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CLINICAL ARTICLE

Exploring disparities in prenatal care between refugees and local South African women

Edith T. Kibiribiri [a], Dhayendre Moodley [a,*], Allison K. Groves [b], Motshedisi H. Sebitloane [a]

[a] Department of Obstetrics and Gynaecology, University of KwaZulu-Natal, Durban, South Africa
[b] Centre on Health, Risk and Society, American University, Washington, DC, USA

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ABSTRACT

Objective: To explore possible disparities in prenatal care between refugees and South African women attending public health facilities in an urban setting in South Africa. *Methods:* A cross-sectional, mixed methods study was conducted at four public health clinics providing prenatal services in Durban between January 29, 2013, and June 15, 2013. Pretested client-satisfaction questionnaires were administered to 200 women attending immunization services at the clinics whose infants were aged 6 months or younger. An additional 16 refugees participated in in-depth interviews. Finally, a maternity chart audit was conducted to compare the quality of basic prenatal care. *Results:* Among the women enrolled, 78 (39.0%) were refugees and 122 (61.0%) were South African citizens. Dissatisfaction was reported by 23 (19.3%) of 119 citizens and 32 (43.2%) of 74 refugees ($P < 0.001$). However, the maternity chart audit of 68 participants (31 refugees, 37 citizens) did not reveal significant disparities in the quality of prenatal care. The most recurring categories arising in the in-depth interviews were linguistic barriers and the challenges faced when using informal interpreters. *Conclusion:* There were no significant disparities in prenatal care; however, refugees unable to communicate in the local languages reported that they were not provided with relevant health information and occasionally faced restricted access to prenatal services.

1. Introduction

By the end of 2011, nearly half the global refugee population (10.4 million individuals) was made up of women and girls [1]. Among the 2.6 million refugees in Africa, women are particularly vulnerable to adverse health outcomes as a result of substandard care and limited access to reproductive health services [1–3]. Inadequate utilization of prenatal care, sociocultural characteristics, pre-existing medical conditions, and a poor obstetric history have also been strongly associated with poor birth outcomes and neonatal morbidity [4,5]. Additionally, the language barrier between refugees and service providers and the prevailing animosity of service providers towards refugees further compromise maternal health and birth outcomes [6]. According to the Sixth Confidential Enquiry into Maternal Deaths in the UK [6], the increase in maternal mortality in 2000–2002 could be partly attributed to a rise in numbers of newly arrived refugees who did not seek prenatal care. Among the 391 maternal deaths, 14 were refugees, eight of whom did not speak English [6]. The report highlighted that the current service provision did not respond to the needs of less articulate women (i.e. women with poor communication skills) or those from poor social circumstances.

As a consequence, refugees often register late for prenatal care or do not meet the recommended number of visits required for basic prenatal care [2,4,7]. Some studies have explored the quality of prenatal care for refugees in high-income countries [3,7,8], but no studies seem to have explored the quality of care provided to pregnant refugee women in South Africa.

South Africa has seen an increase in the influx of asylum seekers, refugees, and immigrants from both neighboring Southern African Development Community countries and other more remote countries, as a result of volatile political and economic conditions in the region. According to South African legislation, asylum seekers are people who have applied for leave to remain in the host country as a result of serious perceived danger in their own country. Asylum seekers whose claims are accepted by the host country obtain refugee status, which allows them to work or receive benefits in line with what is available to South African citizens. Maternal and child health programs in South Africa are designed to meet the basic needs of all communities following the introduction of free healthcare services for pregnant women and children younger than 6 years in public health facilities in 1998 [9]. Refugees can exercise these rights; however, there is evidence that the healthcare needs of refugee women in South Africa, particularly when pregnant, are not being met [10,11].

The aim of the present study was to examine disparities in the quality of prenatal care received by pregnant refugee women and local South African pregnant women attending the same primary healthcare

* Corresponding author at: Department of Obstetrics and Gynaecology, University of KwaZulu-Natal, Durban 4051, South Africa. Tel.: +27 312604685; fax: +27 312604037.
E-mail address: moodleyd1@ukzn.ac.za (D. Moodley).

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facilities in Durban, South Africa, on the basis of national maternity care guidelines [12].

2. Materials and methods

A cross-sectional, mixed methods study was conducted using a questionnaire-based survey and in-depth interviews of women whose children were aged 6 months or younger and who attended the immunization services at four primary health facilities between January 29 and June 15, 2013. The four urban public primary health clinics included in the study are located within a 10-km radius of the Ethekwini Municipality and serve a common catchment population of over 100 000 individuals. Each clinic is staffed with two professional nurses attending to prenatal clients and registers an average of 350 prenatal attendees per year. Women who had sought prenatal care at these clinics and had delivered within the past 6 months at the referral maternity hospital located within 10 km of each of the clinics were screened for inclusion; a convenience sample of the first 50 women enrolled in each of the four primary health clinics who consented to participate in the survey was used. Ethical approval was obtained from the University of KwaZulu-Natal Biomedical Research Ethics Committee (Ref. BE 237/11, dated November 2, 2011).

To establish whether women were South African citizens or refugees, the 200 study participants were asked for proof of identity. A pretested, structured questionnaire was then administered by the researcher (E.T.K.). The primary languages spoken by healthcare workers (HCWs) and the resident population are isiZulu and English, but the questionnaire was administered in English, isiZulu, French, or Swahili. The questionnaire included obstetric and demographic characteristics, citizenship, educational level, language proficiency, and client satisfaction with prenatal care. Primary outcome measures for the survey were the proportion of refugees seeking prenatal care, their demographic and obstetric characteristics, and the quality of prenatal care received in comparison with South African prenatal attendees.

