

**Women's experience and perception of maternal health care
and emergency services in rural Zimbabwe**

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CONTENTS

List of Tables.....	iv
List of Figures	iv
Attestation of Authorship.....	v
Acknowledgement.....	vi
Acronyms	vii
Abstract	viii
CHAPTER 1 INTRODUCTION	1
1.1 Introduction	1
1.1.1 Statement of Problem.....	2
1.2 Aim and scope of the study	3
1.2.1 Area of Study	3
1.3 Theoretical framework of the study	5
1.4 Study contribution to maternal and public health	6
1.5 Definitions of terms used in study	8
1.6 Thesis Structure.....	9
CHAPTER 2 LITERATURE REVIEW	11
2.1 Introduction	11
2.2 Maternal Health Globally: Inequalities, Policies and Initiatives	11
2.2.1 Inequalities in maternal health	11
2.2.2 Causes of maternal mortality globally	12
2.2.3 The global Safe Motherhood initiatives.....	14
2.3 Maternal Health in Zimbabwe	14
2.3.1 Maternal mortality in Zimbabwe	15
2.3.2 Social determinants of maternal health	17
2.4 Maternal health services in Zimbabwe: Policies and programmes.....	19
2.4.1 Quality of maternal health care in Zimbabwe during 1980-2013.....	19
2.4.2 Maternal health policy and actions	20
2.4.3 Key programmes	23
2.5 Defining ‘Safe Birth’ and ‘Safe Pregnancy’ across cultures.	27
2.6 Community participation to improve maternal health	29
2.7 Summary	30
CHAPTER 3 METHODOLOGY	32
3.1 Introduction	32
3.2 Theoretical framework and methodology	32
3.2.1 Feminist interpretive research paradigm.....	32
3.2.2 Critical qualitative research methodology	34
3.3 Researcher’s positioning and the role of reflexivity	34

3.4	Ethical consideration	35
3.5	Field work and data collection	36
3.5.1	Recruitment	36
3.5.2	Participants	37
3.5.3	Data collection tools	39
3.6	Thematic data analysis	41
3.7	Establishing rigour	42
3.7.1	Triangulation	42
3.7.2	Referential adequacy	42
3.7.3	Applicability	43
3.8	Summary	43
CHAPTER 4 RESULTS		44
4.1	Introduction	44
4.2	Study context of research participants	45
4.3	Women's experiences of maternal health care.....	46
4.4	Quality of maternal health care.	48
4.4.1	Staff attitudes and work ethics	48
4.4.2	Staff's skills and experiences	50
4.4.3	Effectiveness of service delivery care.....	51
4.4.4	Accessibility of maternity health facilities.....	52
4.5	Women's knowledge of maternal health Care: Kuscero and bed rest	54
4.5.1	Kuscero - measuring women's weights	54
4.5.2	Kupihwa mubhedha - giving a woman a bed rest	57
4.5.3	Sources and quality of knowledge	57
4.6	Priority areas of improvement.....	58
4.6.1	The health systems	58
4.7	Summary	65
CHAPTER 5 DISCUSSION AND RECOMMENDATION		66
5.1	Introduction	66
5.2	Summary of key research findings.....	66
5.2.1	Women's knowledge of maternal health care services	67
5.2.2	Women's experience of maternal health care	68
5.2.3	Women's awareness of dangerous signs in pregnancy.	70
5.2.4	Priorities areas of improvement in MH programmes and policies	71
5.3	Implication of this Study to MH Policy and Programme in Zimbabwe	73
5.3.1	Recommendation 1: The incorporation of human rights and sexual and reproductive rights in MH policy and programmes	74
5.3.2	Recommendation 2: Revisit the national agenda in relation to equality and women's empowerment	76

5.3.3 Recommendation 3: Further research on maternal health in rural Zimbabwe	78
APPENDIX A – ETHICAL APPROVAL	80
APPENDIX B – PARTICIPANT INFORMATION SHEET	81
APPENDIX C – CONSENT FORM	84
REFERENCES.....	85

List of Tables

Table 2.1 Zimbabwe Maternal Health Profile.....	15
Table 2.2 Causes of Zimbabwe maternal deaths.....	16
Table 2.3 Non-governmental maternal health funders in Zimbabwe	22
Table 2.4 The United Nations process indicator for EmOC	26
Table 3.1 Demographic profile of participants	38

List of Figures

Figure 1.1 Map of Zimbabwe and Mutare	4
Figure 2.1 Global maternal deaths	12
Figure 2.2 Places of death for 243 women. (ZMPS, 2007).....	17
Figure 4.1: Health Education Activity Chart	55

Attestation of Authorship

I hereby declare that this is my own work and that to the best of my knowledge and belief, it does not contains material previously published or written by another person or material which has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made.

Signed: .. 

Date:7 October 2014.....

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Acronyms

ANC	Antenatal Care
AIDS	Acquired Immune Deficiency Syndrome
BEmOC	Basic Emergency Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
FGD	Focus Group Discussion
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ICM	International Confederation of Midwives
IMF	International Monetary Fund
MDG	Millennium Development Goals
MIMS	Multiple Indicator Monitoring Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal Neonatal and Child Health
MOHCW	Ministry of Health and Child Welfare
PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal Care
RHC	Rural Health Clinic
SBA	Skilled Birth Attendants
STI	Sexually Transmitted Infections
TB	Tuberculosis
UN	United Nations
UNICEF	United Nations Children's Emergency Fund
WHO	World Health Organization
ZDHS	Zimbabwe Demographic and Health Survey
ZMPMS	Zimbabwe Maternal and Perinatal Mortality Study

Abstract

Approximately, 3000 women die every year in Zimbabwe during pregnancy, child birth or postpartum. According to the Zimbabwe Demographic Health survey (2011/12), maternal mortality has worsened from 720 deaths per 100, 000 to 950 between 2007 and 2012. Most of what needs to be done is known. Past efforts have managed to sustain high levels of antenatal care (ANC) visits among pregnant women and skilled birth deliveries yet maternal mortality estimates remain high. While quality of care in maternal health services is needed for progress towards reducing maternal mortality, women's perspectives for policy and action in maternal health seem to be the missing link.

The study examined women's perceptions and experience of maternal health care services and to what extent such understanding can be used to explore strategies to improve the quality of maternal health and obstetric care in rural Mutare. A feminist interpretive paradigm was employed in the study. A critical qualitative research methodology, using guided in-depth interviews and focus group discussions collected data from 25 women using antenatal, postpartum care services and maternity waiting homes at the time of the research. All focus group discussions and interviews were recorded, translated and transcribed. Transcripts were coded and analysed thematically.

Four broad themes were identified: 1) women's experience of maternal health care; 2) quality of maternal health care; 3) women's knowledge of maternal health care; 4) priorities areas of improvement. In summary, women's knowledge of maternal health care services was low. Women understood that quality of care; barriers to maternal health care; lack of awareness of dangerous signs in pregnancy; and gender inequality had contributed to poor maternal health in the district.

Women's stories and experiences suggest that behind issues of inadequate maternal health care are the shadows of many other urgent development issues - gender inequality; poverty and unemployment; inadequate education and public health spending and above all, lack of skilled birth attendants and enabling environments. Women's empowerment through basic education and employment was identified as keys to improve maternal health and quality of care in this district.

CHAPTER 1

INTRODUCTION

1.1 Introduction

Maternal healthcare is an important cornerstone in global safe motherhood programmes (De Brouwere & Van Lerberghe, 2001; Koblinsky, 2003; Kongnyuy, Hofman, & van den Broek, 2009; Ronsmans & Graham, 2006). Yet the existence of maternal health services around the world does not always guarantee positive outcomes for women. Globally, 800 women die of pregnancy and childbirth-related causes every day (World Health Organisation (WHO) Fact Sheet, 2012); 99 percent occur in developing countries (WHO, 2012). This alludes to the existence of maternal health inequalities between the developed and the developing worlds. (Khan, Wojdyla, Say, Gülmezoglu, & Van Look, 2006; Spicker, Leguizamon, & Gordon, 2007).

The 2010-11 Zimbabwe Demographic Health Survey (ZDHS) stipulates the current maternal mortality ratio (MMR) to be 960 deaths per 100,000 live births (Zimbabwe National Statistics Agency (Zimstat), 2012b). Clearly, the current MMR has increased by 33 percent from 720 deaths per 100,000 live births reported by the Zimbabwe Maternal and Perinatal Mortality study (ZMPMS) in 2007 (Munjanja, 2007). Major causes of maternal deaths include haemorrhage, infections or toxemia, and obstructed labour which occurs around the time of delivery (AbouZahr & Wardlaw, 2001; Figa' - Talamanca, 1996; Gribble & Haffey, 2008; K. Hill et al., 2007; WHO, 2005c). The Human Immune Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and malaria have also been responsible for the increase in MMR in Zimbabwe and other countries such as South Africa, Botswana, Swaziland, Lesotho, Kenya and Zambia (Paxton & Wardlaw, 2011).

Inadequate health services and the absence of qualified and skilled health personnel have created impediments to maternal and child health in Zimbabwe (Meldrum, 2008). Likewise, international isolation (Mhofu, 2012), shortage of foreign currency for a country that mainly relies on imported supplies and equipment have impeded the capacity of the health sector to adequately meet the healthcare needs of the population (Lancet, 2008; Truscott, 2009).

Further, studies also suggest that the interplay of gender inequality in rural areas of Zimbabwe are likely to contribute to women's poor maternal health outcomes (Freedman et al., 2007; Interagency Gender Working Group, 2011; Right to Maternal Health, 2008; United Nations (UN) Women, 2013; WHO, 1999).

In the past five years, the Zimbabwe National Health Strategy of 2009-2013 has focused its efforts to address the gaps in maternal and newborn health care by providing skilled birth attendance for antenatal and postpartum care and during delivery and emergency obstetric care facilities (Ministry of Health and Child Welfare, 2008); yet much more effort is required to achieve the desired results. Possibly, women's participation and voices in developing maternal health strategies or activities, is the solution. This study aimed to examine rural women's experience and understanding of the maternal health and emergency obstetric services in Zimbabwe. It also aimed to capture women's aspirations for the priority areas requiring improvement in maternal healthcare. This study was conducted in one rural district of Manicaland Province – Mutare, east of Zimbabwe.

1.1.1 Statement of Problem

Many studies noted that the current formulation of maternal care strategies and interventions have overlooked the context of women's life experiences (Baltussen & Ye, 2006; Figa' - Talamanca, 1996; Urassa, Carlstedt, Nystrom, Massawe, & Lindmark, 2002; Van Duong, Binns, Lee, & Hipgrave, 2004). Studies on women's maternal health have generally focused on addressing gaps in women's knowledge or aiming to modify women's behaviour (Hasan & Nisar, 2002; Kumbani & McInerney, 2002; Shah, 2002; Soltani et al., 1999; Tadesse & Muula, 2004). They continue to see women as the object and not the subjects of maternal health services. Furthermore, in Zimbabwe, current maternal health services continue to favor meeting the needs of the urban population. Access to adequate maternal health and emergency services for rural women remains lower in quality compared to those for women in the urban areas (Zimbabwe Maternal and Neonatal Health Road Map, 2007-2015).

