



Healthcare access challenges facing six African refugee mothers in South Korea: a qualitative multiple-case study

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Purpose: Following legal reform in 2013, the annual number of asylum seekers entering South Korea has increased from 1,143 in 2012 to 5,711 in 2015. We interviewed six African refugee mothers of young children regarding their health needs and barriers to access maternal child health services.

Methods: We recruited mothers who had visited a clinic for immigrants between July 2013 and August 2015. Participants were African refugee women, aged over 18 years, who had given birth in Korea within the previous 5 years and had come to Korea over a year before recruitment. Interview questions examined participants' experiences in pregnancy and childbirth and concerns regarding their child's health status. Initial data analysis involved all researchers' immersion in the entire collection of transcripts. We then noted recurrent topics and themes and identified similar issues.

Results: At the time of giving birth, 5 participants were asylum seekers and one had undocumented status. The following barriers impeded their access to maternal child healthcare: socioeconomic factors (unstable social identity, low economic status, difficulty obtaining health insurance), language barriers (lack of linguistically appropriate health information, limited access to translation services), and cultural barriers (religious and cultural differences). Weak social support also hindered access to healthcare soon after migration; however, social links with the community emerged as a key coping strategy following settlement.

Conclusion: We identified barriers to maternal and child healthcare and coping strategies among African refugee mothers in Korea. Future research should assess refugees' health status and improve health access and literacy among refugee mothers.

Key words: Refugees, Parturition, Infant, Korea, Health services accessibility

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Introduction

The number of foreign residents in South Korea (Korea) has increased: approximately 1.9 million foreigners (3.7% of the Korean population) were living in Korea during 2015¹. Most of these people are laborers, marriage-based immigrants, or students; however, the number of refugees and asylum seekers is rising steadily. Specifically, following the enactment of the Refugee Act in 2013, the annual number of asylum seekers increased from 1,143 in 2012 to 5,711 in 2015. In Korea, over the last two decades, 15,250 people have applied for refugee status—16% of these are female and 94.1% are aged 18–59 years. Among 8,001 applicants whose status was determined, only 576 (7.2%) received the status of refugee².

The Korean government has worked to improve the immigrant support system; however, that system retains numerous limitations compared with those implemented in other developed countries; accordingly, asylum seekers' quality of life and right to health are

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poor^{3,4}). Refugees typically experience malnutrition, difficulty obtaining clean water, trauma, and exposure to infectious diseases in their home countries and during the migration process due to limited or nonexistent healthcare; additionally, they often experience modification of family roles and the separation of family members. After migration, refugees may face barriers to healthcare access and often hold a low socioeconomic position in their new countries⁵⁻⁹). Refugees experience more physical and mental health problems than the native population due to these pre- and postmigration social determinants^{10,11}). Specifically, refugee women of childbearing age may face problems in perinatal health and child-rearing practices⁵).

Several studies have examined maternal and child health among nonrefugee immigrants in Korea; most of the examined immigrants were marriage-based and had arrived from China or southeast Asia¹²). Regarding maternal health, this population received less perinatal care, typically held poor nutritional status, and experienced language challenges during using health services¹³). Additionally, this population faces higher risks of adverse birth outcomes compared to native women (e.g., preterm birth, low birth weight, small for gestational age)¹⁴). However, few studies have examined African refugee women and children's health needs in the perinatal and infant period.

In this context, the present study aimed to identify the health needs and barriers to health services facing African refugee families regarding pregnancy, childbirth, and infant care. Additionally, we aimed to describe the strategies these women used to cope with these obstacles. To achieve these aims, we conducted six qualitative interviews with African refugee mothers of young children living in Korea.

Materials and methods

1. Recruiting process

After the present research was approved by the Institutional Review Board at Seoul National University Hospital, we telephoned African refugee mothers who had visited a clinic for immigrants run by the Seoul National University Hospital and the Red Cross Hospital between July 2013 and August 2015. Eligibility criteria included African refugee women, aged over 18 years, having experienced childbirth in Korea within 5 years of recruitment, and having come to Korea over 1 year before recruitment. Each potential participant was informed of the purpose and process of this study, their rights as participants, and the researchers' obligations.

