal mental health in Cape Town, South Africa. As part of this discussion, this chapter highlights the sociological assumptions of maternal mental health issues of African immigrant women in the section. Thereafter, the chapter outlines the problem statement, the rationale of the study, the research aims and objectives, the research methodology, concept clarifications, an overview of the chapters and a conclusion.

1.2 Background

Underlining the relocation experiences of migrants are some unforeseen challenges that often impact their mental health in the host countries. For African immigrant women of reproductive age, maternal health experiences could further expose them to vulnerable situations in host countries, which might increase their chances of developing mental health disorders due to resettlement stress, lack of or inadequate support, low level of education and negative maternal healthcare experiences (Jankovic et al. 2020). These situations are some of the leading causes of maternal health disorders amongst immigrant women in host societies.

These challenges can be severe because African immigrant women are often reluctant to seek professional mental healthcare services due to structural factors. Some of these factors include poor implementation of mental healthcare services for pregnant women in healthcare facilities, attitudes of healthcare professionals, institutionalized barriers to accessing care, and non-structural factors such as those resulting from cultural beliefs about mental health, fear of stigmatization, and language barriers (Jankovic et al. 2020). All of these factors limit African immigrant women's perception of maternal mental health and their ability to seek help in host countries, which could in turn lead to maternal mortality (De Freitas et al. 2020).

Previous studies have shown that a high prevalence of maternal mental health conditions during the perinatal period significantly contributes to the score of maternal mortality (Zachary Ward et al. 2024, Jankovic et al. 2020, Ihejirika et al. 2018). To give a brief background, maternal mortality contributes significantly to the global records of death annually, and it is high in low-income countries due to poor infrastructure and under-resourced public healthcare facilities in LMICs. To curb this global health crisis, the United Nations (UN) stressed the systematic implementation of Goal 3:1 of the Sustainable Development Goals (Ward et al. 2024, SDG Report, 2023). The UN set a target of reducing the global maternal mortality ratio to less than 70 per 100,000 live births and ending preventable deaths of newborns and children under five years of age (Ward et al. 2024). However, this effort has so far yielded a disproportionate increase in maternal mortality across countries of the world, with Africa bearing the greater burden. Poor maternal mental health and maternal substance use disorder have been recently linked to the high rate of death amongst new mothers, thereby increasing the number of maternal mortalities amongst women globally (Lauren Gimbel et al. 2024).

Given the seriousness and impact of poor maternal mental health amongst women of reproductive age, studies have shown that African immigrant women experience high levels of maternal mental health conditions more because of their positionality as both immigrants and women within their host countries (Lorentzen and Viken, 2020). This positionality results in African immigrant women experiencing additional disadvantages in comparison to foreign men and national women (Ihejirika et al. 2018). A review conducted by the Multicultural Centre for Women's Health (2020) noted that it is difficult for immigrants and refugee communities to access mental health services and support. This is particularly so for women with maternal responsibilities in host countries.

The same study identified a trend in gender disparities linked to the mental health of immigrant women and native women born in Australia, and between immigrant men and immigrant women living in Australia (Multicultural Centre for Women's Health, 2020). It was reported that, in Australia, there is a higher incidence of psychological distress among women—migrants and citizens alike—compared to men. This suggests that there is a link between poor mental health and gender inequality. Inequalities manifested in gender pay disparities, workplace discrimination, disproportionate casualisation of women in precarious employment and gender prejudices about women's care-giving roles expose women to physical and mental harm (Multicultural Centre for Women's Health, 2020).

In a similar study, De Freitas et al. (2020) also stressed that ethnic minority women and women with migrant backgrounds have an increased odds of experiencing maternal mental ill-health and maternal mortality than native women in host societies. Mahin Delara (2016) has also identified a pattern in the phases of the mental health of the immigrant population and argued that various phases characterize different stages of adaptation for the immigrant population in their host societies. The first phase, known as euphoria, is the phase that immigrants experience at arrival phase, where their mental health is equal to or even better than the mental health of the host population. Meanwhile, in the second phase, referred to as nostalgia and disillusionment, the mental health of immigrants deteriorates, and at the last phase, where adaptation finally occurs, the mental health of immigrants approximates that of the host population. Nevertheless, there is a steady decline in the physical and mental health of the immigrant population over a long period. Several factors are often responsible for this decline, including socioeconomic status, employment, acculturation problems, language barriers in accessing healthcare, discrimination, level of education, gender, and marital status, among others (Ayele et al. 2020; Mahin Delara, 2016).

In another qualitative study that focused on the mental health of African immigrant women, Abimbola (2021); Ngui et al. (2011) emphasised that African immigrant women experience underutilisation of various health services due to a lack of awareness about the availability of such services in their host countries. The authors also noted that Sub-Saharan African immigrants, including Nigerian immigrant women, face health disparities and health inequality in accessing mental health services and treatment due to stigma, discrimination, and racial prejudice in the United States of America. Interestingly, studies that were conducted amongst African immigrant women in South Africa point to similar challenges that are faced by African immigrant women when accessing healthcare services in South Africa. Meanwhile, many of these studies failed to highlight or document the maternal mental health challenges of African immigrant women in their perinatal period (Bauer et al. 2022). Therefore, my study contributes to efforts to fill this gap by documenting opportunities and challenges of maternal mental healthcare services in South Africa by drawing on the experiences of African immigrant women in Cape Town.

In conducting this study, I explored the structural and non-structural social indicators of access to maternal mental healthcare services in Cape Town by using the population at risk (African immigrant women's experiences) as my units of analysis. Drawing on my participants' overall experiences of maternal healthcare in Cape Town, this study examined

the individual experiences of the participants in the light of Andersen's (1995) theoretical framework on healthcare utilisation. The Ronald Andersen's (1995) behavioural model of healthcare utilisation (BMHU) framework was originally developed in 1968 as a conceptual framework that provides a basis for understanding the determining factors that influence the pattern of healthcare service utilisation. The framework provides a model through which access to medical care is measured in terms of factors such as the 'predisposing factors, enabling factors, and need factors (perceived and actual needs) for health care utilisation. The framework currently focuses on the overall health outcomes of the patient while considering all the elements that exist within the factors listed above.

In many countries, health policies centre around the agency to provide and improve access to healthcare, which is then, evaluated against the quality of improved health outcomes of the population. Access to healthcare services is therefore, determined by the availability of medical resources, organizational structure—how resources are used and distributed within the healthcare system. It refers to how healthcare professionals within the health facilities are coordinated and directed or controlled to achieve the overall health outcome for the population at risk (Andersen 1995).

Andersen (1995) also argued that the characteristics of the population at risk, which he described as the individual's determinants of healthcare utilisation often determine predisposing, enabling, and need components. This simply means that access to and the utilisation of healthcare services are determined by factors that are subjective to the specific needs of the population at risk, which in this study addresses the maternal mental health needs of African immigrant women in Cape Town.

The researcher conducted this study against the above theoretical background because it provides an analytical lens through which we could understand the relationship between access to available maternal mental healthcare services and the actual willingness to utilise such services by African immigrant women (AIW) in Cape Town. Furthermore, the justification for choosing this theory is that it helps us to understand the predominant factors that influence African immigrant women's perception of maternal mental healthcare, categorized as structural and non-structural factors that impact maternal mental health experiences, opportunities and challenges.

1.3. Problem statement

Recent studies show that the healthcare system in South Africa is characterised by unmet maternal healthcare needs (A van Ri et al. 2018; Lasater et al. 2017; Njeri et al. 2013). Such unmet maternal healthcare needs are more visible in the areas of screening and treatment for common perinatal mental health challenges of women in South Africa (Honikman et al. 2012). The situation is even more disturbing when one considers that South Africa reportedly has a “75% treatment gap for common mental disorders” (Lasater et al. 2017; Emily Baron et al. 2015, p. 503). This means that South Africa is one of the countries with the highest rates of mental health challenges in the world. Among the immigrant population, these challenges mean that healthcare services are scarce, fragmented, and under-resourced in most parts of the country, with only about 7% of professional psychologists working in public health settings (Baron et al. 2015).

Yet, we know little about how structural and non-structural factors associated with maternal healthcare of the African immigrant population affect these challenges. Hence, this study examines the maternal mental health experiences, challenges, and opportunities of African immigrant women in Cape Town to identify possible maternal mental health challenges that they face in South Africa as immigrants already predisposed to social circumstances of vulnerability in the country. This will deepen our understanding of the situation and equip both the state and healthcare professionals with more evidence-based findings to address some of these challenges. The study draws on the experiences of African immigrant women in Cape Town to explore how structural and non-structural factors impact these women’s experiences of maternal mental health. The assumption is that these structures influence African immigrant women’s decision to seek perinatal mental healthcare in their migratory contexts. By exploring their lived experiences, this study provides critical insights into the factors influencing maternal mental health among African immigrant women.

1.4 Rationale of the study

The maternal mental health needs of immigrant women often receive less attention in many host countries. This undermines the health of the mother and poses potential risks to the child’s developmental stages in life as well as the broader family dynamics. Studies have shown that African immigrant women in host societies are faced with various post-migration challenges that expose them to the risk of developing mental health conditions such as depression, stress disorder, anxiety and in severe cases, bipolar disorder and schizophrenia (Adegboyega et al. 2019). Quite often these are due to lack of social support and care,

difficulty in navigating the new immigrant environment, language barriers, as well the challenge of being a mother in a new environment (Adegboyega et al. 2019). Despite the increasing number of female immigrants of reproductive age in South Africa, little is known about the status of their mental health. Understanding their mental health status within the context of maternal health experiences and how it impacts their mental health conditions during pregnancy and after birth is necessary for providing culturally relevant support for this group.

Furthermore, the desire to conduct this study on the maternal mental health challenges of immigrant women in Cape Town was stimulated by my engagement with African immigrant women within the immigrant community in Cape Town. By observing how these navigate everyday challenges they face, combined with their maternal responsibilities, I was motivated to interrogate and get a better understanding of their unique challenges and maternal experiences as immigrants in Cape Town. Knowing that many of these immigrant women rarely qualify to receive any form of social support from the South African government, majority of them are unemployed mothers who cannot afford basic necessities, but had so much hopes for their future hence their decision to come to South Africa with the hope of getting a better life, some of these women live in very deplorable conditions due to lack of resources, documentation and employment. Amid this social context and situation of many African immigrant women in Cape Town, I felt compelled to have a deeper understanding of the maternal mental health experiences of these women.

Available studies that have examined the prevalence of maternal mental health in South Africa have mainly focused on native women, while others that have studied the maternal experiences of immigrants in South Africa have only highlighted the impact of structural barriers that impact immigrant women's experiences in accessing healthcare services in South Africa. For instance, Crush and Tawodzera (2011) focused on language barriers, xenophobic attitudes of healthcare workers, and the impact of cultural beliefs. The significance of this study is highlighted below.

Significance of the Study

The present study is therefore relevant because it will contribute to filling the gap in the literature on the maternal mental health condition of African immigrant women in Cape Town, by providing better insights into the prevalence of mental health challenges among African immigrant women in Cape Town, by studying their challenges, coping mechanisms,

and their maternal experiences in Cape Town. I hope that the evidence generated by this study will draw the attention of stakeholders to addressing the challenges that this group of women face in accessing maternal healthcare in South Africa. Which will in turn contribute to improving maternal mental health outcomes through the implementation of social support to care at the pre- and postnatal stages of pregnant immigrant women, promote supportive, inclusive intervention and culturally sensitive care to immigrant women of African descent in Cape Town.

1.5 Research aim, question, and objectives

This study aims to explore the maternal mental health experiences, challenges, and opportunities in accessing healthcare services by African immigrant women in Cape Town. To achieve this aim, the study has the following research objectives:

1. To determine the level of awareness about maternal mental health amongst African immigrant women living in Cape Town.
2. To determine the prevalence of mental health challenges among African immigrant women in their perinatal period.
3. To understand how migration context impacts the maternal health of African immigrant women and the challenges they face in Cape Town.
4. To identify the coping mechanisms that African immigrant women employ to deal with mental health challenges that arise from their maternal experiences in Cape Town.

Research Question

What are the maternal mental health experiences, challenges, and opportunities of African immigrant women in Cape Town?

1.6 Research Methodology

This study is informed by the philosophical paradigm of interpretivism. This school of thought believes that social phenomena should be studied from an individually subjective perspective which contributes richness to the phenomena under investigation. Interpretivism argues that social realities are constructed through the subjective experiences and meanings people attribute to such phenomena, hence social factors such as time, cultures, context, and

circumstances leading to these events are taken seriously when interpreting the events (Alharahsheh and Pius, 2019).

According to Alharahsheh and Pius (2019), interpretivism tends to agree more with qualitative research methodology because interpretivism seeks to understand the deep meanings and perceptions of events that people subjectively relate to their realities. Thanh and Thanh (2015, p.26) define qualitative research as a means of understanding and exploring the meanings that individuals or groups assign to social problems. Since the focus of this study is to explore the subjective experiences of African immigrant women regarding their maternal mental health challenges, qualitative data were collected using one-on-one semi-structured interviews with fifteen African immigrant women in Cape Town. A qualitative research method is suitable for this study because it provides empirical tools for understanding participants' subjective experiences of maternal mental health and the challenges that they face. A purposive sampling strategy was used to recruit a sample size of fifteen African immigrant women living in Bellville, Cape Town, to participate in this study. This sample size was chosen because of the scope of the study, limited resources, and the length of time to complete this project. The study sample was selected from a respondent-driven sample of African immigrant women who live in Bellville and its surrounding suburbs based on the criteria below.

I drew the participants from African immigrant women: (i) who have lived in South Africa for at least two years; (ii) who are within the reproductive age of 18-45 years; (iii) who have given birth to their children in South Africa; (iv) who have lived experiences of the South African healthcare system; (v) could be married or single mothers; (vi) are nationals of other African countries e.g., Nigerians, Zimbabweans, Congolese, Ghanaians, Somalis, and English-speaking Cameroonians.

The study involves the use of a semi-structured (open-ended questions) interview to allow participants to provide a detailed perspective on their maternal experiences and how it impacts their mental health. The interviews were conducted in-person. However, in situations where participants were indisposed, online options were available. The research tools included the use of an audio recorder to record our conversations for purposes of word-for-word transcribing, a field note, and a pen to document all external characteristics, such as the setting of the interview, a detailed description of my participants, and the non-verbal expressions made by my participants. After the interview, the data were transcribed word-for-word with the help of an Otter transcribing device. To eliminate any form of error, I listened

to the recording and read the transcribed documents several times to ensure maximum accuracy.

1.7 Concept clarifications

At this point, it is crucial to define a few terms and concepts used throughout this study. For instance, “mental health and maternal health” are concepts that have been applied in different contexts with different meanings. Hence, this section defines terms like “African immigrants and refugee women,” “mental health,” “maternal health,” and “maternal mental health.” For the purposes of this study, the term “African immigrant women” will specifically refer to women of African descent who reside temporarily or permanently outside their countries of origin. Based on their migratory statuses, these women may be categorized as refugees, asylum seekers, migrants, or foreign or diplomatic migrants.

I acknowledge the fact that the above-mentioned categories of women do experience maternal healthcare differently, but I argue from a feminist standpoint that these women often share intersecting experiences that are common to them in their maternal journey as non-native women in host countries. For example, migration, socioeconomic status, level of education, gender, age, and race all intersect to shape the kinds of maternal health experiences of women in host countries. To support this claim, Aderonke Bamgbose et al. (2022) in their study of Black immigrant women argued that Black immigrant women experience persistent inequities and mental health problems because they are positioned at the intersection of race, gender, and migration, which positions them at the junction of several socioeconomic disparities that often determine the quality of physical and mental health that they enjoy.

In clarifying the concept of mental health, it is important to highlight that the word “mental health” has a different connotation from the word “mental illness,” albeit they are closely related concepts. Mental health is more comprehensive and delves deeper into examining a person or group’s perspectives of emotional well-being, the magnitude of coping strategies, and the influence of the social environment. It entails dissecting how people think, feel, and act in their daily lives in the most unbiased manner possible (Monterrosa-Castro et al. 2023; Melanie Varin et al. 2020). Meanwhile, “mental illnesses,” on the other hand, solely examines the presence or absence of any mental diseases or disorders. Investigating mental health, therefore, entails figuring out how men and women successfully deal with life

situations such as trauma and abuse, as well as their capacity for interpersonal connection and willingness to make quick judgments (Monterrosa-Castro et al. 2023; Melanie Varin et al. 2020). These concepts are carefully unpacked in the subsequent chapters of this study.

1.8 Overview of chapters

This study consists of seven chapters, and below is an overview of the content of each of them.

Chapter 1: Provides a general overview of the study. The chapter introduces and provides the context for the study. Besides describing the background and rationale behind the study, the chapter also explains the methods and methodological approach used in the study, offers a definition of key concepts operationalized in the study, and outlines the research question and research objectives guiding the enquiry.

Chapter 2: This chapter, which deals with literature review, provides the scope for a thorough understanding of the existing body of knowledge on maternal mental health experiences and challenges of African immigrant women, as well as their healthcare-seeking behaviour and how these experiences impact their mental health outcome.

Chapter 3: This chapter discusses the theoretical framework that underpins the study. It maps out various concepts and ideas that are used in the study to interpret and foreground the maternal mental health experiences and challenges of African immigrant women within the concepts of predisposing factors, enabling factors, and actual need for using maternal mental healthcare services. It also explores the relationship between migration context and maternal mental health among African immigrant women.

Chapter 4: Chapter four documents the study design, methodology, and fieldwork experiences from the study. The chapter includes an explanation of the sample design, the sampling techniques that are used, and the criteria used in the choice of sample size. The chapter then provides a more detailed rationale for adopting this research design. It also presents and discusses the methodological processes, the methods of data collection, the research setting, sampling method, the population, the criteria for recruiting participants, the method used for data analysis, and other research components such as trustworthiness, credibility, reflexivity, ethics procedure, as well as reflections on the limitations of the study.

Chapter 5:

This chapter is a presentation of the main findings of the study, and it gives insights into the interpretation of the data. The chapter outlines the themes in terms of the findings that help us understand the kinds of challenges that African immigrant women face in their diasporic context, and how these challenges contribute or exacerbate their maternal mental health conditions.

Chapter 6: Chapter 6 summarizes the main findings by comparing those findings to the available literature. It examines and discusses African immigrant women's perception of maternal health in Cape Town, experiences of accessing maternal health services, and lastly, the maternal mental health condition of African immigrant women in South Africa.

Chapter 7: This chapter presents the conclusions and recommendations of the study. It summarises the main findings and provides recommendations for addressing the problems identified in the study.

1.9 Conclusion

This chapter introduces the study and provides the context of maternal mental health challenges in the South African migration contexts. The chapter provides a general overview of the study and explains the rationale behind the study. The chapter also explains the methods and methodological approach used in the study, defines key concepts operationalized in the study, and it outlines the research question and research objectives guiding the inquiry.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter sets out to provide a context through which a thorough understanding of the issues around maternal mental health of African immigrant women in Cape Town can be understood. What we know in the literature about maternal mental health is presented here in a narrative style of literature review to synthesize existing literature and present it in the form of comprehensive summaries that are logical and readable to identify the existing gaps. The sources used in conducting this review were systematically searched for, carefully evaluated, and reviewed in order to identify existing gaps in the literature.

A review of previous literature on maternal mental issues is relevant because it provides the scope for a thorough understanding of the existing knowledge on maternal mental health experiences and challenges of African immigrant women. Furthermore, it enables me to contextualise how healthcare-seeking behaviours are impacted by the perception and conceptualisation of healthcare in Cape Town. This chapter of the study, therefore, discusses and highlights some of the key issues associated with maternal mental health outcomes of African immigrant women in Cape Town. It begins by conceptualizing and defining mental health and further discusses the following relevant concepts, such as maternal health, common maternal mental health condition: prognosis of postpartum depression, anxiety as a common maternal mental health disorder, maternal mental health conditions of immigrant women, health conditions of immigrant women in general, trajectory of migration and the experiences of African migrant women in South Africa, synopsis of maternal health of immigrant women in South Africa and conclusion.

2.2 Conceptualising and Operationalising Mental Health

Mental health continues to attract attention and global concerns as a top public health issue. The rising cases of mental health disorders amongst different age groups, as well as racial and ethnic populations, are alarming. The disease burden of mental health is predicted to be first on the list of the global burden of diseases by 2030 (Mary-McCauley et al. 2019; Albert, 2015). It is important to clarify that these concerns exist in both low, middle-, and higher-

income countries. While there have been various efforts to address this condition, policies and intervention programmes have not been proportionate to the constantly rising cases across many settings. As indicated in the 2020 Mental Health Atlas, mental health still receives less public health attention in many countries, especially in developing and underdeveloped countries. While there has been steady progress in the adoption of policies, plans, laws, and improvements in the regular reporting of core mental health indicators over time, the results of the Mental Health Atlas (2020) reveal gross inequality in the availability and distribution of mental health resources in high-income countries, across regions, and around the world.

The same can be said of the implementation of services at the primary health care level. While guidelines for including mental health in primary health care settings are well established and being implemented in many countries with ongoing training and supervision efforts, the integration of interventions to deliver services (for example, pharmacological, psycho-social interventions to treat mental health conditions), is still limited. The Mental Health Atlas also reveals major gaps in the reporting capacity of many countries' mental health information systems on key indicators, including service utilisation (Mental Health Atlas 2020, Paolo et al. 2020).

Addressing mental health is crucial to the successful achievement of the Sustainable Development Goal. Hence, it is now a priority for the World Health Organization (WHO, 2019). In a bid to address mental health conditions in various countries, the WHO made a concerted effort by creating a special initiative for addressing mental health over a five-year period (2019-2023). Under this initiative, the WHO made a budgetary plan to allocate \$ 60 million in the fight against mental health crisis in twelve countries that have been prioritised with a population target of one hundred million people. This initiative aims to advance policies, create positive interventions, and empower the work of advocacy and human rights in intensifying mental health care services for individuals suffering from mental health challenges (WHO, 2019).

Operationalising Mental Health

As mentioned above, the terms “mental health” and “mental illness” are closely related concepts, although they have different meanings (Alvaro et al. 2023; Melanie et al. 2020). Mental health is regarded as a complex term that does not have a single meaning. Its complexity emanates from its interconnection with other factors that span social, biological,

and lifestyle conditions that determine the kinds of meanings attached to it (Katrin Westberg, 2021).

Nevertheless, the most widely accepted definition of mental health by the World Health Organization (2018) states that, “*mental health is a state of wellbeing in which an individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and can contribute to his or her community*” Paolo et al. (2020, p.35). It is evident that mental health determines a person’s state of well-being and general state of wellness, which affects other aspects of a person’s life, for example, community, family, and society. A good state of mental health is fundamental to the quality of life that a person enjoys (WHO, 2012). More so, mental health is a fundamental human right of an individual, and it reinforces the quality of life a person enjoys (Katrin Westberg, 2021). The definition of mental health can have both positive and negative meanings. On the positive side, we view mental health as a health asset that an individual possesses, which enhances positive well-being and enables a person to actualise their optimum potential to full capabilities (Patel et al. 2018). This definition of mental health provides another form of mental health narrative that focuses on the perspective that is resource-based, other than the traditional perspective that focuses on the pathological dimension of mental health problems. On the other hand, the negative connotation of the term “mental health” refers to a symptomatic condition that requires clinical intervention. To this end, some symptoms are associated with depression, anxiety, stress, and insomnia in some severe cases (Patel et al. 2018).

Notwithstanding the evident prevalence of mental health in people, inadequate knowledge exists about the topic. This is because, in many low-income resource settings, the treatment gaps are associated with various factors such as denial, fear of stigmatisation, and different cultural and traditional meanings and interpretations of symptoms, poor diagnoses, and treatment for related mental health conditions. For others, a mental health condition is associated with the possession of an evil spirit or the consequences and punishments for wrongdoing, especially in many African contexts (Aina and Famuyiwa, 2007). Hence, this results in unmet care needs for mental health across different settings, races, and genders (Patel et al. 2018).

To put the gender disparities in mental health problems in perspective, Jishnu Das et al. (2012) noted that women's mental health scores are significantly poorer than those of men globally. This gap is unfortunately linked to the sexual and reproductive health of women, which significantly impacts their lives and their general health conditions. Campbell et al. (2021) and Paul Albert (2015) also mention that women bear more of the disease burden of mental health disorders than men. To corroborate the above argument, research on the gender disparities in mental health of adolescents argues that girls score lower on mental health than boys (Katrin Westberg, 2021). It is believed that mental health disorders are often experienced by women from the onset of puberty (Katrin Westberg, 2021; Paul Albert, 2015). However, Paul Albert (2015) argues that mental health among women is higher irrespective of age, race, and geographical location. The author contends that major mental health conditions that women experience, such as depression, stem from internal factors that differ from men, which arise from external factors. By internal factors, the author implies the changes that occur in the form of hormonal imbalance in the ovaries of the woman. This usually occurs at different developmental stages within the life cycle of a woman. For example, associated mental health disorders such as 'premenstrual dysphoric, postpartum depression, and postmenopausal depression and anxiety', are linked to changes in the ovarian hormones of women, which explains the high prevalence of mental health disorders in women compared to men (Paul Albert, 2015). It is therefore important to explore the impact of mental health from a maternal perspective, to which I now turn.

2.3 Maternal Mental Health

Maternal mental health refers to the mental state and well-being of women during pregnancy and one year after giving birth—known as the postpartum period (Marlette et al. 2020). Maternal mental health, according to the World Health Organization's definition, is "*a state of well-being in which a mother realizes her abilities, can cope with the normal stresses of life, can work productively and fruitfully and can contribute to her community*" (Alisha and Sonali, 2024, p.1; McCauley et al. 2019; Rahman et al. 2013). The onset of pregnancy often predisposes women to experience some mental health disorders. Maternal mental health is a family challenge that, when ignored, can have far-reaching consequences on the mother's well-being, the child's development, as well as other family members (Michelle et al. 2021; Turner and Honikman, 2016).

As noted by Turner and Honikman (2016), when maternal anxiety is left untreated, it may lead to hormonal changes in the intrauterine environment, and this could negatively affect the emotional, physical, and cognitive development of the neonate (unborn child). Women with common mental health-related disorders during pregnancy are usually at risk of experiencing preterm labour and premature births, bleeding associated with pregnancy, exposure to caesarean birth, the possibility of miscarriages, lower birth weight, prolonged labour, and, in some cases, child morbidity and mortality (Turner and Honikman 2016; Emily et al. 2016).