This study was based on the premise that women can provide insight into the risk factors and potential strategies to prevent maternal morbidity and mortality. Thus, in

giving credence and having faith in women's voices, maternal healthcare services can be strengthened, barriers removed and good maternal health outcomes can be uplifted.

1.2 Aim and scope of the study

This is a qualitative study that examined women's perceptions in regard to the quality of maternal health and emergency obstetric care services and women's aspirations on improvement priorities of rural maternal health care in Mutare, east of Zimbabwe. The researcher acknowledges that newborn health is also a pertinent area of study in Zimbabwe. In order to provide a more in-depth understanding of the topic, this study focused on maternal health. Further, to be able to identify the gaps in service delivery, narrowing this study to include three primary level facilities and one hospital – rather than those on a macro-scale appeared to be a more appropriate way to examine the challenges the local and national government face in reducing the ever increasing maternal mortality in Zimbabwe.

The research questions developed in this study aimed to examine women's:

1. knowledge of maternal health care;
2. experience in maternal health care services;
3. perceptions of the maternal health care;
4. understanding of the danger signs in pregnancy, childbirth and postpartum period;
5. knowledge about postpartum care as a means of reducing risk;
6. proposed priorities for improvements in maternal health and emergency obstetric care.

1.2.1 Area of Study

This section provides a general description of Zimbabwe's population, current maternal health services and maternal health statistics.



Figure 1.1 Map of Zimbabwe and Mutare

Source: The World Atlas 2013

Zimbabwe is divided into ten provinces which are comprised of three main strata of urban and semi-urban areas (32%); communal farming areas (50%); and commercial farming areas (18%). Communal and commercial farming areas cover the largest rural component of Zimbabwe. Manicaland, a province in the eastern side of Zimbabwe was selected for the study. The 2007 ZMPMS stipulates Manicaland to be one of four provinces with a high maternal death rate, high number of births, high number of religious groups that resist modern medicines and low number of institutional deliveries (Munjanja, 2007).

Mutare rural, a district in Manicaland Province was the chosen area of study based on its high number of maternal mortality reported by the Ministry of Health and Child Welfare (MoHCW) (Munjanja, 2007). With regard to the 364 maternal death notification forms submitted in 2006 to the Head Office of the MoHCW, the Manicaland province accounted for 28 of those deaths and 23 out of 28 maternal deaths occurred in Mutare district.

The Mutare district is situated about 8 km from the border with Mozambique. Mutare's rural population of 260,567 (Zimstat, 2012) is located between fields of subsistence farming of cash crops, mainly maize, cotton and tobacco. The population is predominantly Shona ethnic group and the majority speak the Manyika dialect.

Out of 43 local government wards in the Mutare district, 38 are located within the communal farming area. Each ward has a rural health center (RHC). The RHC offers

basic maternity care services for low-risk women and it usually has a few beds for childbirth. Maternity waiting shelters are also available in some facilities to provide accommodation for a woman who lives far away from the health centre while waiting for the time of her childbirth. In Zimbabwe, it is recommended that all rural women should be offered to stay at a waiting home between three weeks prior and three days after delivery (UNFPA, 2012b). A RHC is staffed by at least two nurses. One of them would have formal midwifery training. The other nurse might have attended 18 months of primary health care training.

Generally a woman is referred to the district hospital if and when complications occur. In this study community, the Mutare Provincial/District Hospital is situated near the district center. It has facilities for obstetric and emergency care including operating theatres. Dirt roads connect the villages and the local rural clinics with the district hospital. By car, the district hospital and the RHC can be reached between 30 minutes to 3 hours depending on the location of the village. RHCs usually do not have an emergency transportation or an ambulance. The ambulance needs to be ordered from the district hospital.

1.3 Theoretical framework of the study

The feminist interpretive paradigm was the framework used in this study. Many women in Zimbabwe are still marginalised by their lack of voice and representation in national programming and policies affecting their lives (UN Women, 2013). The voices of poor women living in remote areas of Zimbabwe may have often been lost or ignored in current maternal health policies (Blaikie, 2007; Hesse-Biber, 2012; Lincoln & Denzin, 2011). The predominant traditional patriarchal rural society frowns upon female participation in development activities. In choosing the feminist paradigm, the researcher acknowledged the importance of the collective voices of women to provide accurate perspectives from their own experience of maternal health care (Campbell & Wasco, 2000; Lincoln & Denzin, 2011). The feminist approach allows for research procedures that empower rural women by establishing collaborative and non-exploitative relationships and avoidance of participant objectification (Payne, 2008).

The interpretive paradigm aims to understand something in its context (Holloway, 1997). Therefore, it further complements the feminist approach in acknowledging the

importance to understand Mutare women's perception of maternal health and emergency services. Further in using the feminist interpretive paradigm, the researcher supports the notions that women's understanding of their life realities is socially constructed. Therefore it is important for the researcher to rely upon Mutare women's perceived understanding of their world and from their view points (Creswell, 2003; Mertens, 2005; Schwandt, 2000). Lastly, knowledge gained through employing a feminist interpretive paradigm is just not 'knowledge for its own sake', it is knowledge committed to bringing about change and improvements in women's lives (Wadsworth, 2001). In turn, such knowledge would also be useful to support long term demand and an increase in quality of services provided (WHO, United Nations Children Fund (UNICEF), United Nations, United Nations Population Fund (UNFPA), 1999).

Although this study was conducted within Mutare rural, it is hoped that results of this study could be helpful in other regions of the country that share a similar context with respect to public health. Following is a detailed description on how the study will contribute to maternal and public health.

1.4 Study contribution to maternal and public health

As noted earlier, MMR is on the increase in Zimbabwe. What is striking is how the poor and developing countries are more liable to maternal deaths than developed countries. This may imply that the wealth of a country correlates with its number of maternal deaths. However, the wealth of a country does not signify the level of maternal deaths that country has. For example, according to Weeks (2007), Nigeria, which is ranked as the 47th highest gross domestic product (GDP) worldwide and is the world's 8th largest exporter of petroleum has a MMR of 800/100 000 live births. In contrast, Sri Lanka, 78th on the GDP list has a much lower MMR of 92 deaths per 100,000 live births. Among the wealthy nations, Sweden ranks at number 20 and has the lowest MMR of 2 deaths per 100,000 live births, while the USA, despite being the richest country in the world, has a MMR of 17 deaths per 100,000 live births (International Monetary Fund, 2006; WHO, 2004c).

Despite spending more money on health care than any other country, the United States has a higher number of maternal deaths than other developed countries (Paxton & Wardlaw, 2011). To be able to interpret these data and conflicting impressions of

progress and decline, this study provides insight and understanding of the groups of women who are most susceptible to maternal mortality than others. It offers logic with regard to the interplay of varying social, economic and cultural factors which would require a socio-cultural and economic sensitivity approach to interventions for those particular groups (Tinker, Finn, & Epp, 2000).

Further, the majority of programme development on maternal health has been based on studies conducted by researchers from developed countries. Policy makers or programme developers of global Safe Motherhood initiatives are often from Euro-American academic circles and grounded in the modes of discourse, ideology, analysis and action that may not be considered relevant to the women or communities in developing nations (Bailey, Leo-Rhynie, & Morris, 1996; Cornwall, Harrison, & Whitehead, 2008; Östlin, Eckermann, Mishra, Nkowane, & Wallstam, 2006). Involving local researchers could therefore remove the mismatch between the scientific interests and the local knowledge of maternal health, childbirth or safe motherhood (Horton et al., 2003). Accordingly, funding for research on maternal health has been very limited. The Global Forum of Health Research (2002) and World Health Organisation (2004a), noted that 90 percent of the global research fund has been used in diseases of global burden such as tuberculosis and HIV/AIDS. This study has purposefully proposed to address this apparent research deficit and from a perspective of a local Zimbabwean female researcher.

Lastly, motivation to conduct this research derives from the researcher's observation that Zimbabwe rural women have not yet been given the opportunity to participate in maternal health programmes. The researcher acknowledges that maternal health is a complex issue and that there is no definite sequence in its programme formulation (who to work with first and next). However, it is neither correct to start putting maternal health care service in place and only work with women and the community to get to use the services. This study shows what may be considered a good practice to programming necessary to produce the desired maternal health outcomes.

The following section includes the definition of terms used in this study.

1.5 Definitions of terms used in study

The WHO defines **maternal health** to refer to the health of women during pregnancy, childbirth, and the postpartum period which encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality (WHO, 2000). In the Zimbabwe Demographic Health Survey, (ZDHS), maternal healthcare refers to healthcare surrounding childbirth; that is, antenatal care, delivery assistance, and postpartum care (Zimstats, 2012b). The definition also includes the provision of emergency obstetric care within the maternal health provision. This study employs the latter definition.

Whilst the WHO definition on maternal health care does not explicitly mention the inclusion of the emergency obstetric care, it is the researcher's understanding and belief that emergency obstetric care is an important pillar in maternal health care services.

Emergency obstetric care (EmOC) refers to a list of services that can save the lives of women with obstetric complications. The rationale underlying this concept is that child birth is, in and of itself, a potentially risk-producing event. Maternal mortality cannot be reduced without the provision of timely and adequate medical care for women with pregnancy complications (UNFPA, 2002). The services are either basic or comprehensive in nature. According to the UNFPA (2002), **basic EmOC** functions are performed in a health centre without the need of or for an operation. The health facility will qualify as a basic EmOC facility if it has performed once over the preceding three months the following six functions: the provision of parenteral antibiotics; oxytocics; sedatives/anticonvulsants; manual removal of placenta; removal of retained products of conception (MVA or D&C); and assisted vaginal delivery (vacuum/breech extraction). The **comprehensive EmOC** functions require an operating theatre and are usually performed in a district hospital. To qualify as a comprehensive EmOC facility, such facilities have to be able to perform all of the six basic EmOC functions as well as caesarean section and blood transfusion.

Antenatal care is defined as having had one or more visits with a trained person during pregnancy to detect any potential complication of pregnancy early, to prevent them if possible. It includes recording medical history, assessment of individual needs, advice and guidance on pregnancy and delivery, screening tests, education on self-care during

pregnancy, identification of conditions detrimental to health during pregnancy, first-line management and referral if necessary (WHO, 2010b).

Literally and linguistically, there seems to be no distinction between **postpartum care** (for the woman) and **postnatal care** (for the infant), yet they are not the same. Providing one of these services does not automatically include the provision of the other neither does the skilled or semi-skilled attendant(s) involved automatically possess both of the necessary skill sets or required training. The study will adopt a single term “**postpartum**” The postpartum period begins immediately after the birth of the baby and extends up to six weeks (42 days) after birth. Postpartum care may include recovery from childbirth, information on newborn care, nutrition, breastfeeding and family planning services (WHO, 2010b).

