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ACCESS TO MATERNAL HEALTH FOR WOMEN IN GURUVE DISTRICT IN ZIMBABWE

BY

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A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE

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Abstract

Rural communities in Zimbabwe face challenges accessing health care facilities due to a number of factors. The country is a signatory to maternal health care global and regional commitments in order to curb maternal health issues. This study sought to unpack the issues on the access to maternal health for women in rural communities, and strategies used to improve the access to maternal health through facilitating the availability of health care centres in local communities of Zimbabwe. This research adopted a case study research approach on three local authorities from Guruve district, specifically Guruve's rural areas. The research employed mixed methods research tools; the qualitative tools being in-depth interviews, informal conversations, observations, document analysis and lived stories on a purposive sample of interest to gather both primary and secondary data relevant to the study. Quantitative data was collected using questionnaires which were distributed using the simple random sampling. Data was analysed through thematic analysis and as narratives. Microsoft excel pivot tables presented the data through use of tables and graphs. Results indicate that women face challenges in accessing health care services in rural areas that include physical, economic, technological access to health care and these are compounded by political, socio-economic, cultural and religious factors at play in Guruve district rural areas. This study concluded that maternal health care access remains a challenge in rural areas as the Zimbabwean broken health care system keep defoliating affecting masses. Some recommendations such as prioritizing programs that support the community who offer major help and are often used by most mothers on all the issues that are related to maternal health were made. The researcher basing on the research findings recommended alternative strategies of better service delivery are also presented in the research drawing key points from literature, perceptions from Civil Societies and lessons from the MDGs, regional commitments and legislator process on maternal health care and mortality issues.

Key words: public health, maternal health, maternal mortality.

Declaration Page

I declare that this dissertation is my original work except where sources have been cited and acknowledged. The work has never been submitted, nor will it ever be submitted to another university for the award of a degree

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_____ _____ _____ 06-06-2020_____

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To my friends and colleagues thank you for the companionship.

Dedication

This work is dedicated to the pillars of my life, my grandparents, Vho Matshikiri Orphious Moyo and kuku Miya Thilivhali, my parents Mr. Ayibulayi Zaba Shoko and Mrs. Precious Moyo-Shoko, all my family members.

To my siblings Craig Rendani Shoko and Mamello Janet Shoko

List of Acronyms and Abbreviations

AU	African Union
CARMMA	Campaign on the Acceleration in Reduction of Maternal Mortality in Africa
CBPLG	College of Business Peace Leadership and Governance
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CSO	Civil Society Organisations
GDP	Gross domestic product
GOZ	Government of Zimbabwe
HIV	Human Immunodeficiency Virus
HTF	Health Transition Fund
ICPD	International Conference on Population and Development
LEDC	Less Economically Developed Country
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MNH	Maternal and Newborn Health
MOHCC	Ministry of Health and Child Care
MOHCW	Ministry of Health and Child Welfare
NHS	National Health Strategy
ODI	Overseas Development Institute
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
RHG	Reproductive Health Guidelines
RHP	Reproductive Health Policy
TBA	Traditional Birth Attendants
UNDP	United Nations Development Programme
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund

WHO	World Health Organisation
WOCBA	Women of Child-Bearing Age
ZMNH	Zimbabwe Maternal and Neonatal Health

Table of Contents

List of Tables

List of figures

List of Appendices

CHAPTER 1 INTRODUCTION

1.1 Introduction

In the post-independence era (1980-1990), Zimbabwe had universal primary health care when the government proposed free health care and education and education. The colonial regime left health infrastructures and initiatives for more health facilities such as rural clinics therefore Zimbabwe inherited a robust and good health network. The era was characterised by hospitals which were a state of the art and manned by qualified primary care givers and staff, proper equipment and drugs were available.

A decade later, Zimbabwe faced a twist characterised by the Economic Structural Adjustment Programs (ESAP). In early 1990s, Zimbabwe coincided with other global interest concerning primary health care which created a move towards the economic stabilization and structural adjustment programmes. ESAP brought with it the neo liberalism period of the economic recession which brought about payments and most Zimbabweans losing their jobs and a negative impact on health. This initiative was imposed by European donor funding institutions on most African governments to improve their ability to repay borrowed loans. African governments were greatly crippled including Zimbabwe's public facilities as many moved from collective to privatisation. The user charges were meant to mobilize revenues which affected the poor and vulnerable as they could not afford to pay for health services.

In 2002, Zimbabwe became a signatory of the Millennium development goals (MDGs). The Fifth declaration aimed at reducing maternal mortality between 1990 and 2015 (Bailey, 2006). Another target was added in 2008 seeking to achieve the universal reproductive health by 2015 (Nyamtema, 2011). Zimbabwe amongst others failed to achieve the health target which dropped by almost half mortality rate but the

number of children dying between the age of five remained tragically high with 6 million children every year (UNDP, 2015), hence the 2030 Agenda on Sustainable development's third goal on good health and well-being (UNDP, 2015). It is focusing on achieving the maternal mortality ratio (MMR) estimates of 2015, with the goal to having less than 70 maternal deaths per 100,000 live births by 2030.

The Government of Zimbabwe (GoZ) faces challenges in providing for efficient and effective health care that is basic to its citizens due to various factors caused by neo liberalism and these include significant brain drain, poor governance, collapsed economy and lack of sufficient funds. Thus the Ministry of Health and Child Care (MoHCC) ability to run and maintain health programs has been affected exclusively, and only minimal progress made in the reduction of maternal mortality. This failure on health provision also compromises the accessibility of maternal health care services for women which positioned as part of an even broader stage of Women Deliver for Development in 2007 (Horton, 2010).

The history, culture and customs of Zimbabwe impacted greatly on the economic system of the country. Zimbabwe's politics and economy are linked and politics affects many economic outcomes. The political economy situation in the country led to the adoption of various global policies being adopted and imposed to improve local economies (Nelson- Piercy, 2011). ESAPs fall under the inter-displinary branch among governments and public policy relationships. This global economic interaction did not improve economies as intended but became an economic impact on Zimbabwe and Zimbabwean citizens. This has contributed the poor performances in most collective institutions with lining factors such as brain drain, poor governance, collapsed economy and corruption by government officials and lack of sufficient

funds. This then forced the government to introduce maternal health user charges in 2002 which played a significant role as an alternative to tax-based financing for government health services while culturally people are turning to alternative medicines.

1.2 Background of the study

Women are key to a society on reproduction as their role include family care, maintenance and child bearing which are referred to by many scholars as the triangular responsibility of women. However, they are dying every day due to preventable and avoidable factors, which are highlighted as the three delays (WHO, 2015). These three delays include the delay by women to seek care; delay due to difficulty in accessing a health facility; and, lastly, the delay faced by a woman within a health facility (Munjanja, 2007). These factors are avoidable neglecting them has contributed to high mortality in Zimbabwe. Fawcus (1996) states that women encounter challenges every day in and outside the health facilities because of delays in going to the hospital. He further states delays that happen during referral from small clinics to highly specialised hospitals; inadequate treatment at the hospital; incorrect treatment by health professionals; lack of transport for them to go to the clinic; delays by health professionals in making the decision to refer patients to the referral hospital where there are specialised health professionals; incorrect diagnosis by the health professionals; inadequate resources at the hospitals and at home; and failure by health professionals to assess the severity of health conditions (Fawcus, Mbizvo, Lindmark & Nystrom, 1996).

Zimbabwe is a recipient of donor funding and despite the assistance, exorbitant user fees have continued to exist, thereby, militating against efficient provision of maternal health, access to maternal health services and proper utilization of health facilities.

The existence of unofficial fees still drain the poor rural women's coffers without the government's knowledge, a misnomer which has to be definitely addressed as many pregnant women now resort to alternative maternal services which can be detrimental to their health. Various studies have showed to this end that this has done much harm than good as the user charges have increased the impoverishment of the poor lessening their abilities in meeting nutritional needs and reducing their chances of healthy childbearing.

The post-independence era advocated the availability of collective institutions such as schools and hospitals. Maternal health institutions were amongst the list which the government of Zimbabwe introduced mothers' shelters. The availability of infrastructure does not determine the quality service in health care and positive outcomes on the right to maternal health is not necessarily guaranteed by the number of clinics or hospitals in the country but by the provisions of health services in that country. Municipal clinics are common primary health care centres in Zimbabwe especially in its rural areas for the communities to gain access to basic medical facilities to avoid crowding at the main government hospitals in the country and to those who do not afford taking it to the nearest hospitals. Emergency or serious ailments are then referred to the main hospitals by municipal transport. Zimbabwe does not only have public health institutions but also private health institutions and the mission hospitals.

This research intended to assess and explore maternal health care access for women in Zimbabwe's rural areas and how the political economy situation in the country has continued to affect the health care services with maternal mortality remaining high. The quality of maternal health care service provision in the country has deteriorated on many public institutions and some of the reasons for this is poor polices introduced

in the country. To assess the quality of maternal health service provisions in the country the research intended to take a comparison of a church mission hospital and a government hospital in the country. These are the institutions that serve the largest and poorest population in the country.

1.3 Statement of the problem

The health of women during pregnancy, child birth and post- partum period is an important component as both the mother and the child's health must be protected which when compromised affects both the mother and the child. Maternal health care has remained an issue in most African countries with too few proper service provisions in hospitals and clinics characterised by less equipped facilities and under staffed therefore rarely provide the care women and infants need. These characteristics results in hindered access to health care and over time become negative impacts on women access to maternal health care services. Zimbabwe is experiencing a high rate of maternal mortality, reported in 2019 to be 462 deaths per 100 000 live births (MICS, 2019), with some record pregnancies of 500 000 to 700 000 per year. In as much the record is a drop from the previous year, in rural areas, maternal mortality remains at 32 deaths per 1,000 live births and 27 deaths per 1,000 live births in urban areas for an urban-to-rural ratio of 0.8 (ZDHS, 2019). The 2017 World Health Organisation report stated that approximately 810 women die from preventable causes related to pregnancy and child birth. Reasons for these high mortality rates are avoidable birth related complications. It is highlighted in most literature that most people in Zimbabwe favour the use of church mission hospitals as compared to using government hospitals (Zwi, Brugha & Smith, 2001). Therefore, the study seeks to reflect on how lack of observation on the right to maternal health service provision is the reason for high maternal mortality rates in most parts of Zimbabwean communities

such as Guruve District and how best the right to maternal service provision for women can be improved to influence an increase in maternal health.

1.4 Research objectives

The study sought to:

1. Examine the health care access problems faced by pregnant women daily in Guruve District;

2. Assess the consequences of lack of maternal health care services on women and other conditions related to lack access to maternal health and

3. Suggest strategies that can be used to improve women's access to maternal health.

1.5 Research questions

The study sought to answer the following question:

1. What are the health care access problems faces by women in Guruve district?

2. What are the consequences and challenges faced by women on the access to maternal health care in Guruve district?

3. What can be suggested strategies to improved access to maternal health by women in Guruve district?

1.6 Assumptions

The study was based on the assumption that there has been a significant change in mortality rates and women still face certain challenges accessing maternal health care services. This research on access to maternal health care focused on how the challenges of political economy in Zimbabwe have affected mortality rates in rural

areas. Distance, religion and culture still play a pivotal role on the access to all health care services in rural areas while political and economic factors are equally crippling.

1.7 Significance of the study

The study helped to identify the political and economic factors to maternal health basing on the findings and also modify the programs that address the needs of those vulnerable and add on the contribution to knowledge on maternal health. The ultimate rationale of this study is to contribute to uncover the underlying healthcare conditions emanating from the providers of maternal health service as well as the patients. A well-crafted policy framework for maternal health care based on political economy should be developed which address value chain linkages, provide for interventions and provide for regulations. It should be structured as a response to maternal mortality rate and why it is remaining high in Zimbabwe where availability of maternity health service providers is a legal obligation in the country. There has been increasing research into maternal health and healthcare, this study is an addition that is significant to guide policy makers as to what policies to implement in order to safeguard the accessibility of health care services for populations living in marginalised communities in general and advocate the millennium development goal number five which aimed at reducing the maternal mortality ratio by three quarters between 1990 and 2015 and also achieve universal access to reproductive health (WHO, 2014) which is now the Sustainable Development Goal number three focusing on good health and well-being (UNDP, 2015).

1.8 Delimitation of the study

The study focused on Guruve district in Mashonaland Central Province of Zimbabwe and on the analysis of women's access to maternal health for women in rural communities and how the Zimbabwean political and economic crisis is responsible for

maternal health outcomes. The study also focused on reports and many other records on maternal health and rights to maternal health as well as legally binding treaties which Zimbabwe is party to. The study covered the period 2009-2019, the decade of continued economic recession. The fact that Guruve district is a big area, a few villages selected including Shinje located in Ward 7 south of Guruve and Gota in Ward 17 north of town were chosen which makes it easier to gain access into all the existing local leadership.

1.9 Limitations of the study

The fact that Guruve district has a population which is highly mobile and a lot of movement that occurs across the farms, the researcher encountered challenges of locating some participants for the research. Poor road network is also another limitation to reaching further remote areas. The current political situation in Zimbabwe of post-election is a potential threat to the confidentiality of respondents.

CHAPTER 2 REVIEW OF RELATED LITERATURE

2.1 Introduction

Maternal health has been defined as safe motherhood, narrowly defined to mean ensuring that all women receive the care they need to be safe and healthy through pregnancy and childbirth (Family Care International, 2000). With the progress made in Africa as well as many other states, there are still challenges faced by women across the continent on full access to maternal health care such as socioeconomic and policy environment on health care provisions.

Furthermore, maternal health is also referred to as the health of women during pregnancy, childbirth and the post-partum period as defined by the World Health Organisation (WHO, 2009). It is a legal entitlement on the Constitution of Zimbabwe and other Conventions on Human Rights making it a top priority for women as they need the maternal attention during pregnancy, giving birth as well as the post-partum period. Every government is responsible on the role of providing for the necessary health facilities which assist in catering for the needs of these women. Facilities needed to cater for the right to maternal health include free service delivery, medication, and skilled stuff especially in rural communities where transport and distance is an issue. It is the right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant (International Conference on Population and Development (ICPD), 1994).

2.1.1 Maternal health and sustainable development

Maternal health has remained an issue that is central to sustainable development in African countries. Globally, maternal health is a challenge each year and Zimbabwe

is among those facing challenges following a series of about 210 million women becoming pregnant and about 140 million new-born babies being delivered hence the sheer scale of maternal health alone makes maternal well-being and survival vital concerns (Graham, 2016). The MDG era which ended 2015 had an estimate that almost half of the world's population of 7·3 billion are female with about 52% of whom were aged 15–49 years the WOCBA. Maternity service is the service provided to women during the prenatal, labour and postnatal period. Prenatal health care includes health education and promotion, and interventions that minimise complications during pregnancy, delivery and the post-natal period. Post-natal health care includes helping a woman recover from childbirth and advice given on new-born care, nutrition, breast feeding and family planning methods (World Health Organisation, 2006). WHO (2015) identified the SDGs as the continuous strategy for the post-MDG period unfinished agenda. Therefore, maternal health remains at the estimated 98% of maternal deaths that are preventable as it has been defined as safe motherhood, further narrowly defined to mean ensuring that all women receive the care they need to be safe and healthy through pregnancy and childbirth (Family Care International, 2000).