Turner and Honikman (2016) further stressed that children born to mothers with mental health conditions are more likely to experience poor mental illnesses themselves in the future. Such children are also more likely to experience poor academic performance. Personal and cultural beliefs about pregnancy, parenthood, and mental health stigma can often impact an individual's understanding of the condition. The stigma surrounding the need for mental health treatment and screening, and the fear of being labelled weak or an unfit mother, can deter individuals from seeking help (McCauley et al. 2019). During their perinatal period, women generally have unique experiences regarding their mental well-being. It is important to note here that women's experiences of maternal mental health depend on many factors. For example, many women in Africa are often unable to identify some of the symptoms that accompany major maternal mental health disorders, such as mood swings, lack of interest, and feeling of tiredness, and in extreme cases, the feeling and thoughts of self-harm or suicide (Marlette et al. 2020).

Another factor that leads to women's experiences of poor maternal mental health is the lack of access to quality healthcare systems that prioritise the health of mothers and children in low-resource settings. As noted by Marlette et al. (2020), women from low- and middle-income countries suffer disproportionately from maternal mental health conditions compare to women in high-income countries. This is due to harsh economic situations, high levels of unemployment, poverty, poor nutrition, violence, low levels of education, and so on.

The burden of maternal mental health in Low-Middle Income Countries (LMICs) is often wrapped within a misconception that has very serious implications for the health of mothers and their children. Misconceptions include the belief that postpartum depression and anxiety are simply normal parts of motherhood, or that they result from spiritual causes such as

witchcraft or curses. Mental illness is sometimes seen as a sign of weakness or as something that only affects Western women. Many communities assume that a married or financially supported woman cannot be depressed, and that talking about emotional distress is shameful. There is also a misconception that traditional support systems always protect women, and that mental health treatment, especially medication, is harmful for mothers. Finally, many people believe maternal mental illness affects only the mother, overlooking its impact on infants and families. These misconceptions contribute to stigma, delayed help-seeking, and poor treatment outcomes (Buruwaa Adomako Agyekum 2023).

For example, of Misconceptions about maternal mental health conditions can lead to underdiagnosis or misdiagnosis and poor treatment of maternal mental health disorders in low-income countries (Rahman et al. 2013). For example, there is the myth that maternal mental health disorder is not an African disease but a Western disease and that it is not common in traditional African societies (Rahman et al. 2013). However, the reality is that the prevalence of maternal mental health conditions in LMICs (including most African countries) is higher than the prevalence rate in Western societies. The statistics show an estimated 18% to 25% rate in LMICs as opposed to the average rate of 10% to 15% in high-income countries (McCauley et al. 2019).

In their investigation of the potential impact of poor maternal mental health in LMICs in Africa, for example, Robert Stewart et al. (2010) and Baron et al. (2016) observed mentioned that poor maternal mental health is a potential risk factor that can lead to low birth weight, stunted growth, increased infant diarrhoeal, and impaired infant vision during the perinatal period. Consequently, Gladys et al. (2023) argue that poor maternal mental health has a significant impact on family stability, which in turn undermines its contribution to community integration. The authors also claim that one out of four pregnant women and one out of five postpartum women in LMICs are exposed to maternal mental health challenges. It is not surprising, therefore, that the high rate of maternal mortality in LMICs has been linked to neglected maternal mental healthcare (Baron et al. 2016), which then results in treatment gaps for common maternal mental health conditions in LMICs.

In contextualising the prevalence, consequences, as well as the factors that exacerbate poor maternal mental health in Sub-Saharan Africa, Gladys et al. (2023) conducted in-depth interviews with 22 healthcare professionals in South-western Uganda and found that the disease burden of maternal mental health was about 27% with a possibility of a higher

number due to underreported and undocumented cases. These findings unwittingly correspond with the statistics on the maternal mental health situation in Ghana. According to McCauley et al. (2019), about 650,000 people experience severe mental health disorders and over two million people suffer from moderate-mild mental health disorders in Ghana. However, the statistics of women who suffer from mental health disorders are unknown possibly because of underreported cases.

2.4 Common Maternal Mental Health Condition: Prognosis of Postpartum Depression

Studies have identified depression and anxiety as the leading maternal mental health disorders affecting women before pregnancy, during pregnancy, and after childbirth. While substantial empirical research exists on perinatal depression, this condition remains common and yet frequently under-reported. In many African societies as well as in high-income countries, postpartum depression receives limited attention despite its impact. Postpartum depression is a birth-related depressive condition experienced by women typically within one month to one year after giving birth (Jacqueline Hoare, 2023; Atuhaire et al, 2020). It is characterised by a feeling of disconnect from the child, a feeling of self-harm, mood swings, fatigue, anxiety, guilt, anger, lack of appetite, and anhedonia (Zlotnick et al. 2022).

Postpartum depression is a major disorder that often has a disabling effect on the health of women during the postpartum period. It is considered the second leading cause of disability in women between the ages of 15–44 years, after HIV/AIDS (Alhasanat and Judith 2015; Falah-Hassani et al. 2015; and Rahman et al. 2013). According to the American Psychiatric Association (1994), postpartum depression often exceeds the symptomatic threshold for commonly screened disorders on the Edinburgh Postnatal Depression Scale (EPDS) (Slomian et. al. 2019; Michelle et al. 2021). Postpartum depression reduces the ability of a mother to function effectively in many aspects of her life, resulting in personal suffering. It affects the relationship between mother and child and impacts the cognitive development, behavioural, and general health condition of the child (Alhasanat and Judith, 2015). Even though it is a treatable mental health condition, many women are ignorant of this condition and often do not seek professional medical help. For instance, in many parts of the African continent, the cultural background of women often makes them overlook some of the symptoms of postpartum depression. These symptoms go underreported, thereby creating a treatment gap in many of these societies (Ria Valerie and Cabanes, 2019).

The etiological explanation of postpartum depression is linked to the causes of other major depressive conditions. Batt et al. (2020) hold the view that postpartum depression and major depressive conditions are caused by the interaction of biological and psychological factors. From the biological explanation, postpartum depression is caused by genetic, neural, and hormonal imbalances, and psychosocial factors such as stressors and their interaction (epigenetics). Postpartum depression is different from major depressive disorder in its timing (following birth), exposure to various types of psychosocial stressors (for example, parenting a new infant, relationship adjustments), and potential physiological underpinnings (the drastic elevation of gonadal hormones followed by rapid withdrawal associated with pregnancy and birth, respectively) (Batt et al. 2020).

The findings in a meta-analysis of an epidemiological study by Schmied et al. (2017) showed that the prevalence of postpartum depression in percentages varies from country to country, with 2% to 82% in high-income countries and from 5% to 74% in low- and middle-income countries (Slomian et al. 2019; Schmied et al. 2017). Untreated postpartum depression often has a ripple effect on the quality of life of the mother and the child. It can affect and reduce the quality of care that an affected mother gives to her child. It also affects the family and the environment and could have an intergenerational effect on the entire life span of the mother and child (Rahman et al. 2013). Marlette et al. (2020, citing Kingston et al. 2012; Kingston and Tough, 2014; Stein et al. 2014; Kingston et al., 2015; Rees et al. 2019) noted that maternal mental health disorders like postpartum depression can affect the overall physical, socio-emotional, psychological, cognitive, psychomotor, and neurodevelopment of a child. This follows that children born to mothers with maternal mental health conditions are at higher risk of developing psychological conditions too.

Similarly, a secondary data analysis by Slomian et al. (2019); Jennifer and Maguire (2019), highlights some of the leading causes of postpartum depression in new mothers. Their study established a correlation between postpartum depression with a high level of stress, lack of, or inadequate finances, poverty, negative or stressful life events, and the ill health of close relatives. The authors found that women who were predisposed to adverse life experiences, such as childhood sexual abuse or adulthood sexual abuse, had an increased risk of developing postpartum depression and were three times more likely to have postpartum depression compared to those who did not experience any adverse life events (Jennifer and

Maguire, 2019; citing Guintivano et al. 2018). In the same vein, suicide ideation in perinatal health experienced by many women accounts for about 20% of deaths in the postpartum period (after giving birth) (Jennifer and Maguire, 2019). Notwithstanding the foregoing, it is pertinent to note that women experience postpartum depression differently. For example, immigrants and refugee women experience postpartum depression more than twice as many women born in host countries.

2.5 Anxiety as a Common Maternal Mental Health Disorder

Anxiety is another common form of perinatal disorder that many women suffer from and experience before, during, and after pregnancy. Women are often more vulnerable to developing anxiety during pregnancy. Anxiety is a normal form of psychological response that women experience in their perinatal periods (Ali, 2018). However, this condition becomes problematic and possibly harmful if it persists for more than three weeks and if it hinders the normal functioning of a person's daily life (Liana Deklava et al. 2015) because it could escalate or progress to another level of anxiety, often referred to as Generalized Anxiety Disorder (GAD).

Generalized Anxiety Disorder is one of the most common forms of anxiety disorders that most women experience during pregnancy and after birth. It is largely described as a form of worry that is usually excessive in nature. This condition affects about 4.1% to 5.7% of pregnant women. Consequently, when GAD is not treated, it can result in serious problems for the newborn child and the mother (Inness et al. 2022; Liana et al. 2015). As noted by Ali (2018); Liana, (2015), some severe outcomes of GAD are often characterised by a lack of attachment between mother and infant, reduced chances of breastfeeding, presence of postpartum depression, risk of social and cognitive impairment due to low birth weight, impaired foetal growth, and the tendency for children to develop anxiety disorders.

2.6 Maternal Mental Health Conditions of Immigrant Women

Immigrant women undoubtedly contribute to the number of recorded births per year in the host countries. However, their perinatal experiences determine their birth outcome which often receives inadequate attention. According to a population-based study conducted by Urquia, Moineddin, and Glazier (2017), we know very little about the factors that determine the birth outcomes of immigrant women. While the number of births by immigrant women

continues to increase at 27%, according to Simone Vigod et al. (2016), there is also a growing concern for the health systems and governments of host countries.

There are several studies on maternal mental health among immigrant women in Western countries. Most of these studies, conducted in Europe, North America, and Australia, show existing treatment gaps for common maternal mental health conditions among immigrant women compared to the non-immigrant population. In a meta-ethnographic study conducted by Schmied et al. (2017), the findings revealed that immigrant women in their host countries often experience poor maternal mental health outcomes when compared to women who are citizens by birth in those countries. Similarly, findings from a study conducted by Moore et al. (2019) in the United Kingdom amongst immigrant women showed that immigrant women are highly predisposed to risk factors that result in poor perinatal mental health outcomes, and they face challenges in accessing care. Schmied Vigod et al. (2017) also support the claim that immigrant women in first-world countries suffer from a high prevalence of perinatal depression, although they also have poor help-seeking behaviours. According to Simone Vigod et al. (2016), immigrant women are two times more likely to suffer from maternal mental health disorders than women in the host countries. This is due to the underutilisation of outpatient mental health services in hospital settings. Given the vulnerability and stressful living conditions of many immigrant women in their host countries, it is evident that the rate of postpartum depression amongst this group is two times higher than that experienced by women who are nationals of the host countries.

In a literature review study, Alhasanat and Judith (2015) focused on identifying and examining the prevalence of postpartum depression as well as the risk factors associated with postpartum depression among Arab women living in industrialised societies, in comparison with women living in their home countries. The result from the study showed that there is a 10-37% prevalence of postpartum depression amongst Arab women in their home countries and about 11.2 -60% prevalence of postpartum depression among Arab women living in industrialized societies abroad. Additionally, Alhasanat and Judith (2015) further noted that the following risk factors exacerbate the experiences of postpartum depression among immigrant women in industrialized societies. For instance, the authors considered low income, lack of social support, intimate partner violence, and stressful life events as factors that encourages the development of postpartum depression among Arab immigrant women and Arab women back home in their country. Immigration stress and lack of access to health care services in the host country were found among Arab immigrant women. Lack of social

support was more common in studies that focused on immigrant women (Alhasanat and Judith, 2015).

The results from a systematic review and meta-analysis study conducted in 2022 suggest that 20% of immigrant women experience postpartum depression in the first twelve months after birth. Compared to non-immigrant women, the prevalence of postpartum depressive symptoms is twice as high among immigrant women (Gil et al. 2022). The study gathered that immigrant women are more likely to experience depressive symptoms if they do not have a social support system, if they have a short duration of stay in their host country, if they have low family income, and if they experience poor marital relationships (Gil et al. 2022). Therefore, one could safely argue that the circumstances surrounding the migration of immigrant women greatly influence their maternal mental health.

2.7 General Conditions of Immigrant Women

Understanding why and how migration affects women in general is paramount to evaluating their lived experiences in host countries. Immigrant women are generally positioned at the intersection of gender, race, migration status, class, religion, and age (Kalpana Hiralal, 2017). This positionality often exposes them to harsh socio-economic conditions in their host countries. Immigrant women have been exposed to gender-based violence due to their migration status which is largely dependent on the migration policies of host countries. Similarly, many immigrant women who are illegal in their host countries are forced to live with abusive partners for fear of retaliation or being deported if they report cases of abuse to the police (Priebe et al. 2022). Thus, immigrant women are two times more likely to experience domestic violence and abuse than women who are nationals of the host countries (Kalpana, 2017).

The topic of women as immigrants has attracted significant attention across different settings and countries over the years. As Kalpana points out, women migrants in the past were often seen as “passive actors in the process of migration without individual agency or social status” (Kalpana, 2017, p.2), as they are often referred to as accomplices of their male counterparts. Hence, they are regarded as dependent in the process of migration. However, this view has been challenged by some feminist scholars who tried to reveal the role and responsibilities of immigrant women as wage earners and heads of households in their host countries (Nolin,

2006; cited in Kalpana Hiralal, 2017). These new roles have somehow been linked to the factors that encourage domestic violence among intimate partners in host countries.

As noted by Priebe et al. (2022), there is a very high prevalence of domestic violence among USA-based Brazilian immigrant women because of the reversal of roles in the traditional role of women when they become financially independent and take on the role of breadwinners in their families. This change often makes their partners insecure. Abha Rai and Joon Choi (2022), in their study of domestic violence among South Asian women immigrants, recount that strict traditional norms and practices, such as patriarchal norms, gender ethos, cultural beliefs regarding the role of women, and the challenges of a new environment, encourage the high rate of domestic violence among South Asian immigrant women. The authors noted that the rate of reporting victimisation is significantly low amongst this group of women because of the enabling cultural norms that discourage and disempower women from seeking justice.

In another qualitative study by Parvin Kiamanesh and Mona-Iren Hauge (2018) among immigrant women in Norway exposed to domestic violence, the authors claimed that about 67% of victims of domestic violence, who are residents in the shelters provided for abused women, are women with immigrant backgrounds. Factors such as migration status, language barriers, lack of decent jobs or employment, social isolation, and similar factors can exacerbate the incidence of domestic violence among immigrant women. The aforementioned factors are inherently linked to the broader context of social, economic, and political forces (Parvin Kiamanesh and Mona-Iren Hauge, 2018). Therefore, the social, political, and economic situations of immigrant women may further impact their mental health and maternal mental health experiences for those with child(ren) in host societies. |

2.8 Trajectory of Migration and the Experiences of African Migrant Women in South Africa

According to the United Nations International Migrant Stock 2020, an average of 2.9 million people with migrant backgrounds lived in South Africa by mid-year (2020), which is a little less than 5% of the total 60 million people living in South Africa (Moyo, 2021). This figure

supports the conclusion that South Africa is a favourite destination country for migrants for different reasons. Due to its relatively vibrant economy, South Africa is the economic hub of Southern Africa, and it is home to the largest immigrant population in Africa (Khangelani Moyo, 2021). While many of these migrants are from the Southern African Development Community (SADC) countries and other African countries, South Africa is also a destination of choice for migrant from outside Africa.

The exact number of migrants, including asylum seekers and refugees, in South Africa is unclear due to poor data collection, irregular migration, and interests in inflating figures for political or financial reasons (Meny-Gibert and Chiumia, 2016). The relatively stable economy, middle-income status, and social and political stability of South Africa, and the economic opportunities it provides, have largely determined the pattern of the migrant population present in the country. At another level, in contrast to the past, the modern pattern of labour migration in South Africa is seeing a change in the number of migrants from predominantly male to female-dominated labour migrants. South Africa is seeing a rapid increase in the number of women as migrants and heads of many households of immigrant backgrounds.

According to a report by the United Nations Department of Economic and Social Affairs (UN DESA, 2019), an estimated 1,875,588 female migrants live in South Africa, which is 44.4% of the migrant population, many of whom are women of African descent. This trend is encouraged by the desire to improve the economic conditions of these women and their families (Chinyakata et al. 2019). However, African immigrant women face vulnerabilities, including a high risk of sexual violence, forced labour, abuses, exploitation, and various health challenges. These women are more likely to work in underregulated places with low pay and in nonvisible spaces or sectors (Aimee-Noel Mbivozo, 2019; Freedman et al. 2020).

More so, Aimee-Noel Mbivozo (2019) claimed that immigrant women in South Africa face 'triple discrimination' that overlaps. First, they face the brunt of extreme racism, xenophobia, and misogyny. Secondly, they endure terrible socioeconomic conditions that expose them to other vulnerable conditions. Thirdly, immigrant women in South Africa face domestic violence, sexual violence, structural or systemic violence, and femicide, amongst others (Aimee-Noel Mbivozo, 2019). While the socioeconomic conditions of migrant

women in South Africa may improve, their general health conditions may be affected by various past and immediate conditions, which often require access to healthcare. It is worth noting that the above-mentioned challenges that immigrant women face in South Africa may also serve as a limiting factor to accessing healthcare services, especially maternal health, mental health and maternal mental healthcare services.

2.9 Synopsis of Maternal health of Immigrant women in South Africa

South Africa has made remarkable efforts to reduce maternal and child mortality amongst people of childbearing age. According to a report by Statistics South Africa (2019), there is a decrease in the National ratio of maternal mortality in facility ratio (MMFR), from an estimated 105,9 deaths per 100,000 live births in 2019 to about 88,0 deaths in 2020. This serves as a significant improvement from the previous years. Access to maternal healthcare is an important priority of the South African government. According to Section 27(1)(a) of the South African Constitution of 1996, “everyone has the right to have access to health care services” (Constitution of the Republic of South Africa, Act 108 of 1996). The above constitutional provision and the National Health Act No.61 of 2003 expressly provide for access to maternal healthcare as a fundamental right of every woman in the country, and they are entitled to such care (Alfaro-Velcamp, 2017, p.54).

This includes the right to legal, free, and safe termination of pregnancy within 13-20 weeks of conception, regardless of race, socio-economic status, age, and location. The right to make sexual and reproductive decisions, including the choice of contraceptives and so on. The Termination of Pregnancy (TOP) Act 92 of 1996, and the Refugees Act of (1998) both grant the right to access free public healthcare for all refugees in the country. Therefore, immigrants and refugee women are granted access to free public healthcare for their health needs in South Africa. However, in recent years, the above legal and policy framework has not been free from implementation barriers and challenges in accessing maternal health and maternal mental healthcare by African immigrant women in South Africa. These experiences will be explored further in Chapter Six in this study, which examines the maternal mental health experiences, opportunities, and challenges of African immigrant women in Cape Town from the perspective of the participants who were interviewed for this study.

2.10 Conclusion

This chapter has reviewed the literature on the maternal mental health of immigrant women in the global North and some countries in the global South (Africa). From the literature surveyed, the chapter established that, first, immigrant women are at a higher risk of developing postpartum depression than non-immigrant women in host countries. Secondly, immigrant women often do not seek help for common mental health conditions. Thirdly, the review also highlighted the position of the South African government in providing affordable and accessible healthcare to all those living in the country, including the immigrant population. The above findings provide a general context for analysing the findings of the present study.

However, the literature reviewed in this chapter is silent about the prevalence of maternal mental health conditions among African immigrant women in South Africa, and how individual and institutionalised components exacerbate the challenges of African immigrant women in seeking or utilising maternal healthcare and maternal mental health services in the country. Thus, the next chapter provides a discussion of the theoretical framework that will help to understand the need to consider structural and non-structural components when addressing the maternal mental health challenges of African immigrant women within the context of predisposing factors, enabling factors, and actual need factors. I now turn to the discussion of these concepts in the next chapter within the Anderson (1995) theoretical framework of healthcare utilisation.

CHAPTER 3

ACCESS AND UTILISATION OF MATERNAL MENTAL HEALTHCARE SERVICES AMONG AFRICAN IMMIGRANT WOMEN

3.1 Introduction

This chapter discusses Anderson's behavioural model of healthcare utilisation as the proposed theoretical framework for analysing the challenges and opportunities of maternal mental healthcare experiences among African immigrant women in South Africa. Adopting an appropriate theoretical framework, such as Anderson's behavioural model of healthcare utilisation, is crucial because it provides the structural foundation for the study, the framework with which the findings are analysed and interpreted for a broader academic discourse. The element in the theory helps us to explain how experiences of maternal mental healthcare can be coloured by structural and ideological factors. It also helps us in explaining healthcare disparities and the challenges of seeking care by different groups of people, especially in cases of African immigrant women in their diasporic environment. Understanding these challenges and factors that inherently determine care is necessary to predict the level of healthcare utilisation, improve health outcomes, and foster social justice (Andersen, 1995; Rice and Kominski, 2011). Healthcare utilisation is an individual's efforts to take proactive measures to enhance their overall quality of health by utilising available healthcare services to prevent or treat health issues, improve overall health condition, and well-being, or gather useful information about their health condition and predict future health challenges (Gellman, 2013).

The Behavioural Model of Healthcare Utilisation (BMHU) model is a widely used model for understanding the pattern of healthcare utilisation among various groups. The (BMHU) highlights three main factors that influence healthcare utilisation among different groups, for instance, "predisposing factors (such as age and education), enabling factors (such as income and availability of healthcare facilities), and need factors such as overall health status" (Krzyz, Antunez, and Lin, 2023, p.2). These factors help to understand structural and non-structural elements that influence an individual's perception of utilising healthcare services.

3.2 Historical Background of Anderson's (1995) Behavioural Model of Healthcare Utilisation (BMHU)

Ronald Andersen's (1995) behavioural model of healthcare utilisation provides the theoretical lens for this study. This study presents the theory as a model for understanding the predominant factors that intersect in the process of maternal mental health care utilisation of African immigrant women in South Africa. This theory was initially developed in 1968 as a conceptual framework that provides a basis for understanding the determining factors that influence the pattern of healthcare service utilisation by different populations in different contexts. The theory provides a model for measuring access to medical care in terms of factors such as 'predisposing factors, enabling factors, and needs (perceived and actual needs) for healthcare utilisation.

The Andersen behavioural model includes four stages of development. The changes were made to the first version of the theory to account for its initial limitations. In the second improved version of the model developed in 1974, Andersen added a new category known as the 'healthcare system', which involves health policies, health resources, and the structure of the healthcare organisation. In addition, the (1974) model of Andersen's healthcare utilisation also highlights other determinants of health outcomes, such as site, waiting time, and intervals between health service utilisation, purpose, and consumer satisfaction with the proposed care. Hence, emphasis is on the concept of availability, accessibility, affordability, and willingness on the part of consumers to utilise medical services (Aday and Andersen, 1974). The framework resonates with the idea that we can view access to medical care from two perspectives: the "inputs" and the "outputs".

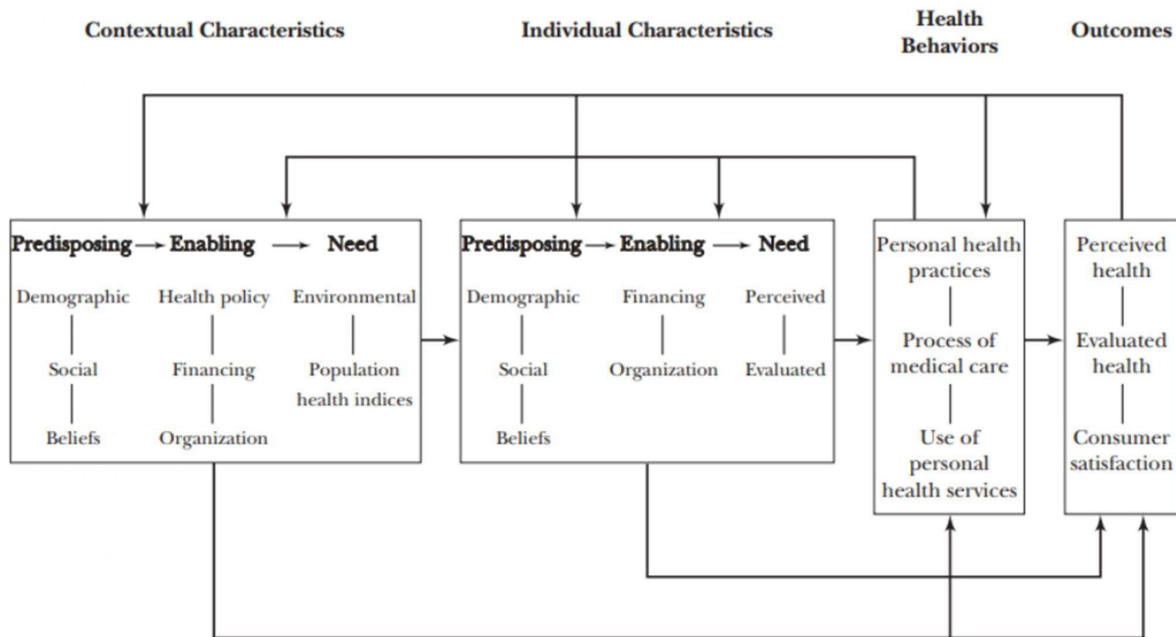
According to Aday and Andersen (1974, p.210), we can conceptualise access to medical care from the standpoint of "health policy objectives through the characteristics of the healthcare system and the population at risk (inputs), and the (outcomes/outputs) which is the actual utilisation of health care services and consumer satisfaction with these services". Health policies are often centred on the agency to provide and improve access to medical care, which is often evaluated against the quality of improved health of the population. Access to health care services is characterised by the availability of medical resources and organisational structure, which means "what the system does with its resources. It refers to how medical personnel and facilities are coordinated and controlled in the process of providing medical services (Aday and Andersen, 1974, p.210; Alkhawaldeh et al. 2023).

The same authors also noted that the characteristics of the population at risk are the predisposing, enabling, and needed components, which the authors described as the “individual’s determinants of utilisation”. This simply means that the utilisation of healthcare services is determined by factors that are relative to the specific needs of the population in need. Furthermore, this framework operationalises access to healthcare from two categories, namely, the ‘process indicator and the’ outcome indicator’.