Maternity charts containing the prenatal record of women participating in the structured interview were requested from the Maternity Hospital Patient Record Registry. These maternity charts are routinely retained by the maternity hospital following delivery and are stored in the Hospital Registry. The quality of maternity care (prenatal service) was compared between refugees and South African women using an Antenatal Care Checklist derived from the Guidelines of Maternity Care in South Africa [12]. Indicators included documentation of history taking, physical examination, investigations performed, medications and vaccines prescribed or administered, and provision of pregnancy warning signs information or planning and advice.

Data from questionnaires and the maternity chart audit were captured using Excel 2010 version 14.0 (Microsoft Corporation, Redmond, WA, USA). The final data sheet was imported into SPSS version 21.0 (IBM, Armonk, NY, USA) for analysis. The χ^2 test was used to examine differences with categorical variables (e.g. demographic variables) and to compare differences in communication, information received, and client satisfaction across refugee and South African women. The Fisher exact test was performed when a sample size within a given category was less than 10. The Student *t* test was performed to assess differences between two means and analysis of variance (ANOVA) between groups. When data were not normally distributed, the Mann–Whitney *U* or Kristal–Wallis non-parametric tests were used. All tests were two-sided and $P < 0.05$ was considered significant.

For the qualitative phase of the study, an additional four refugees from each of the primary health clinics were enrolled and consented to an in-depth interview with the primary author (E.T.K.). Audiotaped in-depth interviews with refugees were transcribed after each session, translated into English, and then computerized for data analysis, which involved the identification of recurrent patterns, themes, and contradictions. Codes were created and assigned to a specific session to allow the text to be easily and meaningfully searched. Translated codes were imported and computerized into ATLAS.ti version 5.6.3 (Scientific Software Development GmbH, Berlin, Germany) and themes were identified. Critical information regarding language barrier, quality of maternal care, and HCW attitude were elicited.

3. Results

Of the 200 women participating in the survey, 122 (61.0%) were South African citizens and 78 (39.0%) were refugees. Among the South African women, 20 (16.4%) were Indian, 26 (21.3%) were colored, and the remaining 76 (62.3%) were black. All the Indian and colored South African participants spoke English, whereas all black participants spoke isiZulu. Most of the refugees were from the Democratic Republic of Congo (23 [29.5%]), Zimbabwe (19 [24.4%]), Burundi (11 [14.1%]), and Malawi (9 [11.5%]). The remaining were from Rwanda (4 [5.1%]), Mozambique (2 [2.6%]), Somalia (2 [2.6%]), Uganda (2 [2.6%]), Ghana (2 [2.6%]), Kenya (1 [1.3%]), Tanzania (1 [1.3%]), Cameroon (1 [1.3%]), and Liberia (1 [1.3%]). Among the refugees, 40 (51.3%) were in South Africa for socioeconomic reasons and the remaining 38 (48.7%) had escaped war and political conflict in their native country. Further, 45 (57.7%) refugees had reportedly been in South Africa for more than 5 years, whereas 11 (14.1%) and 22 (28.2%) refugees had been in South Africa for less than 1 or 2–5 years, respectively.

The mean number of previous pregnancies was 2 ± 1.04. Parity was similar between South African and refugee women ($\chi^2 = 1.098$; $P > 0.05$). Hypertension in the most recent pregnancy was reported by 12 (9.8%) South African participants and 8 (10.3%) refugee participants ($P > 0.05$). A similar proportion of South African (93 [76.2%]) and refugee (59 [75.6%]) women reported an uneventful pregnancy ($P = 0.48$).

Overall, the proportion of women who were not satisfied with the quality of prenatal care was significantly higher among refugee women than among South African women ($P < 0.001$) (Table 1). When asked whether they would return to the prenatal clinic in a subsequent pregnancy, a significantly smaller proportion of refugee women than South African women affirmed that they would do so ($P = 0.013$) (Table 1). Similarly, a smaller proportion of refugee women reported that they would recommend the clinic for prenatal care ($P = 0.005$) (Table 1). Interestingly, the English-speaking Indian ($n = 20$) and colored ($n = 26$) South African women also mentioned that HCWs not speaking English was a reason for not recommending the facility (data not shown). Nevertheless, staff attitude and neglect were the most common reasons for refugees stating that they would not recommend the facility (Table 1). There was a general agreement that refugees only attended a particular health facility because they resided in that specific area (Table 2). Other common factors that made the refugees dislike the health facility were reported HCW xenophobia (43.6%), carelessness (42.3%), and inability to communicate with refugees (37.2%).

A significantly higher proportion of refugees reported that they did not receive enough information about labor and child birth, self health care during pregnancy, the laboratory tests performed, or treatments received during their pregnancy ($P < 0.05$ for all) (Table 3).

Following several failed attempts to locate the maternity charts of all 200 participants, only 68 charts were obtained and included in the analysis (31 [45.6%] refugees and 37 [54.4%] South African citizens). The chart audit revealed that an overall average of 70% of charts contained a complete history; however, refugees were less likely to have a complete history ($P = 0.18$) (Table 4). In a comparison with their South African counterparts, questions least completed for refugees included family and medical disorders and allergies. Generally, all other prenatal procedures performed were similar in both groups of participants. The provision of information on pregnancy warning signs to prenatal attendees, and planning and advice on the best and safest approach to the current pregnancy were limited in both groups of women (Table 4) and were therefore substandard for all prenatal attendees.

The most recurring categories mentioned during the 16 in-depth interviews were language barriers and challenges using informal