A **skilled birth attendant** is defined as a health professional such as a midwife, doctor or nurse who has been trained to acquire an established proficiency level in knowledge and skills needed to manage normal pregnancies, childbirth and the immediate postpartum period, as well as in the identification, management and referral of maternal complications (WHO, Confederation of Midwives (ICM), International Federal of Gynaecology and Obstetrics (FIGO), 2004).

Maternal Mortality: The death of a woman whilst pregnant or within 42 days of the termination of the pregnancy and which results from any causes related to or aggravated by pregnancy or its management, yet not from accidental causes (WHO, 2004). It is measured by the maternal mortality rate (MMR) which is the annual number of female deaths per 100,000 live births.

Maternal Morbidity: It is an overarching term that refers to any serious disease, disability or physical damage caused by pregnancy-related complications or childbirth (WHO, 2004).

1.6 Thesis Structure

This thesis is comprised of five chapters. Chapter one provides a background and rationale for the study. It further provides a brief description of the current maternal health status in Zimbabwe; the theoretical framework, aim and scope which includes the research questions and definition of terms that governs the study. The chapter also states

its contribution to maternal and public health. Chapter two provides a review of global maternal health and its challenges. Chapter two also includes a review of the literature in relation to Zimbabwe rural maternal health programmes and policies; cross-cultural understanding of safe pregnancy or dangerous signs in pregnancy; and community participation to improve maternal health. Outlined in chapter three is the research paradigm, the methodology process and the tools used in the field work. Further discussed are the demographic characteristics of the study participants; the method used in data analysis; and the measures used to deem the data collected credible. Chapter four presents the findings of the study context followed by the findings from the women participants. Lastly, chapter five discusses the key findings; the implications of this study in future maternal health policies and practices in rural Zimbabwe; and the limitation of the study.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This review consults literature on global maternal health and its challenges; cross-cultural understandings of safe motherhood; and national and rural maternal health programmes, policies and actions in Zimbabwe. This chapter includes five main sections: 1) global maternal health: inequalities, policy and initiatives; 2) maternal health in Zimbabwe and its social determinants; 3) health services for women in Zimbabwe: policies and programmes; 4) cross-cultural understanding of safe pregnancy and dangerous signs of pregnancy and; 5) community participation to improve maternal health in rural communities.

2.2 Maternal Health Globally: Inequalities, Policies and Initiatives

Trends in global maternal mortality show a reduction of maternal deaths worldwide from 400 deaths per 100,000 live births in 1990 to 210 deaths per 100,000 live births in 2010 (WHO, UNICEF, UNFPA, & WORLD BANK, 2012). Despite these achievements, high maternal mortality rates continue to be observed in Africa and South East Asia regions and global efforts to reduce maternal deaths largely must focus on reducing global maternal health inequalities in these regions (Khan et al., 2006; Spicker et al., 2007).

2.2.1 Inequalities in maternal health

Inequalities related to maternal health outcomes exist between and within countries (Khan et al., 2006; Spicker et al., 2007). MMR in developed countries is the lowest worldwide, averaging between 2 and 14 deaths per 100,000 live births; while MMR in developing countries stands at 290 deaths per 100,000 live births (Global Maternal Mortality Fact Sheet, 2012). More than three-quarters of the global maternal deaths occur in the regions of Africa and South-East Asia (WHO, 2012), with 99 percent of the deaths occurring in Sub-Saharan Africa annually (Marmot, 2005). See Figure 2.1. Maternal health inequalities have also been observed within nations. A demographic health survey involving 45 developing countries including Zimbabwe showed maternal health disparities between urban and rural communities (Houweling, et al., 2007).

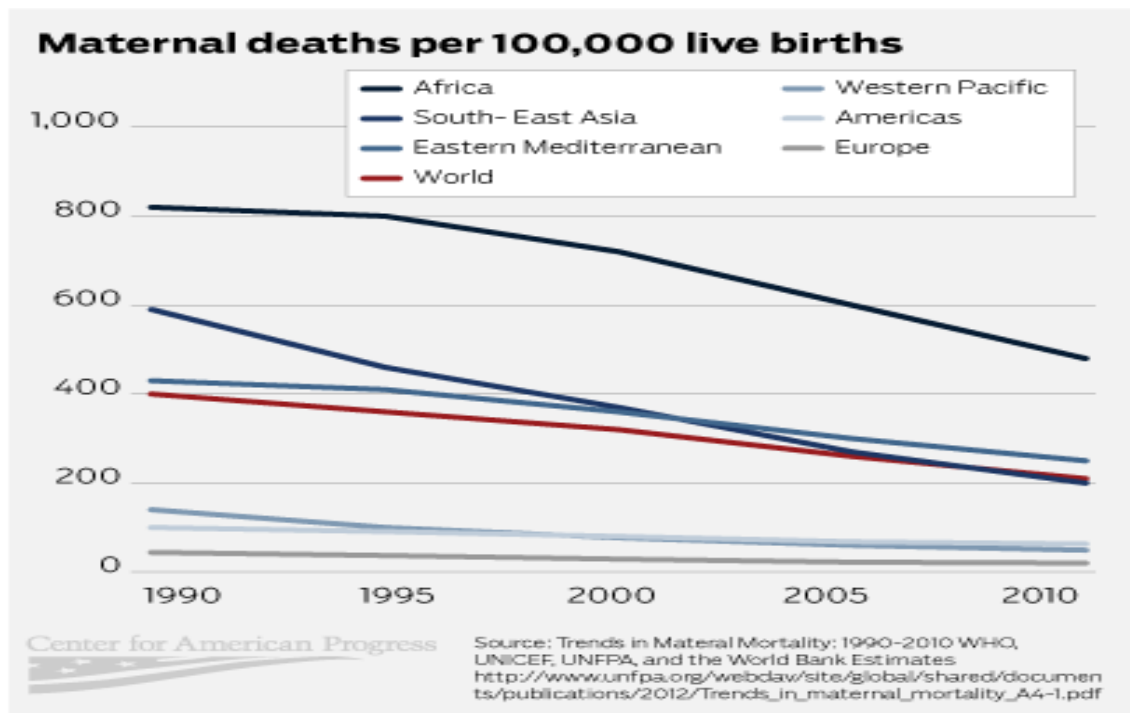


Figure 2.1 Global maternal deaths

The greatest inequality has been related to women's access to skilled birth attendance (Boerma, Bryce, Kinfu, Axelson, & Victora, 2008; UNFPA, 2012a; United Nations, 2013b; WHO, ICM, & FIGO, 2004). Whilst 84% of women in urban areas have access to skilled health professionals, only half of rural women are able to enjoy the same (United Nations, 2013b). Moreover, rural women are also likely to have limited access to health information, counseling and education. This may reflect the failure of the states to fulfill women's needs to adequate health information and quality health services (Ministry of Health and Child Welfare, 2008).

2.2.2 Causes of maternal mortality globally

The accuracy of maternal mortality data is often compromised by under-reporting and misclassification of deaths in third world countries (Nove, Matthews, Neal, & Camacho, 2014; Rogo, Oucho, & Mwalali, 2006). About 80% of maternal deaths globally are caused by severe bleeding (mostly bleeding after birth); infections (usually after childbirth); high blood pressure during pregnancy and obstructed labour. The remainder are associated with diseases such as malaria or AIDs during pregnancy (WHO Fact Sheet, 2012).

Medical factors

Although the immediate medical causes of maternal death are well known and similar for women all over the world (Figa' - Talamanca, 1996), the distribution of such causes differ from region to region (AbouZahr & Royston, 1991; Khan et al., 2006). For example, maternal deaths associated with anaesthesia and caesarean sections are prevalent in developed countries (Khan et al., 2006). Haemorrhage is the leading cause of maternal deaths in Africa and Asia (at 34% and 31% respectively); while hypertensive disorders (9%) and HIV/AIDS (6%) in pregnancy also contribute to maternal deaths in Africa (Khan et al., 2006). Maternal deaths due to sepsis (10%) (van Dillen, Zwart, Schutte, & van Roosmalen, 2010), induced abortions (13%) (WHO, 2012), and malnutrition (20%) (Black et al., 2008) are also important determinants of maternal health in developing countries.

Social factors

Social and cultural factors that contribute to maternal deaths include lack of education, access to family planning, adequate antenatal, postpartum and emergency obstetric care (United Nations Development Programme, 2011; WHO, 2005a). Studies also document links of sexually transmission infections (STIs) including HIV/AIDS, high fertility and child marriages to maternal morbidities and mortalities (Mungcal, 2012; Tadesse & Muula, 2004; UNFPA, 2003). Thaddeus and Maine's (1994) in their 'Three Delays' model also explains delays in making the decision to seek care, reaching care facilities and receiving care at the facility contribute to poor maternal health outcomes. It has also been established that there is a link between maternal health outcomes and women's socioeconomic position and power in decision-making within the household (Allendorf, 2007; Griffiths & Stephenson, 2001; Woldemicael, 2007).

All of the causes of maternal deaths are preventable (Khan et al., 2006; Spector et al., 2012; United Nations, 2013a). Various international forums, conferences, and related agreements reiterate that no woman should die from pregnancy complications. It is against this background that gave birth to the global Safe Motherhood initiatives (Ravindran & Berer, 2000; Starrs, 1997).

2.2.3 The global Safe Motherhood initiatives

In 1987, the first global Safe Motherhood initiative was launched in Kenya, calling for a reduction in maternal mortality and morbidity by half by the year 2000. This global initiative was supported by a number of key international conferences including the International Conference on Population and Development in Cairo in 1994; the Fourth World Conference for Women in Beijing in 1995; and the Social Summit in Copenhagen in 1995. A key focus of these international conferences was on addressing the social, cultural and gender determinants of maternal health globally. Since the year 2000, newer initiatives such as the Maternal Health Task Force, Women Deliver, and the White Ribbon Alliance (Dodgson, Lee, & Drager, 2002) were launched to support global maternal health initiatives.

The Millennium Declaration has been an important milestone to address inequalities in global maternal deaths (Hunt & Bueno de Mesquita, 2010). The Millennium Developmental Goal (MDG) 5 was specifically developed to promote the reduction of maternal mortality by three-quarters by 2015 (UN, 2011). While developing countries are struggling to reduce maternal deaths, little attention was given to improve maternal health globally at the recent Rio+20 Conference in 2012. Although the aim to develop Sustainable Developmental Goals is to build upon the MDGs, the Rio+20 Conference lacked the emphatic, ardent and high-spirited commitment necessary to promote women's reproductive health and rights (Troilo, 2012).

2.3 Maternal Health in Zimbabwe

Zimbabwe shows little progress in achieving its set MMR target of 174 deaths per 100,000 live births by 2015 (United Nations, 2010). In fact, in the past five years, 2005-2011, maternal deaths in Zimbabwe have worsened from 612 deaths per 100,000 live births to 960 deaths per 100,000 live births (Zimbabwe National Statistics Agency, 2012b). High maternal deaths mostly occurred in rural areas (USAID, 2005). Likewise, the proportion of childbirths attended by skilled health workers (69%) has not changed much in the last five years (United Nations, 2012); whilst the MDG5 targeted 80 percent. Table 2.1 shows indicators of maternal health in Zimbabwe.