According to Aday and Andersen (1974), the ‘process indicator’ refers to the standard of measurement that can be used to assess the (delivery system) and the (population at risk) to ensure that entry into the system is gained and how satisfied consumers are with the system. The ‘outcome indicator’ refers to the measure of the actual utilisation of the system and the satisfaction thereof, and it “reflects the end products of health policy regarding access”. These measures include both the “objective and subjective descriptors of the population's entry to and passage through the system (this means the acceptability and experiences of service delivery by providers) (Aday and Andersen, 1974, p.210).

Furthermore, the Andersen’s (1974) model of healthcare utilisation was again revised in the 1980s to include another category of healthcare determinants, such as physical, economic, and political determinants, categorised as an external environmental factor, that impact the use of healthcare services (Gelberg, Andersen and Leake, 2000). However, the Andersons’ (1995) behavioural model of healthcare utilisation has evolved and currently focuses on the overall health outcome of the patient while considering all the elements that exist within the previous models described above. It introduces the concepts of feedback to evaluate the relationship between ‘treatment outcomes and health behaviour’ (Yang and Hwang, 2016; Krzyz et al. 2023).

Figure 1. Evolution of Andersen’s Behavioural Model of Health Service Utilisation from 1968 to 1995.



Source: (Krzyz et al., 2023, p.3)

3.3 Application of Andersen’s (1995) Behavioural Model of Healthcare Utilisation (BMHU) in the present Study

Many studies have applied Andersen’s (1995) model in investigating healthcare-related problems, diseases, and healthcare systems in different settings, contexts, and among various ethnic populations (Sherinah Saasa et al. 2021, Bauldry and Szaflarski, 2019; Giano et al. 2020). In some studies, more than one version of the model is used; in others, only one version is utilised (Yang and Hwang, 2016, Babitsch et al. 2012). For example, some studies have applied Andersen’s model to investigate vulnerable people such as elderly people, immigrant population, and homeless people, in different contexts and settings (Krzyz, Martinez, and Lin, 2023, Alkhaldeh et al. 2023; Andre Hajek et.al. 2021, Yang and Hwang, 2016; Babitsch et al. 2012).

Furthermore, the Andersen’s (1995) behavioural model is widely regarded as the most utilised model for examining the healthcare-seeking behaviour for mental health among the immigrant population, with the application of different variables of the model (Birgit Babitsch et al. 2012; Krzyz et al. 2023). However, 70% of these studies were conducted in the Global North (particularly, North America), with 89% of the studies using a quantitative research

design (Krzyz et al. 2023). However novel these studies in the Global North may have been, their generalisation is limited to the Western context in which the studies were conducted.

Hence, my study applied Andersen's (1995) behavioural model to explore the maternal mental healthcare utilisation of African immigrant women in Cape Town, South Africa (a country in the Global South). The theoretical model is suitable for this study because previous studies have applied other models, which have not directly addressed the gap in knowledge about our understanding of immigrant women's mental health in Cape Town. To the best of my knowledge, this study will be the first to apply Andersen's (1995) BMHU to the study of African immigrant women in Cape Town, and the theory gives us new insights and perspectives of the issue. Secondly, the theory will deepen our understanding of maternal mental health among African immigrant women in South Africa by measuring the validity of the framework and its applicability to different contexts, for example, the Global South (in this case, Cape Town, South Africa). Applying this model to my study will help me examine the operationalisation of some specific variables of the model, such as cultural, social, economic, and political predispositions that interplay in maternal mental health experiences and challenges among African immigrant women in Cape Town. It could underscore the strengths or otherwise of Andersen's behavioural model and its applicability to the South African context.

3.4. Operationalising key concepts of Andersen's theory

Andersen's (1995) behavioural model of healthcare utilisation (BMHU) is a multilevel model that examines the healthcare system and the external environment where treatment occurs, in other words, the environmental conditions. Yang and Hwang (2016, p.3) refer to the external environment as "exogenous variables, that are independent of the population characteristics". These variables help us to understand the factors that determine (why and how) people utilise healthcare services, evaluate factors that promote inequality in accessing healthcare services, and help us to develop policies that promote equitable access to healthcare (Andersen, 1995).

Within the propositions of Andersen's theory is the concept of predisposing factors. Predisposing factors interplay in the process of an individual trying to seek healthcare services, known and it is known as an "individual's predisposition" to the use of healthcare services. In addition, the model conceptualises terms like "enabling factors" and "actual or

perceived need” for seeking care. The enabling factors to healthcare utilisation are theorised as factors that encourage or facilitate the use of healthcare services. Understanding these three factors is necessary for assessing the level of efficiency, effectiveness, equity, and inequitable access to healthcare, as well as the external environment that impacts the utilisation of healthcare services (Jasmine et al. 2020).

The outcome (feedback loop) and consumer satisfaction are additional concepts that the Andersen (1995) behavioural model conceptualised (Andersen, 1995; Jasmine et al., 2020). I will discuss these concepts below based on their specificity to the characteristics of African immigrant women who participated in this study and utilised maternal healthcare services in Cape Town.

3.4.1. Predisposing factors (population characteristics) to healthcare utilisation

The predisposing characteristics or factors stem from various sources and variables within the existing model. It refers to already existing characteristics of an individual that may serve as barriers to health service utilisation. The willingness to utilise mental health services by African immigrant women in Cape Town is affected by various predisposing factors such as ethnicity, marital status, culture, gender, age, spirituality, demography, and religious belief, all of which significantly impact illness behaviour, illness beliefs, and illness experience (Baek et al. (2020). The Andersen (1995) model proposed that individuals are exposed or predisposed to several factors that interact with the healthcare system beyond their control, and being an immigrant is also an important risk factor that exposes individuals to mental health challenges (Moore et al. 2019; Perez-Urdiales et al. 2019; Ying-Yu Chao et al. 2020; Mahin Delara, 2016).

i. Ethnicity

An individual’s ethnic identity has been considered a significant component that influences their illness experience and attitude toward seeking healthcare in their host countries. It is important to note here that ethnicity is closely linked to race. It is a formidable indicator of a person’s race (Perez-Urdiales et al. 2019). Underlying the concept of race in the context of (African immigrant women in Cape Town) is the idea of discrimination against foreign nationals of African descent. Perez-Urdiales et al. (2019), in their qualitative study that explored the experiences of African immigrant women's access to appropriate healthcare

services, argued that racial discrimination along ethnic lines amounts to a social determinant of health outcomes of immigrant women and it can harm their mental health and physical well-being (Perez-Urdiales et al. 2019).

Similarly, Ichou and Rivenbark (2020); Evans Na'Tash and Jiunn-Jye Sheu (2019); and Ahad et al. (2019), agree that discrimination on grounds of ethnic identity can hinder the motivation for seeking mental healthcare among ethnic minority groups in the host environment. Ethnicity as a predisposing factor plays an important role in determining an individual's perception and experiences of mental health illnesses and mental healthcare decisions, just like race, cultural beliefs, and practices embedded in ethnic identity.

ii. Age

Age is a common component of predisposing factors to healthcare utilisation that plays a very significant role in the physical and mental health outcome of an individual. Ying-Yu Chao et al. (2020) claimed that older immigrants are at a higher risk of developing mental health problems. The study by the same authors established a link between age and mental health service utilisation among different age groups within the immigrant population. Older immigrants often exhibit negative attitudes (serving as barriers) to seeking treatment for mental health-related problems.

According to Chao et al. (2020, p.1339), older immigrant “adults often had knowledge deficits regarding mental health problems or psychological services”. Hence, they resist seeking help or utilising available services in the host countries. There is a preference for, and a tendency for the immigrant population to discuss perceived mental health challenges with families and friends rather than a healthcare professional. Meanwhile, another study by Hochhausen and Perry (2011) claims that young people with an immigrant background are more likely to seek and use mental health services than the older population of immigrants. Hochhausen and Perry (2011) findings also support the argument that women immigrants are more likely to seek mental healthcare than immigrant men.

iii. Gender

Women and men generally have different perceptions and experiences of gender roles in society. This greatly manifests in the ways they handle personal matters, including making decisions concerning their health matters (Adegboyega et al. 2019). Unlike men, immigrant

women usually face a double portion of migration challenges. Many studies that explored the experiences of immigrant women in their host countries claim that immigrant women continue to face various challenges even after resettlement. Oftentimes, these challenges stem from factors that are within and outside the control of these women, and they can have negative mental health outcomes for these women (Mahin Delara, 2016). Pre- and post-migration experiences often exacerbate the underlying mental health condition of many immigrant women more than men (Adegboyega et al. 2019).

Yang and Hwang (2016, p.6), claim that “women are more likely to self-report poorer health conditions, and therefore, have greater need for services than men because they are more likely than men to express pain and distress and to factor in less serious ailments in their reports”. This also explains the treatment gap that exists between women and men in mental healthcare utilisation. However, these disparities also exist between white women and women of colour. For example, Hochhausen and Perry (2011) highlight the disparities between white women and Latina immigrant women in mental health service utilisation. They found that 67% of white women are more likely to seek mental health care, and 90% of them follow through and use the services, compared to 50% of Latina immigrant women who sought mental health services, but only 75% of them use it.

The findings from the study by Hochhausen and Perry (2011) correspond with a similar study conducted by Evans and Sheu (2019). Evans and Sheu (2019) claimed that white women are more likely to receive treatment for mental health illness than African Americans and Caribbean Black women. This can be explained by the cultural and religious disposition of these women. For example, the societal norms about gender often influence how gender roles, duties, and health-related matters are conceptualised (Adegboyega et al. 2019).

Some existing studies about the healthcare-seeking behaviours and utilisation of available services by the African immigrant population found that men and women from this group exhibit similar symptoms of psychosocial stressors relating to discrimination, isolation, and the challenges of resettlement. However, women expressed more symptoms of anxiety than men and more willingness to seek help than men (Perez-Urdiales et al. 2019; Escamilla and Saasa, 2020, Ichou and Rivenbark, 2020).

The intersection of ethnicity, age, and gender predisposes immigrant women, especially to need and utilise healthcare services in host countries. However, these are not the only leading factors that influence the decision to use or not to utilise healthcare services by immigrant women.

iv. Demographic characteristics

Within the predisposing characteristics explained in the conceptual framework of Andersen's (1995) behavioural model of healthcare utilisation, demographic characteristics are identified as a macro factor that interplays with cultural identity as an essential variable that influences the decision on or perception of mental health treatment among the immigrant population (Andersen, 1995). When one links this to the experiences of immigrant women with newborn babies or those who are pregnant in their host countries, it can be argued that culture plays a very significant role in influencing the decision to seek or use perinatal mental health care by these women. This buttresses the need for community involvement in the care for, prevention, and treatment of common perinatal mental health conditions among African immigrant women.

v. Spirituality

Another important feature of cultural beliefs among African immigrants is the role of macro and microcosmic forces in determining a person's vitality. According to traditional African beliefs, vitality is the central property of the African metaphysical system (Motsamai Molefe and Mutshidzi Maraganedzha, 2022). Vitality characterises a person's harmony with metaphysical forces. Many Africans who hold this belief regard their positive health status as implying harmony with God, the universe, or divinities, while they consider weak health to be the result of disharmony with the cosmological forces. In many African communities, the idea of good versus poor mental health is defined and measured by the standards of metaphysical beliefs. Albeit this kind of belief often interferes with how illnesses are conceptualised and treated in these contexts.

As documented by (McCann et al. 2018; Park et al. 2018; Bukola, Jordana, and Kathleen, 2019), African immigrants in host societies face the double burden of concealing their mental health status for fear of being stigmatised and shamed because poor mental health could be regarded as consequence and punishment for wrongdoing by the gods. This is particularly disturbing for women of reproductive age whose poor perinatal mental health may be

misunderstood as a case of being a ‘bad mother’. In addition, women may feel resistant to utilising available healthcare services due to their perception of maternal mental health-related illnesses, stigma, and shame.

vi. Marital status

As part of the predisposing characteristics, studies have shown that an individual’s health status is linked to their marital status. Yang and Hwang (2016) claimed that married people are likely to be healthier and less likely to utilise healthcare services than unmarried individuals are, but married people are more likely to use preventative services than unmarried people are. Studies that focused on exploring the relationship between marital status and healthcare utilisation as a predisposing factor have validated this claim. For example, Rutaremwa et.al. (2015), in their study, found that married women often lack the willingness to use healthcare services due to religious and cultural reasons.

Marital status also impacts the use of inpatient and outpatient healthcare utilisation, and it has also been very instrumental in determining and influencing decisions about perinatal and post-natal healthcare use. For example, studies conducted in Ghana and Bangladesh showed that most women with Muslim backgrounds seek permission from their husbands to seek maternal healthcare services (Ngwira and Lulin, 2021; Alkhaldeh et. al. 2023).

3.4.2. Enabling factors / Need factors

Enabling factors are characterised as factors that can facilitate access to and the use of healthcare services. They can also be factors that can hinder an individual from seeking healthcare services (Tanwani, 2023). In the subsequent chapters, this study will examine other variables such as employment status, access to private healthcare services in the case of South Africa (the role of medical aid), perception and experiences of the South African healthcare system by immigrant women, influence of education, and distance to healthcare facilities. I will examine these variables in detail in the next two chapters of this study. With regard to need factors, I will explore variables such as the perceived need for maternal mental healthcare utilisation by African immigrant women in Cape Town, as well as the evaluated need on the side of the healthcare professionals.

3.5 Conclusion

Andersen's (1995) behavioural model of healthcare utilisation (BMHU) is recognised widely for its significant contribution to the development of and understanding of access and utilisation of healthcare services among African immigrant women. This model forms the theoretical lens through which access to, and the utilisation of, maternal mental healthcare services by African immigrant women in Cape Town is conceptualised in this study. This study conceptualises and operationalises certain variables such as age, gender, cultural and religious beliefs, within the Andersen (1995) version of the model to explain the intersecting factors that determine healthcare utilisation by African immigrant women in Cape Town. Within this section, I highlighted three main factors, namely, predisposing factors, enabling factors, and need factors, all of which affect the decision to access healthcare services.

Part of the reason for adopting Anderson's behaviour model of access is because of its suitability for analysing health care challenges, experiences, and patterns of mental health care utilisation in other settings. Its applicability in this context enables one to make a critical and well-informed analysis of African immigrant women's challenges, experiences, and opportunities in Cape Town. The next chapter discusses the methodological background of this study.

CHAPTER 4

METHODOLOGY

4.1 Introduction

Given that this study aims to explore African immigrant women's experiences of maternal mental healthcare, I decided to adopt a qualitative design as an appropriate methodology for conducting the study. The present chapter presents the research components of qualitative research and justifies why and how I adopted each of the components in the research. These include the research design, the methodological processes, data collection methods, the research setting, sampling method, the population of the study, the criteria for recruiting participants, the data analysis method, and other research components such as trustworthiness, credibility, reflexivity, ethics procedure, as well as reflections on the limitations of the study.

4.2 Aim and objectives

This study aims to explore the maternal mental health challenges and opportunities of African immigrant women in Cape Town. More specifically, the study hopes to achieve the following objectives:

- i. To determine the level of awareness about maternal mental health amongst African immigrant women living in Cape Town.
- ii. To determine the prevalence of mental health challenges among African immigrant women in their perinatal period.
- iii. To understand how migration contexts impact the maternal health of African immigrant women and the challenges they face in Cape Town.
- iv. To identify possible coping mechanisms that African immigrant women employ to deal with the mental health challenges that arise from their maternal experiences in Cape Town.

4.3 Research Design

A qualitative research approach of inquiry will guide this study. I adopt a qualitative research method of inquiry in order to understand ‘why’ and ‘how’ people's experiences are shaped by social realities, as well as how they make sense of it. Qualitative research involves the collection, gathering, and analysis of non-numerical data such as texts, audio, and video to understand people’s perceptions, experiences, and views about social phenomena (Mohajan, 2018; Allan, 2020). Qualitative research is used to understand and to gather in-depth information about a research problem, which helps to generate patterns and new sets of ideas for further research (Chinyere and Val 2023; Allan, 2020; Cresswell, 1998). Qualitative research design is widely used in social science research across a wide range of disciplines to understand social phenomena. Its applicability cuts across disciplines like sociology, anthropology, history, health sciences, and education (Chinyere and Val, 2023). The phenomenological assumptions of the qualitative research approach are that it advances subjective knowledge rather than objective knowledge. In a qualitative research approach, participants’ subjective knowledge based on their lived experiences is very important to understanding individual realities (Chinyere and Val 2023).

Given that my study seeks to understand the maternal mental health challenges and opportunities of African immigrant women in Cape Town, I considered this research approach most suitable for the study based on the following features of the qualitative research method.

- An interpretive position that emphasises the need to understand participants’ social worldview through the interpretation of their lived realities.
- Recognition of an inductive idea that emphasises the relationship between research and theory, and in which the theory is generated from the research.

Bryman (2010); Silverman (2013) consider these features acceptable for knowledge inquiry because these features constitute the ontological, theoretical, and epistemological assumptions of qualitative research. In the context of this study, these features represent the theoretical, ontological, and epistemological assumptions with which the data collected for this study is gathered, interpreted, and analysed. Thus, these features allow me to explore and gather a subjective understanding of the meaning, perceptions, experiences, and challenges

African immigrant women in this study face in accessing maternal mental healthcare in Cape Town. Moreover, qualitative research is ideal for collecting data that addresses research of this nature using the interview process. This kind of research design can go beyond description and can potentially translate ‘health research into policy and practice’ (Meyer & Ward, 2014).

4.4. Research setting

A research setting is the physical and social place or site where the data for a study are collected. The study was conducted in Cape Town, Western Cape Province, South Africa. Cape Town is a major city located on the southwest coast of South Africa. It is one of the world’s most exciting cities, known for its stunning beauty and the rich array of nature’s blessings to mankind. It is home to over 4.6 million people, including foreign nationals, amounting to about 5.7% (City of Cape Town 2020).

Bellville is a major Northern suburb of Cape Town, which functions as both a residential and commercial hub. The area exhibits a mixed residential profile, with higher-income suburbs to the North and more mixed- or lower-income housing near industrial and older areas. While Bellville benefits from employment opportunities, urban renewal initiatives, and relatively affordable housing, parts of the CBD face challenges such as infrastructure strain, informal economy pressures, and urban decay. Immigrants, particularly from Somalia and other African countries, are active participants in Bellville’s economy, often clustering in the CBD. Their activities include retail and wholesale trade, informal trading, and low-cost lodging services. Immigrant-run businesses provide employment for both local and migrant workers and serve as key nodes in broader informal and formal economic networks, contributing to local commercial revitalization (Migration, 2017).

The immigrant women who participated in this study live in the neighbourhoods of Bellville, Mowbray, Parow South, Tygervalley, Parkland, and Durbanville, as shown in Figure 2 (map of Cape Town) below.

Figure 2. Map of Cape Town



Source: <https://municipalities.co.za/map/6/city-of-cape-town-metropolitan-municipality>.

4.5 Sampling

A purposive sampling technique was used to recruit immigrant women for this study. Purposive sampling is a type of sampling technique that focuses on a subgroup of a population in which all participants in the sample have and share identical characteristics (Wim et al. 2019). Purposive sampling is a non-probability sampling method mostly used for qualitative studies. It is used to gather rich data about a given research topic. It is also known as selective sampling, purposive, or judgmental sampling. It allows the researcher to deliberately select participants who know about the given research problem (Campbell et al.2020; Gill, 2020).

Purposive sampling is effective for this study because it is cost-efficient, convenient, and time-saving, but more importantly, it helps in recruiting participants who fit the selection criteria, that is, people who can give useful information. The selection of all the participants in this study was based on the application of sound judgment about the possible contribution of the participants' stories to the study. The intention was that the participants would provide rich in-depth information at their convenience, despite the sample size. More so, using such participants would enable me to focus on selected African immigrant women in Cape Town, who had lived experiences of utilising maternal healthcare services by self-identifying.

4.6 Sample size

According to Malterud, Siersma, and Guassora (2016, p. 1754), "sample size is the information power that a given sample holds". The sample size of qualitative research is determined by the aim of the research; the broader the aim of the study, the larger the sample size, and the smaller the aim of the study, the smaller the sample size, and vice versa (Malterud et al. 2016). Gill (2020, p.580) also defined sample size in qualitative research as referring to the "number of persons, but also to the number of interviews and observations conducted or numbers of events sampled".

Fifteen African immigrant women constitute the sample size of this study. I conducted eleven individual (face-to-face) interviews and one focus group discussion with four African immigrant women. I decided to conduct one focus group discussion in order to get a balanced perspective of the maternal mental health experiences, challenges, and opportunities of African immigrant women in Cape Town.

To enrich the discussion, I purposively selected four women with refugee backgrounds who live on one of the busy streets of Bellville to share their experiences of maternal health and maternal mental health challenges. Using a focus group discussion serves as a backup for the semi-structured interview by way of enriching the data and enhancing its reliability and accuracy. I facilitated the discussions to determine the group's perceptions and experiences of maternal health and the maternal mental challenges they have experienced as immigrant women in South Africa. I selected participants in the focus group discussion based on the selection criteria of this study, as well as their availability at the time of conducting this study.

4.7 Participant recruitment

One of the many advantages of purposive sampling is that it is convenient to implement the data collection process and to easily recruit participants who share similar characteristics. I recruited participants for this study from the list of my contacts, where I shared an advert explaining what the current study is about, the study criteria, and encouraged those who are willing to participate in the study to message me privately on WhatsApp. However, before I began the participant recruitment process, I had obtained ethics approval from the University of the Western Cape Humanities and Social Sciences Research Ethics Committee (HSSREC) for ethics clearance (Appendix 1). After the ethics clearance was approved, I then sent *WhatsApp* messages to some immigrant women in my contact list whom I thought met the selection criteria.

Initially, seven women reached out to me to inform me of their willingness to participate in the study. Given that I needed fifteen participants, I also called some of the women on my contact list telephonically to inform them about the study and seek their informed consent to participate. I identified and contacted fifteen women to participate in this study. Four of those fifteen women participated in the focus group discussion. I briefed all the participants about the study, its aims and objectives, the reason I selected them, their right to voluntary participation, their right to withdraw at any time from the study, and the benefits of taking part in the study. I also explained how their information would be protected (confidentiality). The participants gave their informed consent to participate in the interview. All the participants were interviewed in a private place of their choice, and at a time and date convenient for them. One participant asked to be interviewed in my home, two participants

were interviewed online via Zoom platform, four participants were interviewed at their place of work, six participants were interviewed at their shops, and the other two participants were interviewed in their homes.

However, there were some challenges during the interview process. I encountered some challenges during the interview process with the participants that I interviewed in their shops, online, and place of work. The participants whom I interviewed in their shops as part of the focus group discussion were non-English speakers. Therefore, expressing themselves in English was somewhat challenging, although they tried to answer the questions in the best way they could. This meant that I had to spend more time trying to explain the questions in such a way that each of them could understand. Another challenge I encountered during the online interview process was that there were network glitches.

4.8 Ethical considerations

Like all qualitative research, adhering to research ethical principles was important in the current research. In all qualitative research, researchers are expected to observe certain ethical standards when conducting research. Such standards protect both the participants and the researcher (Macleod et al. 2018). Researchers should also ensure that they conduct the research in an acceptable manner and within acceptable standards. Standard ethical principles considered in this current study include:

4.8.1 Ethics clearance

The ethics approval for this study was obtained from the University of the Western Cape Humanities and Social Sciences Research Ethics Committee (HSSREC for ethics clearance (Appendix 1). I applied for ethics clearance through the Sociology Department, Arts and Humanities Faculty, who then sent it to the Ethics Committee for review and approval in March 2023.

4.8.2 Informed consent

Before commencing with the interviews, I gave each participant a consent form (see Appendix 2) to sign and an information sheet to review. Although all the participants willingly indicated interest in participating in this study, it was important to obtain their written or verbal consent to ensure voluntary participation in the study and their right to withdraw from the study at any time. Macleod et al. (2018) have emphasised the importance

of obtaining informed consent from study participants as well as ensuring the protection of their identity (confidentiality) in research.

I also read and explained the information document to the participants for clarity and asked them if they understood the details of the document or had any questions (s) before they signed the documents. Details of the relevant contact person within my department were available on the information document (see Appendix 3). For example, the Head of Department (HOD), my supervisor, and the (HSSREC) details for any queries. I also provided the contact details of mental health counsellors and psychologists to participants for free counselling sessions in case any participant needed any form of psychosocial support.

4.8.3 Maintaining confidentiality

Maintaining confidentiality in research is an important part of ethical standards and procedures. Maintaining confidentiality relates to how we safeguard a study participant's information, which a researcher cannot divulge to third parties without the necessary permission from the participant. Confidentiality in this study is ensured by way of assuring the participants that their information will not be disclosed to anybody without their consent. As part of observing the ethical code of conduct in this study, I gave all the participants pseudonyms to protect their identities while ensuring confidentiality. During the data storage, I allocated special identifier codes to all the participants to ensure anonymity.

4.9 Method of Data Collection

I conducted the interviews in different forms based on the preferences of the participants. Some of the participants preferred one-on-one interviews, while others preferred online interviews. It is important to note here that, for the online interviews, one participant chose to give written consent, and I emailed the consent form to the participant, while the other online participant preferred to give verbal consent to participate, and I recorded the consent before the commencement of the interview. I used a set of semi-structured questions to guide the interview (see Appendix 4) that had been designed and evaluated by the relevant committees at the Faculty of Arts and Humanities, University of Western Cape. All the physical interviews were conducted at a place and time convenient for the participants. I interviewed two online participants from home. I conducted one of these interviews during the day, and I conducted a second one at night. I did this to accommodate the different participants' schedules.

The online participants incurred the cost of buying data bundles to participate in the interview. I also incurred a similar cost. For the other physical interviews, I covered the cost of my transportation for all the participants I interviewed one-on-one, including those I interviewed at their preferred places and those who came to my house. All the participants gave me consent to record the interviews. I recorded the interviews using an audio recorder device for word-to-word transcription. During the interview process, I also made use of field notes to record non-verbal events such as the participant's facial expression and body language.

I experienced some challenges during the online interview with one of the participants because we both struggled with internet connectivity problems during the Zoom meeting. However, we later decided to log out and rejoin the meeting. At this time, the interview went on successfully. Each interview lasted between 45 minutes to 1 hour and 15 minutes. This amount of time allowed the participants to provide detailed information about their experiences and the challenges of maternal mental health conditions they have experienced. I conducted the interviews in English. I then transcribed all the interviews verbatim and read over each transcript to ensure accuracy. After the first interview, I realised that some of the open-ended questions lacked clarity. I then refined the questions before interviewing subsequent participants.