Women are regarded as human beings who have human rights which should be considered by all sectors such as the government and their male counter parts. There is need to improve reproductive and maternal health as it will increase the value in and of women since they do not only exist but because they are reproducers of children, families, communities and cultures (Lule, 2005). The right to maternal health care for women emphasizes women entitlement like other citizens of countries with entitlements to quality services that are to be provided by the state. Women have the right to demand accountability from the government and its institutions whose duty

lies on fulfil these rights to maternal health and health care services. Women's right to life, to health care and to non-discrimination has been codified in multiple international covenants. Governments have committed themselves to promote the sexual and reproductive health and rights of women in international agreements, plans and programmes of action (Freedman, 2005 and Lule, 2005).

Principles of Human rights practitioners' places maternal health care at the top list of things to be provided exclusively by the state. Responsibilities of the health care system include the health care services that are available, accessible, acceptable and of good quality and are distributed through a network of centres from primary to tertiary level. Efficient health care systems provide maternal health services which are accountable. In addition, it is free from discrimination as it ensures there is active participation in decision-making for women. There are challenges on maternal health which were identified on the 2005 MDG National which then employed the strategies in dealing with African countries determinants on maternal health care services. Women at higher risk of dying or experiencing pregnancy-related complications often also face the pressures of poverty, poor infrastructure, and restrictive gender norms that undermine their ability to care for their health (Smith et al., 2009). The shortage of hospital beds and medical professionals in prenatal clinics is also an important obstacle. Recommendations include better training of providers to improve early recognition of potential complications of pregnancy, improvement of family planning services, prenatal screening, re-equipment of maternity homes, improvement of services, improvement of reproductive health monitoring and increased health education among high-risk groups (Ronsmans, 2006).

2.2 A Political Economy Conceptual Framework

Zimbabwe's maternal health care challenges can best be described by the country's political economy and globalisation as well as neo-liberalisation of policy that Zimbabwe is a signatory to. Factors such as cost, access, and infrastructure remain the major obstacles on the maternal deaths that occur in rural communities of Zimbabwe (UNICEF, 2008). Most of these contributed to the nationwide political, economic and social factors. Zimbabwe has more than 50 primary health care centres in one district, with a maximum of two ambulances that are available to deal with emergencies (Mutseyekwa, 2010). This section will focus on these challenges and how they are the reasons behindinadequate antenatal care.

Globalisation and neo-liberalisation created new power dynamics where local forums of social, spatial organisations are being dismantled through practices such as privatisation of public spaces brought by the ESAPs in Zimbabwe promoting economic and political exclusion. Politics affects economic outcomes in many ways that range from the ability of the state to ensure public order and the distribution of resources in a beneficial way for the most regular people. Maternal mortality remains an obstetric challenge with suggestions that are not within the scope of lowering maternal mortality rates (Nelson- Piercy, 2011). The nature of governance of third world countries has been affected as economic, political and social policies by governments have followed the trends of globalisation. Zimbabwe has adopted policies that have an impact on the economy hence affecting all other sectors such as the health sector where the distribution of health budget is centralized which affects primary health care centers. Below is an illustration of the political economy of maternal health.

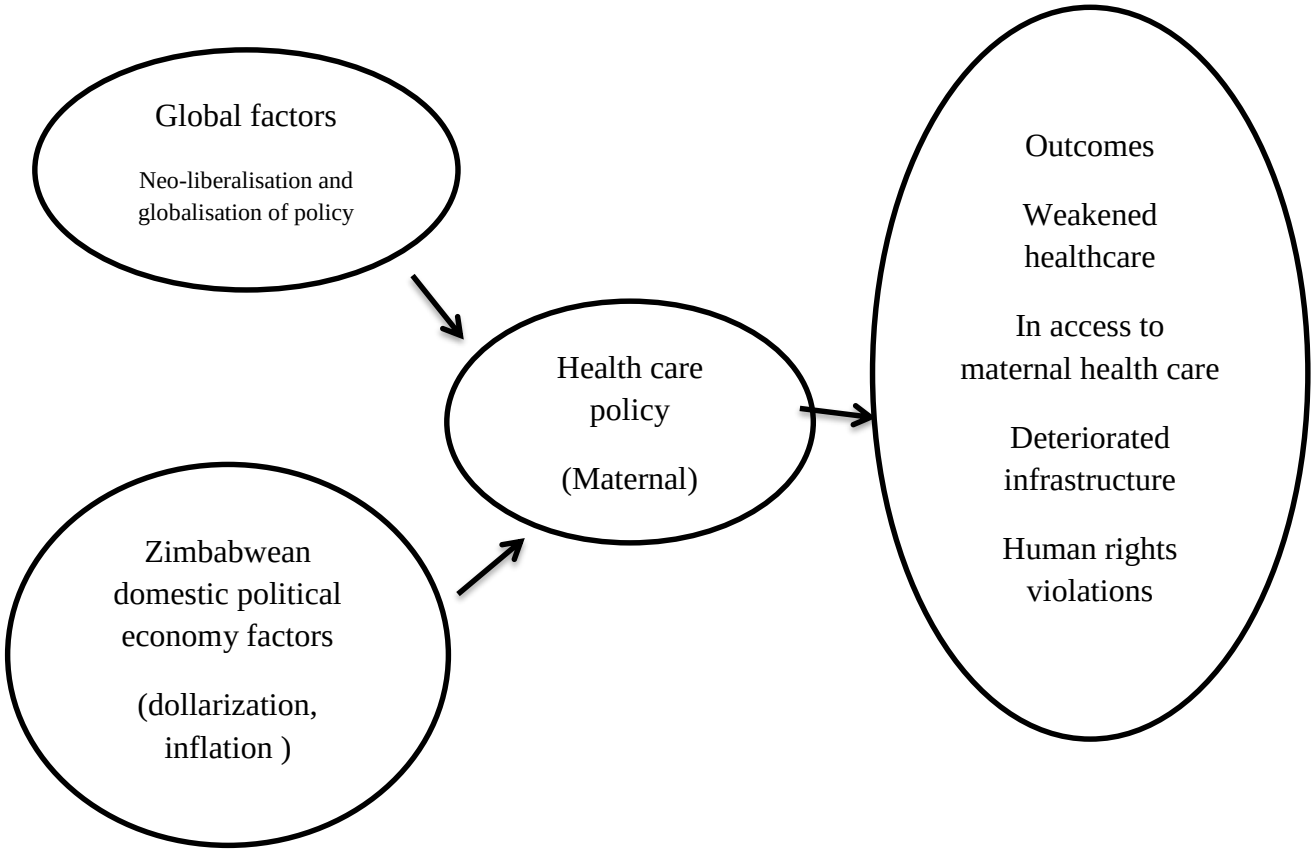


Figure 1 Political Economy of Maternal Health

The political economy of maternal health sets out conditions that describe any government policies that have an impact on the country's health system which the government created by promoting unsuitable economic conditions which did not attract investments in Zimbabwe. The global factors on health care policies can be addressed through various ways such as the effects they have on formulation of policies and how African governments seem to have lost control of the policy making process and the outcomes in the health and health care access. Zimbabwean domestic economic policies opened road for the economic system that is owned, controlled and run by private entities (Lienert, 2009). The private entities created private sector health care delivery systems and run these on high prices which limited the poor's access. It also undermined the effort of NHS of equity and equality health care services hence

increasing public health significance such as high maternal and child mortality rates (ZIMSTAT, 2015).

Continued economic recession in Zimbabwe, debit accumulation and overspending by the government in the hope of turnaround in the minerals revenues resulted in no support for hospitals and public health care centres hence the deterioration of health services. Local governments failed to sustain themselves hence weakened health care and the political economic situation has exerted direct control over the economic life of Zimbabwe through planning and nationalisation.

2.2.1 **Cost**

"As 44% of the population in Sub-Saharan Africa, where most maternal deaths occur, are living from less than a $1 a day", (MDG 2006 Report:4), these costs are unaffordable for most families. It is with regard to various literatures that user charges then have been placed within the spectrum of enhancing sustainability, efficiency & equity. These costs fees for the use of facilities, services and drugs are high enough on their own. When combined with the cost of transportation to clinics and the possibility of lost wages from work, they are often prohibitive which make pregnant women vulnerable (Women Deliver, 2010). It has been emphasised that there should be a sound financial mechanism in health systems to ensure that women access services and reduce out of pocket spending (Honda, Randaoharison, & Matsui, 2011).

Cost of services is a constraining factor in accessing maternal health services. Tunçalp (2012) state that the cost of service was a factor limiting accessibility to health service in Ghana because the national health insurance only covered delivery; if a woman has a severe maternal morbidity, the cost of hospital charges would rise rapidly. Drugs, for example, are not included in insurance and are not found at the hospital. The

current foreign currency fiasco in Zimbabwe continues to show the impact of political economy and economic policies in the country as global funds are now being handled by the organisations and not the ministries.

2.2.2 **Access to health care**

In most rural areas in Zimbabwe, women are unable to access quality health care services when needed. Africa faces a health-worker crisis on average, there are only 13.8 nursing and midwifery personnel for every 10,000 people (WHO 2004 - 2009). The geographic distribution of health workers further complicates the issue of access. The health-worker average does not give a full picture of the shortage in rural areas, where there are far fewer health workers than in urban areas. For example, Zimbabwe's rural population account for about 46 per cent of the population but only 12 per cent of doctors and 19 per cent of nurses (WHO 2009). Distances to health centres in developing countries are very long and there rarely is an ambulance available to transport the women, although geographical access to delivery care and level of care offered at a health facility are determinants of facility delivery (Lohela et al., 2012). The resurfacing fuel shortages and lack of cash has impacted access and service delivery both physically and economically leaving rural population vulnerable in access to health care.

2.2.3 **Infrastructure**

Deteriorating economy has had significant impact on infrastructure in the country. Infrastructures in rural communities remain a major barrier to health access especially on maternal mothers. Poor road for transportation remain a hurdle even on the health care facilities on transportation of drugs and other services especially in rural areas, clinics are often too far away. The Overseas Development Institute reported that in

rural Zimbabwe, transportation problems were cited in 28 per cent of maternal deaths, compared with 3 per cent in Harare (ODI, 2007). Despite many efforts made in relation to the promotion of quality care to meet the right to maternal needs such as availability of health personnel to attend to women health issues at each facility, infrastructure developments to meet basic maternal health care, provide overtime pay to health care personnel for extra hours worked, among others (Mathole, Majoko etal. 2004) and women's perspectives on the quality of care across all the regions of the country to have a continued exploration.

2.2.3.1 Hospital Facilities

The basic facilities on hospital Infrastructure includes mostly the equipment needed for a hospital that functions properly. The availability of scientific equipment, electricity and hospital infrastructure measures the essential of maternal health and also plays an important role on matching the services that are needed as according to the client's perspective. When hospital facilities match these perspectives, they provide for a service delivery that is acceptable for the user and for the provider. One scholar highlighted that the population is aware of non-availability of obstetric services and this affects their accessibility to obstetric care (Ameh 2012) hence hospital facilities a challenge to maternal health access.

2.2.3.2 Availability of basic equipment

The issue on the lack of availability of equipment does not affect only Zimbabwe but most countries in Africa have faced challenges regarding basic equipment. A study carried out in rural Tanzania found that the working environment at government hospitals was not conducive to health professionals working at night because there was no electricity and lamps had to be used for lighting (Kahabuka, 2012). Service delivery requires this basic infrastructure to plays its role as well since the absence of

equipment causes hospitals to become dysfunctional with women failing to even access the basic maternity services.

2.3 Concepts on Maternal Health

2.3.1 The Human Rights Perspective

Constitutions all over the world and other jurisdictions provide for maternal healthcare as a legal right. The Human Rights Perspective asserts that human rights are meant for the protection of individuals against actions interfering with fundamental freedoms and human dignity which are indivisible and independent on the protection of the citizens. The right to maternal health as well as the right to non-discrimination and the right to life are included in regional and international instruments where Zimbabwe is also a signatory on treating the health as a human right as well as the creation of environments that are conducive for maternal health services.

Individuals are the holders of civil, political, economic, social and cultural rights. Governments have corresponding obligations to respect, promote, protect and fulfil these rights (Asher, 2004). These include the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Women's Protocol, Vienna Declaration, International Conference on Population and Development Program of Action, the Millennium Declaration, Abuja Declaration Maputo Plan of Action, African Charter on the Rights and Welfare of the Child and many more which the Zimbabwean government has to comply and consider when creating national laws and policies to fulfil and protect the right to maternal health.

Thomas Jefferson identified moral rights which he states as the right to life, liberty and pursuit of happiness. Over the years' moral rights have assumed a lot of

importance throughout the world and hence they are now referred to as universal rights or fundamental rights showing that they cannot be removed or given away such as civil and political rights and economic, cultural and social rights. Most governments have included them in their constitutions and in the Zimbabwean constitution they are contained in Chapter 3. Maternal health falls into the economic, cultural and social rights category of second generation rights which are sometimes referred to as the red rights as they are related to equality. African countries have made a recognised progress on increasing the availability of maternal healthcare hence the majority of women across Africa still remain without full access to this care with factors like policy environment; socio economic factors still remain prevalent in affecting the improvement of maternal health care services.

2.4 Maternal Health Governance

Governance refers to a process through which institutions such as values, policies, laws, rules and regulation and customs, of a given country are implemented (UNEP, 2006) and relies upon the interaction between the state, civil society and private sector. From a national perspective, the Zimbabwean government adopted health policies and frameworks such as the Millennium Development Goals (MDGs) to assist in incorporation of the right to health in Zimbabwe and was done so as to ensure that Zimbabweans where not disadvantaged in terms of health accessibility. These include the Public Health Act, National Health Strategy, and many more to be listed. The following table indicate health facilities in Zimbabwe.