Table 2.1 Zimbabwe Maternal Health Profile

MATERNAL HEALTH COUNTRY PROFILE	
Total Population (000); % Urban	12,644; 38
Adolescent Population (15-19) (000); % of Total	1,656; 13
Number of Women of Reproductive Age (15-49) (000); % of Total	3,246; 26
Total Fertility Rate (children per woman)	3.4
Crude Birth Rate (per 1000 population)	30
Births per year	377
% of All Birth registered	74
Number of Maternal Deaths	3000
Number of Pregnant Women tested for HIV	175,223
Midwives authorised to administer a Core Set of life Interventions	Partial
Density of Midwives, Nurses and Doctors per 1000 population	0.9
Estimated Workforce Shortage to attain 95% by 2015	360
Gross Secondary School Enrolment (male; female)%	43; 39
Literacy Rate (age 15 and over) (male; female)%	94; 89
MDGs INDICATORS	
Maternal Mortality Ratio (per 100,000 live births)	960
Proportion of Births attended by Skilled Birth Attendance	69
Contraception Prevalence Rate (Modern Methods)%	60
Adolescent Birth Rate (births per 1,000 Women aged 15-19)	101
Antenatal Care Coverage (at least one visit; at least four visits)%	- ; -
Unmet need for Family Planning	13
Source: UNICEF & WHO (2013)	

Table 2.1 shows the latest Zimbabwe maternal health profile and MDGs indicators. In summary, approximately 26% of total Zimbabwe population are women of reproductive age groups between 15 and 49 years old. The success of the country's family planning programme is shown to be relatively low with a total fertility rate of 3.4 children per woman. Teenage pregnancy is relatively high at 10 percent. It may suggest continuing practice of early marriages.

2.3.1 Maternal mortality in Zimbabwe

In Zimbabwe, about a quarter of the maternal deaths occur in young women aged 15-19 years (Ministry of Health and Child Welfare, 2012). The Zimbabwe Maternal Deaths

Audit Report 2010/11 indicates that the majority of the women (82%) who died of pregnancy related complications were married (MoHCW, 2012). This may suggest that the institution of marriage does not guarantee women having better maternal health outcomes (Allendorf, 2007; Woldemicael, 2007).

Biological or medical factors

One in four maternal deaths are indirectly related to HIV/AIDS in Zimbabwe (ZMPMS, 2007). Table 2.2 show the four main direct causes of maternal deaths: postpartum hemorrhage, sepsis, pregnancy related hypertension and malaria (MoHCW, 2012). Nearly one fourth of the deaths are due to postpartum haemorrhage.

Table 2.2 Causes of Zimbabwe maternal deaths

CAUSE	2010	2011
Post-Partum Haemorrhage	23%	24%
Sepsis	20%	21%
Eclampsia	9%	11%
Malaria	10%	7%

Source: Maternal Death Audit Report 2010/11; MoHCW

The 2007 Zimbabwe Maternal and Perinatal (ZMPM) study, conducted nationwide by the MoHCW showed maternal deaths to be strongly associated with substandard health services and lack of medical equipment and supplies at the time of labour, delivery, or immediately after childbirth. This study noted that of the 243 maternal deaths officially reported, 63 percent occurred during the postpartum period; followed by 24 percent during the antenatal period; and 7 percent during delivery. Maternal deaths mostly occurred at home at 43 percent. About 30 percent of deaths also occurred in district or tertiary hospitals (Munjanja, 2007). See Figure 2.2.

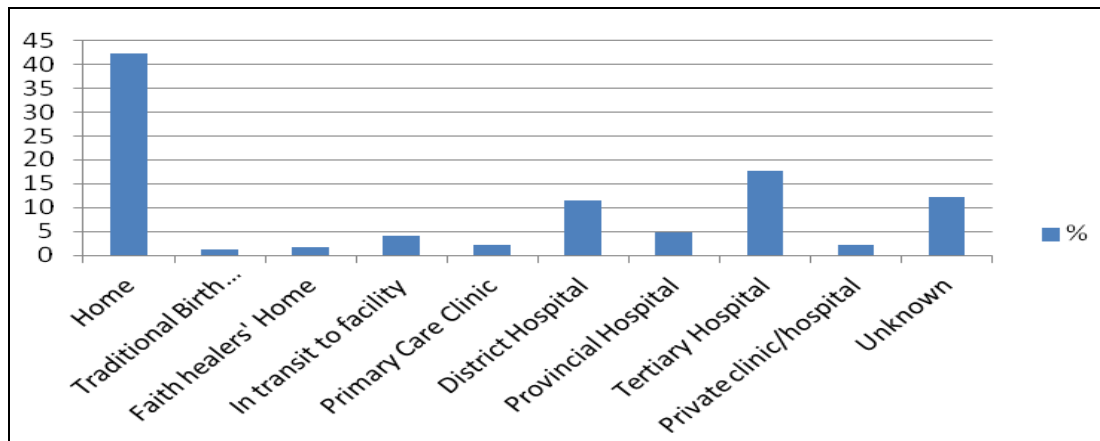


Figure 2.2 Places of death for 243 women. (ZMPS, 2007)

Delays either in making decisions regarding care, reaching health care facilities or obtaining adequate and relevant care contributed to 73 percent of the total maternal deaths. The first delay contributed to 137 maternal deaths (57%), the second 13 cases (5%) and the third 27 cases (11%) (Munjanja, 2007).

2.3.2 Social determinants of maternal health

Maternal health may also link with women's social, economic and cultural status. For example, a woman's status within her household may associate with the power she has to make a decision regarding care.

Women's status in rural communities

A woman's status is often described in terms of her reproductive role as a wife and mother as compared to a man's identity as a husband, and father. The institution of marriage also occupies a key link in the formulation of this woman's identity and woman's dependence on her husband (Hungwe, 2006; Mungwini, 2008). In many cultures including those in Zimbabwe, a marriage or a union between a woman and a man often expects women to bear children (Howard, 2013). To prove her worth in the society, a woman often conforms to those expectations, with often little voice in her own reproductive health decisions.

A woman's health is often secondary to the needs of her family. For instance, a heavily pregnant woman is still expected to continue working in the farms, signifying the importance of women's labour in the family farms. Farming or gardening is the main source of livelihoods in rural communities in Zimbabwe (Poverty Reduction Forum Trust, 2013). Women however, do not have any control over the cash or money in the

family. A study by Chitsike (2000) in one rural area in Zimbabwe showed that some cultural norms or practices cause women's lack of self-confidence and autonomy in participating in economic activities. Likewise, women may also lack skills, education, time and ability to travel outside home. In addition women's roles as primary care giver and family provider hinder women's participation in the informal or formal labour market. These conditions may indirectly affect women's maternal health outcomes (Braveman, Egerter, & Williams, 2011; Kanchense, 2007; United Nations Development Programme (UNDP), 2011; WHO, 2005a).

Gender and maternal health outcomes

The association between maternal health outcomes, gender relations and norms, and the roles applied to women have been well documented (Barker, Ricardo, & Nascimento, 2007; Interagency Gender Working Group, 2011; Singh, Bloom, & Brodish, 2011). Gender discourses argues that negative attitudes towards women and girls, and the limited power women have over their sexuality and reproductive lives has an adverse effect on women's health (United Nations WOMEN, 2013). It further discusses maternal morbidity and mortality as a result of gender inequities (Freedman et al., 2007; Right to Maternal Health, 2008). In many cultures, for instance, a woman is financially dependent on her husband and decisions on maternal health care are often made by her husband or mother-in-law (Télesphore Somé, Sombié, & Meda, 2013; UN WOMEN, 2013; White, Dynes, Rubardt, Sissoko, & Stephenson, 2013).

Power imbalance is also a common feature in a user-provider relationship which is often exacerbated by disparities in social status (Biddlecom & Fapohunda, 1998). The power imbalance is likely to be greater when the provider is a male (Upadhyay, 2001); and so the male provider exhibits authoritative traits toward a submissive female client. This may explain why rural women feel afraid to ask questions or to discuss their health with health providers (Lloyd, Kaufman, & Hewett, 2000; UNDP, 2011). Ironically, health practitioners are positioned strategically in the health system to identify these social inequalities in maternal health care yet they lack interest in addressing them (Flores & Falcoff, 2004).

Gender disparities also feature in women's lack of voices and representation in decision making for policies and programmes affecting their lives and well-being (UN WOMEN,

2013). This is regardless of the fact that women are both major health care users and providers (Gijsbers van Wijk, van Vliet, & Kolk, 1996; UN WOMEN, 2013). These gender dimensions in maternal health have influenced how maternal health is being defined and constructed in the public health arena.

2.4 Maternal health services in Zimbabwe: Policies and programmes

In 2007, the government of Zimbabwe formulated a country-specific road map known as the Zimbabwe Maternal and Neonatal Health (ZMNH) Road Map (2007-2015). The objectives of this road map are twofold: 1) providing skilled birth attendants (SBA) at all levels of maternal health care system and 2) strengthening the capacity of individuals, families, communities and civil society or organisations to improve maternal and neonatal health (MoHCW, 2007). The road map further outlines a comprehensive package of maternal health services to include family planning (FP), antenatal care (ANC), clean and safe delivery plus emergency obstetric care (EmOC), and postpartum care. Although this package was deemed to be cost effective (MoHCW, 2007), no evidence has been provided to that effect. Prevention of Mother to Child Transmission (PMTCT) was also integrated in this package (MoHCW, 2008). The next section discusses the milestones of maternal health care policies and programmes in Zimbabwe since the 1980s.

2.4.1 Quality of maternal health care in Zimbabwe during 1980-2013.

During the first three decades after Zimbabwe's independence in 1980, the quality of healthcare in Zimbabwe seemed to be a much neglected area. Various efforts to address health care inequities also existed prior to the 1980s. Healthcare in the pre-independence Zimbabwe era was similar to that of other third world nations, marked by high mortality and morbidity amongst the poor whilst the affluent enjoyed the health status at the level of a developed country (Bloom, 1985).

Without the efforts and work of church-run hospitals or clinics provided by white farmers for their peasant workers, the rural communities would have had received little or no medical attention. Even so, the emphasis of healthcare during the colonial time was curative rather than preventative. At that time, most of the diseases affecting the indigenous African population were communicable diseases, maternal diseases or diseases related to nutritional deficiencies (Taylor, Sanders, Bassett, & Goings, 1993).

Soon after its independence, Zimbabwe adopted the concept of health equity in its Primary Health Care Policy, which ensured universal access to primary healthcare for people of all ethnicities and racial backgrounds (Bloom, 1985; Taylor et al., 1993). The policy however, did not succeed; the health inequities in Zimbabwe worsened especially after the introduction of the Economic Structural Adjustment Policies of 1991-1995 (Nyazema, 2010; Taylor et al., 1993).