4.10 Selection criteria

I selected participants for this study based on certain criteria. The selection criteria, also referred to as eligibility criteria, are a set of characteristics that the identified participants in a study must possess to be eligible to take part in the study. African immigrant women between the ages of 18 years to- 45years at the time of this interview were identified and recruited for this study. Immigrant women who have given birth to their child(ren) in South Africa in the last two to five years; immigrant women who have lived experiences of the South African healthcare system, immigrant women who have used maternal mental health services in Cape Town, and self-identified as experiencing or have experienced common mental health challenges. Women who are married or unmarried; women from other African countries like Nigeria, Zimbabwe, Congo, Ghana, and Cameroon who can communicate clearly in English, were identified and recruited.

I chose this set of women from different countries to gather rich information about their different experiences, views, and perceptions of maternal mental health challenges. All these women had migrated to South Africa from other parts of Africa, and they have lived in South Africa for more than twenty-four months (2 years). I chose these participants for the study because they were the people who could assist with answering my research questions. All participants were asked whether their real names should be used. Eight participants did not mind me using their real names for the study, five participants did not want me to use their real names, and the last two participants gave their consent for me to use their real names. However, for uniformity and anonymity, I decided to identify each participant with a pseudonym according to how I interviewed them. Below is the participant's demographic and how they were identified.

4.10.1 Table 1. Descriptive data on the maternal background of participants

Participants Pseudonym	Country of origin	Migration status	occupation	Level of education	Number of kids	Type of Birth facility Used.	Age
Grace	Nigeria	Has permit	Self-employed	Postgraduate Diploma	2	Public hospital	43
Voyu	Nigeria	Permanent resident	Researcher	PhD	2	Private/private hospital	35
Jabu	Nigeria	Has permit	Stay-at-home mom	BSc	2	Public hospital	30
Nikki	Cameroon	Permanent resident	unemployed	Masters	3	Private/public hospitals	35
Sarah	Rwanda	Has permit	unemployed	Master's degree	3	Public hospital	45
Loveth	Zimbabwean	No permit	Stay-at-home mom	Master's degree	3	Public/Private hospital	37
Esther	Ghanaian	Has permit	unemployed	PhD	3	Public hospital	33

Fortune	Nigerian	Has permit	Lecturer	PhD	2	Public hospital	34
Asanda	Nigerian	Has permit	unemploy ed	Masters	2	Public hospital	34
Lulu	Congoles e	Has permit	unemploy ed	Masters	3	Public hospital	35
Rumi	Congoles e	Refugee	Self- employed	Matric	4	Public hospital	35

Table 2. Details of participants in focus group discussion

Pseudonyms	Country of origin	Migration status	occupation	Level of education	Number of kids	Type of Birth facility Used.	Age
Hazel	Congolese	Asylum seeker (no permit)	Hairstylist	Diploma	3	Public hospital	33
Mia	Congolese	Asylum seeker (no permit)	Hairstylist	Diploma	2	Public hospital	32
Amery	Congolese	Asylum seeker (no permit)	Nail technician	Matric	1	Public hospital	33
Elita	Congolese	Refugee (has permit)	Salesgirl	First degree	1	Public hospital	32

The above tables show the demographic information of all the participants in the study. These participants are immigrants from other parts of Africa. Apart from the initial selection criteria I mentioned before, immigration status and level of education were not included as part of the selection criteria. However, I saw the need to populate this information on the table in order to evaluate the quality of data from the participants against their educational backgrounds and immigration status. The table also helps to shed light on the relationship between the participants' ages and their perception of maternal mental health. I will explore these points in detail in the next chapter. This is because immigrant women in their host countries identified

age in the literature review and theoretical framework sections of this study as a factor that affect the use and access to maternal mental healthcare services.

Four of the participants in this study mentioned that they gave birth to one or two of their children in their home countries and the last child here in South Africa, while the remaining eleven participants had their first experiences of being a mother in South Africa. This further enriches the data from the participants in terms of their assessment of maternal healthcare in the South African context. The type of healthcare facilities that the participants accessed is also a factor that I will examine during data analysis hence I highlighted it in the table above. All the participants reported that they were married and living with their partners here in South Africa.

4.10.2 Descriptive Statistics

The demographic information of the participants is presented visually in the graphs and tables below to give a vivid description of the participants' details.

4.10.2.1 Age Distribution

The distribution of participants' ages ranged from 30 to 50 years, with the most frequent age group being 35-45 (36.4% of the sample), as shown in Table 1. The cumulative distribution indicates that nearly all participants (90.9%) are aged 45 or below, and only one participant is aged 45-50. This suggests that most of the participants are in their mid-adulthood, which could influence factors such as employment status, family responsibilities, and migration motives. The age distribution is visually depicted in Figure 1, which illustrates that the 35-45 age group is the most represented, followed by the 30-35 age group.

Table 3. Frequencies of Age

Age range	n	Frequencies (%)
30-35	2	18.2 %
30-45	1	9.1 %
33-40	1	9.1 %
34-45	1	9.1 %
35-45	4	36.4 %
37-45	1	9.1 %
45-50	1	9.1 %

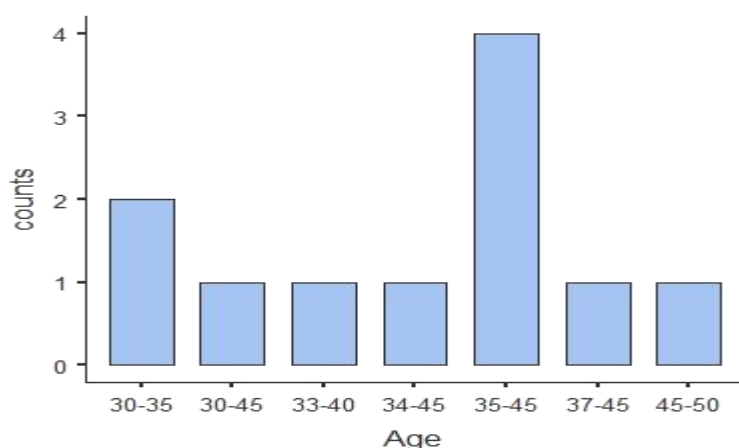


Figure 3. Frequencies of Age

4.10.2.2 Country of origin

As shown in Table 2, participants in the study represented six different countries, with Congo, Cameroon and Nigeria being the most frequent countries of origin, each accounting for 27.3% of the total sample. The visual representation in Figure 2 highlights that these three countries constituted over half of the participants (54.6% combined), followed by smaller proportions from Zimbabwe (18.2%) and participants from Congo making up (54.6), Ghana, and Rwanda (18.2). The geographic diversity of the sample may reflect common migration routes or networks into South Africa. The concentration from specific countries suggests that the participants may share cultural or socio-economic backgrounds potentially influencing their adaptation experiences in the host country.

Table 4. Frequencies of Country of Origin

Country of origin	n	Frequencies (%)
Cameroon	3	27.3 %
Congolese	6	54.6 %
Ghana	1	9.1 %
Nigeria	3	27.3 %
Rwanda	1	9.1 %
Zimbabwe	1	9.1 %

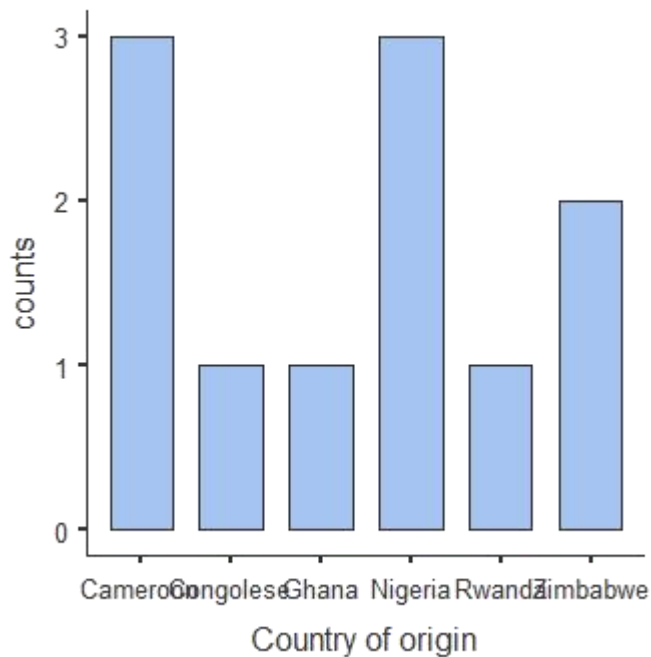


Figure 4. Country of Origin *Distribution of Participants*

4.10.2.3 Years in South Africa

As shown in Table 3, most participants have lived in South Africa for 7 to 9 years, accounting for 54.6% of the sample. Only one participant has resided in South Africa for over 10 years. This suggests that most participants have had significant exposure to South African society but are not long-term residents, potentially positioning them at critical points of integration or adaptation. Figure 3 visually demonstrates this distribution, where the 7–9-year category is predominant, with other categories being less frequent.

Table 5. Number of Years in South Africa

Years in SA	n	%
10 and above	1	9.1 %
5	2	18.2 %
7	3	27.3 %
9	3	27.3 %
6	1	9.1 %
8	1	9.1 %

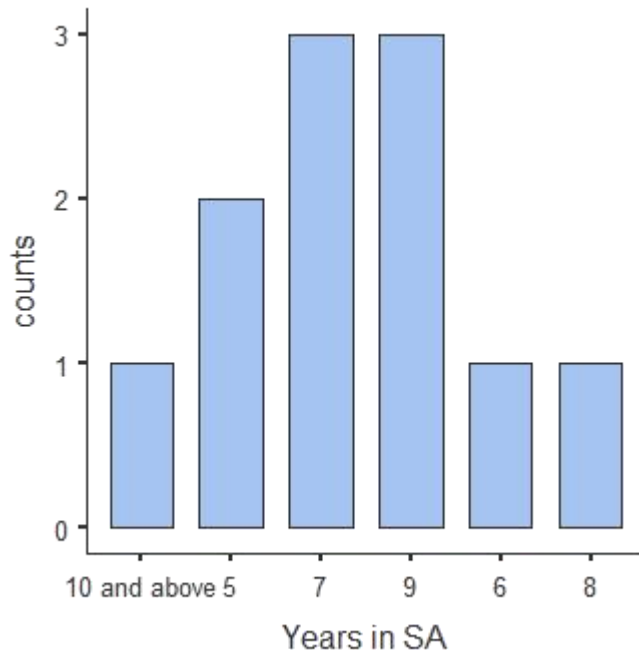


Figure 5. Years in South Africa

4.10.2.4 Number of Children

As shown in Table 4, nearly all participants reported having either 2 or 3 children, accounting for 90.9% of the sample. This indicates that the sample consists of individuals with relatively large families, which may have implications for their socio-economic situation, particularly in terms of housing and education needs. Figure 4 demonstrates this distribution, where families with 2 or 3 children dominate, and only one participant reported having 4 children.

Table 6. Frequencies of Number of Children

Number of kids	Counts	%
2	5	45.5 %
3	5	45.5 %
4	1	9.1 %

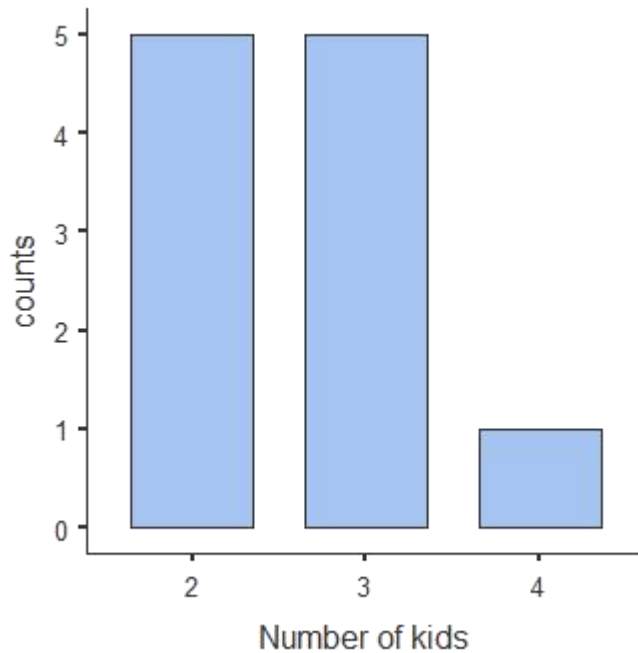


Figure 6. Number of Children Distribution

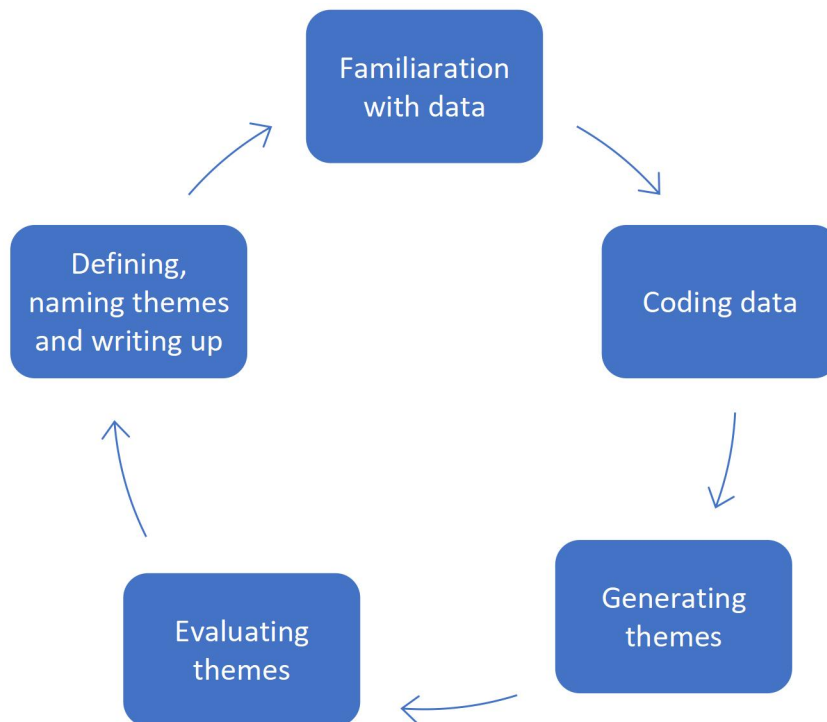
4.10.3 Procedures for Data Analysis

The data collected were interpreted and analysed using inductive thematic analysis. “Inductive thematic analysis is defined as a flexible method of qualitative data analysis, often useful for descriptive research designs. It is used for exploring patterns and themes across qualitative data from participants” (Clarke and Braun, 2014, p.197). According to Clarke and Braun (2014), thematic analysis is the most suitable approach for any study that aims to discover the subjective interpretation of meanings that people ascribe to their experiences.

The significance of inductive thematic analysis is that it helps to identify themes within the data collected and then use these themes to form patterns that help to interpret and make sense of the given research problem in the study (Maguire and Delahunt 2017, Vaismoradi and Snelgrove 2019). Another advantage of inductive thematic analysis is that it is flexible for working with huge data systematically. It also increases the chances of interpreting and understanding data accurately (Braun and Clarke 2014).

I followed the six-phase thematic analysis framework developed by Braun and Clarke (2006) in order to analyse the data collected from participants in this study. The six-phase thematic analysis comprises the following: familiarisation with the data, coding, generating themes, evaluating themes, defining and naming themes, and lastly, writing up (Braun and Clarke 2006; Victoria Clarke, 2019).

Figure 7. Systematic stages of data analysis by Braun and Clarke (2006, p. 79), and Victoria Clarke (2019).



4.10.3.1 Familiarisation with data

The analysis started with the data familiarisation process, where conscious effort was made to demystify the data collected from the interviews. The data from the one-on-one interviews and those from the focus group discussion was first subjected to the process of data triangulation. Data triangulation in research refers to the process of using different sources of data to analyse a particular study in order to achieve a desired outcome. This process helps to combine data from multiple sources to enhance the credibility and validity of a study (Anita and Benjamin, 2021). Triangulation in research differs from mixed methods approach.

Anita and Benjamin (2021) highlighted four potential benefits of using data triangulation in research. Firstly, it helps to reduce biases, thereby increasing the validity and credibility of the study. Secondly, it helps the researcher to get a deeper understanding and insight of the phenomena and as well as the ability to provide better solutions. Thirdly, the different data sets help to confirm and compliment the research findings. Finally, data triangulation

strengthens the theoretical and methodological approaches used in research studies (Anita and Benjamin, 2021).

I combined the data from the one-on-one interviews and the focus group discussion and carefully listened to the recorded audio interviews before manually transcribing them into words (Braun and Clarke 2006). After the first exercise, I listened to the recordings once again while reading the transcripts. This helped me to gain a better understanding and interpretation of the data. This process is considered an invaluable way of getting a clearer sense of the text, (Dalington and Scott 2002). The table below gives a breakdown of the interviews, the number of pages, and the duration of the interview.

Table 7. Description of interview transcripts and audio interview of each participant

Participant interviews	Length of interview transcript in pages (Times New Roman 12, 1.5 spacing)	Minutes of each audio
Grace	18 pages	48:09
Voyu	43 pages	1:00:52
Jabu	34 pages	1:17:44
Nikki	11 pages	19:56
Sarah	16 pages	33:45
Loveth	14 pages	30:24
Esther	12 pages	32:58
Fortune	16 pages	35:11
Asanda	20 pages	1:03:33
Lulu	8 pages	53:45
Focus group discussion (Hazel, Mia, Amery, and Elita)	20 pages	43:02
Rumi	5 pages	15:14

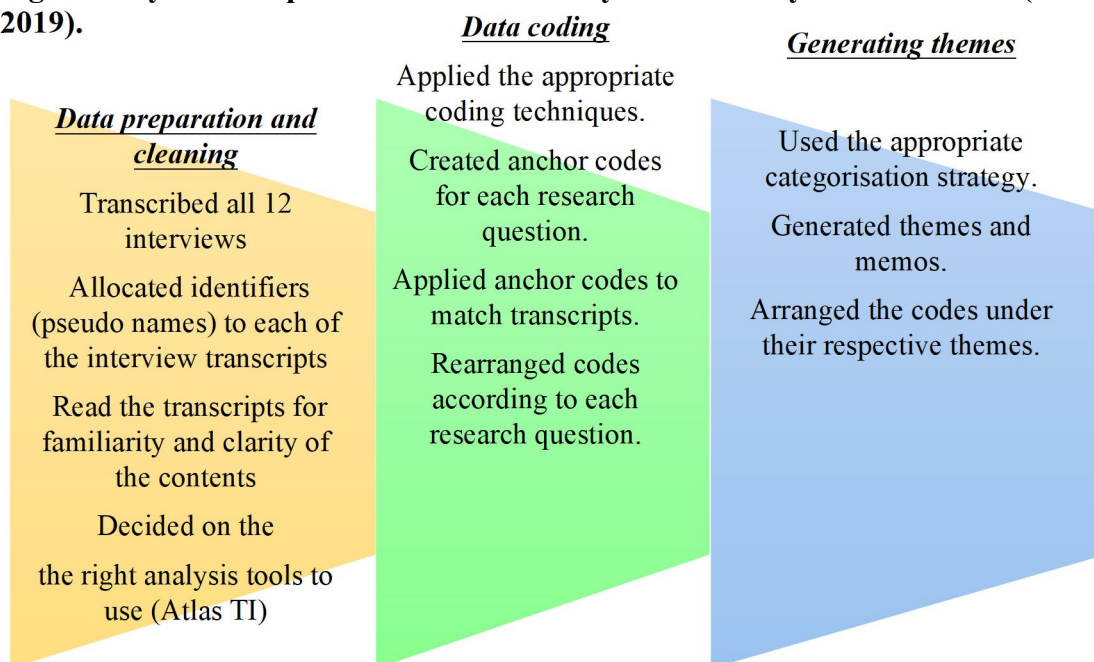
After familiarising myself with the data, the next phase of the study was coding.

4.10.3.2 Coding

Coding involves sifting through the data to generate themes and subthemes. It helps the researcher to create labels for aspects of the data that are relevant to answering the research questions. Coding is important because it not only helps to reduce the data but also helps to identify semantic meanings from the data (Creswell et al. 2011).

The process of coding in this study was aided by using a thematic analysis software known as **Atlas TI**. After coding the twelve transcripts, I was able to generate about five hundred and fifty-seven codes (557 codes extracts. I later merged and remerged these codes into similar codes to reduce the size of the data (the process of data reduction) (Philips Adu 2019). The process of coding ended after generating sixteen themes, and from these sixteen themes, main themes and subthemes were created. I undertook this process after thoroughly checking and revising the codes to be sure that they adequately represent the themes that will help me to answer the main research questions of this study. Each of the themes and subthemes are fully discussed in the next chapter.

Figure 8. Systematic processes that this study used to analyze the raw data (Philips Adu 2019).



However, before I started coding the transcripts, I checked my research questions to develop an anchor code for each of the research questions. According to Adu (2019), an anchor code

is a label that is given to a research question. It is usually in the form of an acronym that represents a short phrase (between 2-5) of your research questions.

Table 8. shows the corresponding anchor codes I developed from my four research questions.

4.10.3.3 Data Coding: A systematic approach

Research objectives and corresponding anchor codes

	Research Objectives	Anchor codes
RO1	<i>i. To determine the prevalence of mental health challenges among African immigrant women in their perinatal period.</i>	Mental health challenges (MHC)
RO2	<i>ii. To understand how migration context impacts the maternal health of African immigrant women and the challenges they face in Cape Town.</i>	Impact of migration context (IMC)
RO3	<i>iii. To determine the level of awareness about maternal mental health amongst African immigrant women living in Cape Town.</i>	Level of awareness (LA)

RO4	<p><i>iv. To identify possible coping mechanisms that are employed by African immigrant women to deal with the mental health challenges that arise from their maternal experiences in Cape Town.</i></p>	Coping Mechanisms (CM)
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4.10.3.4 Identifying themes

The process of generating themes from the data is a very vital aspect of data analysis. Researchers believe that searching or identifying themes is an active process that requires the researcher to summarise and decode hidden information within the data (Clark 2019).

I began the process of searching for themes by first coding each participant’s data before categorising the themes. This process helped me to systematically work through each data and identify repeated themes that form patterns for categorisation. Braun and Clarke (2006) refer to the process of identifying themes as ‘searching’, while Clarke (2019) refers to this stage as an ‘active process’ of developing themes. I collated all the codes that were important to each theme, and I separated the data that did not relate to the research questions and stored them for later use. I included direct quotes from the interviews in the discussion where necessary. I grouped common reemerging themes from the coding based on the relationships, similarities, patterns, and meanings they present.

4.10.3.5 Reviewing and naming the themes

The fourth phase of the data analysis was to review the themes. This involves checking that each theme that I identified corresponds to the original data and the codes. I did this by reflecting on the identified themes to check whether all the themes I have chosen from the data set are convincing enough to help me answer my research questions. I then named each of the themes to help me begin the process of presenting a detailed analysis of each theme.

4.10.3.6 Defining and writing-up

The last phase of data analysis according to the data analysis framework of Braun and Clarke, (2006) is the writing-up stage. According to Clarke (2019, p.4), “writing-up involves the weaving together the analytic narrative and (vivid) data extracts to tell the reader a coherent and persuasive story about the data and contextualizing it in relation to the existing literature”. The writing-up phase is presented and interpreted in the next chapter of this thesis.

4.11 Ensuring rigour and limiting biases

4.11.1 Trustworthiness

Trustworthiness is an intricate part of qualitative research evaluated by considering criteria such as credibility, dependability, transferability, and confirmability. Meanwhile, in quantitative research, trustworthiness evaluates the issues of validity, reliability, and objectivity (Adler 2022; Cloutier and Ravasi 2021; Amin et al. 2020). Trustworthiness in research shows the rigour and level of thoroughness of the information presented in the study, for example, the rigour in the collection, analysis, and presentation of the research findings. The trustworthiness of this study is demonstrated in the way and manner that all components of the study were conducted, right from the conceptualisation of the topic, the objective of the study, methodology, data collection tools, choice of participants, data collection, analysis, and presentation of the findings. All aspects of this study were well thought through. I debriefed the participants before the commencement of the interviews; I made sure there was clarification in instances where information was not communicated clearly; and the study was well-grounded in an existing theory. Therefore, this study can stand the test of transferability.

4.11.2 Credibility

Credibility in qualitative research involves authenticating that the results of a study are believable or trustworthy from the perspective of the participants involved in the study (Cloutier and Ravasi 2021). The credibility of this study is demonstrated through the amount of time I spent engaging with each participant. I ensured that responses from participants were accurately transcribed and interpreted. All aspects of the interview process were adequately communicated to the participants for clarity. I tried to immerse myself in the study by paying keen attention to each participant’s story as it unfolded during the interview. This was to allow me to get a clear insight into each participant’s context and experiences, and the challenges of maternal mental health conditions in Cape Town.

This was significant in fostering confidence and establishing trust with the participants. I also sent the transcript of the interviews to my participants to read for any corrections, in this case, they can validate the accuracy and quality of the data they provided for this study. This process is also to guarantee the level of credibility of this study. Additionally, the process of data triangulation also helps enhance the credibility of this study.

4.11.3 Dependability

According to scholars, dependability in qualitative study ensures that one can repeat the outcome of a study and that that outcome can be depended upon (Cloutier and Ravasi 2021). Amin et al. (2020) noted that dependability helps to strengthen the researcher's ability to understand the methodologies used and their significance to the current study. Cloutier and Ravasi (2021) refer to dependability in qualitative research as the standard that guides the execution, implementation, presentation, and appraisal of a qualitative research study. To show the dependability of this study, I followed the appropriate procedures for conducting a qualitative study. Every aspect of the data collection, findings, and analysis was explained in detail. Adequate steps were taken to ensure that the data collection, analysis, and presentation were accurately presented and audited. Personal biases were eliminated from the findings and interpretation of the results.

4.11.4 Transferability

Transferability in qualitative research describes the degree or extent to which other researchers can transfer or generalise the results of the current study in other contexts (Cloutier and Ravasi 2021). To ensure the replicability and generalisation of the findings in this study, I have provided a comprehensive description of the context of the current study, the study population, settings, and the methodological procedures followed in the study. The transferability of this study is further guaranteed by the contextualisation and applicability of Andersen's (1995) theoretical framework that foregrounds this study, as well as the interpretivism philosophical assumptions guiding this study.

4.11.5 Confirmability

Confirmability refers to the extent to which one can verify or corroborate the results of a study by other studies. It is the degree to which the outcome of a study “transpires from the respondent's experiences and viewpoints and is supported by the data gathered and appraised by the researcher” (Cloutier and Ravasi 2021, p.118). It ensures that as much as possible, the

research findings are entirely based on the experiences, perceptions, and beliefs of the participants rather than the researcher's characteristics or preferences. To ensure the confirmability of the results of this study, I checked to ascertain that the interpretations of the results and the conclusion of the study are consistent with other studies that investigated similar groups of immigrant women in their diasporic contexts.