Table 1 health facilities profile for Zimbabwe

Facility level/ managing authority	**All Facilities**	**Hospitals**	**PHF**
Central hospitals	6	6	

Provincial hospitals	8	8	
District hospitals	44	44	0
Mission hospitals	62	62	0
Rural hospitals	62	62	0
Private hospitals	32	32	0
Clinics	1 122	0	1 122
Polyclinics	15	0	15
Private clinics	69	0	69
Mission clinics	25	0	25
Council/Municipal	96	0	96
Rural health care	307	0	307
Total	1 848	214	1 634

Source: Zimbabwe Service Availability Readiness Assessment (ZSARA) 2015

2.4.1 **The Public Health Act**

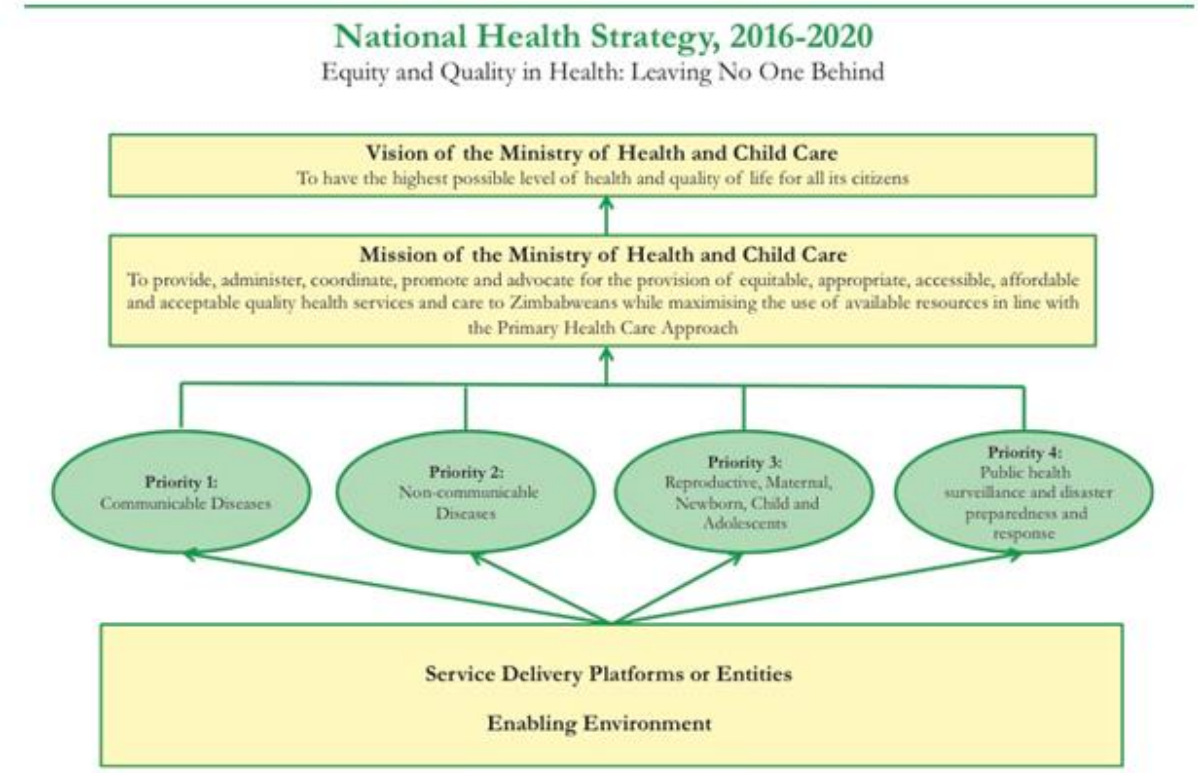
The right to health issues in Zimbabwe is provided in the Public Health Act Section 15 subsection 03. This is the regarded as the main legislation that deals with issues of health in Zimbabwe. This has the ministry which is responsible for public health in Zimbabwe as well as the promotion of public health and health education. This reflects the obligation of the country to cater and provide health care to its citizens. Despite no clear specification of maternal health care, this Act shows that there is a political will

by the government in providing for public health which encompasses all the possible health issues on the planet.

2.4.2 National Health Strategy for Zimbabwe 2016- 2020

The National Health Strategy 2016-2020 – Equity and Quality of Health: Leaving No One Behind builds on the 2009- 2013 strategy which is basically layering of policy to provide for continuation. It sets out the strategic direction for the health sector over the next five years in order to attain this vision as illustrated in the diagram below. Ministry of Health and Child Care (MOHCC)is another evidence of the provisions of maternal healthcare in Zimbabwe responsible for increasing inter-sectional coordination and collaboration with relevant sectors and other organizations, towards improving health and quality of life of the population. Its main goal is focussed on the quality as well as equity in health care services of maternal and child health. MOHCC had a goal to reduce the Maternal Mortality Ratio from 725 to 300 per 100 000 live births by 2015 through the increase in the availability and utilization of quality focused antenatal care including PMCTC services, improve access to skilled attendance at delivery and to strengthen the capacity of health system for the planning and management of MNH (Maternal and Newborn Health) services (National Health Strategy, 2009). It is furthering its health care motive by focussing on a Zimbabwe where pregnancy and child birth do not pose threat to the lives of mothers and new born providing high quality comprehensive and integrated maternal, new born and child adolescence health services. The ministry stated that the goals to be achieved by scaling up proven cost effective intervention at high population coverage through family and community, outreach and health facility level care (MOHCC Reproductive Health Department, 2017). Hence the main objectives still focus on reducing maternal mortality ratio 651 to 300 by 2020 and neonatal mortality from 29 to 20 deaths per

1000 lives by 2020.As a result, MOHCC allocated a budget of $520 million for the 2018 financial year towards Health delivery system. Below is a diagram indicating the possible route to the highest possible level of health and quality of life for all Zimbabwe's citizens (NHS, 2016).



Source: National Health Strategy (NHS) 2016-2020

2.4.3 **The Patient's Charter of Rights**

The Patient's Charter of Rights is another piece of legislation in Zimbabwe which provides information on the rights and responsibilities of patient's health providers. The charter originally developed in 1996, was revised and distributed in 2011 to serve as a framework for how clients should be treated throughout the health system and it defines the rights of clients and their responsibilities within the health system (ZIMSTAT, 2015). It advocates free immunisation for pregnant women among all the services required by women during maternal health care however, threats are posed to

the charter both politically and economically. There are no user fees for women seeking maternal health care in Zimbabwe rural communities hence the government is making progressive provisions on the right for maternal health care**.**

2.4.4 Reproductive Health Policy and the Reproductive Health Guidelines

Attempts to improve maternal healthcare led to the development of Reproductive Health Policy (RHP) and Reproductive Health Guidelines (RHG). The Zimbabwean Government made efforts in the creation of an enabling policy environment on consideration of the implementation of various maternal, neonatal and child health programmes**.** The policies are regarded amongst most progressive policies in Zimbabwe which focus on the provision for maternal healthcare (Manjanja, 2009)**.** These provisions play an important role on the plight of women in most cases its rural women that are deprived their right to maternal health

2.4.5 Zimbabwe National Maternal and Neonatal Health Road Map (ZMNH) (2007-2015)

The MNH Road Map is a national framework for planned activities aimed at significantly improving maternal and new-born health services at institutional and programme levels, in line with the MDG health related targets (ZMNH, 2015). The vision of the Zimbabwe Maternal and Neonatal Health Road Map is focused on the attainment of the highest level of Reproductive Health working together with the national health policy, the national health strategic plan, and the reproductive policy. The Road Map focus on improving the basis for an increased and long term investment to reduce the current levels of maternal and neonatal mortality and morbidity, and to provide guidance to all strategic partners, stakeholders and programmes for a more coordinated, multi-sectoral and national response to improved health service delivery

at all levels: from community based services to rural health facilities, to district and provincial referral centres, through to highly specialized tertiary hospitals.

2.4.6 The Constitution

The right to health care is essential for one to fully enjoy their right to health. The health care must be accessible, available, acceptable and of good quality. The Constitution of Zimbabwe explicitly provides for the right to health care in Section 76, sub-section 1 - 4 that every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health (Constitution of Zimbabwe Act, 2013).It also supports the view as shown through some of the promises that have been made by government in human rights instruments that guarantee the right to health such as the African Charter on Human and Peoples' Rights, International Covenant on Economic, Social and Cultural Rights, Convention on the Elimination of All Forms of Discrimination Against Women and Convention on the Rights of the Child for the right to basic health care to be enjoyed in Zimbabwe.

2.5 Regional and Global Commitments

The health sector recognised both global and regional commitments on improving the access of health care and the right to health care. In provision of the right to health care in Zimbabwe is still proven by the confrontation the unfinished Millennium Development agenda which did not meet all the targets and goal by 2015. According to the 2014 Multiple Indicator Cluster Survey (MICS), the maternal mortality ratio remains high at 614 deaths per 100,000 live births (versus a target of 174 deaths per 100,000 live births); the under the age of five child mortality rate is at 75 deaths per 1,000 live births (versus a target of 43 per 1000 live births. The continued confrontation strategy is aligned to the Sustainable Development Goals (SDG) agenda, thus taking into consideration the unfinished MDGs agenda. It consists of 17 goals

with two focusing on health and these include, ensuring healthy lives and promoting well-being for all at all ages and any other related diseases that affect women and girls. This strategy, as described in the SDG framework seeks to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls. The Africa Union and United Nations Population Fund Agency also launched an initiative in 2010, the Campaign for Accelerated Reduction of Maternal Mortality in Africa, to further strengthen the Maputo Declaration of 2006 which was targeted to reduce maternal mortality and improve sexual and reproductive rights (Africa Union Commission, 2011).

2.5.1 **Millennium Development Goals 2015**

Zimbabwe as a member of the United Nations also adopted the Millennium declaration of the Millennium Development Goals (MDG) which came in as efforts to enhance development in LEDCs. Most African countries challenged themselves to these MDGs with the perfect goal 5 for this thesis that is reduction by three quarters between 1990 and 2015 of the maternal mortality ratio and its indicators for measuring progress. The Zimbabwean government identified the challenges associated with the failure to meet the target in 2015 and these are unaffordability of maternity fees, reduced attendance of expectant mothers at antenatal clinics due to cost, long distance to clinics and inability of some women to make choices on reproductive health issues due to social and cultural pressures (Constitution of Zimbabwe Act, 2013).

The MDGs as already mentioned above focus mostly on health issues which are global in nature. The initiative had countries coming together signing the declaration and 189 countries signed including 147 Heads of states. This signified the global commitment of all the developed and developing countries to work together towards addressing the

global health challenge. UN agencies like the United Nations Development Program assisted the member states with financial and technical support in meeting the target. Notwithstanding the almost lapse of the 2015 MDG target the leaders have made greater strides in trying to address the global health challenges. A challenge however, remains for the developing countries which are incapacitated and lack coping mechanisms to meet the targets. A 2010 MDG Summit and a 2010 G8 Summit further committed to providing additional funding to support childbirth, maternity, and early childhood health. The challenge for developing countries is that they often suffer from inadequate health systems and these weaknesses typically include shortages of health professionals, chronic underfunding, dilapidated or non-existent infrastructure, and a persistent lack of access to essential medicines, including vaccines. Margaret Chan, director general of the World Health Organization (WHO), has identified weak health systems as the greatest threat to global health. Although Zimbabwe among most countries also adopted the principle of health as a fundamental human right, it remains lagging as too few developing nations have actually strengthened their health systems.

2.5.2 **Sustainable Development Goals**

Failure to meet the millennium development goals led to the foundation of the sustainable development goals to be reached by 2030. It consists of 17 goals with 169 targets and between 1 and 3 indicators. The SDG goal number three merged goal five of MDGs on ensuring healthy lives and promoting the wellbeing for all at all ages. The goals within health targets of goal number three includes the reduction on global maternal mortality ratio to less than 70 per 100 000 live births by 2030.This is to be done through ending preventable deaths of new-borns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under five mortality to at least as low as 25 per 1000 live

births. SDG focuses on reducing premature mortality from non-communicable diseases by one third through prevention and treatment and promoting maternal health well-being by 2030. It goes further and discusses reducing maternal mortality by ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. Section 3.8 of the SGDs identifies lack of universal health which is a situation in most African countries that rural areas tend to be neglected hence to achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. There is need to substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States and strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks (SDGs, 2030).

2.5.3 **Maputo Declaration 2008**

Zimbabwe joined other countries ratifying the Maputo declaration in 2008 which was done for the purpose of fair distribution of health regionally in Africa. Their focus was specifically on the promotion and protection of women's rights. The Maputo declaration highlights the need to work on improving women's health as well as reducing maternal mortality working together as regional states on goals and priorities for African countries towards the achievement of the MDGs. The African Union state it as a short-term plan for the period up to 2010 built on nine action areas: Integration of sexual and reproductive health (SRH) services into PHC; repositioning of family planning; developing and promoting youth-friendly services; unsafe abortion; quality

safe motherhood; resource mobilisation; commodity security; and monitoring and evaluation (African Union, 2006). “Zimbabwe embraced the declaration as it has managed to review the curricula for nurses, midwives and doctors and has also integrated Sexually Transmitted Infections (STI)/Human Immunodeficiency Virus (HIV) and nutrition”, (African Union, 2006:11).

2.5.4 Campaign on the Acceleration in Reduction of Maternal Mortality in Africa (CARMMA)

Zimbabwe joined other African countries on the realisation of the need to curb mortality in Africa and launched CARMMA in year 2012.The theme of the campaign was that, Zimbabwe Cares, no woman should die giving birth. This initiative focused on the Maputo Plan of Action for it to come up with its objectives when it was launched. The ICPD plan of action was also included as the context of the objectives. The campaign was then initiated on the focus to reduce mortality by the African Commission. UNFPA contributed to the realisation of challenges to accessing health care and solutions needed for the country to fight maternal mortality. Recognising the regional challenge in Africa, the Africa Commission challenged the countries to curb maternal mortality by 75% as a way to accelerate the MDG targets of 2015. This called for redoubling efforts in order to reach the target. It is derived from the key priority areas enshrined in the AU Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa (2005) and the Maputo Plan of Action (2006) (African Union Commission, 2010). The main objective of CARMMA is to expand the availability and use of universally accessible quality health services, including those related to sexual and reproductive health that are critical for the reduction of maternal mortality (African Union Commission, 2010). With the help of

the health transition fund, Zimbabwe is revitalising its maternity waiting homes and strengthening the use of traditional birth attendants and village health workers.

2.6 Women access to maternal health care in Zimbabwe (A National Perspective)

Women's access to maternal healthcare facilities as well as other health facilities is vital to saving lives through the provision of these essential services. This is necessary in the case that it helps to avoid low level of women utilization of maternal health care services and has an effect on increasing women's vulnerability to encounter the worst health outcomes such as death. There are many factors that play a role in this inadequate use of maternal health care services for example lack of information, cultural factors, and educational attainment of the women especially among those residing in rural areas (Ngomane & Mulaudzi, 2010). The rural context of the country presents the greatest challenge to the government because most households and locations are scattered far apart from each other. Women in rural settings tend to use maternal health services far less than women in urban settings.

The quality of maternal health care and health facilities in Zimbabwe is a profound factor with impacts on the delivery of continuum of the right to health care as well as accessibility on women. The importance in understanding the quality of health care operations will lead to the improvement in maternal health care service delivery in rural communities in Zimbabwe. Quality of care in countries that have increased the number of skilled health personnel to achieve MDG 5 continues to vary considerably without improved information and services (United Nations, 2013b). This is attributed to existence inequalities within and between the developing countries in the way operation management of health care services is implemented. This situation subsequently affects the quality of care, and it increases the women's use of alternative

health care services as opposed to the conventional public-supported health care facilities (Palamuleni, 2011).

Furthermore, the government of Zimbabwe is still trying to redress the existing inequalities which affect the right to maternal health by investing especially in rural health services. Thus the country acknowledges the idea that health was considered an integral part in development and a human right. Although there are currently over 1,500 health facilities around the country, there are still hard to reach areas that are not yet serviced (Ministry of Health and Child Welfare, 2009). Therefore, the access to maternal health in rural areas in most cases still depends on traditional birth attendants (TBAs) which lack antenatal screening for high risk pregnant women which has an impact on the mortality rates. Dodzo (2017) established that 25% of deceased women had delivered in the community.