2. Study process

Interviews were conducted in the houses in which the participants cared for their child and lasted 1–2 hours. Participants

voluntarily provided a written indication of informed consent, then completed a short survey examining their socio-demographic information and self-reported health. Interviews were conducted in English or Korean according to the participant's language proficiency. All participants reported they were comfortable with either English or Korean as a second language. The interviewer was a trained pediatric researcher with 3 years of experience in immigrant healthcare and language abilities in Korean and English. The interviewer used an interview guide that contained 6 questions relating to experiences in pregnancy, childbirth, and concerns about the health status of one's child. These questions were developed by the research team in consultation with experts in immigrant healthcare and tested in a preinterview with one African refugee mother who was not included among the interview participants. Example questions are as follows: "Could you tell me about your experiences in the course of the pregnancy and birth of your child?; Did you have any concerns with regard to your child's health?; If so, how did you solve them at that time?; During your stay in Korea, was there ever a time when you felt that your child needed healthcare, but didn't receive it?" The interviewer engaged in a flexible, semi-structured interview process using probes to clarify information relating to key themes and allowing the participants to change the course of the conversation and bring up relevant issues. All interviews were digitally recorded with permission. The recordings of the interviews were transcribed verbatim into text documents.

Initial data analysis involved immersion in the data as a whole; therefore, all members of the team reviewed and discussed the complete collection of transcripts. We then performed analysis noting recurrent topics and themes and recruiting similar issues, and categorized to the five components of the barriers of accessing health care and one positive experience during using health services.

3. Ethics approval and consent to participate

The study was approved by the Institutional Review Boards at Seoul National University Hospital (approval number: 1508-048-694). Written informed consent was obtained from all participants. This study was carried out in accordance with the Declaration of Helsinki.

Results

Participants were 6 African refugee mothers aged 25–39 years who had delivered at least one of their children in Korea within 5 years of recruitment (Table 1). The participants collectively had 12 children, 10 of whom were born in Korea at full-term. Two women came from the Republic of Liberia, 2 from the Republic of

Cote d'Ivoire, one from the Republic of Mali, and one from Ethiopia. Four participants had been denied official refugee status by the Korean Government but were approved as humanitarian status holders (G-1-6 visa). Two women were legally approved as refugees (F-2-4 visa) but one of them was undocumented at the time of childbirth (Table 2). Four were married and two were single. Participants' education ranged from no schooling completed to high school graduation. Four participants reported a household monthly income under US \$1,000 and mentioned that their income varied widely depending on their husband's employment circumstances. Three participants described themselves as Christian and two as Muslim. All but one reported their Korean language proficiency as "not good."

1. Socioeconomic status

The majority of participants experienced economic problems. Single participants were unable to take employment due to their child-rearing responsibilities. Married participants' husbands rarely found work due to language or health problems. Participants' economic status affected their families' health behavior.

If there was rain, water leak into the house. Especially in winter, rain made the house much colder. It was hard to sleep and eat, and the stress made hypertension. The cost of baby's diaper was very expensive and I put my sanitary pad to my baby instead of diaper. The formula milk was too expensive so I gave soybean milk to my baby after I could not produce breast milk. (Woman C)

All participants were asylum seekers or of undocumented status at the time of childbirth; most had not obtained refugee status during the interviews. This unstable immigration status also affected participants' health, particularly regarding using health services.

To visit free hospital for perinatal check-up which was far from here, I should take a bus. But immigration officers usually watch there so I had to take a taxi to avoid them, even if it was very expensive for me. Sometimes, hospitals refused to check in because the process was too complex especially during night time. (Woman C)

Table 1. Participants' characteristics

Characteristic	Participant					
	A	B	C	D	E	F
Country	Republic of Liberia	Republic of Cote d'Ivoire	Republic of Mali	Republic of Liberia	Republic of Cote d'Ivoire	Ethiopia
Age (yr)	35	34	36	39	25	32
Current visa status (at childbirth)	G-1-6 (same)	G-1-6 (same)	F-2-4 (undocumented)	G-1-6 (same)	F-2-4 (G-1-6)	G-1-6 (same)
Marital status	Single, never married	Married	Married	Married	Single, never married	Married
No. of children (born in Korea)	2 (1)	2 (2)	4 (4)	2 (1)	1 (1)	1 (1)
Education	High school graduate	No schooling completed	Nursery school to 8th grade	High school graduate	Nursery school to 8th grade	High school graduate
Monthly income (US dollar)	<500	500–1,000	500–1,000	1,000–2,000	500–1,000	1,000–2,000
Duration of residency in Korea (yr)	2	9	11	3	3	2
Korean language proficiency	Not at all	Not good	Very good	Not good	Not good	Not good
Health status	Very good	Fair	Poor	Poor	Very good	Poor
Religion	Christian	Muslim	Muslim	None	Christian	Christian