4.11.6 Reflexivity

Reflexivity refers to the introspective process of the role that a qualitative researcher plays during the research process. According to Erlinda Palaganas et al. (2017, p. 427, citing Parahoo, 2006), reflexivity “is a continuous process of reflection by researchers on their values and of recognising, examining, and understanding how their social background, location, and assumptions affect their research practice”. Reflexivity helps the researcher to acknowledge the research process, the impact it has on the researcher, and how these shape and challenge the researcher's views, personality, and values. It also helps to evaluate the extent to which the researcher influences the views of the participants in the research process (Brendan Gough 2017).

As a postgraduate student, I belong to a marginalised group of African immigrant women in South Africa, and I recognise the significance of my position and level of education within my academic capacity as a researcher. Despite being an immigrant woman who has experienced multiple challenges in South Africa, including accessing maternal mental health care, I recognise, value, and respect the uniqueness of each participant's experiences, and I did my best not to interfere with each participant's story as much as possible. I recognise the role of my personal experiences as an African immigrant woman in shaping my ideological narrative of maternal mental health experiences in South Africa. Furthermore, because of the numerous literature I engaged with in preparing this study, it was, however, necessary to put aside my biases, personal beliefs, feelings, and knowledge about MMH while engaging with the participants during the interviews. I maintained reflexivity by consciously journaling my thoughts, feelings, and emotions after each interview.

4.12 Conclusion

This chapter provided a comprehensive discussion of the methodological steps and processes involved in conducting this study. The study participants were purposively selected based on their knowledge of the study. They consisted of women from six African countries who had lived experiences of accessing maternal healthcare in Cape Town and women who self-identified as having experienced maternal mental health challenges in South Africa. A Semi-structured, one-on-one interview was conducted with eleven women and one focus group of four participants to add richness to the study. The qualitative data were analysed following Braun and Clarke's (2006) five steps of data analysis. I addressed all issues of trustworthiness, credibility, transferability, dependability, and reflexivity to ensure rigour in the study. I observed all ethical guidelines for qualitative research during and after the interviews. The findings of this study are systematically presented in chapter five and six, respectively.

CHAPTER 5

PREDISPOSING FACTORS TO MATERNAL MENTAL HEALTH CHALLENGES IN DIASPORIC CONTEXTS

5. 1. Introduction

The present chapter is the first data analysis chapter of this study. The chapter presents and examines the findings of this research based on the primary data collected from the participants, following the five-step process of thematic analysis by Braun and Clarke (2006). The chapter begins by providing an overview and a tabular description of the research themes and subthemes, largely supported by quotes from the participants during the interviews and focus group discussions. The aim is to make it easier to identify the relationships between the main themes and subthemes. The presented themes, sub-themes, and quotes from the participants' transcripts provide a deeper insight into immigrant women's maternal mental health experiences, challenges, and opportunities as it relate to the research objectives of this study. The ensuing analysis highlights some of the significant challenges that African immigrant women face in South Africa as they navigate access to maternal mental healthcare services.

5.2. Interpretation of Themes and Subthemes

Following the merging and remerging of codes as already explained in the methodology chapter, sixteen themes were generated, from the sixteen themes, five main themes with subthemes were further generated to form the main discussion of this section. The table below shows a breakdown of the initial themes, main themes, and subthemes.

Table 9. Clustering of initial themes to form main themes

Initial themes (sixteen themes)	Main themes (five main themes)
Disrespect Long waiting time Challenges of Immigrant Women Discrimination Feeling of loneliness	Encountered challenges

Willingness to pay for services Experiences with healthcare workers Good maternal experiences Traumatic experiences of immigrant women Obstetric negligence	Immigrant women's expectations and experiences of maternal healthcare services in Cape Town
Resilience in host country Maternal education Available support for immigrant women Role of culture and religious beliefs.	Immigrant women's coping mechanisms
Language and the use of services	Language and access to maternal services
Maternal mental health	Maternal mental health conditions of immigrant women in Cape Town

The above themes were redefined by grouping the codes according to the contextual meaning they represent in this study. This process is relevant because it is useful for organising common recurring ideas that can be generalised to answer the research questions and achieve the research objectives in a study (Vaismoradi et al. 2016). The main themes and corresponding sub-themes are presented in the table below.

Table 10. Modified themes and subthemes

Main themes	Subthemes
Encountered challenges in Cape Town	Unemployment Lack of government support Loneliness Unequal access to services Migration status Discrimination
Expectations and experiences of maternal healthcare in Cape Town	A. Positive experiences and perception of maternal health B. Negative perception Negative perception of healthcare workers.

	<p>Language barrier to accessing services</p> <p>Long waiting time Obstetric violence Obstetric negligence Disrespect</p>
Maternal mental health coping mechanisms of African immigrant women in Cape Town	<p>self-help (books) self-medication social network (friends and migrant communities) Church members Resilience Prayers Cultural and religious belief</p>
Maternal mental health conditions of African immigrant women in South Africa	<p>Fear of stigmatisation Postnatal Depression Trauma Anxiety</p>
Experiences with access to maternal mental health services	<p>Low level of awareness about available mental health services</p> <ul style="list-style-type: none"> • Financial barriers to seeking maternal mental healthcare • language proficiency and access to maternal services

The main themes and subthemes are generated from the primary data that I collected through interviews and focus group discussions for this study. The subthemes presented in Table 10 above are concepts that emanated from the transcripts used by participants to relate or express their subjective experiences of maternal mental health situations in Cape Town. I will further discuss the themes and subthemes below to provide a detailed description of the meanings that each participant ascribes to her individual experiences as an African immigrant woman accessing maternal mental healthcare in Cape Town.

5.3 Theme 1: Encountered challenges in Cape Town

Highlighting some of the challenges faced by African immigrant women in Cape Town as they appear from the analysis of the primary data in this study serves as a foundation for understanding the origin of their preconceived and pre-existing mental health conditions and stressors that are compounded by their maternal experiences in the post-migration state. My study contributes to the literature on African immigrant women's physical, social, economic,

and psychological challenges in host societies. More specifically, it deepens our understanding of the significant elements that engender psychological stressors among African immigrant women in South Africa. To elaborate on this point, participants in the study extensively expressed several challenges they face in South Africa as African immigrants (ethnicity), women (gender), and mothers (gender roles). This suggests that the intersection of ethnicity, gender identity, and gender roles is a significant aspect of the international discourse of migration that shapes the experiences of women and their health conditions in host countries.

Existing studies have shown how gender (women) and migration have been analysed to portray the vulnerability of immigrant women within the context of race, unemployment, identity, class, and health inequalities (Kalpana, 2017; MacFarlane et al. 2023). These factors, amongst others, have been examined in other empirical studies that show a direct link between predisposing factors, enabling factors, and the actual need for the utilisation and or non-utilisation of mental healthcare among the African immigrant population (Saasa et al. 2021). Florence and Rufaro (2021), in their study, argue that black African immigrant women's migratory experiences have not been well captured in existing literature, especially regarding the unique challenges they experience at all stages of immigration, and it is hoped that this thesis will contribute to bridging this gap.

The challenges African immigrant women face in host societies are predisposing factors that affect their mental health and general life conditions (Botchway-Commey et al. 2024). Some of the challenges that were mentioned during the interviews were issues around loneliness, unemployment, lack of government support, and the impact of legal migration status. Kalpana Hiralal (2017) argues that the challenges that immigrant women face in South Africa are likely to disadvantage them and change the pattern of their post-migration experiences when compared to the male counterparts. According to a comparative study that examined Somali immigrant women's sexual and reproductive care attitudes by Iyi and Amaechi (2024), the authors argued that structural and non-structural factors influence how immigrant women's experiences are shaped in host countries, which also explains the kinds of challenges they face.

To understand the maternal mental health conditions of African immigrant women in the South African context, it is important to highlight some of the structural and non-

structural challenges that exist as stressors amongst this group of women. In this study, participants' experiences of loneliness can be generalised and regarded as a non-structural factor that affects women in host countries. Loneliness is a predominant feeling of family separation that many studies of this nature have identified amongst the migrant population. For example, loneliness and isolation have been associated with depression among African immigrant women in diaspora (Botchway-Commey et al. 2024).

A study by Tyrone Pretorius (2022) examined loneliness among a randomly selected sample of 337 adult participants and argued that loneliness is one of the most noticeable consequences of mental health conditions among adults who self-isolate. The result of the study also revealed that women tend to experience higher levels of loneliness than their male counterparts. According to Pretorius (2022, p.1), "Loneliness is defined as the discrepancy between one's actual levels of interaction with others and the desired levels thereof". It is a subjective and distressing emotional state characterised by the perception of social isolation and a sense of feeling alone. Loneliness has been linked to risk factors for adverse physical and mental illnesses, including depression, cardiovascular disease, Alzheimer's disease, and other problems such as suicide, lower life satisfaction, reduced work performance, and mortality (Chiao, Chen and Yi 2019; Maguire, Hanly and Maguire 2019; Chang et al. 2017).

Hence, the assessment of loneliness has been identified as a significant public health issue (Killgore et al. 2020). According to evolutionary theory, loneliness serves as a signal to reconnect with significant others (Luchetti et al. 2020). Although the context of the above study by Pretorius (2022), differs, some lessons could be drawn. For instance, in my study, African immigrant women explained with sober expressions the difficulties and challenges of living far away from their families back home (countries of origin).

As indicated by three participants, the feeling of loneliness in South Africa after they arrived made some of them experience depressive moods that impacted their mental health and ability to function optimally. This experience is very important to note because some of these participants fell pregnant after they relocated to South Africa, while others came into the country pregnant. For example, Esther and Jabu arrived in South Africa already pregnant. Esther shared that coming to South Africa to study alone without her family members or any friends in South Africa made her feel lonely, and the experience was traumatic for her, especially because she came to South Africa pregnant.

Yeah, it was very traumatising for me. I was at the lowest point of my life; it was not easy. My research work was not progressing. I was alone. But I was literally alone throughout the pregnancy [Esther, 18/08/2023].

Meanwhile, Jabu expressed that she felt rather unwelcome and rejected by the people she met on her arrival in South Africa. She also mentioned that having South African friends is often not easy, and this made her resettlement experiences very difficult. I asked about her initial experience when she first arrived in South Africa, and her response was:

“South Africa was cool but not accepting, because I think they have built their system in a way that you feel rejected. Both physically and emotionally, they have a way of always making you feel you are not from here. I think South Africa is the place where I’ve never felt accepted much, but in other things, like meeting people, like saying Oh I have a friend from South Africa, you know, it’s not easy for us, it was lonely” [Jabu, 11/08/2023]

It is important to note that these experiences of loneliness and feelings of rejection and discrimination faced by immigrant women at the hands of the citizens of host countries are not peculiar to the South African context. Immigrant women in other contexts, such as the United States of America, have also shown that discrimination and feeling of loneliness affect their mental health, especially in their post-migration phase (Escamilla and Saasa (2020). This experience is very challenging for immigrant women, especially when these immigrant women do not receive any form of social support, which was the case of the participants I interviewed for this study. It is important to understand this pattern of experiences (i.e., loneliness and feeling of rejection) among African immigrant women in host societies, especially in this study, because it provides the layer for understanding all other kinds of challenges these women face in South Africa, including access to maternal mental healthcare.

When asked about the post-arrival challenges they faced in South Africa, another participant noted that she faced many challenges after she arrived in South Africa, especially the stress of leaving her family back home to settle in South Africa. According to her, this was very challenging:

“When I came to South Africa, of course, there were so many challenges. Everything was new to me. I mean, it was my first time leaving my country or leaving my family, my immediate family. So, it was really challenging for me, trying to adapt to so many things, food, personalities and all that” [Voyu, 10/08/2023].

Most of the women I interviewed in this study also expressed that leaving their families behind and relocating to South Africa has been very disruptive and emotionally draining for them. According to result from a cross-sectional survey study that examined the relationship between gender and symptoms of depression and anxiety among the African immigrant population in the United States, family separation and loneliness is linked to the manifestation of symptoms of depression amongst African immigrant women (Escamilla and Saasa 2020).

In addition to loneliness, unemployment also emerged as a subtheme in the structural challenges my participants said they face in South Africa during our discussions. Based on their educational backgrounds, most of the women interviewed for this study have some form of formal education. Some of the participants in the study have postgraduate degrees (masters and PhD), some had first degrees and others diploma and matriculation qualifications that they obtained in South Africa or before they migrated to South Africa. Despite holding these qualifications, many of the women expressed their frustrations for not being able to secure employment in South Africa. Nine participants in this study said that being unemployed makes them vulnerable in the South African system and by extension, the healthcare system. As Mia puts it:

'For me also living in South Africa as a refugee is very difficult in many ways. It is very difficult to pay rent. Raising the kids in South Africa is not easy. No support as a refugee and no jobs. Sometimes you have the potentials to do something but they're not giving you that opportunity to achieve your dreams' [Mia, 12/05/2024].

Similarly, Grace expressed that she is qualified and ready to work, but all her efforts to secure a decent job have been abortive since she came to South Africa. According to Grace:

"They should try to employ us. We have all these qualifications in our hands. We are not getting jobs. You come here; you can't do anything meaningful with your life. I'm using myself as an example. I was working in my country before I came here with my husband. If I had known that I would come here and not get anything to do, then I would have preferred to stay back in my country. And if I was back in my country, I would have gone far than what I am today because practically, now I'm just here doing nothing and it's not as if I'm not educated. I am. But the jobs are not there to be given to the foreigners. I have what it takes to work over here, but there's no company, but there's no place

that's willing to give you a job as far as South Africa is concerned”
[Grace,20/07/2023].

Unemployment among the immigrant population is a major structural challenge identified in many contexts. As indicated by my study, unemployment serves as a predisposing factor that disempowers African immigrant women in the South African context. The participants in this study believe that they are indirectly excluded from getting formal employment in South Africa because of their foreign status. They perceive this as a weapon of vulnerability that affects their mental health and overall standard of living in South Africa. A study that examined the structural impact of unemployment and gender disparity using a logit regression method, Nursel and Piovani (2021) found that women are likely to suffer more from unemployment and substandard or poor jobs than men are. Aydiner-Avsar and Piovani (2021) citing Latif (2015), argues that unemployment has a significant impact on women and increases the presence of depression for women than in men.

Souza (2021) specifically examined the integration of African immigrant women into the South African labour market by investigating their prospects of formal employment and access to employment opportunities. The study revealed a significant gap in the incorporation of immigrant women into the South African labour market. The study also shows that African immigrant women are less likely to be integrated into the labour market than Black South African women are. For the minority that participate in the labour market, the employment levels are significantly lower. In this regard, researchers have advanced some reasons to explain and help us understand the phenomenon of unemployment among African immigrant women in South Africa.

The results from a quantitative study that surveyed three-hundred and thirty-two African immigrant women from twenty-three African countries who were purposively selected by Ncube et al. (2020), from six big South African metropolitan cities, revealed that African immigrant women not only lack formal employment, populate the semi-informal job sector that deskills their educational qualification. Another significant barrier the study identified is the existing legislative frameworks in South Africa that govern foreign qualifications from other countries. Furthermore, some hold the view that South African employment policies are by nature unfavourable to foreigners since the policies give priority “to local South Africans and only scarce skills jobs can be given to foreigners if no qualified local is available” (Ncube et al. 2020, p. 1172).

According to the report from a statistical and econometric analysis of migrant's participation in South Africa's labour market, Deborah and Christine (2014) noted that foreign migrant women are more likely to experience employment-related discrimination in South Africa with a higher probability of experiencing underemployment. The same authors further argued that the overrepresentation of migrant population within the informal sector is explained by the low cost of entry into the labour market and it is often characterised by precarious employment conditions, exploitation, and low earning power (Deborah and Christine 2014).

My findings in this study suggest that unemployment not only affects the economic power of African immigrant women, but it also translates to poor human and national capacity development and hinders the economic contribution those migrant women make to the host country (South Africa). This in turn, has far-reaching implications for the general living conditions and maternal mental health status. My findings in this study therefore emphasize the point that there is a relationship between unemployment and poor maternal mental health outcomes among participants in this study.

My study also identified lack of government support as a form of socioeconomic challenge that African immigrant women face in South Africa. During the interview, some of the participants described how lack of government support limits them from actualising their potentials. They explained that the failure of the government to issue necessary legal documentation to them exacerbates their vulnerability, helplessness, and mental health conditions, especially as mothers in South Africa. Some of the participants expressed that due to the failure of the government to provide them with documents showing that they were permitted to live and work in South Africa, their lives became very miserable, and they experience financial hardship because they cannot work to provide for themselves or take care of their children. The ambiguous immigration status of these immigrant women places them at the mercy of the South African healthcare system where, according to some of the participants, they experience dehumanising treatment because they cannot afford private hospitals. For instance, according to Hazel, as an immigrant woman in South Africa with no job, no government support or any source of income, you are at the mercy of the public healthcare system when you or your child needs medical attention:

“Oh, you sit there the whole day, and they cannot treat the baby, or they cannot see you. So, the service at the clinic towards foreigners is very bad. To think of, we do not

have money or the medical aid to go to the private hospital or to go to call the private doctor. That's why sometimes we do not have a choice but to go to the clinic. But the service we get at the clinic, we do not know if South African women also go through the same type of service. But personally, the service I get at the clinic all the time that I'm there, it's a terrible one” [Hazel, 12/05/2024].

The above quote from the interview with Hazel shows that the immigration status of African immigrant women in South Africa has a major impact on their lived experiences. For example, women who have legal documents to stay in South Africa are more likely to use different healthcare facilities of their choice (private hospitals) as opposed to women who do not have legal documents. Some of the participants in this study who are illegal and waiting for the adjudication of their permits shared their daily life struggles living in South Africa. According to Amery,

“I can also say so about the paper, because with asylum seeker, we are very limited. We can't move forward. Like there are many things we can't do, like there is no shelter, there is no refugee camps in South Africa and without paper, how do we survive because we don't have work, you can't work with asylum paper because in some places, they would not take you, so you see, you can't even rent a house as an asylum seeker. Some agencies would not even take you so where are you going to sleep? Because, no shelter, no camps, no paper, no work, so the government must have to think about that. For example, you are living in South Africa, and you want to get a wi-fi, they will tell you that you need a green ID, but you are living in South Africa, how will you survive? To get a house, they said I need a green ID, no support, nothing, even to get a shop, you must have a green ID, we are so limited. So, the paper is very important for us to survive here in South Africa” [Amery, 12/05/2024].

Also, the migration status of the participants in my study has been linked to their inability to get a decent job (unemployment) and this in turn impacts their maternal mental health conditions during pregnancy and after childbirth. As some of the women expressed, they become very anxious because they do not have money to take care of themselves or their children. Amery states:

“Like for me, I graduated as an IT in my country, it is what I studied, but here in South Africa, I can't do anything, because I am an asylum seeker. They only accept four years paper, you don't have choice, you have to survive, and you have kids, so

you will find yourself here doing dirty jobs like cleaning, but I am not happy with it, but I have to do it for my child to eat” [Amery, 12/05/2024].

The participants’ lack of documentation (resident permits or visas) is a major barrier to their ability to access maternal mental health services in South Africa. Some of the women mentioned that they were asked to provide their documents at the hospital and clinics before they could access or commence antenatal services during pregnancy and at the point of delivery. As Grace, one of the participants, points out,

“I went to the clinic, and they asked me if I was a foreigner, and I said yes. And they told me all the documents I was to bring before I could start antenatal care. I got all the documents and gave to them, and I was asked to start my antenatal care” [Grace, 20/05/2023].

Another participant said that she was asked to present her document at the hospital when she was in labour and about to give birth to her child. The nurse asked her to present her document before she would receive medical attention but because her labour had progressed and she was in pain, she pushed the baby out. However, after the delivery, she was told to pay R1500) for the services.

“And she (nurse) asked me, where's your paper? I said, I didn't come with my paper. Oh no, if you didn't come with your paper, you're going to pay. I said, no, I left my paper at home. Oh, if you didn't come with your paper, we're going to charge you. You're going to pay. And they are still calling me from the hospital even till now, they are calling me to go pay the money because I didn't come with the paper that day. How will I remember to go to the hospital with it my papers when I am feeling pains? And they said, no, if you don't come with it, you're going to pay. Yeah, I think R1500. And they are calling me like every day to ask me, when are you going to pay the money? Yeah. So, it's very difficult” [Mia 12/05/2024].

The above findings from the interviews corroborate a qualitative systematic review that explored the experiences and barriers faced by migrant women with perinatal depression in Canada. In the study, Dela et al. (2022) noted that the migration status of immigrant women is tied to financial and employment status in such a way that the absence of both exacerbates the vulnerability of immigrant women who are often financially dependent on their spouses

and others for support. These types of challenges affect the quality of life of these women, which often become “a major stressor notably impacting provision for the child but also affecting how the mother is able to cope with her perinatal depression” (Dela et al. 2022, p .7).

In the South African context, the lack of documentation as seen from the data, has significant impacts on both the lives of the parents and children born to illegal immigrants, not only in accessing healthcare but also in accessing other services such as basic, secondary and tertiary education in South Africa. For instance, children of undocumented immigrant parents face major barriers to accessing basic, secondary, and tertiary education through marginalisation and exclusion. These children experience limited access to opportunities, healthcare services and social benefits as they are often regarded as “stateless children” in some cases. Sarah, Dominic and Moll (2022) argue that this situation is compounded by the legal contradictions in some provisions of key legislation on education and schools and immigration in South (RSA, 1996a; and RSA 2002). So far, the South African government HAS not been able to provide a solution to this problem.

Different stakeholders, including politicians describe the problem as emanating from various factors such as discrimination, systemic xenophobia, and ‘administrative violence’ in the form of the Department of Home Affairs’ (DHA) refusal to expedite the turnaround time for permit adjudications as a way of facilitating the deportation of illegal immigrants in the country (Roni and Norma, 2014; Emmanuel and Alexandra, 2022). During my interview with Rumi, she mentioned that she has a resident permit, but her three children do not have resident permits. This situation is currently a major stressor right now because she has been sending emails to the Department of Home Affairs without receiving any response. According to her,

“The biggest problem I have right now is that my children do not have legal documents. Like me, I have a four-years legal status, but my three kids do not have document. I have been sending emails upon emails to Home Affairs, but they don't reply. So, documentation is a problem. It's another big problem. Job is a problem. My three kids can't go to school because they don't have documents. But I have and I'm sending emails to Home Affairs all the time. For family joining and no one is responding” [Rumi, 15/05/2024].

The above transcript narrates the challenges immigrant women experience and the nexus between their inability to obtain legal documentation, sometimes due to poor service

delivery system at the Department of Home Affairs (South Africa), and the stressors that impact their mental health. Therefore, it is important for the South African government to tackle these challenges by implementing best practices in the immigration process in South Africa in order to mitigate the unintended consequences that certain vulnerable groups endure. My study suggests that there is a nexus between economic hardship, poor living conditions due to lack of jobs, untold suffering for children born to immigrants, and poor perinatal mental health conditions for both immigrant women and their families. These consequences may need to be further assessed to determine the relationship between documentation and the position of the state in terms of exercising its authority (Roni and Norma 2014).

5.3 Conclusion

The migration phase is usually challenging in the lives of many African women in South Africa. The findings presented and discussed in this chapter contribute to the existing literature that has explored the lived experiences of African immigrant women in their diasporic contexts. The theme: *encountered challenges* and subthemes such as loneliness, unemployment, lack of government support, and lack of documentation discussed in this chapter highlight the interconnection of events that occur in the post-migration stages of the African immigrant women's lives and close off on how these experiences then shape the quality of maternal mental health conditions of these women.

Although this study focuses on exploring the maternal mental health experiences of African immigrant women in Cape Town, South Africa, the above discussion provides a pathway for contextualising their experiences by looking at some of the major multifaceted issues that aggravate maternal mental health conditions among African immigrant women in South Africa. The chapter also deepens our understanding of some of the predisposing factors that stand as barriers to maternal mental healthcare utilisation by African immigrant women in South Africa. The next chapter further discusses the four remaining themes from the data that was analysed from the interviews.

CHAPTER 6

OPPORTUNITIES FOR ACCESSING MATERNAL HEALTHCARE SERVICES AMONG THE AFRICAN IMMIGRANT WOMEN IN THE STUDY

6.1 Introduction

In the previous chapter, I discussed some of the challenges identified in this study that encourage poor maternal mental health conditions among African immigrant women in South Africa. This background understanding is necessary for this study because it helps us to put in proper perspective the discussion of the subsequent themes that we shall present here. In the previous chapter, issues of loneliness, unemployment, lack of government support, and the impact of migration status were analysed to show how these factors potentially impact the physical and maternal mental health conditions of African immigrant women in Cape Town. The present chapter will discuss key themes from the study that encapsulate the maternal mental health experiences of African immigrant women in this context. The chapter begins by examining and discussing African immigrant women's perceptions of maternal health in Cape Town, their experiences of accessing maternal healthcare services, and lastly, the chapter will discuss the maternal mental health condition of African immigrant women in Cape Town.

6.2 Expectations and experiences of maternal healthcare in Cape Town

According to this study, African immigrant women's expectations and experiences of maternal healthcare in Cape Town refer to the subjective sense of and interpretation of their experiences of accessing and utilising maternal healthcare services in hospitals in Cape Town.

This theme presents the collectively shared sentiments of participants in this study about the Cape Town healthcare system. The theme is important to this study because it presents a paradox of challenges, opportunities, and experiences of accessing and utilising maternal health services by African immigrant women in healthcare facilities in Cape Town. To understand the pattern of maternal mental health stressors among African immigrant women who participated in this study, I asked them to describe their experiences with the kinds of maternal healthcare services they used during their pregnancies and after giving birth. The findings of the interviews revealed that all fifteen participants have used one or more public or private healthcare facilities in Cape Town to access maternal healthcare.

All the fifteen participants have used the South African public healthcare facilities to access maternal health services. While only three participants had experience in both public and private healthcare facilities. It is important to mention that the three participants who used both public and private hospitals for their maternal healthcare needs had different experiences of using the different facilities. The participants who had experience using both public and private hospitals had some form of stability regarding their documentation and socioeconomic status, for example, Voyu used both public and private hospitals. She is a researcher and highly educated and has a permanent resident permit, while Nikki also has a permanent resident permit, but she is unemployed and uses her husband's medical aid to access maternal healthcare services in private hospitals. Loveth also shared that she used private and public hospitals, but she is a stay-at-home mother without a resident permit, even though she has a master's degree. Loveth also used her husband's medical aid to access maternal healthcare at private hospitals.