Further, in 2006, the government decided to reduce funding for social welfare and introduce user charges. The decision to introduce user charges was necessary to fund and support the national health services. This however, resulted in the decline in the number of service users (Bremner & Shelton, 2001; Osika et al., 2011), further worsening the outcomes of some national health indicators. The introduction of the user fees did not guarantee for better health outcomes for rural women (Creese, 1991). In 2012, in order to increase the number of women who are accessing government funded maternal health services, the Zimbabwean Government waived delivery fees in public hospitals (Mhofu, 2012). Unfortunately the policy does not extend to treatment for pregnancy complications. Whilst the delivery cost is free, the majority of women found that the other costs incurred at hospital for food, soap or bedding to be burdensome (Mackenzie, 2013). Even though the Zimbabwe Health System Assessment in 2010 showed a dramatic increase in the coverage of maternal health services in Zimbabwe the quality of those services remains inadequate (Osika et al., 2011). Users do not get the care they need and the care is not effective when they get it.

2.4.2 Maternal health policy and actions

Globally, many women's health is shaped by unequal distribution of money, power and resources (Sen, Östlin, & George, 2007; UNDP, 2011; WHO, 2007). High maternal deaths in developing countries, have been associated too with a shortage of trained health professionals and practitioners like doctors, nurses and midwives in rural or remote areas (Maine & Rosenfield, 1999; WHO, 2005b; WHO et al., 2004).

Human Resources

The policies of the International Monetary Fund and the World Bank are often blamed for exacerbating the global maternal health toll by preventing a country's ability to hire civil servants to address a shortage of health staff (Friedman, 2004; Gerein, Green, &

Pearson, 2006b; Huddart & Picazo, 2003; UN Millennium Project, 2005). According to the 2010 World Development indicators, human resources for maternal health in Zimbabwe is of serious concern with only 0.16 physicians per 1,000 population and 0.72 nurses or midwives per 1,000 population. Further, the absence of a registry system for certified midwives along with the fact that mid-wives are not recognized as independent professions in Zimbabwe (UNFPA, 2012a), makes it difficult to take stock of the number of practicing mid-wives in the country.

Others also suggest that the lack of human resources working in health sectors is not due to the above mentioned policy shift (Meldrum, 2008; Ministry of Finance and Economic Planning, 2004). It may also reflect a 'brain drain' phenomenon in which skilled health workers migrate to neighbouring countries such as Malawi, Nigeria, Swaziland, Zambia for a better opportunity and financial reward (Gerein, Green, & Pearson, 2006a). Although less well documented, the 2010 Zimbabwe Health system Assessment reported the 'brain drain' phenomenon to be associated with skilled birth attendance choosing to work in non-health sectors (Osika et al., 2011) or loss of health workers affected by HIV/AIDS (UNAIDS, 2010). In 2007, the Zimbabwe National Health Strategy:2009-2013 introduced a training programme for Primary Care Nurses to meet the country's needs for primary health care workers (MoHCW, 2008). In order to increase the number of nurses to take a further training in midwifery, qualified midwives were to be rewarded with a substantial allowance. A similar initiative was introduced to retain medical doctors to work at the district level (MoHCW, 2008).

Funding

There has been a high competition for safe motherhood programmes in accessing public health funding with various health programmes like child health, communicable diseases which includes tuberculosis, malaria and HIV/AIDs (Lawn, Tinker, Munjanja, & Cousens, 2006). Tuberculosis have been responsible for 2.4 million deaths every year, while malaria and HIV/AIDs contributed to respectively one and three million deaths yearly (Costello & Osrin, 2005; Schlipkötter & Flahault, 2010). Unger and colleagues (2009) have noted that most funding from international donor agencies has been allocated to control the spread of these communicable diseases from third world countries to first world countries. Maternal deaths and morbidities are therefore not perceived as a health threat by industrialised nations; they are of secondary importance

compared with communicable diseases. Further, maternal deaths may have been seen to affect only women of a relatively narrow age range and that the number of maternal deaths may seem to be smaller compared to deaths associated with HIV/AIDs or other communicable diseases (Costello & Osrin, 2005).

Zimbabwe's funding for social safety networks is very limited in addition to the unavailability of a national health insurance programme (MoHCW, 2007). Major sources of funding for healthcare derive from patients (user fees and charges), government subsidies, and non-government donors (MoHCW, 2008). Table 2.3 shows examples of non-government maternal health funders in Zimbabwe.

Table 2.3 Non-governmental maternal health funders in Zimbabwe

Non-government funders	Areas of focus
WHO	Reproductive health and HIV/AIDS
European Commission	Health systems strengthening, HIV/AIDS, human resources for health
UNFPA	Reproductive health and rights
UNICEF	Child protection; under-5 mortality, health systems strengthening, PMTCT, paediatric HIV, supply chain management
USAID	Health systems strengthening; skilled birth attendance, quality of care, paediatric HIV
DFID	Maternal and new born services, child protection, health systems strengthening,
SIDA	Women's rights; girls' education
CIDA	Human resources for health
JSI	Supply chain management family planning products
MCHIP	Maternal and child health
LAT H	Maternal and newborn services
Marie Stopes	FP training; contraception distribution
Population Services	FP training, contraception services

International donors, non-government health organizations, and mission health programs have provided substantial funding to support local maternal health projects. This includes remuneration for the health workers, training of skilled birth attendances,

provisions of drugs and medical supplies or building maternal waiting homes (UN Higher Commission of Refugees, 2010). Some of these agencies have also been providing education for girls and campaigning to stop the practice of early marriages (Mungcal, 2012).

2.4.3 Key programmes

Without furthering the discussion on family planning (FP) services in Zimbabwe, this study acknowledges the importance of strong national FP programmes to improve maternal health outcomes (Ravindran & Berer, 2000). The use of contraception however, has no benefit to reduce the risk of complications and death once a woman is pregnant. The following section focuses on programmes in antenatal care (ANC), delivery, postpartum care and emergency obstetric care (EmOC) to prevent maternal deaths.

Antenatal, safe delivery and postpartum care

The availability of trained health workers for antenatal care is deemed to be an important part of care to monitor maternal health during pregnancy and to allow for an early detection and management of pregnancy complications (Inam & Khan, 2002; Lincetto, Mothebesoane-Anoh, Gomez, & Munjanja, 2006). The rate of ANC visits in Zimbabwe in recent years has been high, with the current record standing at 93 percent of women receiving at least one ANC (Zimbabwe National Statistics Agency, 2009). Due to the HIV/AIDs pandemic in Zimbabwe, voluntary counselling and testing for HIV/AIDs are also offered to pregnant women (Khan et al., 2006; National AIDS Council of Zimbabwe, 2010). The HIV prevalence in pregnant women was estimated at an extremely high 16 percent in 2009 (UNICEF, 2010). The prevention of HIV transmission from a mother to her child, therefore, became an important element in ANC (Ferrand, Corbett, & Wood, 2009).

The effectiveness of ANC in reducing maternal deaths however, is questionable as it is especially difficult to predict birth complications during pregnancy when quality of antenatal care and communication systems across different levels of care is poor (Starrs, 1997). Moreover, the majority of pregnancy complications and maternal deaths are likely to occur during childbirth or during the first few hours of the postpartum period (Sinces, Syed, Wall, & Worley, 2007; WHO, 2010a). ANC visits therefore, do not

guarantee an automatic opportunity to correct identification of pregnancy complications. The Zimbabwe National Integrated Health Facility Assessment (2012) offers some explanation for this phenomenon. The assessment showed that less than 50 percent of the health workers had ever provided routine preventative medicines. Only 14 percent were able to identify dangerous signs in pregnancy; or provide adequate education and counselling in dangerous signs in pregnancy. Further, 36 percent have ever provided education on childbirth preparation.

These findings confirm other Zimbabwean studies (Fawcus, Mbizvo, Lindmark, & Nystrom, 1996; Faweus, 1997; Mbizvo, Fawcus, Lindmark, & Nystr, 1993; Mugweni, Ehlers, & Roos, 2008), that women received inadequate knowledge of dangerous signs in pregnancy. The 2010-11 ZDHS also showed that compared with urban women aged 20-34 years who had completed secondary education; rural, uneducated and younger women were less likely to receive health information or education (Zimbabwe National Statistics Agency, 2012b). Furthermore, with respect to HIV testing, of the 93 percent of pregnant women who had visited antenatal clinics, only 4.7 percent had known their HIV status; and only 1.8 percent of HIV-positive pregnant women had ever received anti-retroviral drugs (MIMS, 2009).

In Zimbabwe information on postpartum care are barely available (MoHCW, 2009). Without any clear guidelines, women are being discharged from clinics within a few hours to five days postpartum (MoHCW, 2008). The WHO recommends postpartum visits within six to twelve hours after childbirth, at six-days, six weeks, and six months postpartum (known as The 6-6-6-6 Model) (WHO, 1998b). Findings in the 2012 ZDHS however, showed that only 57 percent of women have ever had postpartum check-ups (Zimstat, 2012b).

Postpartum care has also been dominated by care for newborns and has shown little impact in lowering maternal mortality and morbidity (Maine, et al.,1997; Ravindran & Berer, 2000). Thirty years ago, an article entitled "*Where is the 'M' in MCH?*" by Rosenfield and Maine (1985) had already raised a concern on the neglect of women's health needs in maternal and child health (MCH) programmes; yet nothing has changed after three decades. A study of a postpartum care with 24 women from Jordan also confirmed that care services provided during the postpartum period had been dominated

by newborn health. On the other hand, the women reported they had never received any information on postpartum care (Khalafi, Abu Moghli, Mahadeen, Callister, & Al Hadidi, 2007).

Emergency Obstetrics Care

Every pregnancy and child birth poses a potential risk to a woman. Maternal mortality rate cannot be reduced without the provision of timely and adequate obstetric care for pregnant women who are experiencing complications (Paxton, Bailey, & Lobis, 2006; UNFPA, 2002). Emergency Obstetric Care (EmOC) is one of the four pillars of Safe Motherhood outlined in the ZMNH Road Map: 2007-2015. EmOC comprises two main levels: 1) Basic EmOC which should be available at any health facility and can be accessed within two hours from where women live; 2) Comprehensive EmOC that includes facilities to perform caesarean section and blood transfusion. They should be accessible within 12 hours from where women live. Table 2.4 (p. 26) describes established indicators, definitions, and recommended action on EmOC globally.

Most primary level facilities with qualified nurses can offer basic EmOC. According to the ZMNH Road Map, Zimbabwe has been able to meet those recommendations of providing at least four facilities with basic EmOC and one facility with comprehensive EmOC per 500,000 people (MoHCW, 2007). In reality however, due to the unequal population distribution or the geographical locations of those facilities, women living in remote villages may find it difficult to access those facilities. Whilst the majority of secondary, all tertiary and quaternary level facilities have the capacity to offer comprehensive EmOC, those services may not be available to women 24 hours a day, or seven days a week (MoHCW, 2007).