During the socio-economic upheaval from 2008 to date, reproduction did not stop, hence the negative consequences in maternal health indicators. Around 2010, the major donors in the country created a multi-million dollar pooled funding mechanism to stimulate the social sectors, including health, education, protection and water, sanitation and hygiene. Among these pooled funding mechanisms was the Health Transition Fund (HTF) (UNICEF, 2017). The fund focused on the improvement in maternal and new-born health through the procurement and distribution of drugs, equipment, as well as paying top-up salaries for health workers. Although it mainly catered to supply-side issues, it did nothing to create demand, change attitudes and improve motivation to seek facility-based health services (MOHCW, 2009).

2.6.1 **National Health delivery system in Zimbabwe**

"Zimbabwe has a Public health service delivery that is organised into four categories of a hierarchical system namely the primary, secondary, tertiary and quaternary", (MoHCW, 2010:3) which is illustrated in table 2. This is a four-tier health service delivery system that is meant to function as a referral chain in Zimbabwe (NHS 2009-2013, cited in Chiremba, 2013). The Zimbabwean government like other governments in Africa signed international and regional treaties that focus on promoting the reduction of maternal mortality and improving quality health care in Zimbabwe and Africa at large. These treaties lead to the improvement of health delivery systems in Zimbabwe as they are responsible for the creation of hospitals and health care centres. The distribution of these health care centres and hospitals is governed by the treaties on equal distribution of health services to all including remote areas. One may argue that despite the fair distribution of health services which international and regional treaties seek to address, "Zimbabwe has its six central hospitals distributed between the two big cities and these include Harare Central, Parirenyatwa, Chitungwiza Central, Ingutsheni Psychiatric, Mpilo and Bulawayo Central Hospitals", (MoHCH, 2010:4). The central hospitals are not only the highest but also most specialised on the levels of maternal and child health. They have specialists and this includes the obstetricians, gynaecologists, neonatologists, paediatricians and paediatric surgeons. The centralisation of quaternary hospital can be classified as human right deprivation as the main health services required for good child delivery are only accessible to the few in central cities therefore hindering all the possible ways to reduce maternal mortality. Strengthening maternal and reproductive health services can also benefit the health system as a whole, enhancing access and use of a broader number of reproductive health care services (Lule et al, 2005). The Zimbabwe health delivery

system is highlighted below in form of a hierarchy drawing clearly showing the four categories of the system.

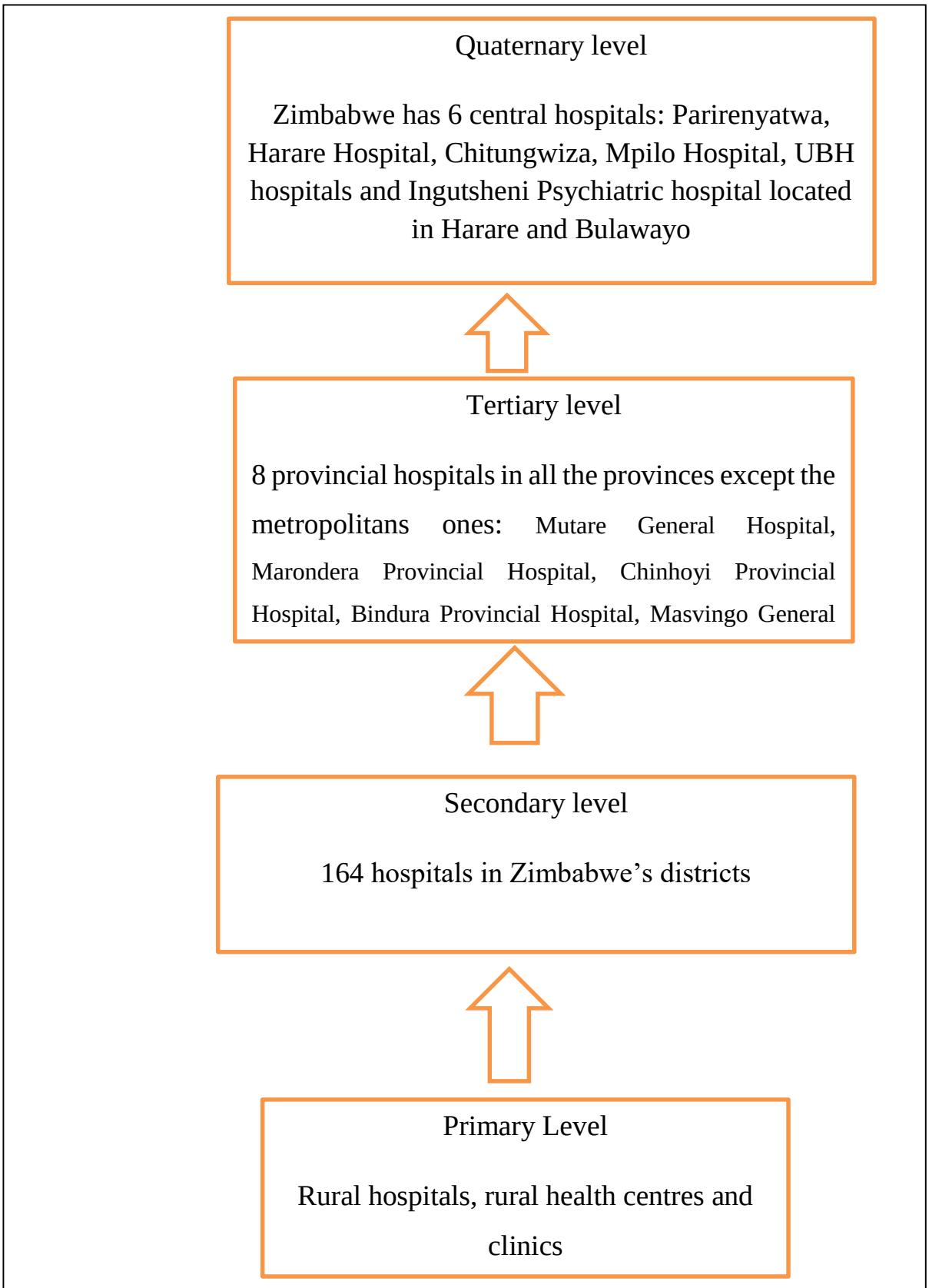


Figure 2 health system structure

The hierarchy system above shows the four levels of health care with Primary health care at the first level of contact for communities when seeking health services and according to the MOHCW now MOHCC primary health care is "the main vehicle by which health programmes are implemented in the country", (MoHCW, 2012:5; Chiremba, 2013:4). "This level comprises a network of clinics and rural health centres assisted by village health workers providing comprehensive promotion, preventative, curative and community health-based services", (MoHCW, 2010:3). Secondary level follows and consists of district and church mission hospitals. There are a total of 164 district hospitals that are classified on the secondary level and their services are enhanced compared to those offered at primary health care centres and surgical procedures. The next level is tertiary which is like in tertiary education it is considered seniors in medical facilities and consists of the 8 provincial hospitals in Zimbabwe. Their duties are similar to district hospitals but they have comprehensive management, emergency care and most cases are referred from the district to the provincial centres. Final on the list is the central level also known as the quaternary and this tier consist of the six central hospitals which are the highest and considered most specialised hospitals even for maternal and child health issues.

The Ministry of health in Zimbabwe carried out a study on the access to health care services were it discovered that 0% of communities live within a 5 km radius of the nearest health facilities, 23 % live between 5 to 10 km away and 17 % are over 10 km from such facilities (MoHCW, 2010) and that the access to health services was extremely difficult because of lack of transport in rural areas and that the majority of roads were in a poor state (MoHCW, 2010).

2.7 Brain drain

Zimbabwe's economic meltdown since 2008 has seen a massive migration of health professionals meant that few experienced professionals remained, leaving the few with skills struggling to train student nurses and midwives well enough to meet the national demands (MoHCW, 2012). Since 2008 to 2019 which is now a decade later, the medical field is still suffering manpower with doctors migrating as soon as they get their clearing to search for greener pastures due to little meagre salaries. Strikes have continued to be the order of the day on health professionals hence the loss of experienced professionals capable of working with minimum supervision and inadequately trained health professionals at the point of care (MoHCW, 2012). The 2019 ongoing doctors' strike and other strikes that happened in Zimbabwe have had leaders threatening medical officials with firing.

2.8 Budget Deficit

Most countries signed the Abuja declaration of 2001 which proposed a goal of 15% allocation from the national budget to public health. There has been a decline on public health financing which most countries including Zimbabwe has not managed to provide these allocations from the national budget. The decline in recent years has been affected by the GDP percentage hence a drop in health expenditure. As a result, to insufficient resources from the national budget, health facilities have been more dependent on user fee revenue to support their budgets (NHS, 2009- 2016).

The budget deficit in the health sector had not only affected the health expenditure but created a huge impact on the public health services led by a crumble which resulted in a lack basic medical supply and equipment. In as much as the deterioration of basic health service, the impact was also felt on health professionals who did not have the basic services to work efficiently hence brain drain. In December 2008, the vacancies

in public sector human resources for health reached 69 % for doctors and over 80 % for midwives (MoHCW, 2012). As result, a high attrition rate of experienced health service and programme managers weakened the health management (MoHCW, 2012).

2.9 Girls and women abuse

Gender based violence is still stereotype in many communities and it underlies sexual and reproductive health care problems that are experienced by women. These include among others, unwanted pregnancies, sexually transmitted infections and HIV. The statuses still match those of SADHS (1998) which revealed that 12% of women have been assaulted before either by a current or ex-partner. Violence on women has been associated with negative pregnancy outcomes especially maternal patients abused by their partners. The stereotyping becomes the reason one does not seek health care assistance which leads to miscarriages and preterm birth as well as low birth weight.

2.10 Summary

This review of related literature looked at the key concepts in the right to maternal health as well as its provisions in the Health policy in Zimbabwe. The nature of mortality on maternal health, its causes and the extent of the problem in Zimbabwe has been looked at by many organisations. This knowledge enabled the researcher to tackle this study with an in-depth analysis and insight as it provided a broad and wider context of the issue of the right to maternal health in rural communities. If ever the right to maternal healthcare in Zimbabwe is to become meaningful to women especially the rural population, Zimbabwe must comply with the ratified instruments by enshrining it in the Constitution by following in the footsteps of other jurisdictions. The next chapter discusses the research methodology.

CHAPTER 3 METHODOLOGY

2.11 Introduction

This chapter outlines the research processes and data collection method used and includes issues such as sampling, design plan, administration of the data gathering tools, response rate achieved and an analysis plan of the information gathered to provide answers for the research questions and objectives of this study. The chapter explored the design, population and sample, the research instruments, the data collection instruments, data collection procedure, the ethical considerations and briefly set out the data presentation and analysis procedure as it aims to answer the research objectives. Questionnaires, observations and in-depth interviews were used as the data collecting instruments for this research.

2.12 The Research Design

The study employed a case study research design using mixed method of data collection. The design was used to explore, interpret and provide an insight into the deeper senses of the access to maternal health care from a community perspective. The research method employed the use of mixed methods data collection tools with quantitative research responsible for data collection from community mothers from the district and qualitative research was used on collection the descriptive information from key informants such as the Rural District Council officer, District Administration Officers and Chiefs. The use of the qualitative data collection in the study increased the acceptance and quality of the results. The study gave precedence to both primary and Secondary sources of data which included field work and content analysis of policy documents employed especially maternal records and the advantage of using existing data is that cost and time are reduced when data from previous studies are readily available (Mouton, 2001).

The case study research approach draws from various sources of information and allows the researcher to use a combination or multiple methods of data sources such as interview questions observational data and analysis of documents to get an in-depth understanding of the phenomenon. A case study design is necessary in this study focusing on selected Guruve villages. Robert, (2003) states a case study as an in-depth study of a particular research problem rather than a sweeping statistical survey. The research findings are presented as a case where strong arguments are presented in support of conclusions. A phenomenological perspective was also used to study human experiences about maternal health care issues faced by communities.

An advantage of qualitative research is that it is an effective model that occurs in a natural setting. Hence the subject is observed or studied in a completely natural and unchanged natural environment thus the community gets to be interviewed within their physical, social and economic natural environment (Kemmis, 1980). The use of quantitative research methods supports hypothesis and help reduce bias during collection and data analysis. It gives results which are valid and reliable hence can be generalised to a larger population.

2.13 Population and Sampling

The study was conducted in Guruve district, specifically ward 7 (Shinje) and ward 17 (Gota). These wards were selected as they are in different rural regions across the Guruve District Centre and their proximity to the town justify the need to explore. Guruve district is dominated by the local Shona people. According to the 2012 Zimbabwe population statistics, the total population is 124,041 with three quarters of the population residing in the rural part of Guruve. The demographic data of Shinje 2019 states that the female population in Shinje (Ward 7) is 4 321 and (Gota ward 17) is 2 518. WOCBA at 22% of the population which is 1 504 and the wards constitutes

of 272 households. Among all the 24 wards of Guruve, Shinje and Gota district were purposively sampled for the study. The researcher selected the villages and identified them as a sampling unit since purposive sampling was employed with help from the rural district council located in Shinje and the questionnaires were distributed for data collection. Simple random sampling was used selecting households for questionnaire distribution. The researcher wrote down numbers from 01 to 272 on a plain paper creating a random number table and cancelled digits two by two. The first two digits was the household which was to receive a questionnaire and the table gave a total of 67 homes.

Table 2 Further Population Sampling Figures:

Female	**6839**
WOCBA	**1504**
Expected pregnancies	**574**

Source: Guruve clinics demographic data 2019

The sample size was derived from the random sampling table and 45 percent of the sample size received questionnaires for data collection and 10 in-depth interviews. The researcher stopped at10 in-depth interviews to avoid data saturation as more interviews start producing the same responses hence a small sample.

2.14 Data Collection Instruments

Data collection is a series of interrelated activities aimed at gathering information to answer research questions. It involves locating the site or individual(s) to the study, gaining access and establishing rapport so that participants are willing to provide

information, determine the strategy for purposeful sampling of the site or individual(s), and determining the rationale for the selected site or individual(s) (Pawar, 2004). In this research study, the researcher focused on one-on-one interviews guides, questionnaires were used as the instrument of data collection as well as observation to collect data. In-depth interviews were conducted for local authorities and NGOs whilst questionnaires were done for the individuals (villagers) using the simple random sampling method.

2.14.1 **In-depth Interviews**

A total of 10 participants were sampled and in each ward only 4 were sampled due to the geographical space and costs involved in conducting a study. According h to Patton (1990) the purpose of interviews is to find out what is in someone's mind and to depict the respondent's perceptions and experiences about a phenomenon under study. An in-depth interview guide was designed in line with the qualitative and quantitative approach which was used in this study for the local authorities and one for the organisations. The interview guides were written in English and whenever an explanation was needed the researcher would be able to elaborate. The interview guides had seven questions drawn from the objectives of this study. The questions included all the issues on access to maternal health for women in rural communities of Guruve districts chosen wards. Items in these interview guides to all have open ended questions to ensure gathering of diverse information. The use of mixed methods of data collection is to be able to do triangulation so that the findings can be transferable to another population of study and results can be generalizable in another research population.