What this background information shows about these participants is that there is a connection between the kind of maternal healthcare facilities accessed and the experiences of that participant, especially for those who accessed private hospitals and those who used public hospitals. From the data that was analysed in this study, the subthemes that emerged from maternal healthcare experiences of African immigrant women show a high disparity of maternal health experiences amongst African immigrant women in Cape Town. For example, I categorised the subthemes into (i) positive experiences and perceptions of maternal health, and (ii) negative experiences and perceptions of maternal health. Some of the women who participated in this study expressed mixed reactions about their perception of the quality of maternal healthcare services that they received at some of the public and private healthcare facilities they visited.

6.2.1 Positive experiences and perceptions of maternal healthcare in South Africa: An opportunity for African immigrant women in Cape Town

Despite the challenges and difficulties associated with access to maternal health services identified by African immigrant women in the previous chapter of this study, some participants spoke positively about the free maternal healthcare services they received at the healthcare facilities that they visited in Cape Town. None of the participants interviewed in this study mentioned that they came to South Africa because of free healthcare. However, some of them mentioned that healthcare services in their home countries are poor, very expensive and difficult to access. Therefore, they welcomed the opportunity to access free healthcare services in South Africa. According to some of the participants, they received good services at the hospitals they visited. Grace used one of the big public hospitals in Cape Town during her pregnancy and noted that her experiences with the doctors were ‘beautiful’:

“My experience over here when it comes to giving birth is beautiful. It's awesome. My experience was beautiful because the doctors were always there to give me a listening ear when I had any questions, they were always there to answer everything I asked them all through the process of my delivery, and the two weeks I spent at the hospital I didn't have any problem with any of the doctors, there were lots of doctors and lots of gynaecologists. They were there to take care of me. So, my experience of childbirth is beautiful” [Grace, 20/07/2023].

Nikki echoed a similar view about her experiences of giving birth at a government hospital. According to Nikki, your experiences are determined by the location of the hospital and its proximity to where a person stays.

“It depends on where you live, where you stay, and your physical address. I was very fortunate to have a physical address that's close to a very good public hospital so, I had my two babies there. It was excellent and beautiful, and the nurses were very kind they attended to me, took all my scans, and had my babies through normal delivery. It was all fantastic” [Nikki, 15/08/2023].

Both Grace and Nikki coincidentally used the same public healthcare facilities that I cannot mention because of confidentiality. It is important to note that Grace and Nikki are strangers and as at the time of this interview, they had never met each other. The commonality about the maternal experiences is the type of healthcare facility that they used. Asanda, Lulu, Sarah,

and Nikki commended the South African healthcare system for making maternal healthcare free and accessible to everyone and they mentioned that it is completely different from the practice in their home countries. According to Asanda,

“I can say that the healthcare system in South Africa is extraordinarily beautiful. It's so, so good. I've never seen this kind of thing before because where I come from, if you do not have money that's the end of you. If you're going to any healthcare facility and you do not have money, I don't think they'll even want to attend to you. So, healthcare in my country back home, is very expensive. It is not free. You must pay for everything. But when I came to South Africa, I was surprised, you know, when I got pregnant the first time, then I was going for clinics. I thought they were going to ask for money. But no, they didn't ask for money. It was free. The scans, the checks, monthly checks, weekly checks, they're all free. And then when I put to birth, but I thought they were going to bring a bill or something, but I didn't get any. Then I discovered at the end that everything was just free of charge, and they do it even to foreigners, even to us coming into the country, not only to their citizens. So, I find that aspect extraordinarily beautiful. South Africa is beautiful when it comes to things like that. Even when I'm sick, I'll go to the government hospitals. It's very free” [Asanda, 13/09/2023]

Unfortunately, the positive remark about the South African healthcare system has a different side to what it may seem to some immigrants in South Africa. Generally, the participants in this study commended South Africa for its beauty and efficient service delivery practices. According to Lulu,

“But I would also say that South Africa is not a bad place when it comes to facilities. I can say that South Africa is a good place. They have good roads, they have good healthcare system as opposed to where I'm coming from” [Lulu, 17/11/2023]

Jabu concludes,

“South Africa is a good country. I came here as a pregnant woman because I came when I was like a month or two, pregnant. South Africa was cool” [Jabu, 11/08/2023]

The practice of free medical healthcare for everyone in South Africa adequately reflects the values in Section 27(1) of the South African Constitution. The section emphasises the right to equal access to healthcare services, including reproductive healthcare and other basic services,

without discrimination for all within the Republic of South Africa (Theresa Alfaro-Velcamp 2017; Hunter-Adams and Hanna-Andrea, 2017). However, while this practice is laudable on paper, the lived reality in practice varies in many public healthcare settings in South Africa. The findings from my study suggest that the practice of access to free healthcare in South Africa falls short of the required threshold in practical implementation and execution. Theresa Alfaro-Velcamp (2017) argues that the law regarding free medical healthcare is left to be interpreted and implemented differently by hospital administrators, which has led to many unfortunate cases of inequality in healthcare access, especially among immigrant groups in South Africa. In looking at the experiences and perceptions of accessing maternal healthcare by participants in this study, overshadowing the positive commendation of the South African healthcare system is the issue of administrative services, which I have categorised as negative perception below.

6.2.2 African immigrant women's negative experiences of maternal healthcare services

This subtheme examined the applicability of the three A's ("Availability, Affordability, and Acceptability") within the healthcare access dimension in South Africa. Ronelle and Carmen (2018) described the three A's as interlinked and a focus on one may inevitably affect an individual's healthcare experiences and health outcome. In the very progressive effort of the South African government to improve the population's health outcome, the government implemented free access to public healthcare policies, which eliminated the payment of fees for everyone thereby promoting healthcare accessibility, particularly for vulnerable populations. However, Ronelle and Carmen (2018) noted that focusing exclusively on affordability alone is not enough to improve access to healthcare and health outcomes of people and that other interventions are required in this regard.

The authors further argue that the perception of poor quality of healthcare services may discourage users from seeking medical attention even if it is "free or affordable". The three A's are also discussed within Anderson (1995) behavioural model of the healthcare framework as enabling resources that facilitate the use of healthcare services. For example, "both community and personal enabling resources must be present for use to take place. First, health personnel and facilities must be available where people live and work. Then, people

must have the means and know-how to get to those services and make use of them” (Anderson, 1995, p.3).

While participants commended the South African public healthcare system for the types of services they offer, some of the participants were not pleased with the kind of treatment they received at the public hospitals visited. For instance, Amery and Esther mentioned that they had a very terrible experience at the public hospital they used while giving birth.

“I gave birth to my only baby here in South Africa, but I had a very bad experience. The person (nurse) that I met that day while giving birth was like a... I don't know how to explain it. She was very rude to me” [Amery, 12/05/2024].

Esther also described her experience of giving birth as terrible. According to her,

“During the delivery was nasty. I was not treated well. The delivery was terrible” [Esther, 18/08/2023].

The above quotes from the transcripts highlight the gap between the availability, accessibility, and affordability of healthcare services in Cape Town public healthcare facilities. While the services are free, the quality of services that vulnerable populations receive in this case (immigrant women) was undesirable and unacceptable. According to the argument proposed by Anderson (1995), an individual’s perception of healthcare services (health beliefs) influences their level of utilisation and quality of health outcomes. From the above narrative, it is evident that some African immigrant women face diverse challenges when accessing maternal healthcare services in Cape Town, South Africa.

Burger and Carmen (2018), citing Honda et al. (2015), argue that there is likely to be an improvement in the quality of health outcomes if patients do not consider the quality of the services they receive acceptable regardless of their affordability or availability. The authors further proposed that the government as policymakers, need to implement policies that are client-centred, by understanding the experiences of clients who access public healthcare services in South Africa. To understand this phenomenon, I asked my participants to share their experiences of accessing maternal healthcare services in South Africa, especially their interaction with healthcare workers as immigrant women. I will discuss their responses in the next section.

6.2.3 The dilemma of accessing maternal healthcare services: Realities of African Immigrant Women

In this study, the dilemma of accessing maternal healthcare services by African immigrant women refers to how the participants contextualise and problematise access to maternal healthcare. The theme highlights the kind of treatment that the participants received at maternal healthcare facilities (primary and tertiary) hospitals in Cape Town. This theme is important for this study because it provides a contextual background for understanding the patterns and trends in maternal healthcare experiences of the participants and how this shape and influence their perception of maternal mental health outcomes and utilisation of available maternal mental health services in Cape Town.

The quality of maternal healthcare services during pregnancy and after birth is essential for the well-being of the mother and child (Koblinsky et al., 2016). As mentioned previously, the affordability of healthcare services without acceptability and availability is tantamount to poor health outcomes (Ronelle and Carmen, 2018). In the current study, the quality of maternal healthcare services administered by healthcare workers and received by the participants at different public hospitals in Cape Town left a bitter taste in the mouths of these participants. Some of the participants in this study mentioned that they received very terrible and dehumanising treatment from some of the healthcare workers. The participants believe that this treatment was due to factors independent of the South African healthcare system, but rather a personality issue with some healthcare workers. To elaborate this point, I will describe the participants' experiences under three categories in this section: (i) experiences of accessing prenatal care, (ii) experiences with gynaecological care during delivery (childbirth), and (iii) access to postnatal care.

6.2.3.1 Experiences of accessing prenatal care: The politics of language

African immigrant women who participated in this study highlighted some of the challenges they encountered when trying to access prenatal care in public health care facilities in Cape Town, before giving birth (prenatal stages of pregnancy). These challenges include language barriers, long waiting periods, and discrimination. Findings from this study reveal that African immigrant women face challenges when accessing prenatal healthcare in public healthcare facilities due to language barriers. Some of the participants in this study said they could not express themselves in the local languages that the healthcare workers spoke. The participants mentioned that the language barrier hindered free communication with the

healthcare workers, especially when trying to describe the pains the participants felt or unpleasant symptoms associated with their pregnancies.

For example, I asked the women whether language was an issue when they interacted with healthcare workers during their prenatal visits. According to Asanda, language was a major barrier to free communication with the nursing staff she met during her pregnancy visits. She stated,

“One challenge I experienced was the language barrier. Many of the sisters (nurses) were speaking Afrikaans or sometimes Xhosa and when you tell them that you don’t understand the language, they will say, ‘well that is the only way I can communicate’. And when she is compelled to speaking English, you see her struggling to pass the message. And the major issue is that they want you to speak to them in their language first before they can give you listening ears. If you want to capture their attention or make them smile, you must speak their language. They prioritise their language a lot more than English. And you as an immigrant, you know when you are in a different country from home, the only language you can speak is English. Especially when you just arrived, except if you are a person who knows how to speak different languages. So, there is a huge language barrier regarding that. More so, their countenance is also a contributing factor. Because when you approach them sometimes and you start to talk with them and they realise that you are not from this place (South Africa), sometimes some of their countenance changes” [Asanda,13/09/2023].

Similarly, Loveth also mentioned that the quality of her prenatal healthcare experiences was impacted by language barrier that she believes was a form of resentment directed at her as an African immigrant woman by some healthcare workers.

“Yeah, the language problem is always there, language is the first barrier. Seriously, you don't know, you will never understand how language impacts seriously on mental health. One of the experiences I had was with the clinical nurse that treats us when we go for antenatal, oh!!! she was so insensitive. I wouldn't know why. So, she will not speak in the language we all understood. I remember when I wanted to ask questions, but I can't speak the language. It's either I get someone who will pity me and interpret, or if I have no choice, I'll have to just say it in English, they will never reply in the language you understand they will also reply in Xhosa. You see this kind of resentment

is so painful, seriously, it's painful and it is not medically ethical” [Loveth, 16/08/2023].

These remarks are not uncommon in the South African public hospitals. South Africa as a multilingual society is already faced with the burden of addressing the internal language barriers in her healthcare system. The language tension between healthcare workers and patients in public healthcare facilities in South Africa has been linked to one of the challenges of ‘language diversity’ that are reinforced by the need for occupational mobility of healthcare workers within and outside South Africa (Konosang, Merwe and Balungile, 2020). Findings from other countries that explored the challenges of accessing healthcare among immigrant populations also identified language as a major barrier to accessing healthcare services (Iyi and Amaechi 2024). Language barriers impact patient satisfaction and the willingness to utilise services (Sobane et al.,2020; Anderson 1995). In other instances, language barrier can lead to misdiagnosis and violation of a patient’s right to privacy in instances where unqualified interpreters are used (Sobane et al., 2020).

Given the aforementioned disadvantages of language barriers, what is significant in the current study is how the lack of effective communication between the participants and the healthcare nurses aggravate prenatal health challenges of the participants. For Loveth, she considered this act as a form of resentment from by the nurses because she is a foreign national. For Asanda, the communication barrier resulted in an unfriendly attitude from the nurses. According to Sobane et al. (2020), language barrier leads to an unempathetic attitude from healthcare workers towards patients. To address this barrier, researchers suggest the use of different innovative approaches such as ‘technology-enabled professional interpretation’ to encourage ‘remote interpretation’, and healthcare policy frameworks should include strategies to mitigate language barriers in healthcare settings (Sobane et al., 2020).

However, Phathushedzo and Tiko (2020) noted that despite the benefits of using technology-enabled services to promote the quality of healthcare services for both health professionals and their patients in healthcare settings, the approach has potential shortcomings. For example, the same authors mentioned argue that problems such as usability, protection of patient information, and accurate translation are common downsides to the use of technology in promoting the quality of healthcare services in healthcare settings. Another major challenge identified with access to maternal healthcare is the issue of waiting time discussed below.

6.2.3.2 How early should I go, how long should we wait?

Another common complaint about accessing prenatal care by all the participants who used public health facilities was the issue of long waiting periods during their prenatal visits to the public healthcare facilities. Long queues and long waiting times are synonymous with public healthcare facilities around the world including South African public healthcare facilities. Waiting time is a major source of concern and discouragement for many patients using public healthcare facilities. A patient waiting time is the amount of time spent by a patient waiting to receive services for which they have visited the facility. Authorities calculate waiting time from when the patients arrive at the facility until when they leave (South African National Department of Health (NDoH), 2015).

Participants in this study said that the long waiting time was a major challenge they faced during the prenatal period of their pregnancy. For instance, the participants complained that to access prenatal check-ups, they had to arrive at the healthcare facilities as early as five in the morning and be expected to go back home around late afternoon. However, when I asked if they were the only ones affected by this practice given the fact that they are foreigners and because some of them had earlier mentioned the issue of discrimination, the participants stated that long waiting time is a general practice that everyone experienced at public health facilities including pregnant South African women. The participants attributed the delays to inadequate staff and the high caseload of pregnant women at the health facilities they visited. For instance, Fortune mentioned that her experience was terrible and that the queue was extremely long.

“The major challenge was the caseloads. I have to get there (hospital) like as early as 6:30 and by the time I'm there, there's already a very long queue. Like I said high patient load. So sometimes you might not find somewhere to sit. We either stand or sit on the floor for that long, it is that bad. The queue is horrible, yeah. So, I think the only thing they can do is maybe employ more staff” [Fortune, 22/08/2023].

Similarly, Grace concurred with the above statement noting that although she lives close to the hospital, she still had to get there as early as she could to receive prenatal care services.

“Normally when I'm going for antenatal at the hospital, I leave my house at 5:30 am. Like I said earlier, I live close to the hospital. Even though I live close to the hospital, I leave my house 5:30 in the morning. But there are still a lot of people in the queue. I

have to join the queue. Sometimes I leave the hospital between the hours of two and three in the afternoon. Because there are large number of women coming for antenatal” [Grace, 20/07/2023].

Similarly, Esther was very expressive in relating her experiences of her prenatal visits. She said it was more difficult for her because she needed to go to the clinic very early and she lived far away from the clinic.

“That was even the most difficult because the distance from where I stayed was far. And I still have to repeat the whole process of going very early and standing on the queue. They wasted time at the hospital and lot of people on the queue. People came very early too. So, the queue was very serious” [Esther, 18/08/2023].

The quotes from the transcript above show the challenges participants faced when accessing prenatal care in Cape Town. All the participants interviewed expressed similar sentiments and frustration about the long waiting time when attending prenatal visits.

Patient waiting time has been identified as a major indicator in determining the efficiency and quality of care that a patient receives in healthcare facilities (Solly and Sisinyana, 2022). In South Africa, numerous attempts have been made to address this issue including intervention policy frameworks, however, the government has not been very successful in this regard (Solly and Sisinyana, 2022). The long waiting time is a major concern that affects both locals and immigrant women. The findings from this study therefore consider this challenge a systemic factor, as all the participants believe that everyone including South African women are affected and this shows a similar pattern of challenges in accessing maternal healthcare between African immigrant women and South African women.

6.2.3.3 Treat us as humans: We are all black

Discrimination is a key finding in this study. Concerns about discrimination appears throughout all the themes identified in this study. It was unanimously echoed by all the fifteen participants in this study at various levels of their experiences. However, the most common stage of discrimination for all the participants was experienced during the prenatal stages of their pregnancy. Discrimination against immigrant population is a common practice among some healthcare workers in public healthcare facilities (Jonathan and Godfrey, 2014). From the interviews, many of the participants were not pleased with the discriminatory practices

they experienced at the hospitals and primary healthcare facilities they visited for prenatal care. Discrimination in healthcare facilities did not only discourage the participants from seeking prenatal services but, that it also affected their mental health, self-esteem, their self-worth, and self-confidence, leading to self-doubts. According to Grace, she felt worthless because of how some nurses treated her.

The participants believed that some of healthcare workers thought African immigrant women were using the limited resources South African government meant for citizens. This finding is in line with the argument by (Jonathan and Godfrey, 2014; Jaiswal, Nunez and Arrow 2024) that there is a general stereotype about foreign nationals South Africa swamping the healthcare services South Africa. Disproportionately, the findings from the nationally representative survey of 2006 conducted by the Southern African Migration Programme (SAMP), revealed that two-thirds of South Africans believe that migrants ‘use up’ South Africa’s resources while half of them claimed that immigrants come into South Africa with diseases. Furthermore, many South Africans believe that only those with valid immigration status in South Africa should have the right to access healthcare services.

The participants in this study view these discriminatory attitudes as ways of blocking access by African immigrant women seeking maternal healthcare services. In this study, Grace and Jabu’s experiences adequately capture the moments when they felt discriminated against while trying to access maternal healthcare services.

“But there is this treatment they give you as a foreigner, they make you feel worthless. They should try to treat us like humans. Some will ask you, why do you come here? Some will challenge you that you're coming to compete with them, that you're coming to take away what their government is giving to them” [Grace, 20/07/2023]

At the time Grace said these words during the interview, she became very emotional and started to cry. We had to pause the interview for a while to help her calm down. I offered her water and a facial tissue paper to wipe her tears. After about five minutes, I asked her if she was okay and if she wanted us to continue or reschedule the interview. She said she felt better and was happy to continue the interview.

What is remarkable about this particular incident is that Grace started crying the moment she recalled memories of her previous life back in her home country working in a big company. She was financially and professionally well-off, until she relocated to join her husband in South Africa, a decision she still regrets to this day. For Grace, relocating to South

Africa financially and professionally incapacitated her growth hence and she feels trapped and at the mercy of insensitive nurses. It is noteworthy that the experience Grace narrated was at the hands of nurses and not doctors because she mentioned that she received good care from the doctors she met at the public hospital.

Similarly, Jabu believed that she experienced a discriminatory attitude from nurses because she was a foreigner.

“If I was a South African, that woman wouldn't treat me that way. It's just that I think some people feel that you're not meant to be here, you're wasting their resources because their character shows it even when they don't say it” [Jabu, 11/08/2023].

In this instance, Jabu narrated the experience she had with a nurse who ignored her for many hours when she went to the clinic to complain about her health and that of her unborn child. According to Jabu, she felt her amniotic fluid sac had burst but the baby was not moving. However, on arriving at the clinic, the nurses told her to wait for several hours without examining her, meanwhile, the nurse was busy on her cell phone. Grace notes,

“And I am not blaming South Africa for it, I'm just blaming the nurse in particular. I blame the nurse, and thinking about my previous experience with them (nurses) when I was pregnant with my first child is giving me a cold foot even as I'm pregnant now. That Sunday I went there (clinic) when my water broke, I didn't see anyone. I only heard one woman who was in labour and had just given birth, I was there. This particular nurse was not the one attending to that woman. I will call her, and I will tell her, please can you come and check me, and she would say just have some patience and she's sitting there pressing on her phone. This is Sunday and I think they don't have anybody to supervise them there or something. So, she took advantage of that. When I even told them you have been keeping me here, she said I should just wait, that is how you foreigners behave. She made that statement, and I was just angry” [Jabu, 11/08/2023]

Discriminatory attitudes from healthcare workers towards foreign nationals is a common phenomenon in many sectors in South Africa. It has a long history driven by the belief that the continued influx of immigrants into South Africa increases the demand and puts pressure on social services, jobs, and access to education and healthcare (Crush and Tawodzera, 2014). Based on this argument by South Africans, access to healthcare for the immigrant population

has been characterised by an attitude now described as ‘medical xenophobia’ (Rowan, Kantharuben and Barbara 2021).

Medical xenophobia according to the definition provided by Kudakwashe Vanyoro (2019, p.2), citing Zihindula et al. (2015, p .2), is “any practice, judgment or behaviour that creates and strengthens oppressive relations or conditions that marginalize, exclude and or confine the lives of refugees”. According to Crush and Tawodzera (2014, p.656) medical xenophobia is “the negative attitudes of health sector professionals and employees towards refugees and migrants on the job”.

In this study, I elaborate on the participants' experiences of medical xenophobia within the healthcare setting by evaluating their gynaecological experiences during delivery and I discuss this as a subtheme below.

6.3.4 Experiences with gynaecological care during delivery

This subtheme helps us to differentiate between the nature of prenatal health experiences of African immigrant women during pregnancy and their childbirth experiences. According to the findings from this study, these experiences have been described as traumatic for many of the participants in this study especially those who used public healthcare facilities for childbirth. Some of the participants in this study complained of the dehumanising treatment they received from some healthcare workers while giving birth. For example, there were issues of obstetric violence, obstetric negligence, disrespect, and unequal treatment, all of which are explored below.

6.3.4.1 Obstetric violence

Obstetric violence in maternal healthcare spaces is not an unusual practice, especially in public healthcare settings in South Africa. Although it is not encouraged by the ethical code of conduct that regulate the behaviour of health workers in healthcare settings, this code of conduct is sometimes violated by some healthcare workers. Obstetric violence in its most basic definition, refers to a form of mistreatment directed toward women and girls during labour and childbirth. The conduct is criminalised but commonly perpetrated against women and girls by healthcare workers in many public healthcare settings in South Africa (Jessica and Lucia, 2020; Rachelle 2016). Obstetric violence includes “the problematic practices such as neglect, verbal and emotional abuse, physical abuse, and sexual abuse, lack of confidentiality and consensual care, and inappropriate use of medical intervention, such as episiotomies, inductions, and unnecessary caesarean sections” (Maura and Leslie 2019, p1).

During the interview for this study, some of the participants became very emotional while when describing how they were treated during the delivery of their children. Two participants even swore never to have another child again after their prenatal and gynaecological experiences with the healthcare workers at public hospitals in Cape Town. For instance, Amery said,

“I will never have a baby in South Africa again because of the bad experience that I had the first time. Like me, that lady (nurse), she left me on the bed with the baby in the cold. She left. She did not help me with anything. I pushed my baby myself. She was there standing. I don't know what she was doing. And I push the baby out alone without support. The baby came out and she's starting to shout at me again. Why are you pushing? You must close your leg. I didn't tell you to push. So, the nurses are very rude” [Amery, 12/05/2024].

Esther had a more traumatising child-birthing experience. She said that she felt ridiculed and regretted falling pregnant in the first place. In her words,

I was treated like a trash like it was as if a mad woman was giving birth by the roadside. If you have ever seen a mad woman giving birth, I was. I was disgraced. It felt like having a baby was a crime. As if what I did was wrong. When I was about to give birth, I was in pain and I was crying, then the nurses asked me, is this your first child? And I said no. That was my second child, and she was shouting at me. Yeah, she was shouting at me. Saying, why am I crying and shouting? People that are younger than me have children, they don't make so much noise. I should become stronger and if I know I am not as strong as I should make sure I don't have more babies again. She said, ‘then next time don't have more children’. They said don't have more children. Then they have to beat me. Yeah, she actually slapped me. Then she punctured my water when I was not ready. Then everywhere were splashes of water and blood. I was walking in blood and water then I was in labour. I had the baby through virginal birth. She tore me without any anaesthetics. She actually cut me without anything. No injection and the pain were too much that I didn't even care. I just wanted my baby out.”

When I had the baby, they just wrapped the baby without cleaning him for me. And they left me in the pool of blood. I was left on the bed that way, in the cold nobody attended to me. So, I have to dress my baby myself. And I saw them taking care of

other people in front of me, the other people that were coloured women, they were South Africans. They took care of them; they helped them to adjust. But I was left in the rubber blood. I was left in the blood with my baby, so I have to dress my baby myself in the blood and everything.

Then in the morning, I said I wanted to pee. They told me not to leave the bed. So, I left and peed. I almost fell on my way. I was dizzy. Nobody cared for me. I left my baby behind to help myself. I was in the blood. I just regretted falling pregnant or even coming to this country pregnant and coming to this country at all” [Esther 18/08/2023]

The above transcript captures some of the profound challenges of medical xenophobia in the form of obstetric violence against African immigrant women that perpetrated by some healthcare workers in some South African public healthcare facilities. However, it is important to note that in general, studies that have explored the prevalence of obstetric violence in South Africa within maternal care contexts, revealed that South African women also suffer from such maltreatment at the hands of healthcare practitioners during labour and childbirth (Rachelle Chadwic, 2016).

Obstetric violence in the South African context is multi-layered, and it is characterised by structural components other than just individual-directed acts of abuse toward women and girls in labour (Maura and Leslie, 2019). In this study, most of the participants who had experienced obstetric violence were left traumatised and afraid of using public healthcare facilities in South Africa, which indirectly compromised their mental health. In addition to obstetric violence, this study also reports on the issue of obstetric negligence.

6.3.4.2 Obstetric Negligence

Although obstetric negligence and obstetric violence share similar elements of maltreatment toward women and girls in the perinatal period or at the point of delivery, in the context of this study, obstetric negligence refers to the lack of care that participants in this study complained about that has resulted in them losing trust in public healthcare workers. These participants reported that they almost lost their babies at birth due to lack of attention and proper care by healthcare workers. For instance, Sarah narrated her childbirth ordeal at one of the big public hospitals in Cape Town, where she was immediately booked for an emergency Caesarean (CS) operation because she was almost at the point of losing her baby.