Table 2. Legal status and health-related benefits for children of refugee mothers in South Korea

Status & benefit	Documented		Undocumented
	F-2-4 visa	G-1-6 visa	
Renewal of status	Every 3 years	<1 year	Not applicable
Working permission	Eligible	Eligible with governmental approval for each employment	Not eligible
Social welfare benefits	Eligible	Not eligible	Not eligible
National health insurance	Eligible	Limited	Not eligible
General healthcare voucher	Limited to a few hospitals	Limited to a few health centers	Not eligible
Prenatal care/delivery voucher	Limited to a few health centers	Limited to a few health centers	Limited to a few health centers
Child wellbeing examination	Eligible	Limited	Not eligible
National immunization program	Eligible	Eligible	Eligible

I asked why and he said that he could not treat me because I am a foreigner and I did not have visa. (Woman B)

2. Healthcare coverage

A lack of national health insurance seriously affected all participants' access to healthcare. No participants had health insurance at the time of childbirth due to their legal immigration status, although at the time of interviews, 2 had recently obtained national health insurance following their classification as refugees by the Korean Government. Free or subsidized prenatal care was offered in only a few health centers; therefore, participants often needed to spend large amounts of time travelling during pregnancy. Monetary and time costs of travel to a free hospital posed a significant barrier, even after childbirth.

I was not living in Seoul. I could not go to any nearby hospital I needed, instead I had to take subway with my young daughter. It takes very many hours to go and come back. (Woman E)

Even if their children were referred to emergency medical services, participants faced financial challenges in obtaining proper care. Healthcare providers at nonfree hospitals often seemed reluctant to care for patients who did not have health insurance.

The hospital people told me, if you want to stay here, it's very expensive. So I came home. After the morning, because it was emergency (premature labor), I went there. They said you cannot afford money so it's better to find another hospital. (Woman E)

Participants reported that they were not offered information about when or how to apply for national health insurance or free hospital care when they received their humanitarian visa. All participants expressed a very strong desire to have health insurance.

3. Communication and health information

All participants reported that their access to healthcare was impeded by a communication barrier. Four women expressed needing more information about child immunization. Poor communication prevented the participants bringing their children to health centers for national immunization programs.

When he was born, I got a pocket book and they told me to do something. But I couldn't understand because it was in Korean. (Woman C)

This language barrier caused information loss between the participants and healthcare providers in the child immunization

process, as well as delaying access to healthcare. Mothers usually received the vaccine's name and subsequent immunization date from health professionals, but could not obtain information about the purpose or possible side effects of each vaccine. One participant described experiencing great stress completing preimmunization check-up documents written in Korean and often being unable to write her child's health status.

Healthcare professionals often provided no proper health education; therefore, participants struggled to obtain health-related information for their children through television, the internet, or acquaintances. One woman described not starting her child on solid food at the proper time due to ignorance; another mentioned missing a child wellbeing examination because she could not understand the document mailed to her for that purpose.

Some participants felt that their children had received inattentive care due to health professionals' unwillingness to provide explanation in a different language. Woman A recounted as follows: "They just say 'it's ok,' but I was uncertain and afraid". Additionally, participants mentioned that their symptoms were often underestimated because of difficulty expressing the characteristics of their pain.

This communication barrier often resulted in deeply unsatisfactory experiences with healthcare usage. Participants stated they were not welcomed to health centers due to a lack of language proficiency, further impeding communication.