2.15 Pilot Study

A total of 10 questionnaires were administered during the pilot study. After the pilot survey the questionnaires are amended by deleting repetitions and clarifying some questions which are vague, dropped irrelevant questions and then refining the questionnaire in line with the respondents understanding of issues. The pilot study was done using systematic sampling method where the researcher distributed 10 questionnaires after every third house from Shinge Primary School.

2.16 Data Collection Procedure

The authority to undertake a research study will be granted by the CBPLG at Africa University, hence the researcher to undertake the research which is processed through an application for initial review to the Africa University Research Ethics Committee (AUREC) as well as the consent guide. As part of the research process, the researcher came up with 3 data collecting instruments which are relevant to the mixed research approach. The instruments include Questionnaire guide for individuals (villagers) and the in-depth interview guide, for local authorities. Secondary data sources will also be used by the researcher accessing them from published documents on Maternal Health care in Zimbabwe.

2.17 Analysis and Organization of Data

Data collected was analysed and presented using both the transcription of data and thematic analysis of data. The information obtained from the in-depth interviews and questionnaires was also presented using graphs and charts for an effective data presentation and analysis. Also collecting data proceedings for the in-depth interviews was recorded to ensure no data loss. The data recorded collected was transcribed soon after the discussion in order to establish a permanent written record of the interview and to serve as a basis for further analysis.

2.17.1 **Thematic analysis**

Themes emerging from the questionnaires and in-depth interviews were analysed and presented so as to establish recommendations required. According to Guest (2012), thematic analysis uses coding which is the primary process for developing themes within raw data by recognizing important moments in the data and encoding it prior to interpretation. The data was put into different categories or themes depending on its nature to analyse questionnaires.

2.17.2 **Quantitative analysis**

Quantitative techniques such as graphs and charts were used to present data. These are the ordinary, categorization, manipulation and summarization of data to obtain answers of the research questions (Zianal, 2007). Quantitative data collected from questionnaires was also entered using the computer analyzing tools in Microsoft as Zianal (2007) stated that microsoft office excel has numerous tools such as charts and graphs that enhance data presentation. The researcher therefore made use of both graphs and charts which are important tools in presenting the data collected.

2.17.3 **Secondary Sources**

A review of literature relevant to the issue of the right to maternal health was undertaken to obtain secondary data. This helps the researcher to understand, among other issues national and international legislation and background information on maternal health issues. Journal articles, books, internet sources, newspaper articles, and Government publications on legislations such as the constitution, Patient's Act, the Health policy act and the Defence Act (Act No. 42 of 2002) and the Child Care Act (1983) also considered.

2.18 Ethical considerations

The researcher realised the sensitive and evasive nature of the topic and problem under study to be observed the ethical obligation to first seek informed consent and assent from respondents and to seek authority from those with authority to allow the researcher to undertake the study. Consent forms were signed by all who participated in this study and no form of coercion was used to gain access to information from the subjects. The researcher disclosed their identity to the participants and explained the purpose and importance of the study as well as providing the participants with all the factual information, risks, and benefits and ensures that the participants were participating voluntarily and are encouraged to open up as they are aware of the motivation of the research. All forms of protocol were observed including a clearance from the University and consent letter before conducting interviews. The research protocol was based on a number of key principles related to ethics and protection. In order to give the respondents an opportunity to express themselves freely, research methods that they feel most comfortable with were used.

2.19 Summary

This chapter looked at the research design that is the descriptive which was used in this research. Simple random sampling defines the size of population using the random table to that every household had a chance to be selected. The qualitative research method, questionnaires, in collecting data for this research was also outlined. The pilot study in the research used stratified sampling and 10 questionnaires were distributed. Research ethics were also incorporated during data collection. As such the researcher was able to collect data needed in this research for analysis.

CHAPTER 4 DATA PRESENTATION, ANALYSIS AND INTERPRETATION

2.20 Introduction

This chapter describes the research results and it looks at the key findings, presentation and analysis on the access to maternal health for women in rural communities in Guruve district. The results describe what is found in the community at personal, household and community level from the data gathered from the respondents. The factors were being highlighted in the chapter. Data from interviews, questionnaires, and secondary sources was presented in line with research objectives and research questions. The information collected is illustrated and displayed in tables, graphs, pie charts and using Microsoft Excel application. The data will be presented according to economic, social factors following the objectives that guided the study.

Table 3 wards that have health facilities/ services

Wards	**Name Of Clinic/ Health Centre**	**Council/Government**
One	Camusasa	Council
Two	Nyamupfuta	Council
Three	Nyakapupu	Council
Four	Matsvitsi	Council
Six	Guruve Clinic	Government
Seven	Shinje	Government
Eight	Chipuriro	Council
Nine	Mugarakamwe	Council
Eleven	Nyamhondoro	Government
Twelve	Bepura	Council
Thirteen	Brandon	Council

Fourteen	Birkdale	Council
Sixteen	Bvochora	Government
Seventeen	Gota	Council
Eighteen	Kachuta	Council
Nineteen	Negomo	Government
Twenty	Bakasa	Council
Twenty-two	Ruyamuro	Council
Twenty-three	Kemutamba	Council

The table above summarizes wards that have health facilities/ services. Council clinics are very small primary health care centres which do not have all the scientifically required equipment but offer general assistance in health care services. Guruve district has more council clinics than government clinics. This shows the effort of the country to provide for basic health services in rural areas even though these do not fulfil the National Health Strategy priority of health care centres on every 8km radius.

2.21 Data Presentation and Analysis

The contribution of lack of infrastructure, poor service delivery and long distances to the right to maternal health is very significant in rural areas as compared to that of urban areas because many live near health centres and the availability of hospitals in terms of ratio is not undervalued to that in rural areas, while communities bear the social cost and are still in a worse of positions as they were before the introduction of MDGs and SDGs. The data presentation will base on the objectives of the study and work to establish the type of maternity services available at rural government hospitals and the primary health care centres such as clinics. The data obtained in the Shinje district on the right to maternal health for women is presented in tables, charts and figures show on the following discussions below.

2.21.1 **Questionnaire Response Rate**

The response rate of participants was very high as the researcher administered the questionnaires to women themselves; who gave birth, and child bearing age with the help of the Rural District Council of Guruve which gave the formal letter of permission to conduct a research in the district hence the high response rate. The response rate alone shows how communities are willing to see the change on issues of maternal health and all health services that can be offered.

Table 4 response rate

	Targeted Respondents	**Actual Respondents**	**Percentage %**
Questionnaire	67	65	97
Interview guide	10	10	100
Total	77	75	97

2.21.1.1 Demographic Characteristics of the Respondents

The questionnaires for research focused on women and willing husbands would answer a few questions in relation to maternal healthcare issues and how accessing it is a challenge in the area. Age of targeted respondents was the WOCBA in the wards. The diagram below shows the majority of age respondents were 18 to 35 years and 18 years and below mothers also exist which shows still exist in Zimbabwean communities. The rate is higher in Shinje which is common because the ward is close to the growth point and believed to be better than other wards and there are the existence child marriages in the other ward hence the young population is not in school but at home heading families. Lack of maternal health knowledge by the young population has been noted among the causes of maternal mortality in rural areas. The

researcher discovered that youngest parents have lost a child before during child delivery or before the age of five years.

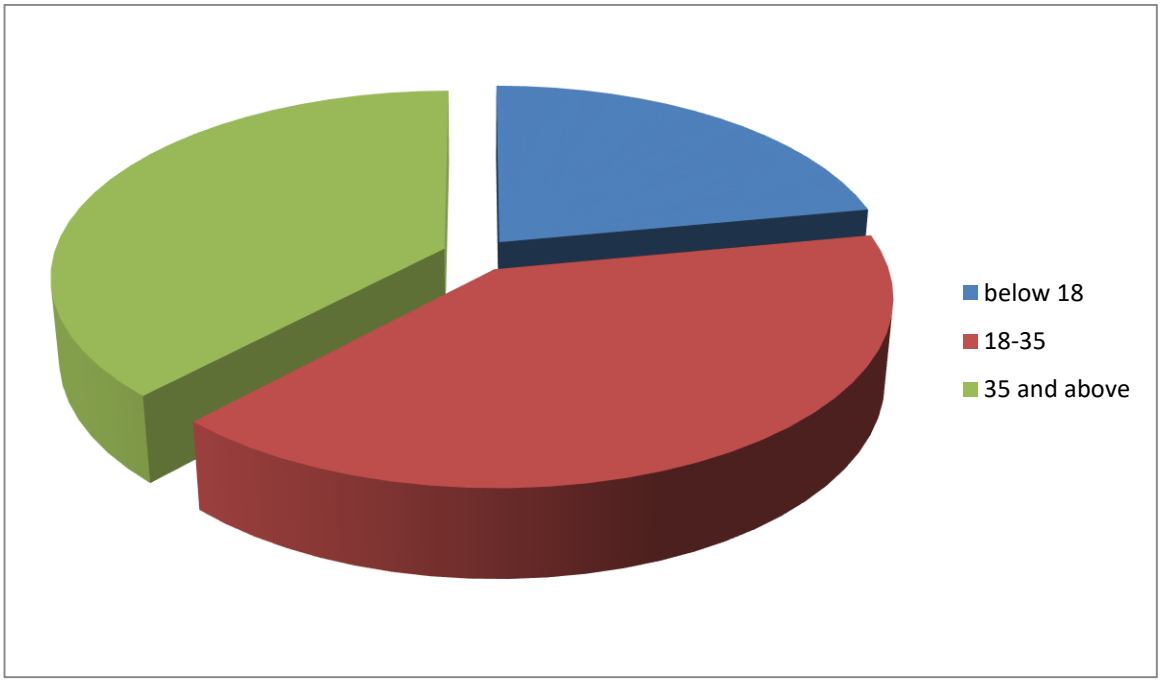


Figure 3age of respondents

Above is the age of respondents shown in percentages starting with 18 years and below. Maternal life for many in rural areas starts at a tender age of 15 years. 22% is a red flag on the gauge for children under the age of 18 which the Zimbabwean constitution defines as minors, to be experiencing early intimacy. This indicates that there is no enough training on family planning and diseases as children are engaging to sexual activities and child marriages are still plays a major role on child mortality. According to Simkhada (2008), bad experiences of early or multiple pregnancies causes negative social, educational and economic outcomes in later life because of unsafe sex or inadequate spacing pregnancies hence issues of maternal mortality remain affected. Majority of respondents is the age of consent thus 18 years and above which stands at 40% of the questionnaire respondents.18 years to 35 years is a

common age for a lot of homes in Guruve communities known as the youths. This is the age that has knowledge about the availability of services in clinics around the area and whether there is also the availability of trained staff in those primary care centres. They know failure to access to maternal health means they resort to other copying mechanisms which is different from young mothers hence mortality remains high. The researcher further learnt that the tender age is from the religious sects where there is a belief of bearing many children for their husband hence the higher the number of children with no proper access to health the higher the risks of mother and child loss.

Above 35 years is another age group that exist in the WOCBA and according to the questionnaire responses 38% of women are 35 years and above. Most in this age group experienced their maternal lives earlier than the rest. One response highlighted that when she gave birth to her first child back in 1993 there was only one clinic which is the now Guruve General Hospital. Transport was rare that they had to walk to the Guruve – Mvurwi highway road. There was also Chitsungo Mission hospital which was not as developed back then. Comments from the 35 and above age group where that the current generation is lucky that there are clinics per every ward where they can access primary health care services. The lowest child bearing age is a concern alone on ways to curb maternal mortality rates in rural areas as young girls are likely to face challenges giving birth hence maternal deaths remain a challenge.

2.21.1.2 Education level

The highest level of education reached by 65% of the respondents from Guruve district is secondary education. This could mean that the community faced challenges accessing education which led to 65% reaching secondary level either seating for Ordinary levels or as dropouts who failed complete their education due to lack of funds and distance to the nearest schools. A small percentage of 17 is represented by some

who managed to walk to the growth point for their tertiary education. The issue of education alone shows that the distribution of services in rural areas did not focus on reaching the population masses same with health care centres hence the violation of human rights both on education and health. 18% of the respondents did not attend school as a result the researcher came across three child headed families exists and survived by working in farms to support the family as one respondent highlighted that she is the oldest and they lost their mother when she was five stayed with uncles until they migrated to the city and never came back. She started working at the age of thirteen to take care of her siblings ended up becoming a parent at a very tender age. the access to health care and education is lagging behind in rural areas hence failure to access education leads to marriages as in ward 7 the respondent of the interview highlighted that there is an expectation of 22% of pregnant women. The more women with no educational activities the higher the birth rates hence pressure on the available primary health care centres. Shinje and Gota clinics have a catchment area of five wards versus the infrastructure of the clinic shows that rural primary health centres lack in providing good services because of the population stress that the community exerted on them.

2.21.1.3 Employment status

The occupation status obtained at the ward shows that there is high unemployment rate with 69 percent of women responding to the questionnaires as not employed. They stay at home whilst their husband work at the nearest farms identified as Chingoma fishing farm. The government cancelled the issue of user fee for people in rural areas where they are able to access maternal health for free. Hence the issue of unemployment is not a challenge when accessing primary health care services. However, it has become an issue of lack of enough funds to travel to the nearest clinic

and to pay rentals to those who offer accommodation near clinics. Poor living conditions are experienced in the district hence it is cheaper to settle for the available health care services despite lack of proper equipment, poor service delivery and lack of midwifery help.

The ICESCR committee gave a general comment on the issues of the right to maternal health care stating that it must be economically accessible which effectively means that women should afford economically to be able to exercise their right to maternal health. This is hindered in this district where almost three quarters of the population is depended upon one salary which is not enough to provide for the whole family therefore these economic constraints have become the reason there is failure for women to exercise their right. The rural communities are generally poor with women having to raise funds through gardening and one stated that they go to Siyalima farm and pick rejected fish which they dry for resale. The women in these communities are even poorer compared to male counter parts hence do not even afford seeking better services at Chitsungo Mission hospital where the services cost as little as RTGS$ 12 for normal deliveries.

2.21.2 **Challenges to access health care faced by pregnant women in Guruve District**

Findings of this study revealed that the reason why women's access to maternal health in rural areas continues occurring in Guruve District is due to lack of sufficient health facilities in the district. Most participants agreed that indeed there are no sufficient health facilities and this had led to travelling for hours to get to the nearest clinic within the district. The consensus was that mode of transport is the reason behind the difficulties in accessing the clinic hence community births without the help of professionals. From the research findings, access to maternal health care in rural areas is mainly violated by distance which was travelled. As a result, mothers mainly rely

on traditional midwifery which they highlighted still need a scotch cart for one to get help. Questionnaire responses from questionnaires clearly indicated the issue of the local distance, noting it is the main issue on that result to violation on the rights to health as according to the constitution.