Sarah narrated how some nurses abandoned her in the waiting room while she was in labour. The nurses left Sarah after fixing the fatal heart monitoring machine to read and monitor the heart beats of the baby. However, because Sarah did not understand how the machine works, she did not realise that the decrease in the bleeping sound of the machine was an indication that her baby's heartbeat was dropping. According to Sarah, it was only by a stroke of luck that another nurse who knew Sarah entered the waiting room for another reason immediately alerted the doctor when she noticed the sound of the machine had dropped. As Sarah puts it,

“I'm telling you, we (Sarah and her husband) just signed because it was an emergency CS, I was at the last minute, actually, they said I was on the time to give birth then the baby went back because no one came to assist me until the sound of the machine was changing. They said that my baby should have died because his heartbeat was low. But we didn't know. I didn't know the sound was changing, I didn't know anything. My husband was looking for those nurses he couldn't find anyone.

Then I tried just to endure the pains, but it was very painful. then those two nurses went somewhere so they didn't see me until I was on time to give birth. You know when you're giving birth you go until 10. So that time, the machine sounds started changing but we didn't know I was with my husband. Until there was another lady who used to check on me when I come for consultation, and then she says yeah, is that you? she just ran to bring the doctor quickly, the doctor came running. They got me. I remember the doctor saying to me to just calm down, you're going to kill the baby”
[Sarah, 15/08/2023]

Lulu had a similar experience in which her baby sustained a head injury because a certain nurse refused to listen to her cries.

“When I had my second son, I didn't really meet a nice person (nurse). You know, she said to me, go outside go walk around, and I was telling her my baby is coming. she was like I said the baby is still far go out and walk. So, she was aggressive. My experience with my second son was not a good one because, when the sister spoke to me like that I went outside. Then I sat on the chair outside, and my baby came out and my baby fell on the floor. My husband rushed and caught the child even though the child a little bit landed on the floor; but my husband held the child. So, when he held the child, my child had some injury on the head. So that was a bad experience I had

for my second child because the sister or the provider at that time that I met was not a good person. No, not all of them are good people. Some of them are extremely good, some of them are not. So, my child had a head injury, so we had to take him to a doctor. The doctor was like there's something wrong with this child's head. So, they had to take him for X-rays, it was an emotional moment for me because I would have lost my child because of the person I met at that time at the hospital” [Lulu, 17/11/2023].

For Rumi, the nurses on duty on the day she gave birth did not listen to her pains. She delivered by herself without the help of anyone. However, there were echoes when the nurses saw that the baby was out, and they were not prepared.

“Even though sometimes you will struggle before you even call the sister to come and help you, the baby's even coming out. Sometimes, like my last boy that I have, I gave birth without anyone having even the gloves on, because when I got on the bed, they were not taking me seriously. I just pushed the baby, the baby came out like that without anybody's help before they were putting on gloves.” [Rumi, 15/05/2024]

The above accounts of the participants indicate a sense of neglect and maltreatment that they experienced at the hands of healthcare workers while giving birth. Jessica and Lucia (2020, p.16) described obstetric negligence within the public healthcare system as “a mechanism of reproductive governance that devalues Black women’s reproduction” in South Africa. As mentioned by the participants, the neglect they experienced was based on the attitude of certain healthcare workers they met. These findings confirm similar claims in the existing literature that attributed the acts of obstetric negligence to interpersonal experience described as an intentional act that reflects the individual attitudes and behaviours of the healthcare workers (Jessica and Lucia, 2020).

The same authors further noted that negligence in obstetric settings is a common practice within the South African public healthcare system, and it is the most distressing aspect of perinatal experiences in public maternal healthcare facilities that women reportedly experience. Just like Sarah, Lulu, and Rumi narrated, obstetric negligence is a deliberate choice that individual nurses make irrespective of their working conditions or circumstances (Dutton and Knight, 2020), and its victims are both South African women and immigrant women. However, the experiences are aggravated by a lack of resources, lack of education,

maternal age, and social vulnerability on the part of the pregnant women (whether South Africans or immigrants), which also determines the quality of postnatal care experiences that they receive.

6.3.4.3 Postnatal care experiences

Postnatal care in this study refers to the experiences of seeking perinatal healthcare including maternal mental healthcare after delivery. To understand the postnatal experiences of my participants as immigrant women, I asked them to describe their postnatal experiences in the healthcare system. Grace gave an account of when she was sick and needed emergency services. She recounts that she did not receive the help she needed because she is a foreigner and that she would have died but for God's intervention.

“After I had my son for two months. I think I was sick on this particular day and my neighbours decided to call the ambulance for them to come fetch me from the house. They called the ambulance; they kept calling the ambulance later they picked. So, they ask for all my details. They gave them my details. Apparently, it was because I was a foreigner, I think because I'm a foreigner, you know, we waited and waited. If I was to give up, I think I would have given up (died). The ambulance never came. I was shivering, my temperature was up, I was vomiting, you know, and you know when, it comes to vomiting and stooling, my temperature was high, so they were scared, but my husband wasn't around, my husband travelled, so they had to call the ambulance to fetch me. My baby was there with me. I was taking care of him alone. So, they called the ambulance. The ambulance asked for my passport number, and they even asked if I had a permit. My neighbours said yes, I'm an accompanying spouse on a study permit. But the ambulance never showed up” [Grace, 20/07/2023].

Hazel explained that she experienced similar treatment when she tried to use emergency medical services in her postnatal period when her baby was sick, at a public healthcare facility.

“As with the children, I have one of my children who has asthma. So, all the time, then he had a problem, difficulty breathing. And then I have to rush him [the child] to the clinic. And then when you go to the clinic, you could see the child is very sick. It's

not breathing properly. It's either the child needs oxygen immediately or any kind of medical assistance. And then you just stay there late until the time they (nurses) come. So, in that case, that thing is an emergency. And some children may die. So, some children die while they are waiting for the nurse or the doctor to show up. So many of the foreigner's children died just like that" [Hazel, 12/05/2024].

Access to postnatal care is very important for determining the well-being of the mother and new-born baby. For immigrant women in Cape Town, using these services can be impacted by the existing social determinants of health, where access to healthcare is also regarded as a social determinant of health for immigrant women. Jaiswal, Nunez and Arrow (2024) argued that the attitudes and perceptions of healthcare workers toward immigrants, also known as medical xenophobia, act as major barriers to accessing healthcare which mostly affects immigrant women of reproductive age.

The experiences of the participants in this study reveal an important aspect of the South African public healthcare system that needs urgent reform. This study found that when women feel maltreated and disrespected in healthcare facilities, it leads to resentment and ultimately a refusal or delay in seeking maternal healthcare including maternal mental healthcare. All the experiences mentioned by the participants above foreground the need for exploring their maternal mental health condition in Cape Town. As the data suggest, the violence and challenges that these women experienced in maternal healthcare settings had negative effects on their mental health outcomes.

6.4 Maternal mental health condition of African immigrant women in Cape Town

This theme explores the maternal mental health condition of African immigrant women in Cape Town based on existing predisposing factors including the kinds of migratory challenges they face and how these challenges are further exacerbated by their maternal healthcare experiences in South Africa which in turn impact their mental health. This theme also explores the level of maternal mental health awareness amongst African immigrant women who participated in this study and how their individual characteristics determine their maternal mental health-seeking behaviour. In this theme, I focused on understanding the individual characteristics that determine the use of maternal mental healthcare services by the participants in this study.

The findings from this study report that certain types of maternal mental health conditions such as (depression, anxiety and stress) record high prevalence amongst the participants that were sampled for this study. The economic, social, psychological, and physical conditions of African immigrant women in this study are characterised by very stressful patterns of life events that reinforce the presence of a poor state of mental health. For instance, some of the participants noted that being an immigrant with a child in South Africa without any form of government support was a very stressful experience for them which impacted their mental health. For Voyu, having a child in South Africa without any form of support was very challenging for her as a new mother. According to her, she was not only dealing with her pregnancy complications but with other migratory challenges such as resettlement challenges which affected her mental health. According to her,

“All those mixed factors really impacted me because I also went into depression at some point, I was always crying because I felt alone and no one to help me” [Voyu, 10/08/2023]

Similarly, Rumi noted that she feels very sad and depressed because she has no one to help her as a new mother. At the time of this interview, Rumi had a four-month-old baby. Rumi stated,

For me, I'm really depressed and sad, I can't lie to you. It's not easy when you give birth and you don't have somebody who can really help you” [Rumi, 15/05/2024]

These findings corroborate the result from a cross-sectional study by Chinenye et al. (2023) which examined the prevalence of common maternal mental health conditions among African immigrant women. The authors report in their results that African immigrant women are at heightened risk of developing depression and anxiety. The same authors also argue that factors such as lack of support system, economic factors, and lack of community acceptance in host countries exacerbate the prevalence of maternal mental health conditions in African immigrant women. Furthermore, the conclusive results from a cross-sectional study of migrant women by Lígia et al. (2016) shows that the socio-economic condition of migrants in addition to their migration status increases the odds of developing postpartum depression, especially when they feel dissatisfied with the kinds of social support they receive.

To determine the level of maternal mental health awareness, I asked all the participants if they knew what mental health is about. Eleven participants have a basic knowledge of what mental health is about while four participants asked me to explain the

meaning of mental health to them. Given the percentage of the participants who understood the meaning of maternal mental health, it is safe to mention that African immigrant women in this study have good knowledge of maternal mental health. From the primary data collected for this study, seven participants self-reported that they experienced postnatal depression, while four said they had anxiety and high levels of stress at the pre and postnatal stages of their pregnancy. Only four of the participants said they did not experience any unusual signs in their mental health during their pregnancy and after giving birth.

I then asked the participants who mentioned that they experienced depression and anxiety to describe any particular event or symptoms they can relate to during their pregnancy or after giving birth that impacted their mental health. Jabu, Esther, Mia, and Amery, narrated their post-natal experiences.

“But I had a serious problem that, at a point I went into post-natal depression at that time my baby was like 4 months. I cry at will. I felt like returning my baby to the hospital at a point. I felt like just throwing him off. Nobody understood what was going on with me” [Jabu, 11/08/2023].

“I didn't even like the child. I was not ready to take care of the child. I was not bonding with the child. I will not even feed the child. Like, why did I bring a child into this world? I was full of fear, I was anxious, I was not sleeping well, as I said, it was my lowest point for my life. I think I had Pre and postnatal depression everything together” [Esther, 18/08/2023].

“But it was just terrible, and I was feeling sad all the time that I look at the baby, and I look at the life, and I look at everything that is happening around me. I was always feeling sad all the time, which is not good for the baby that I will be raising” [Hazel, 12/05/2024].

“Yes, I had depression I was even getting high blood pressure. Yeah, so I was like not sleeping at night, crying every day. My baby was a crying baby. She didn't want anyone, so I can't sleep at night. I can't sleep during the day. And I was busy as a new mother, I have to fix everything, just alone and it was very stressful. And then after one month, I think I got the blood pressure. It was so bad for me. So, it was not easy at all” [Amery, 12/05/2024].

Based on the description of the postnatal experiences that the participants in this study provided, it is evident that they experienced perinatal mental health challenges after giving birth. This finding is consistent with the result of Chinenye et al.'s (2023) qualitative study, which reveals the prevalence of postnatal depression and anxiety as a common feature among African immigrant women that manifest within two years of giving birth.

However, given the severity of the perinatal mental health condition that participants in this study experienced, one would expect that they sought and received professional help. To better understand their maternal mental healthcare seeking behaviour, I then asked the participants if they sought any form of treatment or spoke to any healthcare worker about their mental health condition. Some of the participants said they were not aware of any available maternal mental health services at the public healthcare facilities they visited. Others mentioned that they were discouraged from speaking to healthcare workers about their condition because of their prenatal experiences with some healthcare workers during their pregnancy period.

The participants' expressions indicate that they had lost faith in the public healthcare system which discouraged them from seeking postnatal mental healthcare services even if such were available. According to Hazel, she was not aware of any maternal mental health services, and she also did not know that she could speak to a healthcare worker about the symptoms she was exhibiting. Moreover, Hazel's previous experiences with healthcare workers discouraged her from seeking help. Hazel stated,

"I didn't go. I didn't know that you can do that. But when you start thinking of the clinic, the treatment from the nurses, the doctor, you just lose hope inside you that things will never be better" [Hazel, 12/05/2024].

The findings in this study of mental healthcare seeking behaviour suggests that African immigrant women in Cape Town are often reluctant to seek help for common perinatal mental health conditions even though the services are available and accessible. This also indicates that the concepts of availability and accessibility are relative and are sometimes not proportionate to actual utilisation thereby resulting in treatment gap (Ronelle and Carmen, 2018). In addition, this study finds that information about maternal mental health services is limited in many obstetric settings in South African public hospitals. Hence, many of the participants in this study do not have adequate knowledge of how and where to access the services. This suggests that the South African policy framework that aim to address maternal

mental health challenges in perinatal settings, is fragmented and spatially implemented across public healthcare facilities in the country.

This is particularly disturbing because “South African women experience some of the world’s highest rates of common perinatal mental disorders. Relative to women in high-income countries, they are almost three times more likely to experience mood and anxiety disorders during the perinatal period. The prevalence of women living with or at high risk of depression in South Africa is an estimated 21%–39%, and the prevalence of postnatal depression is an estimated 16%–32%” (Shelley, Gillian and Courtenay, 2020, p.126).

Similarly, Simone Honikman et al. (2012) noted that South African primary healthcare settings do not provide screening and treatment for common maternal mental health disorders. And the lack of integration between perinatal services such as child health, maternal health and mental health services create a gap in the treatment and screening for maternal mental health disorders in primary healthcare settings. This means that both South African women and African immigrant women experience maternal mental health challenges that are often underreported and are not treated due to lack of screening services in maternal healthcare settings. This finding reflects systemic inadequacies on the part of the South African government’s efforts to reduce mental health disorders in the country.

6.5 Reflections on the South African Perinatal Mental Health Policy

In recent years, the South African government has attempted to address the maternal mental health treatment gap in the country while contributing to SDGs in mental health promotion amongst women. The South African government has developed different versions of maternity care guidelines with mental health passively mentioned in some of the guidelines. However, a recent maternal care guideline developed for 2019 - 2022, has seen a gradual but steady improvement in the implementation outcome of maternal mental health services in primary healthcare settings in some parts of the country.

The South African policy statement on maternal, perinatal, and Neonatal policy (2021), attempts to provide a context for establishing policy guidelines that integrate mental health and maternal neonatal healthcare services into the South African healthcare system, at the national level. According to the Adult Primary Care guidelines of (2019 - 2020), section (38) under routine antenatal care, there are recommendations for mental health screening at each maternal healthcare visit. For example, question two of the brief document screens for depression. Questions such as the following are being asked in the screening survey.

“In the past month, has patient,

1) felt down, depressed, hopeless? or

2) felt little interest or pleasure in doing things?

If yes to either, follow referral protocol for further assessment” (MMh Guidelines, 2021, p.9).

Additionally, the guidelines also provide referral advice for support of mental health risk patients such as mothers with previous history of depression or anxiety; mothers with a family history of depression; mothers who are less than twenty years old; mothers with incidents of unwanted pregnancy; mothers with poor or lack of social or family support; lack of supportive partner or no partner; issues of violence at home; challenging life events in the preceding year; undisclosed or disclosed HIV status; (MMh Guidelines, 2021). Meanwhile the guideline does not explicitly offer any special consideration that addresses the mental health of immigrant women other than recommending that clinic staff should consider mental health risk factors from broader perspectives for example, “poverty, social power, unemployment, ill health, homelessness, migrancy, immigrants, isolated persons, HIV positives and so on” (MMh Guidelines, 2021, p.12).

Therefore, since the guidelines do not specifically mention specialised care for mental health intervention for immigrant women, it is safe to conclude that it creates a gap in the level of awareness about maternal mental health intervention services available in public healthcare settings for African immigrant women in South Africa and an institutionalised challenge to accessing maternal mental healthcare services.

Aside from such institutionalised barriers that hinder African immigrant women from utilising available maternal mental healthcare services in South Africa, participants in this study also highlighted other non-structural barriers or factors that discourage them from using MMH services. These factors are often referred to as ‘need factors’ under the Anderson (1995) behavioural model of healthcare utilisation. According to Anderson (1995), an individual need factor are the actual determinants of healthcare services utilisation. Krzyz et al. (2023) categorised need factors for mental healthcare service utilisation as relating to conditions that propels or encourages the development of mental health disorders, for example, stressful life events that are linked to postmigration experiences, loss of work, chronic medical conditions and traumatic life experiences.

My findings in this study established a relationship between stressful postmigration life event and maternal health experience to a predisposition and development of maternal mental health conditions amongst African immigrant women in South African context. My study also identified high levels of mental health condition among participants who self-reported. However, factors such as institutionalised challenges and pre-existing health beliefs among participants in this study are significant factors that impact healthcare utilisation. In this instance, Yang and Hwang (2016) refer to health belief as the attitudes, predisposed knowledge, and values about health and healthcare services that may impact on how people perceive the need to seek healthcare services.

During the interviews, I asked participants to explain the kinds of personal or cultural beliefs that influenced how they dealt with their maternal mental health experiences after giving birth. Some of the participants identified issues of mental health stigma, cultural and religious beliefs, and the concept of resilience. Some of the participants said that even if they experienced mental health challenges again, they would still not seek professional help but would prefer to speak to their partners, families, and friends because of the stigma attached to being mentally ill as a mother. For instance, Grace had postnatal depression but instead of talking to a professional about her condition, she opted to speak to her mother about it. In her words,

“They consider the person as ‘crazy’, even if I experience mental health challenges again, I will still not use the service of a professional. Instead, I prefer to speak to my husband, my families or close friends” [Grace, 20/07/2023]

This finding agrees with Oluwatoyin et al.’s (2022) study on a focus group discussion with African immigrant women. The authors’ findings revealed that mental health was stigmatised and labelled as being “crazy” by the participants. The same authors noted that despite the need to use mental health services, African immigrants are reluctant to use those services even when available. They authors argue that several factors such as stigmatisation, and cultural beliefs about the causes of mental health conditions, influence the need and willingness to seek professional help for mental illness by African immigrant women.

Moreover, the knowledge, culture and religion religious practices heavily influence African immigrant women. Some participants in my study mentioned that due to their religious understanding of God, they preferred to pray about their maternal mental health conditions rather than seek professional help. Amery shared that back authorities in her home country do not teach or create awareness about the concept of mental health. They just pray to God and believe everything will be fine. Amery stated,

“See, most of us are not used to that, since we were small back home, they don’t speak to us about that. The church also, we believe in God and we just know it’s going to be fine” [Amery, 12/05/2024]

For Nikki, she maintained a positive mindset throughout her pregnancies and after giving birth. She believed that God blessed her with her children and with that mindset; she did not experience perinatal mental health condition. In her words,

“I always believe that God gave me my children. I’m a born-again child of God, so I believe that none of my children came by error. So, with that mindset, I was already prepared to receive my child. So, with that mindset, I was highly positive as far as my pregnancies are concerned” [Nikki, 15/08/2023]

Seeing that most of the participants in this study are reluctant to use professional mental health services, I tried to explore other ways through which they coped with their maternal mental health challenges by asking them to explain the kinds of support and coping strategies that they adopted during their perinatal period.

6.5 Maternal mental health coping mechanisms of African immigrant women in Cape Town

According to the findings in this study, some of the participants adopted different coping mechanisms when facing maternal mental health challenges. Coping mechanism in this context refers to other preferred methods and support systems that serve as alternatives to seeking professional mental healthcare services by African immigrant women in this study. Sunday and Pranitha (2024), define “coping mechanisms” as the ability of an individual and communities to create alternative means to handle critical challenges of life by developing strategies that help them navigate the complexities and intricacies of the existing situations.

The same authors noted that coping strategies could be either ‘emotion-focused or problem-focused’. An emotion-focused strategy is an individual’s attempt to reduce distressing emotions by seeking help from others, which effectively minimises the impact of the problem. Problem-focused strategies refer to an individual’s effort to take proactive and reactive steps to solve problems to reduce potential stressors (Sunday and Pranitha, 2024).

Participants in this study adopted emotional-focused strategies to cope with their mental health challenges. As noted by Kurniasari and Khoirunnisa (2024), emotion-focused strategies play a significant role in reducing depression. Some participants in this study mentioned that they relied on prayers, self-medication, and self-help books, as well as relying on spouses, family members, and friends to cope with mental health challenges. The mothers of the participant who live back home in the participant's home countries played a major role in supporting and helping some of the participants to overcome their mental health conditions through prayers and words of encouragement.

Prayers have often been used as a coping strategy for mental health challenges in some contexts. Some studies have shown that women often rely on God to help them go through and overcome perinatal health challenges, (Kurniasari and Khoirunnisa 2024; Simao et al., 2016). In my study, it emerged that Loveth and Sarah believed very much in praying to God asserting that they found peace after praying and it helped to improve their mental health. According to Loveth,

“The only thing that was there for me was prayers. I prayed a lot. I would prefer to discuss it with God. Yeah, I would prefer to discuss what I'm feeling with God. You know, I talk to God as a father. I don't have a father anymore, so I talk to Him and my mother is not close to me as a father. Seriously, after discussing it with my husband, I just take it as it is to God. Just like I'm discussing with you now, I just tell it to God, and I do feel great relief, it's a practice I've been doing for so long and it has been helping me” [Loveth, 16/08/2023].

Sarah narrates her own practice as follows:

“Sometimes people don't know that if you know God, maybe you can feel at peace. This peace from God, you feel like maybe I am not alone, or maybe it can happen like this, but I am not dying. At least I'm still living. So even God is in control” [Sarah, 15/08/2023]

The impact of prayers in addressing physical and emotional health such as stress, anxiety, heart disease, and depression has been widely studied. Simao et al. (2016), suggest that there is a correlation between improved mental, physical health outcomes and religious practices.

Family support and support from friends have also been very instrumental in improving the maternal mental health of participants in this study. Strong social support is

very useful in reducing or preventing psychological distress in women. Many researchers believe that social support improves people's interactions that also reduces common mental health conditions like stress, depression and anxiety, which in turn reduces the risk of experiencing adverse birth outcomes in women (Bedaso et al., 2021).

All the participants in this study mentioned that their husbands and mothers were their strongest support systems. For Esther, Jabu, Asanda, Elita, and Voyu, as well as the other participants, their mothers live in their countries, but they communicate with their mothers on a daily basis. The participants stated that the encouragement and prayers of their respective mothers were very helpful in overcoming their maternal mental health challenges. For instance, Elita said that she would not consult a psychologist because her mother is always there to meet her emotional and psychological needs. She explained in the following words:

“Well for me, I speak to my mother a lot on the phone, and she gives me all the moral support that I need. So, for me, I wouldn't think going to a psychologist would be necessary personally because, life is full of surprises. And sometimes, we just accept situations as they come. Yeah, but my mother did a great job. My mother was my big support system” [Elita, 12/05/2024].

For her part, Asanda states,

“Yeah, my parents especially my mother was always calling to encourage me. And hearing her voice everyday was so much of a comfort for me” [Asanda, 13/09/2023].

Vuyo shares a similar view when she stated:

“And my mom is a very spiritual person, so most times I call my mom. The fact that my mom was there made a whole lot of difference. So, I took my mom's advice, and because my mom was speaking to me about the need to trust in God” [Vuyo, 10/08/2023].

The above quotes suggest that a strong social support system is essential for recovery and improvement of the postnatal health of women after birth, especially those with mental illnesses. The above conclusion corroborates the view of Biaggi et al. (2016), whose study emphasised that women who received family support after giving birth reduced the risk of developing adverse health conditions like depression and anxiety. The above view is also in line with (Mirzakhani et al., 2020; and Garfield et. al., (2015), who argued that women with poor socio-economic backgrounds lack social support during their perinatal periods, which

harms their health outcomes. Family support played a significant role in helping participants in this study to cope with maternal mental health challenges. For instance, all the participants in this study depended heavily on their husbands for emotional, financial, social, and material support.

According to the participants in this study, their husbands provided everything for them including taking care of them before and after delivery as narrated in the following quotes,

“The only support I got is my husband, I got some motivation from my husband [Grace, 20/07/2023].

“Yeah, of course I got support from my husband.” [Vuyo, 10/08/2023].

“I have my husband there with a lot of support. You know, he would cook for me. He would bring me food, breakfast in bed and all that.” [Lulu, 17/11/2023].

“Ok, it was a struggle, but anyway, my two kids were older because they go to school, their father takes them to school, then maybe wake up very early, make food for me, then takes the kids to school, go to struggle, find something to work, then come back in the evening, make food for us, it was just only my husband” [Sarah, 15/08/2023].

“My first baby, there was nobody. It was just me and my husband. I think he took about one or two weeks off from work to take care of me. He was helping. He will make breakfast for me before going to work just so I can have something to eat and get some energy to cook later. Me and my husband, he will help me to press with hot water, but yeah, give me bath with very hot water just to help me recover as his own support. He really did that for me and I'm grateful for that, before going to work” [Nikki, 15/08/2023].

From the data presented above, the husbands of the participants in this study played a significant role in helping the participants through postnatal recovery period. Other studies have also found that support by husbands is crucial to reducing the risks of postnatal mental health conditions in women, as well as their recovery from such conditions (Adnan et al., 2021; Armini et al., 2017). Meanwhile, studies have also found the absence of a father's support during pregnancy and in the postpartum period to be a major factor that triggers postpartum depression in some mothers (Armini et al., 2017).

6.6 Conclusion

The migration phase is usually challenging in the lives of many African women. The findings in this chapter contributes to the existing literature that has explored the lived experiences of African immigrant women in their diasporic contexts. The themes I discussed above in this chapter explored the interrelationship between events that occur in the post-migration stages of the immigrant women's lives and closes off with how these experiences translate to the quality of maternal mental health conditions of these women. Meanwhile, it emerged that the level and percentage of maternal mental health conditions amongst African immigrant women in Cape Town is very high and underreported. Different factors hinder women from seeking mental healthcare besides the structural challenges. This study identified some individual factors that discourage the use of professional mental healthcare services by participants in this study. More significant is the role that the husbands and mothers of participant play in supporting the participants' postpartum recovery process.

CHAPTER 7

CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

This chapter provides an overall summary and conclusion of the findings of this study in a more simplified manner, by synthesising all aspects of the study. The chapter appraises the four research objectives in light of the findings by demonstrating how I achieved each objective. This chapter also explains the limitations of the study and concludes by proposing recommendations for future research based on the findings and limitations that emerged from this study. To recap, the overarching aim of this study is to understand the maternal mental health experiences, challenges and opportunities of African immigrant women in Cape Town.