Here, it is very difficult to find a doctor speaking English. When you go to hospital and you talk in English, people do not like this because none of them speak English. But my Korean is not more than that. So sometimes it's difficult to explain what you want and how you feel. (Woman E)

4. Cultural differences

A majority of participants described consequential cultural differences in symptom modification during pregnancy and childbirth. Particularly during their first pregnancy in Korea, mothers were embarrassed by these differences.

It was very different because when you are pregnant in Africa, there are certain foods like leaves that make you feel good. But it is not in Korea. (Woman A)

In our culture, we should not shout or cry for pain. So I did not even I had severe pain and doctors or nurses did not come to me. (Woman C)

Muslim participants reported experiencing cultural differences relating to religion. In Islam, male infants are traditionally circumcised; however, participants experienced difficulty obtaining

information regarding a male circumcision in Korea. Contraception was also an important issue for Muslim mothers.

In Islam, there is no way to prevent child birth. Husband and wife can avoid sex but if my husband wants sex then I cannot refuse it. Having oral pill is forbidden. We can be punished by god. Condom is permitted but usually husbands don't like it and wives cannot require it. (Woman C)

5. Social networks

All participants experienced separation from family members and lacking social support during the early phases of their migration. Participants who gave birth during this period experienced particularly extreme physical and emotional hardship.

It is not easy to be pregnant in Korea. When you need support, but you know here we don't have any family. When I was in the airport, I was alone. (Woman F)

Participants' social networks in Korea developed over time. Participants usually met other people in their region belonging to the same or a similar ethnic group and thereby obtained help regarding settlement and healthcare usages. Christian participants had the advantage of being able to develop relationships with Koreans, as well as other Africans, through church. These networks were partly able to fill the family role in the postpartum period.

African in Ansan introduced people who came from Cote d'Ivoire. One woman came from the same country visited me when 4 days after birth. She brought me to the hospital every day. (Woman B)

I did not know anything about pregnancy because it was my first time. My friend who I met in the church helped me and informed free hospitals. (Woman F)

When I met her in the church, she told me that there was a Korean pastor who helps pregnant women. (Woman A)

6. Delivery experiences

Nearly all participants expressed satisfaction and positive memories regarding delivery. Participants paid little or no money for delivery and felt that they were treated same as native Koreans. They described receiving high-quality healthcare and emotional support during antenatal care and delivery. Participants who had experienced delivery in their homelands described particularly strong satisfaction with delivery in Korea.

The cost was more expensive in Liberia. Delivery in Korea

was very safe but in Liberia you would be afraid because most people who left for delivery do not come back (Woman A).

I was so much satisfied with the care because every time when I went for antenatal care, the service was good. I think in Korea the doctors think life first, more especially, when it comes to baby and mother. They give them good care and attention (Woman D).

Discussion

Previous research has examined health-related challenges facing Asian immigrants, but has not examined the healthcare experiences and unmet needs of African immigrants in Korea^{14,15}. This study therefore examined African refugee women's unmet needs regarding pregnancy, birth, and childrearing and these women's coping strategies. Interviews with this study's participants suggest the presence of the following key barriers to equitable access to maternal child healthcare:

Unstable social identity, poor economic status, and difficulty obtaining health insurance

- Lack of linguistically appropriate health information and limited access to translation services
- Religious and cultural differences impeding access to proper maternal child healthcare
- Insufficient social support in the early stages of migration

Poverty affects immigrants' ability to access necessary healthcare services¹⁶. Socioeconomic deprivation is related to adverse health outcomes^{16,17}. Similarly, our participants described receiving inadequate healthcare because they did not have national health insurance or were experiencing financial hardship or due to healthcare providers' reluctance. In Korea, 98.2% of the domestic population has national health insurance, enabling those people to access most essential healthcare services with little financial stress. This coverage has been progressively expanded¹⁸; however, asylum seekers in Korea still have limited access to national health insurance coverage. If asylum seekers are not granted official refugee status (i.e., the F-2-4 visa), they have few opportunities to subscribe to national health insurance, despite their status as humanitarian immigrants (i.e., the G-1-6 visa). Rarely, G1 visa holders may obtain insurance if they are regularly employed by a merciful company¹⁹. In addition, the Korean government provides a subrogation payment system for assistance in the event of a medical emergency; this is also available to asylum seekers and undocumented immigrants. However, neither hospitals nor refugees are well-informed regarding this support system and hospitals tend to be reluctant to use it due to its administrative complexity. In consequence, one participant in