EmOC is also dependant on the availability of skilled health professionals who are trained to detect and manage pregnancy complications from developing into a life threatening situation (WHO et al., 2004). However, a review of ten observational studies from developing nations including India, Pakistan and Bangladesh show little evidence on the roles of skilled birth attendants in reducing the risk of maternal deaths (Scott & Ronsmans, 2009). The review showed that having one or more skilled health workers based at a health clinic did not guarantee for safe pregnancy or safe delivery for

women when medical supplies, training and supervision for health workers are insufficient.

Table 2.4 The United Nations process indicator for EmOC

UN process indicator	Definition	Recommended level
1. Amount of EmOC services available	Number of facilities that provide EmOC	Minimum: 1 Comprehensive EmOC facility for every 500,000 people Minimum: 4 Basic EmOC facilities per 500,000 people
2. Geographical distribution of EmOC facilities	Facilities providing EmOC well-distributed at sub national level	Minimum: 100% of sub national areas have the minimum acceptable numbers of basic and comprehensive EmOC facilities
3. Proportion of all births in EmOC facilities	Proportion of all births in the population that take place in EmOC facilities	Minimum: 15%
4. Met need for EmOC services	Proportion of women with obstetric complications treated in EmOC facilities	At least 100% [Estimated as 15% of expected births]
5. Caesarean sections as a percentage of all births	Caesarean deliveries as a proportion of all births in the population	Minimum 5% Maximum 15%
6. Case fatality rate	Proportion of women with obstetric complications admitted to a facility who die	Maximum 1%

Source: UNICEF, WHO, UNFPA (1997).

The quality of EmOC services is also reduced by delays in accessing timely and effective medical or emergency obstetric services (Thaddeus & Maine, 1994). To prevent these delays, the Zimbabwean government introduced maternity waiting homes as an essential part in obstetric care. The maternity waiting homes have also been introduced in other countries including Afghanistan, Eritrea, Lesotho, Mozambique, Nepal, Sri Lanka and Timor-Leste (Wild, Barclay, Kelly, & Martins, 2012).

Maternity waiting homes

Maternity waiting homes (MWHs) are residential facilities designed to accommodate women who live far away before giving birth at a nearby health centre (Spaansa, van

Roosmalenb, & van Wiechenc, 1998). Education sessions on maternal health, safe delivery and newborn care are also provided at these facilities (van Lonkhuijzen, Stekelenburg, & van Roosmalen, 2012). MWHs were introduced with an expectation that more women from remote areas would access safe birthing facilities if they were to be provided with accommodation near a clinic or hospital (Mathole, Lindmark, Majoko, & Ahlberg, 2004; WHO, 1996).

In Zimbabwe, it is recommended that all rural women should be offered the chance or opportunity to stay at a MWH between three weeks before and three days after delivery (UNFPA, 2012b). The implementation of MWHs in Zimbabwe aims to prevent delays in women's accessing obstetric or emergency services due to poor referral or communication systems or lack of transportation or ambulance services in remote areas (ZNHS, 2008). A review of 105 maternal deaths in rural Zimbabwe revealed that lack of transportation contributed to nearly 30 percent of maternal deaths (Fawcus et al., 1996).

The provision of a maternity waiting home however, does not guarantee for improved maternal health outcomes. Women's maternal health outcomes also depend on socio-cultural factors. For example the power imbalance between a woman and her husband in making decisions regarding care has been associated with a low utilization of MWHs (Roush, Kurth, Hutchinson, & Van Devanter, 2012). A study in Kenyan women revealed that 95 percent of the women from the Kilifi region needed to obtain permission from their husband to go to health facilities or MWHs (Mramba, Nassir, Ondieki, & Kimanga, 2009). The contexts of women's social and cultural lives are therefore important to understand women's explanation of safe birth or safe pregnancy.

2.5 Defining 'Safe Birth' and 'Safe Pregnancy' across cultures.

Jaffre' and Prual (1994) noted that poor quality in maternal health care as perceived by women was associated with poor interpersonal interaction between midwives and pregnant women. The authors observed different understanding and expectation of the whole process of pregnancy and childbirth between the women and their midwives. In another related study of 105 Quechua Indian women from rural Peru, a 'good childbirth' experience was explained as giving birth at home; women feeling familiar with the birth attendant and women being treated kindly or spoken to softly. Midwives' disrespectful attitudes or lack of interpersonal or communication skills were barriers to

women asking and telling about their health problems (Grossmann-Kendall, Filippi, De Koninck, & Kanhonou, 2001).

In other countries, such as South Africa, studies showed that women did not perceive significant health threats during pregnancy and believed that only one antenatal care visit was sufficient (Myer & Harrison, 2003). Other studies found that fears of caesarean section and anxieties with 'unfamiliar' hospital settings made it difficult to get women to accept referrals (Adams et al., 2005; Rööst, Johnsdottor, Liljestrand, & Essén, 2004). Some women also believe that obstetric complications are rare; and this influenced women's decision on when to visit antenatal clinics and where to give birth at (Osubor, Fatusi, & Chiwuzie, 2006). In Zimbabwe, there is a cultural belief that a pregnant woman is particularly vulnerable to witchcraft, especially during the very early stage of pregnancy (Mathole et al., 2004; Osubor et al., 2006). Although a woman is expected to book for the first antenatal visit at the 12th week of pregnancy (Zimstat, 2012a), such beliefs cause women to defer attending antenatal clinics until late in their pregnancy.

Zimbabwean communities are religious. Religious practices, teachings and doctrines as well, influence women's decisions regarding care for herself and her newborn (Ha, Salama, Gwavuya, & Kanjala, 2012; Maguranyanga, 2011). One study conducted in Zimbabwe by Maguranyanga (2011) examined behaviour that led to acceptance or rejection of preventive and precautionary health and the social practices among apostolic communities¹. The study concluded that negative maternal outcomes were the product of poor or no uptake of modern health care of such religious groups whose teachings and doctrines forbid followers from seeking medical care.

Community participation has also been recognized as an important vehicle to promote safe motherhood programmes (WHO, 2006).

¹ Apostolic churches emphasize prophet-healing through prayers and Holy Spirit and the use of western and modern medicine is seen as having little faith in God and highly prohibited (Ha et al., 2012).

2.6 Community participation to improve maternal health

WHO define community participation as a 'collaboration' in which people 'voluntarily or as a result of some persuasion or incentive, agree to collaborate with an extremely determined project, often by contributing labour and other resources in return for some expected benefits' (1999, p. 5). In this study, a 'community' is defined as a group of people who live in a geographical region who have similar characteristics in common (Chile, 2007). The benefits of encouraging the community participation approach in maternal health programmes relates to its ability to directly working with women, their families and communities to:

1. remove barriers to women's accessing quality and timely care (WHO et al., 1999);
2. develop culturally and socially relevant strategies to prevent maternal deaths (CARE, 2011);
3. be involved in the decision making process of local maternal health programmes (Brett, 2003).

The Safe Motherhood Demonstration project in Kenya (Warren & Liambila, 2004) has been successful in using the community participation approach to reduce maternal deaths. All of the problem identification, analysis and solutions to high maternal deaths in the community were discussed by the community. Efforts to improve maternal health outcomes included building partnerships; strengthening community action; promoting the use of skilled attendance during the antenatal, childbirth and postpartum period; and ensuring institutional preparedness at all levels.

In 2007, the Zimbabwe government conducted a Maternal and Perinatal Mortality study with 45,000 pregnant women participants between the ages of 12 and 49 from all ten provinces. The study used questionnaires. One of many objectives of the study was to capture women's voices on how maternal health could be improved. Women recommended areas of improvement were in the policy which included free deliveries at district hospitals and better remuneration of health workers to improve work satisfaction. Other suggested areas were improvement in the infrastructure, such as the maintenance of good roads to health facilities and its water supplies; the installation of electricity and generators at health clinics and constructing kitchens for maternity

waiting homes. In the area of service provision, women requested more health education about pregnancy; staff to update and maintain midwifery skills; sufficient drug supplies, and food and clean drinking water for in-patients; staff to treat clients with respect; and to encourage male involvement in pregnancy.

2.7 Summary

Maternal health inequalities exist amongst and within countries. Although there are similar causes for maternal mortality around the world, some of the causes are more frequent in certain regions of the world. For example, sepsis is more common in developing countries whilst maternal deaths due to caesarean sections are more prevalent in developed countries. As a result, to prevent these deaths, Safe Motherhood initiatives around the world have been on the increase.

Maternal morbidity and mortality in Zimbabwe has been attributed to the overall health system of the nation. There has been insufficient public funding or human resources in maternal health care services. On the other hand, ANC attendances have been high in Zimbabwe. However, ANC has not been found to be relevant in identifying complication to reduce maternal deaths based on the inability of the health workers to identify dangerous signs in pregnancy or to provide accurate and adequate education on that subject. Additionally, postpartum care has focused on the newborn, neglecting the health of the mother. None-the-less, the Zimbabwe MNH Road Map recognises the risk associated with childbirth, thus providing EmOC at all facilities, although they may not be available to women all around the clock; neither do they guarantee for a safe delivery without a supportive clinic environment like the availability of skilled birth attendants, equipment, medicines and MHW to address the three delays.

The key success of maternal health programmes have depended on how well the programmes integrate cultural understanding of safe motherhood; utilised local or indigenous knowledge, and harnessed community resources capacities and leadership. Accordingly, for policies to be effective, they should be informed and driven by women in their communities as well as other interested and relevant stakeholders, in order to effectively and positively tackle the social determinants of maternal health. This is necessary and paramount in formulating maternal health policies and programmes that

address maternal health issues by taking into account the social, cultural and economical factors that influence women's everyday lives.

CHAPTER 3

METHODOLOGY

3.1 Introduction

This chapter outlines the research paradigm, methodology, ethical concern, recruitment of research participants, data collection, analysis method and credibility of data collected. It begins with a discussion outlining the feminist interpretative research paradigm that guided the choice of the methodology and data collection methods. A review detailing the selection of the critical qualitative research methodology will follow. Next, the researcher's position will be explained, followed by a discussion on the key ethical concern of the research. The final four sections comprise of details of the field work and data collection; an explanation of the thematic analysis method used; methods used to enhance credibility of findings; and finally the summary of the chapter.

3.2 Theoretical framework and methodology

Thomas Kuhn's (1962) explains a research paradigm as an interpretative framework, which is informed by a set of beliefs about the world and how the world should be studied. Denzin and Lincoln (2011) explain the three major dimensions of a research paradigm to include ontology, epistemology and methodology. Whereas ontology is concerned with the nature of being and the question of what is real, epistemology is a branch of philosophy that studies the nature of what is knowable and the process of acquiring and validating the knowledge. And finally methodology is often explained as an artefact on how the researcher views and gains knowledge of the world.