This study contributes to the discussion about the maternal mental health of African immigrant women within the context of migration. It sheds light on how migration contexts impact the pattern of maternal mental health experiences, challenges and opportunities of African immigrant women in Cape Town. Within this context, the study examined the post-migration experiences, challenges and opportunities that the participants faced in South Africa together with the maternal experiences and how all of these impact their mental health. To achieve the above-stated objective, I conducted semi-structured in-depth interviews with fifteen African immigrant women living in Cape Town, South Africa. The data were thematically analysed using Braun and Clarke's (2013) five-step thematic analysis.

I adopted Andersen's (1995) Behavioural Model of Health Service Utilisation (BMHU) as a theoretical framework for examining the relationship between African immigrant women's attitude to utilising maternal healthcare services, and unwillingness to use professional mental health services. The study then explored how the above translates into the quality of maternal mental health African immigrant women enjoy by using the following categorisation of factors that influences health outcome as experienced by the participants in this study: predisposing factors, enabling factors and need factors.

7.2 Summary of the Key findings in the Study

There is huge literature on the impact of migration on the physical and physiological well-being of immigrant populations in their diasporic contexts. However, few studies have investigated the intersections of migration, maternal health, and the mental health of African immigrant women in host countries like South Africa. The present study attempts to fill this

gap by highlighting several themes that brings into perspective the pattern of maternal mental health experiences with regard to challenges and opportunities among African immigrant women in the South African context. The study revealed a high level of prevalence of maternal mental health conditions amongst African immigrant women in South Africa. Nevertheless, the study found evidence of unwillingness to seek professional services for common maternal mental health conditions by most African immigrant women.

This study found that the attitude of African immigrant women to seeking healthcare services is driven by structural and non-structural factors that hinder the use of maternal mental health services. According to the findings from this study, African immigrant women in Cape Town are burdened with other forms of resettlement challenges that already take a toll on their psychological well-being. This means that upon arrival in South Africa, these African immigrant women face several challenges such as loneliness, lack of formal or decent employment, lack of government support, and the challenges of getting proper documentation status in the country. The findings indicate that these challenges impact the mental well-being of the participants. It is important to mention that the themes that emerged from this study are not the only issues affecting the maternal mental health of African immigrant women in South Africa, because we can examine the concept of maternal mental health from different theoretical dimensions using different scientific methods of inquiry. Therefore, the findings of this study are peculiar to the cases of African immigrant women who participated in this study while living in Cape Town. Further research is required to compare these findings to other non-African immigrant women groups in South Africa to find out whether there are similarities or difference in their maternal mental health experiences as immigrant women.

From the findings in this study, it is evident that various themes contribute to possible explanations of other external factors that exacerbate maternal mental health conditions of African immigrant women in South Africa. The themes that emerged from the findings of this study include the underutilisation of maternal mental healthcare services by African immigrant women. This underutilisation is due to structural factors that are based on the participants' experiences of accessing maternal healthcare in public healthcare facilities. These factors are referred to as structural barriers. On the other hand, participants' beliefs and perceptions of mental health challenges informed by cultural and religious sentiments are referred to as non-structural barriers to the utilisation of maternal mental healthcare services. This study found that African immigrant women resist the use of mental healthcare services

even if it were free (affordable), available, and accessible because of their views about maternal mental health challenges and the cultural beliefs of their home country. The participants feared the stigma associated with accessing mental health services in which such persons are regarded as 'crazy'. One could argue that these African immigrant women feel very strongly about this issue. As some of the participants in this study pointed out, even if they experienced mental health challenges again, they still would not use the services of mental health professionals. Instead, they feel more comfortable speaking to their families or close friends.

In addition, this study stresses that African immigrant women are ignorant of the available maternal mental health services in clinic and hospital settings, and they are reluctant to speak to healthcare workers for extra maternal health support. Negative experiences with some healthcare workers discourage immigrant participants from seeking further maternal services such as post-natal mental health services. The perceptions of African immigrant women interviewed for this study was that they healthcare workers discriminate against them clinics and hospital settings because of their nationality. The participants described how they experienced xenophobic attitudes from nurses and other healthcare workers. These unethical practices were more rampant at primary healthcare facilities than big hospitals. It is therefore important for policy makers and hospital management to discourage all forms of discrimination within healthcare settings.

Generally, while most of the participants commended the infrastructural development of South Africa, others believed that South Africa is a harsh place to live because of the xenophobic attitudes and racism that exist in many systems and places within the country. For example, within healthcare facilities, Home Affairs and so on. Some participants believe that some people in the country have "No respect for human life". To elaborate on the findings of this study, I summarize each theme below to demonstrate how they helped the research to answer the main research question and achieve the main objectives of this study.

7.2.1 Appraising Research Objectives

This study set out to achieve four objectives and this section provides a concise summary of evidence of how the study achieved the research objectives.

i. Objective One: To determine the prevalence of mental health challenges among African immigrant women in their perinatal period

This study attempted to evaluate the processes involved in the utilisation and access to available maternal mental health services by African immigrant women. According to the findings, the study concludes that there is a high prevalence of unmet maternal mental health outcomes among African immigrant women in South Africa. The findings identified a gap in the South African maternal and neonatal health policy framework that do not specifically cater to the maternal mental health needs of the immigrant population. Meanwhile, very few public hospital settings implement maternal mental health intervention programs. All the participants in this study who used public healthcare facilities stressed that they were not aware of any maternal mental health intervention programs. The study therefore reiterates that affordability and availability do not often equate to accessibility, (Aff +Av = ± Acc).

Meanwhile, the study also finds that the underutilisation of maternal mental health resources by African immigrant women is not only a factor that is subject to availability and affordability, but it is significantly impacted by personal beliefs about mental health generally. As some participants mentioned during their interviews, using professional mental health services was not an option because of the stigma that is associated with mental illness for example when members of society label the person as “crazy”. In such circumstances, the participants preferred to confide in their close relatives and friends rather than seek professional help. This attitude could lead to trivialising mental health conditions and may lead to future cases of severe psychosis in in some instances.

To emphasise this point, I asked the participants if talking with their relatives or friends about their mental health conditions was useful. Some of the participants responded positively, indicating that talking to family and friends helped. Besides, the participants emphasised that back in their home countries, there was no awareness about mental health and the church encourages congregants to “just pray” if they had any problem and move on. It is therefore safe to conclude that health beliefs, cultural practices and spiritual beliefs impact African immigrant women’s perception and experiences of maternal mental health challenges, which also undermines their willingness to report or utilise professional services.

A more significant determinant of maternal mental health service utilisation by African immigrant women that emerged in this study is their previous experiences of using maternal healthcare services during the perinatal period of their pregnancy and after birth. The findings in this study highlighted disturbing practices within public healthcare spaces, which I categorised in Chapter 6 of this study under the dilemma of accessing maternal health

services. These practices such as language barriers, long waiting times, discrimination, obstetric violence, obstetric negligence, and disrespectful treatment, all contribute to discouraging African immigrant women from seeking postnatal mental health services. Put together, these factors encourage resort to alternative support systems and mechanisms to cope with their maternal circumstances, explored in the fourth objective of this study.

ii. Objective Two: To understand how migration context impacts the maternal health of African immigrant women and the challenges they face in South Africa

The second objective of this study was to understand how migration contexts impact the maternal health experiences of African immigrant women and the challenges they face in South Africa. This study revealed that immigration contexts play a major role in the maternal health experiences of African immigrant women and their perception of maternal mental health challenges. The findings in this study suggest that external factors exacerbated the maternal mental health conditions of the participants, including resettlement challenges like loneliness, unemployment, lack of government support, and documentation. These challenges are more structural and external than internal. I extensively discussed this issue in chapter five of this study.

To achieve this objective, I asked participants to describe the trajectories of their migration to South Africa and explain the kinds of challenges they faced when they arrived. The data revealed that participants were exposed to very harsh living conditions, far from what they expected. Some of the participants who came to South Africa pregnant had worse experiences when they realised that they could not get decent jobs because of their documentation status. One participant mentioned that she felt useless when she realised that she could not work in South Africa to make money to take care of her needs and those of her unborn baby. Another participant believed that there was no future for her and her children because the government had not been able to support her by giving her the proper documents that would allow her to work or study. According to her, her children who were born in South Africa will still suffer from the same hardships. Overall, the participants believed that the structural challenges they face rendered them very vulnerable in South Africa and their vulnerability exposes them to developing psychological stress, trauma, anxiety, and depression before and after childbirth. The participants expressed a desire for government to empower them through employment opportunities so that they would be able to take care of their needs and their children.

iii. Objective Three: To determine the level of maternal mental health awareness amongst African immigrant women living in South Africa

The data shows a very high prevalence of common maternal mental health conditions among the participants in this study. Seven participants self-reported that they experienced postnatal depression, while four said they had anxiety at the pre and postnatal stages of their pregnancy. Only four of the participants said they did not experience any unusual signs in their mental health during their pregnancies and after giving birth. It emerged from the data that the participants have good knowledge of mental health and during the interview, I asked participants to explain why they think they had any of the identified mental health conditions and to describe the symptoms that they experienced. The outcomes of the discussions match the symptoms of commonly diagnosed mental health conditions as identified in other studies of this nature.

Participants mentioned that they had never been so unhappy all their lives, some describing the experience as the lowest moment of their lives. For some of the participants, this condition was worsened because they were living far from their extended family members back home in their countries. Lamenting that their maternal experiences would have been completely different if they were back home because they could depend on family members to provide different kinds of support for them and their babies while they get enough rest that could help alleviate their perinatal mental health conditions. The findings therefore reiterate the significance of including a special kind of support system for African immigrant women to access in their postnatal period in maternal healthcare facilities in South Africa. This could include home visits by nurses or certified carers who can provide supports to the specific needs of the new mothers.

iv. Objective Four: To identify possible coping mechanisms African immigrant women employ to deal with the mental health challenges that arise from their maternal experiences

This study found that African immigrant women rely on the support of their extended families, particularly their mothers and their husbands in order to overcome postnatal depression, anxiety, and stress. This attitude has been shaped by the African cultural belief that accentuates the practices of communal support by every member of the family. In most African cultures, family members play a significant role in the postnatal recovery of new mothers than professional healthcare services in that context. All the participants in this study

wished they had their babies back in their home countries so that they could receive the ceremonial care and attention that new mothers in those societies receive. This also contributed to their reluctance to utilise postnatal medical services for maternal mental health recovery because some of the participants regarded resort to professional services as undermining their strengths and resilience as African women. Prayers and spirituality was another formidable coping mechanism that all the participants identified as tools that helped them overcome maternal mental health challenges. Prayer is a major source of strength for African women because they strongly believe in the Supreme Being (God) to clear their paths and help them overcome any life challenges.

7.3 The Main Contributions of the study

The relevance of this study lies in its articulation of the maternal realities and the lived experiences of African immigrant women in South Africa. Owing to the rich diversity of the sample size, the study was able to mirror different aspects of the participant's lives which provides better insights into how migration context shapes their maternal mental health experiences in South Africa. Moreover, using a qualitative research method allowed me to gather rich and robust data that to answer the main research question and meet the four objectives of the study. The study also benefits by testing the applicability of Anderson's (1995) behavioural framework for evaluating the attitudes of African immigrant women in accessing maternal mental healthcare services in South Africa.

7.4 Limitations of the Study

Notwithstanding the aforementioned contributions, this study is not without some limitations. The first limitation of this study is the inability to generalise the findings. Like most qualitative research, the findings from this study do not lend themselves to be generalised to other similar demographics. For example, African immigrant women in other localities in South Africa (or elsewhere), African immigrant women with low level of formal education or African immigrant women without formal education at all. Notably, the findings in the study contribute to the level of awareness about maternal mental health, and African immigrant women's ability to self-identify their healthcare conditions; yet the limited number of participants (sample size) and the uniqueness of the contexts make it illogical to draw conclusions that go beyond the immigrant women in Cape Town. Even though the experiences may be similar with those of participants in other demographics in South Africa and elsewhere, they do not present enough grounds to draw conclusions about experiences of

all African immigrant women in other contexts. As this study confirms, several structural and non-structural factors influenced these experiences. Secondly, the use of purposive sampling in this study meant that the data were fundamentally biased and from like-minded participants. Thirdly, this study is limited because for non-English speaking participants, narrating their maternal health experiences in English was a little challenging and this affected the quality of the interview transcripts the findings of the study. Lastly, the sensitive nature of the study made it difficult to recruit participants who met the selection criteria and who were willing to participate in the study. In addition to the other selection criteria in chapter four, the participants had to be women who self-identified as having experienced traumatic life events, depression, anxiety, and stress because due to being an immigrant woman in South Africa.

7.5 Recommendations

This study proposes the following recommendations for South African policymakers and future researchers:

- The findings in this study identified a high prevalence of maternal mental health challenges among African immigrant women in South Africa often unreported. It is necessary for policymakers to redouble efforts in implementing and incorporating routine check-ups for early detection and treatment interventions for common maternal mental health conditions for all women at all public hospitals and clinics in South Africa.
- The South African National Health Department should allocate more resources and support for staff to undergo training programmes as part of task-sharing efforts that will certify them fit to detect, refer, and manage mental health crisis in women at primary healthcare and tertiary maternal healthcare settings.
- The government should develop implementable sections of maternal and neonatal health policies that specifically cater to the needs of immigrant women.
- The government should empower African immigrant women by providing jobs and documentation that will enhance human capacity development within immigrant communities in order to mitigate the hardship and vulnerability of these women.

- Healthcare professionals should be sensitive to the needs of African immigrant women who visit their facilities, avoid unethical conduct and all forms of discrimination and disrespect at perinatal settings.
- The government deserves commendation for providing affordable and available healthcare services for all in South Africa; however, the government should implement a monitoring system that checks the quality of care provided for mothers, especially African immigrant women in the country.

7.6 Recommendations for future research

I recommend that future research should focus on the following:

- How to expand the findings in the present study to other non-African immigrant women in South Africa and compare the results with data from studies that focus on the maternal experiences of South African-born women.
- When focusing on African immigrant women, future research should explore the perceptions and experiences of African immigrant women who have no formal education because this will allow the government to identify and address the specific needs of these women within relevant policy frameworks.
- Future research should consider exploring intervention strategies that will help reduce the prevalence of mental health conditions amongst African immigrant women.

7.7 Conclusion

This thesis examined the maternal mental health experiences of African immigrant women in Cape Town, South Africa. It explored factors that affect the utilisation of maternal mental health services by African immigrant women. Key findings were analysed using thematic data analysis. The study was foregrounded in Anderson's (1995) behavioural model of access to healthcare services. The findings of the study show significant similarity with other studies of this nature conducted in different countries, especially in countries in the Global North. This study highlights structural and non-structural challenges that impact the use of available maternal mental health services by African immigrant women in South Africa and recommends that healthcare practitioners should be sensitive to the needs of African immigrant women. The media needs to work closely with the government in demystifying the negative perceptions of the immigrant population in South Africa because negative media

stereotypes contributes to stirring up hate and unnecessary discrimination faced by immigrants in different settings within South Africa including hospitals and clinics

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APPENDIX A: ETHICAL CLEARANCE APPROVAL LETTER



**UNIVERSITY of the
WESTERN CAPE**

Ethics clearance

10 May 2023

Mrs LE Iyi Sociology

Faculty of Arts and Humanities HSSREC Reference Number: HS22/10/44

Project Title: Access to Maternal mental health: A study of Experiences, Trends, and Patterns among immigrant women in Cape Town

Title was later changed to: *Narratives of Maternal Mental Health Challenges and Opportunities Among African Immigrant Women in Cape Town*

Approval Period:

09 May 2023 – 08 May 2024

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above-mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit an annual progress report at least two months before expiry date. Failure to submit your annual progress report on time will result in the immediate lapse of your ethics approval and you will have to resubmit an entirely new ethics application.

For permission to conduct research using student and/or staff data or to distribute research surveys/questionnaires please apply via:
<https://sites.google.com/uwc.ac.za/permissionresearch/home>

The permission letter must then be submitted to HSSREC for record keeping purposes.

The Committee must be informed of any serious adverse events and/or termination of the study.



*Ms Patricia Josias
Officer: Research Ethics
University of the Western Cape*

NHREC Registration Number: HSSREC-130416-049

University of the Western Cape, Robert Sobukwe Road, Bellville 7535, Republic of South Africa

APPENDIX B: CONSENT FORM

Key Informant (interview)



Consent Form

University of the Western Cape

Project Title: Narratives of Maternal Mental Health Challenges and Opportunities Among African Immigrant Women in Cape Town

Researcher: Lydia Eghosasere Iyi

Please **initial** the boxes to show your agreement and understanding of what is expected for this study.

1. I confirm that I have read and understood the information sheet explaining the above research project and I have had the opportunity to ask questions about the project.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without any negative consequences. In addition, should I wish to withdraw, I may contact the lead researcher at any time to do so).
3. I understand my responses and personal data will be kept strictly confidential.
4. I give permission for members of the research team to have access to my responses without revealing any part of my identity.
5. I understand that my name will not be linked with the research materials, and that I will not be identified or identifiable in the reports or publications that result for the research.
6. I agree for the **anonymized** data collected to be used in future research.

7. I hereby agree to be audio recorded. (*Circle the appropriate answer*). Yes /
No

In terms of the requirements of the Protection of Personal Information Act (Act 4 of 2013), personal information will be collected and processed:

- I hereby give consent for my personal information to be collected, stored, processed and shared as described in the information sheet.
- I do not give consent for my personal information to be collected, stored, processed and shared as described in the information sheet.

Name _____

Signature _____

Date _____

_____	_____	_____
_____	_____	_____
_____	_____	_____
Name of Participant (or legal representative)	Date	Signature
_____	_____	_____
_____	_____	_____
Name of person taking consent (If different from lead researcher)	Date	Signature
_____	_____	_____
_____	_____	_____
Supervisor	Date	Signature

Copies: All participants will receive a copy of the signed and dated version of the consent form and information sheet for themselves. A copy of this will be filed and kept in a secure location for research purposes only.

Researcher: Lydia Eghosasere Iyi 4164921@myuwc.ac.za

Supervisor: Professor Emmanuel Mayeza emayeza@uwc.ac.za
--

HOD: Professor Emmanuel Mayeza emayeza@uwc.ac.za

APPENDIX C: INFORMATION SHEET



University of the Western Cape

Date:
DD/MM/YYYY

Information Sheet: Maternal Mental Health of African immigrant women

Topic: Narratives of maternal mental health challenges and opportunities among African immigrant women in Cape Town

Dear.....

My name is Lydia Eghosasere Iyi. I am pursuing my MA degree in the Department of Sociology at the University of the Western Cape, South Africa. I would like to invite you to take part in my research project. Please take time to read the following information carefully, and feel free to ask questions if anything you read is not clear to you or if you would like more information.

What is the study about?

The study focuses on exploring the maternal mental health experiences and challenges of African immigrant women in Cape Town.

Why are you being invited to participate in this study?

You are invited to participate in this study because, I believe you sharing your maternal mental health experiences and challenges as an African immigrant woman in Cape Town will enhance the findings from this study which will, in turn, contribute to informing policies that will improve the lives of African immigrant women in South Africa through its recommendations.

What will I be expected to do in this study?

You will be expected to voluntarily share your maternal health experiences and challenges and how they impacted your mental health in the pre-and post-natal stages of your pregnancy. This will take the form of a semi-structured interview that will last between 45-60 minutes.

What are the potential risks involved in this study?

This is a low-risk study with no anticipated risks. However, I have provided a list of free counselling and support services that you might want to use should you feel the need.

Counselling support groups

- Hope House, a family counsellor in Cape Town. 382 Main Rd, Tokai, Cape Town, 7945. Phone number: 021 715 0424.
- The counselling Hub, 52 & 54 Francis St, Woodstock, Cape Town, 7925. Phone number: 021 462 3902.
- Kwanele- Bringing Justice to women. www.kwanelesouthafrica.org. Email: leonora@kwanelesouthafrica.org
- Masithethe counselling services. Phone number: 043 7222 000, Cell: 084 091 05410

What are the potential benefits involved in this study?

The study will help to identify treatment gaps and other potential challenges that African immigrant women in South Africa are experiencing while accessing maternal mental health services. And then, this study will help to provide recommendations that will be useful in advocacy and providing relevant interventions.

What Covid 19 Protocols are in place? (If applicable)

I will ensure to provide a facemask, and hand sanitizer and ensure a distance of 1.6 meters apart during the interview process.

Will my details be kept confidential?

Yes, data collected from you will be anonymous and your confidentiality will be maintained.

In terms of the requirements of the Protection of Personal Information Act (Act 4 of 2013), please note additional information:

What type of personal information will be collected?

Age, place of residence, occupation, nationality, level of education, and ethnic group, and will not be shared with any third parties

Who at UWC is responsible for collecting and storing my personal information?

As mentioned above, your data will be collected and stored by me (Lydia E. Iyi) the primary researcher. Some of your personal information will be collected used solely for the purpose of this study. All information collected from you will be coded for analysis purposes.

Who will have access to my personal information outside of UWC?

No person will have access to any of your personal information.

How long will my personal information be stored?

All data will be kept on a hard drive with two-factor authentication protection for at least five years. All recordings and documents would be anonymously labelled with a code number for each participant, with a conversion file held in a separate, secure place. Using digital equipment, all data sets will be stored on a single compact disc, and all electronic archives will be erased after five years. All personal information will be anonymized and de-identified. The anonymized data will be coded and used in the data analysis chapters of this study. All data will be kept on a hard drive with two-factor authentication protection for at least five years and then disposed of immediately in line with ethical practices. Paper records would be destroyed/disposed of in a manner that leaves no possibility for reconstruction of information

Who do I contact for further information?

Should you require any further information, please do not hesitate to contact me Lydia Eghosasere Iyi on my cell phone (0740149663) or via email (4164921@myuwc.ac.za). Alternatively, you may also contact my supervisor (Prof Emmanuel Simo Mayeza) in the Department of Sociology, University of the Western Cape (UWC), emayeza@uwc.ac.za

To report any adverse or unexpected effects emergent from this research, please contact the UWC HSSREC Ethics Committee at: 0219592948/2909

Email: research-ethics@uwc.ac.za

APPENDIX D: INTERVIEW GUIDE

INTERVIEW GUIDE FOR STUDY PARTICIPANTS

The following qualitative questions will help to guide the researcher and the respondents during the interview process. The questions are semi-structured in nature, and they aimed at providing an opportunity for respondents to freely express their views and perceptions on their perinatal experiences and challenges in Cape Town and they impacted on their mental health.

SECTION A: BACKGROUND /DEMOGRAPHIC PROFILE OF PARTICIPANTS.

I would like to get to know you better. The following information is necessary to this study but only with your permission and consent.

- How old are you?
- What ethnic group do you identify with?
- What is your educational level?
- What is your occupation?
- What is your nationality?
- How long have you been living in South Africa?
- Do you have family members in South Africa?
- How many child(ren) do you have and where did you give birth to them? (Public or private hospital?)
- How many of these children were born in South Africa?

SECTION B: Postmigration experiences in South Africa

I would like to know of your initial experiences and expectations when you first arrived in South Africa.

- Can you describe your overall experiences in South Africa since you first arrived?
- What form of support systems were available to you when you first arrived?
- In what ways were these supports relevant to you?
- In the event that you did not get any support, how did you cope with navigating the system and how did this experience impact your life as an individual?

SECTION C: MATERNAL EXPERIENCES AND THE SPECIFICATION OF SERVICES USED

I would like to find out about your maternal experiences in South Africa and what is or could be different in your home country.

- What is your general perception of the South African health care system?
- Describe your pre- and post-natal maternal experiences in South Africa. Please tell me the kind of services you used before, during and after pregnancy: (e.g., hospital, physician, dentist, emergency care, home care) - maternal, reproductive health and psychological services.
- Where did you receive the services? (The site at which care was rendered eg, home, office, clinic, inpatient hospital, etc.)
- What was the purpose of the care received? (preventive, curative, stabilizing, custodial)?
- What was the time interval involved in receiving the care?
- Did you continue to receive the services? (I would like to know how often you saw a physician, counsellor or therapist during pregnancy and after childbirth).

- Did you experience any pregnancy related health concerns?
- Is there any history of mental illness post pregnancy or during pregnancy in your family?
- Did you experience any form of anxiety or depression during pregnancy?
- What kind of special or general support did you receive during pregnancy and after giving birth?
- What kind of postnatal psychological care did the hospital provide?
- Was there any particular support you got from your families and friends during and after giving birth?
- What do you think would have been different if you were pregnant and had your baby in your home country?
- What kinds of challenges did you encounter during your antenatal and postnatal stages in your pregnancy?
- How would you describe your relationship as an immigrant woman with the health care workers you have engaged with during and after pregnancy?

- Is there any particular experience (s) you would like to share with me in your maternal journey?

SECTION D: MENTAL HEALTH CARE EXPERIENCES

I would like to know your mental health experiences and how you deal with it.

- Are you familiar with the term mental health? If not, I will explain it to you. What does it mean to you?
- What kinds of personal experiences can you relate to that have impacted your mental health during your pregnancy and after giving birth?
- What kinds of postpartum mental health support did you receive after giving birth?
- Did you seek any help? If yes, what kinds of help and from whom?
- Did you receive the kind of help you desired?
- Was the help suitable and sensitive to your needs?
- What kinds of personal or cultural beliefs influenced how you dealt with your maternal mental health experiences after giving birth?
- What kinds of challenges did you face when you were pregnant?
- How did these challenges affect your mental wellbeing?

Do you have any suggestions on how available health care services can be improved upon to meet the needs of immigrant women in South Africa?

APPENDIX E: TURNITIN RECEIPT

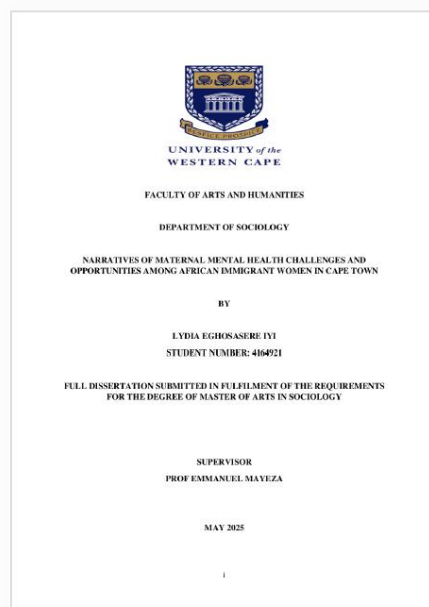


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