Various discussions highlighted the distance issue as contradictory to that which the Zimbabwean government signed to when it became a signatory to the ICESCR. Distance is among the factor that shows the rate that Zimbabwe remains lagging on issues of the realisation of right to maternal health care services in rural areas. The National Health Strategy (NHS) of 2009-2013 provides in its RHP that Zimbabwe has established clinics which will be in every 10km radius. Although it is provided, the discussions dispute the fact as 46% of the respondents from the wards are from a 10km and above radius from the nearest clinic. In the RHP of the 2013 health strategy it is discussed that clinics will be available in every 10km radius and in also within the radius of 8km, hence these provisions remain the paper tiger discussions. Women in rural areas still have to walk long distances despite the proposed distance of 10 km radius by the NHS to the nearest clinic. Below is a narration of distance to the nearest health care centre

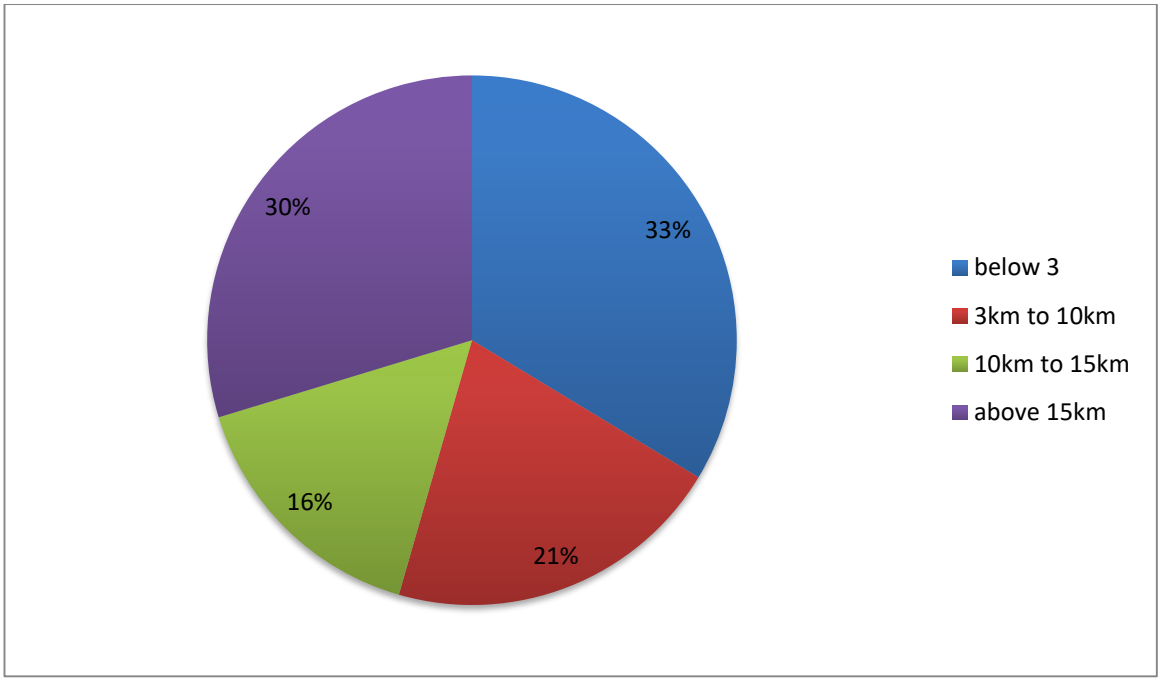


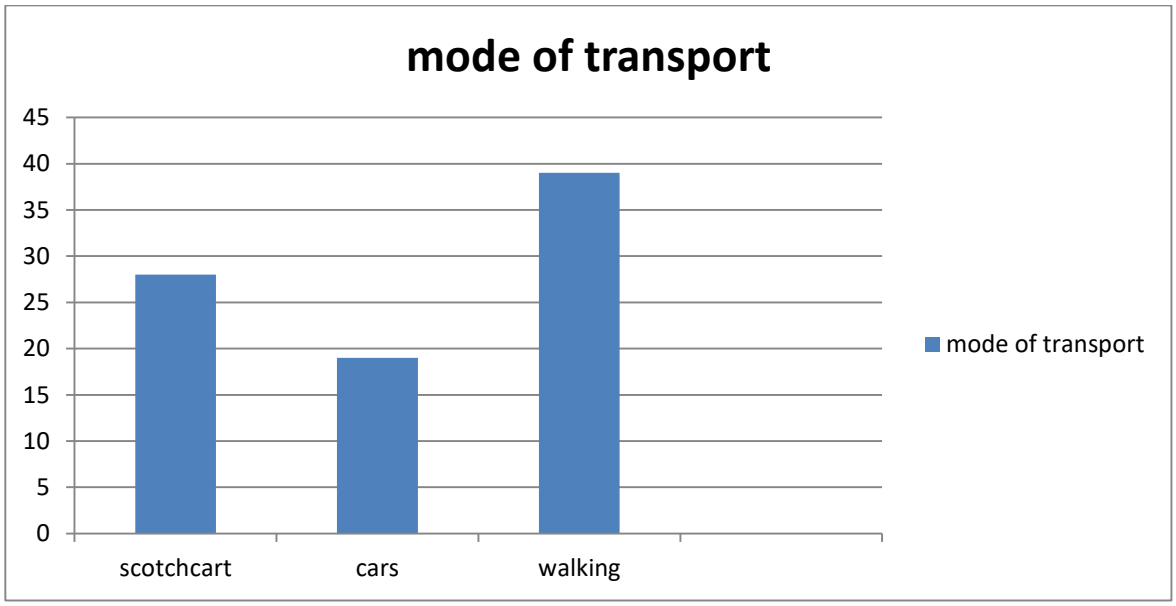
Figure 45 Distance travelled

Participants as they responded to the distance question of how people travel from various homes and went to seek health assistance where there is one small clinic that covers at least 5 villages and one clinic per ward at most. 34% of the population walk short distance to the clinics and these are from village number one, number three and five. Villages are not in order they are scattered with village number one far away from village number two and the rest of the catchment are walking more than 3km.Most rural areas are the areas that the discussants pointed out to be the hotspots of maternal mortality and that lead to high deaths at birth. One mother interviewed noted that she once lost a child on the way to the hospital as she had to walk 17 km from village number 13 in Magwenya to Shinje clinic which if they had mothers' shelters it would have saved her child.

It was learnt from the questionnaire interviews that the main issue in rural areas such as Guruve rural is the mode of transport. The questionnaire probed to get information

pertaining the nearest health facility and 40 percent response highlighted that they walk to the nearest clinic the reason being unable to afford transport costs which range from RTGS$5 and for local people who are not employed it is likely not to afford and resort to easy way which is walking. From the research conducted evidence came up that indeed mode of transport has been causing many community births within the District of Guruve hence this shows how the country is lagging behind towards the realisation of the right to maternal health with those intended beneficiaries still facing distance problem to access it.

Table 5



This is similar with other rural areas in Zimbabwe such as Beitbridge rural areas where they relying on one Clinic that is located in Lutumba Growth point. The discussion still remains that access of health services in most rural areas is still a challenge that need to be taken into consideration when focusing on issues of mortality rates in Zimbabwe. The car percentage is for those who afford to pay RTGS $5 of public transport. One discussant from Ruvinga indicated that there is one car which is used by the community but with the current situation of fuel shortages, it might not always

be available. The simple mode is cart free and affordable. However, this mode of transport is slow and chances are giving birth without supervision.

2.21.2.1 The consequences of lack maternal health care services on women

The research conducted has highlighted many challenges women face during maternal periods. The district consists of 19 clinics in all the 24 wards with most clinics located at the growth point and the rest scattered in rural areas. According to Shinje Clinic Demographic Data 2019, the population of women of child bearing age (WOCBA) is 22 percent in total with 4.2 percent expected the clinic hence challenges they face include lack of proper medical assistance, mothers' shelters, and lack of stable income. One female respondent aged 33 mentioned that this is a government clinic put in place by the government for the communities to have access to health facilities but there are no doctors at the centre. Complications are forwarded to the only general hospital which is in Guruve growth point.

From this standpoint, the researcher found that with what the discussants said, it contradicts with the Patients' charter, as well as international human rights laws on provision of overseeing that healthcare was to be catered for the citizens. Most women from all age groups highlighted they get better assistance from *ana mbuya nyamukata* which is vernacular for midwife in Zimbabwe. In each age group there is a total of 15 percent still accessing help from midwives. The masowe denomination consists of the young population mothers as well who do not access medical services as according to their religious beliefs. Lack of transport upon admission for referral purposes to major public hospitals contributes to inaccessibility of maternal health services (Mutseyekwa, 2010).

Table 6 Place of birth

Women	No. of children	G.Hospital	Clinic	Traditional midwife
One	Five	0	2	3
Two	Two	0	1	1
Three	Two	2	0	0
Four	Three	1	0	2
Five	Six	0	4	2
Six	Five	2	3	0
Seven	Four	1	3	0
Eight	Three	3	0	0
Nine	Seven	2	4	1
Ten	Three	0	2	0
Eleven	One	1	0	0
Twelve	Three	0	2	1
Thirteen	Five	3	1	1
Fourteen	Five	0	5	0
Fifteen	Three	0	3	0
Sixteen	One	0	0	1
Seventeen	Four	0	3	1
Eighteen	Six	2	4	0
Nineteen	Two	1	0	0
Twenty	Four	0	4	0
Twenty one	Two	0	0	2

Twenty two	Three	3	0	0
Twenty three	Five	0	5	0
Twenty four	Three	1	1	1
Twenty five	Five	0	5	0
Twenty six	Three	2	0	1

As evidenced in the table, the access to maternal health is expressed from the discussion that most women in rural Guruve have had child bearing at home due to failure of walking long distances to gain access the nearest clinic. The portion captured about half the responses of similar experiences. The maternal health care facilities in rural areas and services are still not accessible which is affecting the intended beneficiaries. It was further learnt from an interview with one midwife that these clinics receive children born at home and record them as clinic birth yet they had already received temporary assistance. The interviewee noted that these clinics will still manipulate data as a way to elaborate clause in Zimbabwe's Constitution on the human rights clarity and properly defined mandate yet it is not put in practice hence still lacking on the realisation of this healthcare right.

Moreover, the findings of the study established that policy implementation in Zimbabwe government is of great concern. From the research clear evidence on the challenge of policy implementation in Zimbabwe was seen as it does not match the one on paper of every 10km radius and in the National Health Strategy (NHS) (2009-2013) that there will be a clinic within 8km radius. The proper functioning of clinics as an important institution for the rural areas, clinics would have prioritised mothers' shelters as well as ambulances available for emergencies. The participants gave a clear

insight and indicated how the issues of home births were less prioritised considering the complications associated with it.

It was further noted that the case with *ana mbuya nyamukata,* does not always refer to the traditional help but in many cases there is no assistance at all. One female respondent stated that there was one time when she had to help a neighbour though an older woman came during the process that then did the rest since she did not have enough knowledge about delivering a child. This is the result of long distances and lack of transport to the nearest hospital or health care services. Mortality rates remain high in rural areas as explained by many. Mothers still lose their children during the process whether in the hospital or at home.

Furthermore, the research findings above highlight the possibilities of women getting assistance from all possible available options which are the general hospital, the clinic and traditional means. The reason as highlighted by another respondent was that she was told her delivery is a C- section and was transferred to the general hospital where she still did the normal delivery and her second child was born at the local clinic. She still used the traditional means of giving birth by coincidence as explained her water broke early she delivered at home with traditional assistance and was then taken to the clinic for further assistance. A few cases were by choice to the traditional midwives as the community believes they offer better services compared to the attitude they get from professional health care givers hence their right to access health care services is hindered.

From the discussions above there are some women who decided to stick to accessing maternal health care services from the clinic. The reason was distance to the clinic where they are located at the below 3km zone. Despite other factors such as distance

and infrastructure affecting the whole ward they are among the few intended beneficiaries to access health care services. This supports the idea that although primary health facilities are situated far from the intended receivers, there are women who have access to health care facilities in rural areas.

In addition, from the participants and the discussants in the study it was learnt that there are some women who never access maternal health care services from the general hospital which is meant to have better services than the primary health care centres. The hospital has doctors, mid wives and maternity wards. Delivering at the general hospital or having antenatal appointments comes with appropriate care for women needs. Therefore, every woman is entitled to all the appropriate services which in rural areas is hindered by lack of sources of income and distance to the hospital hence resorting to primary health care services and other copying mechanisms.

The research findings show that access to maternal health care in rural areas remain an issue that has women seeking copying mechanisms. Traditional midwives are still training future midwives passing knowledge to the younger generation since there is no hope that primary health care services in Zimbabwe will reach the grass roots. The fact that even today they are women facing challenges accessing health care shows that Zimbabwe has not achieved the right to maternal health realisation and the right to health in general.

Key informants interview sessions provided somewhat similar responses as those gathered from questionnaires and that there was a great need to understand lack of healthcare access within a group dynamic. Respondents emphasized that women are deprived of access to maternal health care due to economic factors as well as lack of

proper facilities to accommodate maternal mothers in these local primary health care centers.

2.21.2.2 Strategies that can be used to improve women's access to maternal health

The study found that since MDGs, the government has made efforts to improve the health care and delivery system though setting up the Health Transition Fund (HTF) in 2011 with the governments of Canada, UK, Ireland, Sweden and United Nations and European Union partner agencies. Despite the efforts, little progress was made in promoting maternal health care and having favourable clinic conditions in rural areas. Asprovided in the Public Health Act Chapter 15 which state that the Health Service Board shall appoint officers for every district together with the district health officer who shall constitute the District Health Executive.

Little progress by the government on appointing these officers was reflected in the findings from the discussants of the villagers from the questionnaires where most participants of the 53 out of 65questionnaires conducted noted on whether they knew of these district health officers besides the SRGN who is always in charge one respondent noted. Campaigns are important strategies to be introduced to help discuss the issues of access to maternal health. Findings of this research revealed that Civil Society Organisations (CSOs) in Zimbabwe and municipalities have grasped opportunities for promoting maternal health and health in general better than the government in rural areas. These CSOs have shown much willingness to address issues of maternal health care within communities. Research findings brought to light that participants were well versed with the role of CSOs such as Zvandiri AFRICAID, Women of Zimbabwe Arise, Global Fund and Enterprise. Most CSOs are bridging the gap between state-led national programmes which take too long to reach grassroots people and seem to involve people in urban areas than rural areas. Therefore, the

government must work together with CSOs in order to improve the right to maternal health care in the country.

Establishing mobile clinics that visit places where *ana mbuya nyamukata* attend pregnant women as one lady suggested. This could play a vital role as these *ana mbuya* do not have proper equipment for helping pregnant women. One midwife stated that:

In as much my services are for free I expose myself to possible health hazards and the consistent in coming for help increase so have to deal with their pressing needs such as food and shelter (6 May 2019).

From the participants and the discussants in the study it was learnt that mobile hospital initiatives were necessary, because in some cases people are still relying on midwifery services which is not as consistent as hospital services. The research indicated the idea as to give communities better facilities as well as service delivery to those who are far from these facilities. It is of importance to highlight that the majority of respondents alluded to the fact *ana mbuya nyamukata* play an important role of helping with maternal assistance in the community hence there is need for assistance which must be applied by relevant authorities such as ensuring they get gloves as well as sterilized razors and needles as well as training.