3.2.1 Feminist interpretive research paradigm

The feminist interpretative research paradigm amalgamates feminist theory and social interpretative/constructive epistemology to produce alternative knowledge with regard to those who are marginalized or oppressed (Hesse-Biber, 2012). Feminist research is politically astute and aware of the way knowledge is constructed by the dominant groups in the society. The feminist theories argue that social settings, institutions, and culture have been dominated by men or the dominant groups to the exclusion of women or others who are oppressed (Cornwall et al., 2008; Guba & Lincoln, 1994; Landman, 2006).

In this research, the researcher viewed oppression as the underplaying or deliberate ignorance of women's knowledge in relation to maternal health, safe pregnancy and safe delivery. The researcher further sees women as the product of the social, cultural, and political realms associated with where they live. Women, especially rural women lack voice and representation in the development programmes or policies affecting their lives (United Nations, 2013a). Women's participation in development activities has been ignored for centuries (Smith, Harper, Potts, & Thyle, 2009; World Bank, 2003). Feminist researchers, therefore challenge the relevance of the Euro-North American centric policies and programmes on global Safe Motherhood initiatives to address poor maternal health for indigenous women living in the Sub-Saharan Africa or South East Asia regions (Bailey et al., 1996; Cornwall et al., 2008; Östlin et al., 2006).

In Zimbabwe, the rural society has been constructed by patriarchal ideologies. Young girls are brought up to accept and submit to the socially constructed and gendered values, norms and roles. Women are expected to be a good wife and a mother; putting her needs secondary to the needs of her family (Sen et al., 2007). Hence, voices of these poor rural women remain unheard (United Nations, 2013a).

Feminist researchers acknowledges the importance of women's collective voice to provide alternative knowledge and meaningful perspectives on matters of importance to their health and well-being (Allendorf, 2007; Campbell & Wasco, 2000; Furuta & Salway, 2006; Govindasamy, 2000; Lincoln & Denzin, 2011). Feminist research supports research methodologies that are empowering and participatory; which build on local knowledge and traditions; and establish scholarships and practices that are women-centered. For that reason feminist researchers invite research participants to a non-exploitative relationship to use their knowledge to inform changes and improvements in women's lives (Wadsworth, 2001).

This research, through discussions with women's groups, the researcher hoped to gather women's collective aspirations and ideas on ways to improve women's positive experience and remove barriers to women's participation at maternal health care services in Mutare. The researcher believes that women should be at the forefront of the development of maternal health policies and actions.

Feminist theory or research is compatible with social interpretive epistemology because both see gender as socially constructed, and that gender categorization is reinforced by the dominance of hetero-normative ideology (Holloway, 1997; Howe, 2003; Lincoln & Denzin, 2011; Schwandt, 2000). In this research, the researcher believes that Mutare women's understanding and interpretation of their social realities is socially constructed. Hence, it was important to seek women's guidance and explanation of the relevant social context of their maternal health. Denzin and Lincoln (2011) argue that 'the knowledge' cannot be separated from 'the knower'. The knowledge of women's life realities therefore would tell a story about women's community, culture, social and political circumstances (Guba & Lincoln, 1994; Holloway, 1997).

3.2.2 Critical qualitative research methodology

Qualitative research methodologies have become almost obligatory for feminist and interpretative research (Mason 1997; Travers 2001; Westmarland 2001; Landman 2006). Qualitative research aims to create in-depth understanding of human experiences and social interactions through collecting and analyzing non-numeric data. Therefore, qualitative methodology was arguably the best method to capture those social phenomena and examine the meanings, experiences, and views of women participants (Holloway & Wheeler, 2004; Lincoln & Cannella, 2004b; Lincoln & Denzin, 2011; Ulin, Robison, & Tolley, 2005).

Critical qualitative research based on social interpretative epistemology aim to explore discourses and mean-making (Parker, 2011). Further, critical qualitative research takes a naïve approach whilst inquiring into a social phenomenon. In this study, the approach challenged taken-for-granted assumptions. It determined to examine social realities as they were bound by historical, political or cultural context (Parker, 2011). For instance, it allowed conversing of sensitive issues like the social dynamics between the women and their husbands with the researcher (Hester, Donovan, & Fahmy, 2010). It also allowed the researcher to adjust, or amend the research process or questions according to the participants' preference (Harding, 2013).

3.3 Researcher's positioning and the role of reflexivity

Born, raised, and married in Zimbabwe, the researcher can relate to the cultural norms and traditions that enforce the submissive nature of women, in which women do not

have much of a say in any decision making. More so, having personally worked in foreign funded evaluation projects, run by donor agencies that had no particular experience in maternal health in rural Zimbabwe, the researcher had insight on what constitutes a ‘good programme formulation’. The researcher’s choice of research topic was therefore influenced by the realisation that the missing link may be on women’s participation in the formulations of interventions to reduce the continuing escalating maternal mortality in Zimbabwe.

The chosen research paradigm and methodology was based on two beliefs: 1.) women, are not being given the opportunity to participate in the programme decision making; and 2) women are better positioned to give insight on the medical and underlying social causes of maternal death and recommendation on how to prevent those deaths. The researcher values the perspectives of women on matters important to their health and well-being; therefore women’s knowledge should be acknowledged and taken into account in all maternal health policies and activities.

The researcher also follows Denzin and Lincoln’s (2011) notion that ‘knowledge’ cannot be separated from ‘the knower’. It helps to maintain critical awareness of the way women’s making of meaning of their experiences during pregnancy or childbirth, which is shaped by their historical, political, economic and cultural context. Thus, in the data analysis stage, the researcher endeavoured to be mindful and conscious of her own thoughts, interpretations, assumptions and emotions (Anderson, 2008; Guba & Lincoln, 1994). During the field research, the researcher recorded her feelings, thoughts and interpretation in a research journal. Later, these field notes and research journals were used to examine the researcher’s interpretative acts as opposed to women’s interpretation of their experiences.

3.4 Ethical consideration

Ethical approval was sought and granted via the Auckland University Ethics Committee [AUTEC] on 1 July 2013, See Appendix A. Authorization to undertake the study in Mutare, Zimbabwe was granted by the Manicaland Provincial Medical Directorate. The primary ethical matters central to this research related to the appropriate use of the *Shona* language; and the recruitment of minor participants aged below 16 years. This group of participants is seen as a vulnerable population requiring the researcher to take

extra care and consideration on the participants' behalf. According to AUTECH (2012), consent must be sought from people of or over the age of sixteen. Where such consent is obtained, AUTECH reserves the right to require parental or guardian's consent as well if it is deemed necessary. Thus, participants recruited for this study were between the ages of 16 and 49.

All participants were made aware that their information would be noted or audio-taped. Participants could refuse their information to be audio-taped. They were assured of the confidentiality of their information and that their identities would be removed from the information. Those who consented to participate in the study could refuse to answer any questions or withdraw from this study at any stage without needing to give an explanation to the researcher. The Participant Information sheet was explained in detail to make sure women understood their rights as participants. (See Appendix B). The researcher was also made aware of the social etiquette and norms she had to adhere to when working with women in rural Mutare. It is polite for a young woman, like the researcher, not to wear trousers and to kneel when greeting the elders.

3.5 Field work and data collection

The field research was conducted in August 2013 during a politically volatile situation of the Presidential election in Zimbabwe (BBC News Africa, 2013). For the safety of the researcher and the safety of the participants, it was appropriate to recruit participants from the health facilities and not directly from the community.

3.5.1 Recruitment

Initially, the plan was to approach and recruit women in the community. Community leaders such as the community chief counsellor or the herd-man would be approached in order to obtain permission to work with women in their communities. Due to the sensitive political nature of the presidential election, community gatherings were avoided amidst fears of being accused as campaigning against the status quo. For safety and practical reasons, the recruitment plan was adjusted. Following the directive of Mutare local health authority, the researcher was accompanied by a figure of authority and the participants were recruited from the health facilities. As there was no public transportation to reach those clinics and some of the clinics were difficult to reach, the researcher relied on transport assistance from a local non-governmental organization

that conducted routine surveillance in rural health clinics. The research schedule and field visits were therefore amended to match the surveillance schedule. Hence, the recruitment of research participants was conveniently conducted in three clinics and one hospital.

A total of 25 women participated in this study. The number of participants recruited was determined by theoretical saturation, where recruitment stopped when little new information was being added (Glaser, 1992; Kuzel, 1992). The inclusion criteria was: women, aged between 16 and 49 years old, who could speak *Shona*, who at the time of interview were accessing maternal health services for antenatal care, childbirth, or postpartum care.

3.5.2 Participants

Of the 25 participants, 13 participated in in-depth interviews and 12 participated in two focus group discussions. The first focus group included eight women and the second included four women. Women who participated in the in-depth interviews were either receiving antenatal or postpartum care; and all women in the focus group discussions were recruited at maternity waiting homes. They were in the late stage of pregnancy. Women's ages ranged from 16 to 30 years old.

In summary, nearly half of the participants were teenagers (N=11). Teenagers in this study are defined as respondents between the ages of 13-19 years of age. All of the respondents except two were married. Most of the women were literate. In Zimbabwe, persons aged 15 years and above who have completed at least grade three of primary education are considered to be literate (Zimbabwe National Statistics Agency, 2012a). The education system in Zimbabwe includes seven years of primary education and six years of secondary education. Children enter a primary school at the age of six. By then most children would have attended two years of pre-school. Generally, students complete their primary education and enter a secondary school at age 13. Students usually choose to leave secondary school at form four (at about age 16) or form six (at age 18). During their fourth form, students are required to sit for a national examination which includes five subjects: English, Mathematics, Science, History and one technical or vocational subject. The majority of the women had some secondary education. However, none of these women respondents had advanced beyond Form four. Six

women only reached and completed their primary education. One woman had not even gone to school. Table 3.1 includes demographic details of the respondents.

Table 3.1 Demographic profile of participants

Data Collection Method	Pseudonym	Age (Years)	Education (Years)	No. of children	Marital status
Interview	Tsitsi	16	10	0	Married
Interview	Anna	17	12	0	Married
Interview	Chipo	17	8	1	Married
Interview	Madei	18	12	1	Married
Interview	Rudo	19	12	1	Married
Interview	Sarudzai	19	12	1	Married
Interview	Martha	23	8	2	Married
Interview	Bertha	23	12	2	Married
Interview	Rumbidzai	23	11	3	Married
Interview	Danai	25	8	3	Married
Interview	Susan	25	10	2	Married
Interview	Tendai	26	8	3	Married
Interview	Kudzai	30	8	4	Married
Focus group 1	Vimbayi	21	12	2	Married
Focus group 1	Tecla	19	11	0	Married
Focus group 1	Melody	24	12	2	Married
Focus group 1	Tino	20	12	2	Married
Focus group 1	Netsai	25	12	3	Married
Focus group 1	Tariro	17	12	0	Married
Focus group 1	Tatenda	18	8	2	Single
Focus group 1	Lydia	17	10	1	Married
Focus group 2	Mildred	21	8	2	Married
Focus group 2	Florence	18	10	0	Married
Focus group 2	Mellissa	22	12	3	Married
Focus group 2	Tinashe	23	0	0	Single

When asked to describe their economic status, all of the respondents said their economic status was ‘average’. Women defined their economic status based on family ownership of material assets, such as a house, land, two chickens and a goat. Others explained

acquisition of herds of cattle. This implies that the meaning and context of economic status is culturally or country specific (Brudy, 2005). Communal and commercial farming is common in the study area. All of women respondents worked in their own vegetable gardens and a few of them operated a small home-based hair-dressing business. Even though women desired to work out-of-farm industries, there were not many job opportunities in the communities.