this study was not able to obtain proper care in an emergency situation and another who had no foreign registration number was rejected by a hospital administrator. Health insurance critically determines this vulnerable population's ability to meet their need for healthcare; this point's importance cannot be overemphasized. Asylum seekers should have the right to take up national health insurance, regardless of their legal status. Further, considering the relatively low rate of health literacy among immigrants, healthcare facilities and immigration officers should provide adequate information about insurance and emergency support systems. Simplification of hospital administration is also necessary to facilitate healthcare access for asylum seekers.

Communication problems are among the most important factors affecting immigrants and refugees' health²⁰. Our participants described difficulties obtaining information, particularly during the perinatal period and their child's infancy. They experienced separation from family members and lacked the social support that would have facilitated their access to health information. Pregnancy may be refugee mothers' first opportunity to contact healthcare systems. This opportunity is highly valuable and this period may affect the lifelong health of children of immigrant mothers; therefore, it is critical that accurate health information is provided to immigrant mothers. Multilingual booklets about vaccination exist; however, only a few healthcare institutions in Korea possess these, resulting in a negligible benefit to refugees. More multilingual materials providing health and childcare information should be produced; additionally, it is important to find means of facilitating refugees' access to these materials. Some local governments run public translation services in several languages²¹. This study's participants experienced communication problems during treatment and were unaware of these services. Connecting refugees with these systems and hospitals may importantly diminish language-related barriers impeding refugees' access to adequate healthcare.

Cultural differences are among the most important barriers to adequate healthcare for pregnant or childbearing Muslim women²²⁻²⁴. Previous studies have recommended that healthcare professionals should offer considerate concern during physical examination and offer information about the location of worship areas, food choices, circumcision, and other medical information necessary to religious requirements²². Similarly, our participants reported experiencing the effects of cultural differences regarding symptom management during pregnancy and delivery. Development of a healthcare system that is able to respond to a diverse range of patients is important to managing the health of minority populations. Care providers who are more likely to encounter patients from minority groups should be informed regarding particular cultural, religious or ethnic requirements in order to help them provide culturally competent care^{22,25}.

In this study, weak social support also impeded participants'

access to healthcare in the early stages of migration. Participants encountered a wider range of problems with language, cultural, and health system differences soon after their arrival than at later stages of their settlement. Additionally, the lack of psychosocial resources negatively affects birth outcomes^{26,27}. This study's participants reported gradually developing social links following settlement; this emerged as a key coping strategy. Therefore, policies or interventions should aim to provide support in the early stages following arrival. The Korean government presently administers 217 multicultural family support centers; these typically focus on marriage-based immigrants from Asian countries²⁸. However, with additional governmental support, these centers might also focus on supporting African mothers. Further, the government might approach refugee mothers through churches and Non-Governmental Organizations, which importantly facilitate the development of social support networks for refugee mothers. This public-private partnership would be likely to enrich the psychosocial resources available to refugees.

This study has the following limitations. First, the sample was small and did not include currently undocumented refugees. All the undocumented refugees we approached declined to participate in the study due to concerns of identification exposure, although one undocumented refugee participated in the preinterview without providing demographic information. Additionally, one participant was of undocumented status when she gave birth; her experiences of that period were discussed in her interview. Second, interviews were conducted in participants' second language because we were unable to find proper translators for African local languages; this may have limited the range of participants' expression.

This is the first research to examine the healthcare experiences of African refugee women and children in Korea. Critically, the participants described difficulties accessing necessary maternal childcare due to socioeconomic deprivation and unavailable national health insurance. Participants who were able to access healthcare described a lack of linguistically appropriate information and experiences of severe and detrimental cultural isolation. Regarding refugee mothers, reducing negative health determinants in the perinatal and early childhood period is vital to securing children's continued health into adulthood and improving and protecting mothers' health. As refugees continue to come to Korea, the government should address these challenges by expanding national health insurance coverage to refugees, providing additional education to healthcare facilities, and disseminating proper information to both healthcare providers and refugees.

Conflict of interest

No potential conflict of interest relevant to this article was reported.

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