One participant highlighted that we cannot denounce traditional midwives' duties as they assist those who fail afford to get to the nearest hospital or clinic hence strategies to assist them on bettering the services they give to reduce deaths during and after birth. The researcher then went on to carry out key informant interviews and it is from the interviews carried out that these clinics have local organisations such as UNICEF, Global Fund whose focus is on HIV/ AIDS patients neglecting improving the quality of health for maternal women at community level. It is alleged that women face several

challenges while in the midst of accessing help during or just after delivery from the *Mbuya Nyamukata* due to excessive bleeding as well as infections hence it is necessary to embrace the duty they perform by educating them about these infections and failures so that they advance to being able to deal with complications. The involvement of traditional midwives might play an important role curbing maternal mortality as noted above that in every five women at least two have had a child delivered outside professional health care. From the participants and discussants in the study it was learnt that child loss outside professional health care in Zimbabwe has left psychological scars on mothers so much that it has become more than necessary for the organisations and government to provide health care services in order to meet these challenges such as child or mother loss.

2.22 Interpretation

2.22.1 Involvement of all Structures of the Society

Many views were raised in the study on the access to maternal health for women in Zimbabwean rural areas. Further diverse views were suggested on how the government could achieve more effective outcomes so as to impact on all structures of the society such as the midwives, *chitsidzo* which is commonly practiced by the Johanne Marange apostolic sect. The views when compared with other studies that have been done concerning involvement of all structures of society showed corresponding evidence. The government must address the issue of maternal health on issues of the political economy perspective and how they tackle it on considering all structures of society on rural access to maternal health and rights violation on health care.

From what was noted by a few respondents on involvement of all structures, it concurs with what Lederach (2003) proposed in his multi-track approach to peacebuilding. This is clear evidence that these government and council clinics are failing to work with the communities on achieving the quality of health and accessibility to further areas such as Nyamondo and Ruvinga.Furthermore the involvement of the four pillars of maternal and child care which are Family Planning, Antenatal Care, Clean and Safe Delivery for the mother and the new-born, and Essential Obstetric Care (Zimbabwe, 2007:13) enhances the right to health and healthcare in Zimbabwe must be taken to far more remote areas and different levels of society so as to make sure it is the health which the government joined the conventions and signed treaties.

2.22.2 **Economic Development**

The crisis in Zimbabwe has worsened the vulnerable situation of pregnant women, lack of basic medication and levels of unemployment in Zimbabwe hence most people in rural areas resort to traditional medicine. According to Zhangazha (2010) when the Global Political Agreement (GPA) was signed the country was facing an economic meltdown, collapsing health sector as well as shortage of basic commodities. Moreover, medical facilities are free for people in rural areas but not available hence maternal women buy herbal medicines which disadvantage those who do not afford to purchase the needed herbal medication. Financial constrains have also affected how clinics works. In this Guruve research, it is argued that though the government initiated free services in promoting access to health care there is still need to have the services in the hospitals and clinics which are currently not offering quality services and other ancillary services which become expensive for the unemployed women.

The 2007 -2008 economic crisis led to the budget deficit especially in the health sector which had a huge impact on public health services and resulted on the not so smooth

functioning of health facilities. Zimbabwe is still recovering from these difficulties then the continued economic recession of 2017-2019hence its hospitals and clinics lack the important equipment and medical supplies. This has led to a low grade of efficient medical services and the migration of health workers. Following the 2008 economic decline was the shift from United States Dollars to the Zimbabwean Dollars known as the RTGS$ which came with a towering rate that had pharmaceuticals selling medication on United States Dollars worsening the situation for citizens who get paid in Zimbabwean RTGS and has caused strikes which weakened the health management and health sector.

2.22.3 **Unsafe means of Delivery**

Women in rural areas tend to resort to copying mechanisms which are unsafe and capable of complicating the baby or the mother during birth. Most of these mechanisms are unhygienic and this become a challenge especially HIV related births which most cases the disease is transmitted to the child during birth once it is not performed correctly. As highlighted these community midwives do not have proper tools and equipment hence the intensity they use the same unsterilized equipment is very high. This goes against the programmes that were initiated on the Prevention from Parent to Child Transmission (PPTCT) which is done in hospitals and clinics using medicines that are meant for the process which reduces the rate of HIV infection and curbs maternal mortality.

Failure to access professional assistance of formal maternity health care, turn mothers to seek other alternative means which is capable of leaving children exposed to diseases that are life threatening hence do not always work. Mothers' health is also exposed to diseases such as diarrhoea, cervical cancer and navel and stomach infections. Parent to child transmission is another risk that is associated with copying

mechanisms endangering the life of the baby to the deadly HIV/AIDS virus and tetanus for both the mother and the new-born child. Women consider unsafe means of delivery an effective way to deal with issues of distance and lack of accessible health care centres. Although it plays that vital role of problem saved, the process comes with consequences as it is risky to the life of both the parent and the child.

2.23 Service Delivery

The Civil Society Organisations have managed to engage rural clinics so as to deliver good and quality services. Access to good quality delivery care is a priority in the reduction of maternal mortality (Lohela, Campbell &Gabrishy 2012). Organisations such as AFRICAID have mentors in most districts in Zimbabwe who help in bettering services that are offered at the clinic. In Guruve District clinics poor service delivery is the order of the day with Shinje clinic getting a high better ranking of 5 out of 10 by the communities compared to other clinics such as Matsvitsi council clinic which is another alternative for other villagers from wards seven, eight and eleven but far from their local homesteads. Poor service accessibility, delay in seeking care and substandard care factors in health institutions were identified as factors responsible for low use of public health institutions and high maternal mortality (Stekelenburg, Kyanaminas, Mukelebai, Wolffers&Van Roosmalen, 2004).

They also have infrastructure under construction which the villagers were told it will be the maternity ward and mother shelters. This therefore shows that without mother's shelters the ratio of home deliveries versus hospital deliveries will be more hence can be used measuring service delivery in rural areas. Once there is a prevailing factor on the failure to access maternal health services there is a high chance of women resorting to coping mechanisms such as back door services with less supervision.

Zimbabwe has a severe shortage of midwives, a problem likely to persist as too few are being trained (Cummings, et al 2011). Rural clinics are usually staffed with trainee nurses who are still on the verge of gaining midwifery skills and the SRGN in charge. This hinders the right to access health care which is defined by proper health facilities and appropriate medical facilities and forces the healthcare provisions to remain stagnant with rural areas still experiencing high mortality rates and maternal mortality. The broken health care system in Zimbabwe needs more than just introspective reflection but genuine commitment to change.

2.23.1 **Consequences of poor service delivery**

The inadequacy of health facilities in rural areas and lack of scientifically appropriate equipment in Zimbabwe has resulted in many complications associated with pregnant women travelling distances to access healthcare at the nearest clinic. Giving birth on the way to the without proper midwife assistance is common in the district. Many lives are lost during the process of giving birth were its either the mother or the child as a result of risks they face during pregnancy. Pregnant women have some risks of problems they face in every pregnancy which is because of their health conditions before they were and some develop during pregnancy. HIV/ AIDS, High Blood Pressure and kidney problems are some of the risks faced. There are some problems that are caused by carrying more than one child, being over age 35 and by the drugs one used at the previous pregnancy which can affect the health of both mother and unborn child. Good prenatal care is needed to help detect and treat these conditions to avoid maternal mortality. Hence the government of Zimbabwe can curb these challenges by fulfilling Section 17 of the Zimbabwean constitution which states the right to health care and how it is the government's obligation to make sure Zimbabwean citizens and permanent residents have the right to access basic health

care and reproductive health care services. Hence there is lack of political will as it is possible for the government through local authorities to help reduce birth complications and miscarriages.

2.23.2 **Mission Hospital Services versus Government Hospital Services**

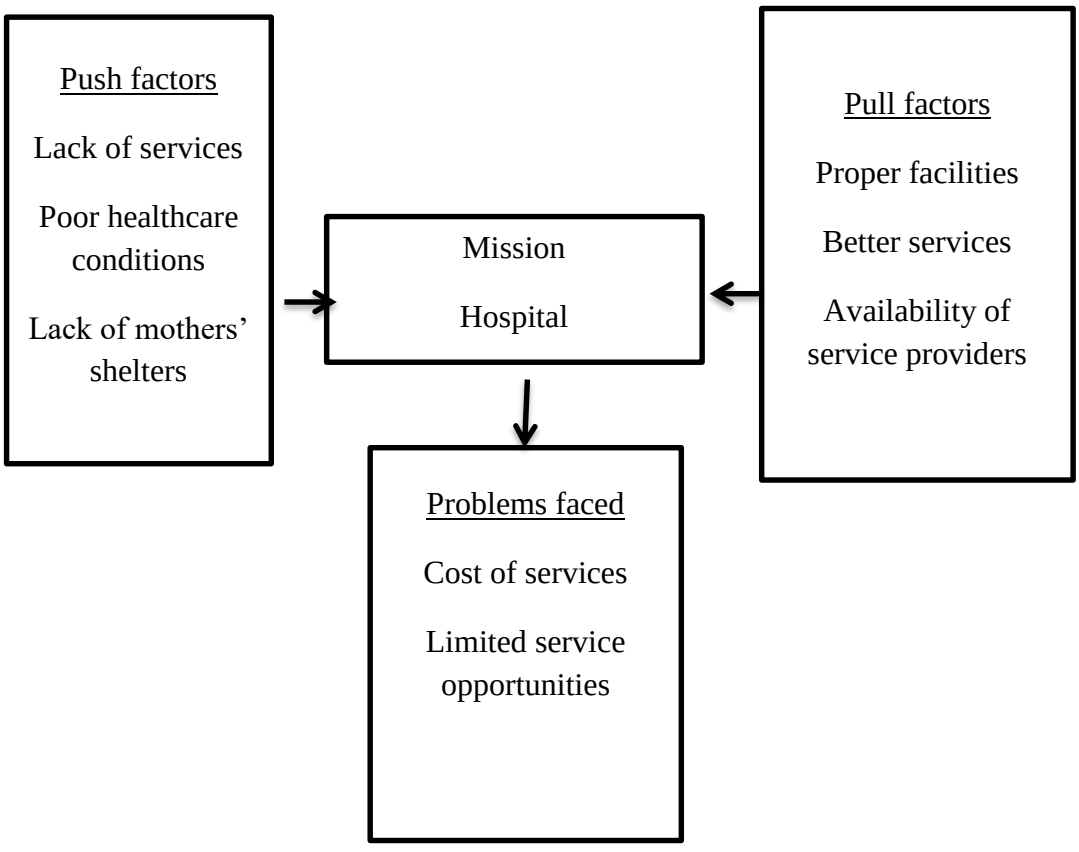
Mission hospitals and clinics are a preference in rural areas and contribute 68% health care delivery in rural areas and 38% nationally in Zimbabwe (ZACH, 2016). As stated above many are located in remote areas to provide services to marginalized and underserved communities. The NHS 2016-2020 sates that in Zimbabwe 14% of health facilities are located in Urban Areas while 86% is located in rural areas. Considering the budget of $ 520 million for the financial year of 2018, health care delivery system in Zimbabwe rural clinics is still indispensable.

Health care service delivery in mission hospitals has had a general perception which states that it is far better with medication readily available in mission hospitals than government hospitals. Most church mission facilities value and promote compassionate services (Gill &Carlough, 2008). They further claim that church mission hospitals have the advantage of more resources and greater access to expatriate staff, especially for training, and more flexibility in hiring and managing staff and in procuring medicines and supplies. Residents in Guruve rural confirmed those patients who are very sick prefer to be taken to Chitsungo Mission hospital than the Guruve growth point General Hospital the reason being the belief that mission hospitals have highly skilled personnel and are well resources. Chitsungo Mission Hospital offer better services than the healthcare centres and has the availability of nurses and student nurses. Despite the availability of good health care services, the Mission hospital is not easily accessible for many communities. Services are not for

free ranging from RTGS$ 7 for admissions which resident may not afford as many rely on farming and are not employed.

Furthermore, many sources highlight the important role played by mission hospitals in Zimbabwe's health care delivery systems with services which include outpatient departments, admission wards, maternity services, family and child health clinic to mention only a few. In Guruve most people favour the use of church mission hospitals as compared to government hospitals as according to the research. Therefore, they ensure that indigents as well as marginalised communities attain the right to health care services. The mission hospital also allows admission payments in form of kindness and agricultural produce, goats and poultry in exchange of treatment for those who do not have hard cash.

Table 8 Mission hospital conceptual understanding



From the above information Mission hospitals are well known for the friendliness and good quality care of health professionals which is not a quality for health care workers in Government hospitals and clinics were the services are associated with factors such as the delays when initiating treatment hence it leads to maternal mortality rates remaining high in rural hospitals. Poor health care conditions in other primary health care centres and lack of maternal shelters is among the push factors from government clinics to Chitsungo Mission which has the availability of better services. Accessing Chitsungo Hospital is not easy for the residents as they pay for services and it has limited opportunities.

2.24 Social Implications

The right to healthcare is not only affected by poor service delivery, long distances to the nearest facilities but by social beliefs in most rural communities in Zimbabwe. Societal perceptions, practices and ideologies form the basis of cultural beliefs, a known but less-explored barrier to accessibility of medical services in rural areas (MacLachlan 2006). Rural communities have their own attitudes, practices and ideologies which have been part of life since the evolution of men and these have become an important way of life at the same time act as environmental barriers in rural areas on the access to health care. As highlighted by the African Union, women in African countries are liable to socio-cultural inequalities that do not allow them to be politically represented, absence of legal protection, unequal education opportunities as well as less access to reproductive health service (AU, 2013). Hence this sector will focus on the socialisations of Guruve rural areas and how they have a bearing as confusion causers to the issue of access to maternal health for women. Negative social norms continue to prevent women from accessing labour markets.

2.24.1 **Culture/ Tradition**

Both culture and tradition plays a central role in assessing health related behaviours in rural areas. Section 23(3) (b) of Zimbabwe's Constitution provides for the supremacy of culture. Cultural beliefs can operate as a disadvantage to health care services and affect women mostly on the right to maternal health. There are families which do not seek medical attention from modern facilities and the tradition is passed from generation to generation which affects even those that get married into that certain family. The cultural groups have different perceptions on the issues of maternal health. Health promoting programmes in developing countries are often not successful because of a lack of compatibility with culture specific beliefs (MacLachlan 2006). The common belief is the use of *ana mbuya* where the elderly in that family performs the midwifery duty and another resort to herbalist who are referred to as professional traditional way compared to *ana mbuya* these perceptions are responsible for health seeking behaviour in communities.

2.24.2 **Religion**

The theme of religious beliefs as a barrier to the access of maternal health care has emerged so strongly in most discussions hence the researcher went on and explored the depth of religion as a concern to the violation of right to health care. The Johanne Masowe is a dominant religious sect in most rural areas as well as rural areas in Guruve district. 37 % of respondents belong to this sect and the major concern is that this sect prohibits access to maternal health care. Women visit *chitsidzo* which is a thatched hut and believed to be the place where they give birth. In this hut is a *masowe* midwife and holy water hence there is God's help which is not demonic compared to hospital medical attention. The issue of religion does not only hinder access to health care but there are oaths which are loosely interpreted as a marriage sacrifice. This hinders the

ways to curb maternal mortality as the same sect does not allow women to seek medical health care and the belief that women are to fulfil their oaths of bearing as many children as possible for their husbands has the same sect believing on multiplying and bearing many children at the same time exposing themselves to the risk of unsafe means of delivery.

2.24.3 **Interpersonal relationships**

Interpersonal aspects in health care facilities may consider the behaviour of health professionals in any given facility. Residents in ward 7 confirmed that there are other factors that hinder the access of maternal health care services in rural areas despite the well-known factors of inadequacy in equipment and antenatal care which is the way are the way people are treated and handled when reaching for the maternal facility. The issue of Social inferiority and discrimination usually lead to poor attitude and treatment by health care providers (Coovadia, 2009). Health professionals tend to disrespect patients and the use of social media such as Facebook, WhatsApp and twitter during working hours has increase the time taken to attend to patient and placed it on personal use hence it takes long before one is attended or given attention and lack compassion. Some scholars argued that from a health systems perspective, service delivery and interpersonal aspects of care play a crucial role and that poor quality health care services affect access and effectiveness (Turnçalp *et al*., 2012). Access to good quality health care is a fundamental human right and the political and economic situation in Zimbabwe has made it unfortunate for a number of citizens who have experienced the loss of relatives and children to poor maternal health care services.

2.25 Summary

The chapter presented and analysed data gathered for this study on the Access to Maternal Health for women in rural communities, a political economy perspective,

and a case of villages in Guruve District. The discussion highlighted that despite all the efforts made to improve the access to health in LEDCs, Zimbabwe still need to consider improving services in terms of good quality health facilities and as well as accessibility. Use of thematic cluster organised in line with the respondents' views was utilised to ensure effective presentation and analysis of all the data collected. The chapter also discussed the trends of presented data in relation with other relevant correspondences used in the section on related literature review.

CHAPTER 5 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

2.26 Introduction

This chapter is a summary of the whole research project, showing objectives and summary of major findings deduced from data analysis. The chapter provides conclusions and recommendations from the findings and highlights how these findings and recommendations can be used in future researches, policy making and implementation of intervention strategies aimed at reducing the problems associated with maternal health care access in rural communities.

2.27 Discussion

The main aim of this study was to assess the access to maternal health for women in rural communities in Zimbabwe. The study also sought to examine constrains that have impacted on the right to access health care services and the work of the government on the provision of section 76 of the constitution on health and examine the potential of this institution focusing on the initiatives and strategies implemented so far to help with health care services in rural areas. It seeks mostly tounderstand the barriers to maternal health care through a detailed analysis of mortality trends/ rates in Zimbabwe.The main research question was; What are the challenges faced by women on the access to maternal health? Both the research questions and objectives for this research were answered through the following arguments. The qualitative and quantitative research design was used for the research study. Ten local authorities were interviewed; sixty-five discussants participated through questionnaires in this research. One sampling method was used to select the participants. The sampling method used in this study was purposive sampling and questionnaires were distributed using the simple random sampling method.

The researcher argued that although health care service delivery is a significant step through which Zimbabwe is trying to achieve following the MDGs and signed conventions and treaties, access to maternal health care in rural areas remains a challenge that is faced by many women. The study went on to argue that long distances to the nearest health care centre, poor service delivery and economics constrains in the form of lack of funds as well as social factors such as tradition and religion which does not make it easy for pregnant women to access free health care services plays a major role on the violation of the right to health care. Based on these arguments, the researcher concludes that Zimbabwe's rural areas are still far from the target of reaching the marginalised communities to promoting health care for all in local communities. One of the biggest challenges women faces is insufficient equipment and ancillary services such as mothers' shelters which force them to rent in homes closer to the clinics so they can get medical assistance. This causes conflicts in homes and requires one to pay for accommodation constraining their little finances trying to balance their homes and the accommodation hence many end up settling for home births which is a risk to miscarriage and child loss. The researcher hence, conclude that political will and or commitment on the part of government is also lacking to adequately tackle the need for health care and facilities in rural areas.

The researcher discovered that availability of services, infrastructure, skilled workers, and good service must be established in rural hospitals and clinics as these are the factors responsible for maternal mortality rates to continue to prevail in these rural hospitals. Rural hospitals are not a preference by many maternity patients who register in both mission and government clinics in this case they would register at Chitsungo Mission for positive health outcomes and at the clinic just in case they do not make it to the mission clinic which is not accessible to resident from other wards. The

discussion also noted that there are other cases that the Guruve General Hospital refers patients to Chitsungo Mission hospital.

2.28 Conclusions

In sum, access to maternal health care for women in rural areas remains a challenge encountered by many as the health care facilities are not enough to improve effects of maternal health. Firstly, a clinic like Shinje has a catchment area of 17km up to five villages relying on it. The same clinic caters for maternity and other diseases such as the top 5 conditions/ diseases that are sometimes prevalent in the district such as ARC, diarrhoea, malaria, injuries and HIV related syndromes.

Secondly, though progress has been made in meeting MDGs, health, water and sanitation, a lot needs to be done in delivering quality services in Zimbabwe (UNDP, 2011). Maternal health care involves both the mother and the unborn child and when complications are encountered, the impact is for the whole families and if it death, it leaves behind and children without families or guardians. Lack of sufficient evidence on the access to maternal health in Zimbabwe has made it difficult for policy makers and programmers to build effective intervention strategies and action plans to assist communities on the effects.

The research findings indicate high prevalence, nature, patterns of copying mechanisms in Guruve district. The research has highlighted the challenges of accessing health care services and how they have affected the mortality rates of rural communities in Zimbabwe. As results indicated the challenges will continue to prevail as long the government does not put in place the financing systems that are efficient on improving quality services in rural areas. Issues of quality health care services

remain popular reason on the violation of the right to health care and these factors have continued to influence maternal patient when they seek maternity services.

Whilst there are several factors which could be hiding the real extent of females' turning to copying mechanisms in Guruve, it appears that there is a general pattern where ladies have had given birth at least once outside health care facilities with proper trained a health care giver and alone. There is evidence that the active Johanne Masowe population are more confident on the *chitsidzo* in the community compared to the available primary care givers. The research also identified the push and pull factors that causes communities to prefer being attended at a mission hospital compared to the government hospital.

2.29 Implications

There are several organisations that assist in meeting the health needs in rural areas in ensuring the availability of essential health care but rural communities are still vulnerable adapting to new ways that meets their medication needs. Clinics have a WOCBA of 22% of the population and expected pregnancies of 4.5% hence a constraint on the access to services. They are required to capture the local needs of health services as possible within the catchment area. It remains critical in rural areas on system delivery hence there is no assurance that these clinics will be able to deliver optimal health effective and meet the expectations in rural and remote health care.

2.30 Recommendations

- It is not a surprise that this study strongly recommends traditional midwives and the need to prioritize programs that support the community midwives especially those common ones who offer major help and are often used by most

mothers on all the issues that are related to maternal health. This starts by making this right a reality through supporting midwives and coming up policies that ensure that midwives needs are taken into consideration. There also is need for involvement of other intervention agencies such as mobile clinics and training these community midwives.

- There is need to capacity build the traditional committees through trainings and allocation of adequate resources and transport to enable these committees to explore medical attention and encourage community and group integration activities so as to avoid stereotyping health care services but to accept the changes of modernisation in order to reduce common cases of child loss. Resident are aware of campaigns done in their community as ways to education them on maternal health issues hence it is the duty of MOHCC to work with organisations as a way to support continuous awareness on safe delivery, family planning, malaria during pregnancy, and to continue monitoring TB and HIV pregnancy issues.
- There is need for the government, intervention agencies and communities to develop strategies to reduce the need for coping mechanisms and lack of proper health care as the push factors that causes maternal mortality. If clinics conditions are improved and mobile clinics are made available, it will reduce these home births and unsafe means of delivery. The Government of Zimbabwe should also revise the budgets they allocate to rural areas and revisit those areas to see if the allocations are being used as per agreement and reaching the targeted groups as well as suit the current economy of the Zimbabwean RTGS$. Ambulances are necessary in these clinics to transport emergency cases and in the case of Guruve they book ambulances at the

general hospital which means all emergency cases will wait for an ambulance from the General hospital. MOHCC as the targeted duty bearer must make sure every clinic in rural clinics has an ambulance.

- There is need to conduct baseline studies for understanding the consequences of lack of maternal health care access in rural areas. This should be done to offer understanding of how the population is affected by losses and ensuring that policy development takes into account the allocation of resources and target primary health care centres in rural areas.

2.31 Suggestions for Further Research

This research has shown that despite the clinics which are there in rural areas, there are still challenges faced by women on accessing maternal health and future researches could take this into consideration as opposed to most existing research that considers that much has been done to improve health care access in rural areas. The research results have shown all the challenges faced as well as the rate it occurs. This helps in future research to choose areas to research on when it comes to health care services. Gaps do remain after this research as it was conducted with limited resources such as on the areas of culture and tradition. The future requires a better look at these issues to better reach a conclusion on health in the rural context.

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APPENDICES

Appendix 1: In-depth Interview Guide for Local Authorities

1) What has been the cause of mortality in Guruve District since year 2012?

2) Who are the most affected by the lack of access to health facilities?

3) What are the major effects that have been posed by this lack of access to maternal health?

4) What has been done towards improving access to maternal health for women in Ward 7 and 17?

5) How has it been effective in enhancing the access for women?

Appendix 2: Questionnaire for community members in Guruve rural District

Section A: biographical data

Age

Below

18

18- 35

35+

Education level

Tertiary

Secondary

Primary

None

Occupation

Employed **Unemployed**

Section B: Maternal Health challenges

Tick where applicable

3.1.1 **Social factors**

a)Accessibility

Distance to the nearest health care centre

Below 3km	**3 -10 km**	**10 -15 km**	**Above 15km**

Mode of transport

Scotch cart **Car** **Walking**

Religion

How are they playing a role on the violation of the right to maternal health care in Guruve

_____
_____
_____
_____

b) Health care

Health care facilities in your area

General Hospital/ Clinic	**Mission Hospital**	**None**

Common place of birth

No of children	**G. Hospital**	**Clinic**	**Mbuya**

Availability of professional stuff

Doctors	**Nurses**	**Midwives**

what are the other alternatives besides hospital maternity services that are available_____
_____
_____
_____
_____

_____
_____

Are there maternal health campaigns that are carried out in the area?
_____
_____
_____
_____
_____
_____
_____
_____

Are locals trained to deal with certain diseases affecting children as well as pregnant women?_____
_____
_____
_____
_____
_____

Economic factors

How is the current economy affecting the population?

_____
_____
_____
_____

What negatives has the community identified on the issues of costs versus the prevailing
economy?_____
_____
_____
_____

How has these impacted the well-being of pregnant women and the community?

_____
_____
_____
_____

Appendix 3: Informed Consent Guide

My name is Geraldine Albertine Moyo a final year Public Policy and Governance student from AU. I am carrying out a study on the Access to Maternal Health for Women in rural communities, a human right perspective in your district. I am kindly asking you to participate in this study by answering to the interview guide and filling in the questionnaires provided.

Purpose of the study:

The purpose of the study is to address issues of mortality and the right to maternal care in the marginalised communities of Zimbabwe and figure out the barriers to maternal care as well as the strengths, weakness and differences between maternal service providers in rural areas and urban areas. You were selected for the study because ward 17 is one of the areas affected by the lack of maternal facilities as well as the distance covered to the main hospital.

Procedures and duration

If you decide to participate you will be given questionnaires which you are required to give own personal opinions. It is expected that this will take about three day minimum to almost a month

Benefits and/or compensation

Benefits are to the general population, as to increase awareness about the issues on maternal health concerning the difference between rural and urban health services.

Confidentiality

Any information that is obtained in the study that can be identified with the participant will not be disclosed without their permission. Names and any other identification will not be asked for in the questionnaires.

Voluntary participation

Participation in this study is voluntary. If participant decides not to participate in this study, their decision will not affect their future relationship with any organization. If

they chose to participate, they are free to withdraw their consent and to discontinue participation without penalty.

Offer to answer questions

Any questions on any aspect of this study that is unclear to you there is freedom to ask questions. You may take as much time as necessary to think it over.

Authorisation

If you have decided to participate in this study please sign this form in the space provide below as an indication that you have read and understood the information provided above and have agreed to participate.

---------- ----------

Name of Research Participant (please print) Date

Signature of Research Participant or legally authorised representative

If you have any questions concerning this study or consent form beyond those answered by the researcher including questions about the research, your rights as a research participant, or if you feel that you have been treated unfairly and would like to talk to someone other than the researcher, please feel free to contact the Africa University Research Ethics Committeeon telephone (020) 60075 or 60026 extension 1156 email aurec@africau.edu

Name of Researcher ----------

Appendix 4: Observation Check List

Area :

Observer:

No of participants:

	Observing aspects	Yes	No
1.	distance		
2.	Availability of clinics		
3.	Are they enough		
4.	Participants freedom		
5.	Village setting		
6.	other		

Appendix 5: AUREC Approval

AFRICA UNIVERSITY
(A United Methodist-Related Institution)
INVESTING IN AFRICA'S FUTURE

AFRICA UNIVERSITY
RESEARCH ETHICS COMMITTEE (AUREC)

P.O. BOX 1320, MUTARE, ZIMBABWE • OFF NYANGA ROAD, OLD MUTARE • TEL: (+263-20) 60075/60026/61611 • E-MAIL: aurec@africau.edu • WEBSITE: www.africau.edu

Ref: AU799/19 23 April, 2019

GERALDINE ALBERTINE MOYO
C/O CBPLG
Africa University
Box 1320
MUTARE

RE: ACCESS TO MATERNAL HEALTH FOR WOMEN IN RURAL COMMUNITIES. A CASE OF GURUVE DISTRICT, ZIMBABWE: A HUMAN RIGHTS PERSPECTIVE

Thank you for the above titled proposal that you submitted to the Africa University Research Ethics Committee for review. Please be advised that AUREC has reviewed and approved your application to conduct the above research.

The approval is based on the following.

a) Research proposal
b) Questionnaires
c) Informed consent form

- **APPROVAL NUMBER** AUREC799/19

This number should be used on all correspondences, consent forms, and appropriate documents.

- **AUREC MEETING DATE** NA
- **APPROVAL DATE** April 23, 2019
- **EXPIRATION DATE** April 23, 2020
- **TYPE OF MEETING** Expedited

After the expiration date this research may only continue upon renewal. For purposes of renewal, a progress report on a standard AUREC form should be submitted a month before expiration date.

- **SERIOUS ADVERSE EVENTS** All serious problems having to do with subject safety must be reported to AUREC within 3 working days on standard AUREC form.
- **MODIFICATIONS** Prior AUREC approval is required before implementing any changes in the proposal (including changes in the consent documents)
- **TERMINATION OF STUDY** Upon termination of the study a report has to be submitted to AUREC.

AFRICA UNIVERSITY
RESEARCH ETHICS COMMITTEE (AUREC)
2 3 APR 2019
APPROVED
P.O. BOX 1320, MUTARE, ZIMBABWE

Yours Faithfully

MARY CHINZOU – A/AUREC RESEARCH ETHICS OFFICER
FOR CHAIRPERSON, AFRICA UNIVERSITY RESEARCH ETHICS COMMITTEE

Appendix 6: Analysis Result