3.5.3 Data collection tools

The main aim of this research has been to explore rural women's understanding and perceptions of maternal health care and obstetric emergency services in Mutare, Zimbabwe and outline ways to improve the services for the better. Six topical research questions were developed as a guideline to explore women's 1) knowledge of maternal health care; 2) experience in maternal health care services; 3) perceptions of maternal health care services; 4) understanding of dangerous signs in pregnancy; 5) knowledge about postpartum as a means to reduce risk; and 6) priorities for improvement in maternal health care and emergency obstetric care.

The data collection method included in-depth interviews and focus group discussions. In-depth interviews focused on exploration of women's understanding and perceptions of maternal health care (questions one to five). The focus group sessions explored priorities for improvement in maternal health care services (question six). An individual in-depth interview lasted between 30 to 50 minutes; whilst each focus group discussion took between 60 and 90 minutes.

Interviews

In-depth interviews were central to this research. In-depth interviews are useful to explore full information about someone's thoughts and behaviours on a specific issue. This kind of interview is often used to provide a better understanding as to why a specific health programme is working or not, and why (Boyce & Neale, 2006). Informed by the feminist interpretive epistemology, in-depth interviews were observed to provide a safe venue for women to express their feelings, emotions, experiences and perceptions on a topic of interest that would otherwise go unheard (Hesse-Biber, 2012).

In-depth interviews therefore, enabled the application of informal social dialogue in order to explore women's personal experiences and perceptions of maternal health care

in greater depth (Harding, 2013). The researcher had developed a list of questions to guide the interview to facilitate the process as this was her first qualitative research experience. These questions only served as a guideline. They were not asked in any specific order. The order of the questions depended on the women's leads. The interviews began with introductions, followed by informal questions asking women about, for example, the gestational age of her pregnancy and the number of children she had. When the situation permitted, the researcher also asked women some demographic questions, for example, their age, education or occupation. The researcher asked the demographic questions until later in the interview as this was less intrusive.

Focus group discussions

The researcher acknowledges women and their community as a unit of identity that has resources and capacities to better women's health and well-being. Therefore, the researcher follows other theorists and researchers who believe in the participatory tenets of research to utilize local knowledge and experiences for community improvements (Green et al., 2003; Israel, Parker, Becker, Allen III, & Guzman, 2003; Viswanathan et al., 2004). Focus groups were therefore suitable for the purpose of solution-focused and exploratory research (Barbour, 2007). A group discussion is also an ideal setting to generate greater elaboration and a fuller discussion of ideas than individual interviews (Fontana & Frey, 2005). Group discussion settings re-balance the power relation between the research participants and the researcher, a distinguishing feature of feminist paradigms (Cooper & Endacott, 2007; Fallon, 2003). Recognising the diversity in the group, a group discussion provides a flexible environment favourable to a free-flow conversation amongst the participants (Silverman, 2002).

The two focus group discussions (FGDs) were conducted at the end of the data collection phase. In this research, the group discussions were used for two reasons: 1) to confirm the result findings from the in-depth interviews (Power, 2002); and 2) to explore women's collective thoughts in relation to priority areas of improvement of current maternal health care services. Each FGD began by a presentation of a summary of the findings from the in-depth interviews. The groups were asked to confirm or challenge it. Members of the groups discussed and exchanged ideas; challenged other's views and opinions; and shared and compared perspectives on maternal health issues (Morgan, 1994; Stringer, 2007).

The use of in-depth interviews and focus group discussions complemented the chosen research paradigm and epistemology. Both methods allowed the researcher to explore the social, cultural, political context of maternal health services in rural Zimbabwean women in a way that was empowering and empathetic to women than other more structured methods cannot (Olesen, 1994). The qualitative research methods gave the research participants the power and authority to decide which matters were of most importance to them.

3.6 Thematic data analysis

Thematic analysis was chosen for this research because it is suitable to identify patterned meaning across stories and experiences voiced by study participants as accurately and comprehensively as possible. It is also a widely used method of data analysis in qualitative research. It is defined as a rigorous, yet inductive set of procedures designed to identify and examine themes from textual data in a way that is transparent and credible (Braun & Clarke, 2006; Harding, 2013). A theme is the meaningful 'essence' that runs through the data (Braun & Clarke, 2006). Thematic analysis brings together fragments of ideas, through identifying patterns in the text that capture recurring or commonalities or differences in meanings or feelings (Gibson & Brown, 2009). Thematic analysis can be used across a range of theoretical and epistemological approaches (Ulin et al., 2005).

Themes were strongly linked to the interview and focus group data (Fereday & Muir-Cochrane, 2006; Patton, 1990). All of the data from the interview and FGDs was audio taped, transcribed and translated into English. The data analysis started off by becoming familiar with the data collected from the women's accounts. This was followed by the coding of the data. The next step involved sorting those codes into themes. For example, a theme related to 'quality of maternal health care' included coding on interpersonal relations between women and health providers; staff's skills and experience; effectiveness of service delivery; and accessibility of maternal health facilities. When an emerged theme did not fit into an existing category, a 'free' or another category was created (Morse 2008). This last process is known as reviewing and defining themes. The writing process took those meaning units, grouped them together, and organized them into themes and sub-themes.

3.7 Establishing rigour

Feminist researchers are usually thought to abstain from evaluating the merit of their research. Feminist researchers who apply the interpretive paradigm accept the principles of validity, objectivity, reliability to deem their work credible (Lincoln & Guba, 1985). To check the credibility of the themes, ideally the researcher should get feedback directly from the participants (Cooper & Endacott, 2007; Guba & Lincoln, 1981; Krefting, 1991). However, this was not feasible given the time and transport constraint of the researcher. It also meant searching for the participants at their household which was not practical as the researcher did not know where they lived. Whereas participant validation was quite difficult more so than it was worth (Krefting, 1991), triangulation was used instead as a means to validate the themes in addition to referential adequacy.

3.7.1 Triangulation

Triangulation uses multiple sources of data or techniques to confirm emerging findings (Cohen, Manion, Morrison, 2001; Cooper & Endacott, 2007; Mason, 2002). The methods applied involved interviews with women of different circumstances (that is, women attending antenatal care, postpartum care and those pregnant women in mothers' waiting shelter); text analysis and observation. This triangulation allowed the researcher to contextualize the knowledge from multiple points of view (Green, 2000), to create a joint and collaborative reconstruction from the multiple existing realities. Furthermore, the methods used in the triangulation identify with the same ontology and epistemology of the feminist interpretive paradigm as they are methods that are most suitable to construct realities together. They were very effective in making sense of the data underpinning this research (Denzin, 2011; Olsen, 2004).

3.7.2 Referential adequacy

The quality of data generated in a research study depends largely on the skills and expertise of the interviewers (Denzin & Lincoln, 2000; Guba & Lincoln, 1981). Prior to the field research, an extensive review of research methodologies employed in similar research was completed. To gain experience related to the basic skills of conducting interviews and focus group discussions, two pilot interviews and a small group discussion were also carried out.

3.7.3 Applicability

The applicability of a research study reflects the degree to which findings can be applied in other areas (Lincoln & Guba, 1985). The direct findings of a qualitative research are not usually generalisable as a qualitative research is usually done in a specified setting and is informed by its study epistemological orientations (Ritchie & Lewis, 2003). However, theoretical insights gained from a qualitative research study can be transferable to similar settings and context (Dixon-Woods, et al., 2005; Lincoln & Guba, 1985; Noyes & Lewin, 2011; Walsh & Downe, 2005).

3.8 Summary

This chapter outlines the research paradigm, methodology, ethical concern, recruitment of research participant, data collection and analysis method. The feminist interpretative research paradigm was chosen to produce alternative knowledge with respect to those who are marginalized or oppressed. Rural women living in Mutare, eastern Zimbabwe are viewed as marginalized with regard to the development of policies and programmes in relation to maternal health care services.

The critical qualitative research methodology was employed to complement the research epistemology and it examined how language, social context, culture and history shape women's lives. The critical qualitative research approach also challenges narrow viewpoints assumptions. In-depth interviews and focus group discussion were utilized to best capture women's experiences and understanding in relation to maternal health, safe pregnancy and childbirth; dangerous signs in pregnancy and priority areas for improvement in maternal health.

Twenty-five women aged between 16 and 30 years old participated in this research. They were recruited from four health facilities. This research was conducted during the volatility of the political situation in Zimbabwe during the presidential election. Recruitment of respondents, places and processes of interviews and focus group discussion were carefully amended to ensure the safety of the researcher and research participants.

Thematic analysis with an inductive approach was employed to analyse data. Triangulation and referential adequacy were methods adopted to establish rigour of the data.

CHAPTER 4

RESULTS

4.1 Introduction

The research study has explored women's: 1) knowledge of maternal health care; 2) experiences of maternal health care; 3) perceptions of maternal health care; 4) understanding of the dangerous signs in pregnancy, childbirth and postpartum period; 5) knowledge about postpartum care as a means of reducing risk; and 6) areas of priority for future improvement of maternal health services and policies. This chapter includes six sections. It begins with the introduction of the chapter structure followed by a brief description of the study context. Sections three to seven include a discussion on themes that emerged from the data. These are on women's experiences of maternal health care; women's understanding of quality of maternal health care; and women's knowledge of dangerous signs of pregnancy. The last section discusses the findings from the focus group discussions. This section outlines women's aspirations, ideas and recommendations on future improvement in maternal health and development of programmes and policies.

To begin this chapter, we will begin with Sarudzai's story:

Sarudzai (not real name) was 19 years old and 8 months pregnant with her second child. Her first pregnancy a few months ago ended up with a still birth and because she was not happy with the first clinic she decided to visit a different health facility. She was still upset about her experience with the other clinic. She believed that staff negligence had caused the death of her first baby. She did not understand how she was made to go for days in labour with no healthcare staff person close by in attendance. She had a caesarean on the fourth day after she felt she was in labour. She said if a healthcare staff person had been there for her, she would have not lost her baby. Like many other pregnant women in her village, every pregnant woman was given a blue card, which she had to bring to antenatal clinic. This card was supposed to record her antenatal visits and what was done during those visits such as blood tests for HIV/AIDS, tetanus toxoid vaccination; nutrition, and hygiene and health education received. Her card was blank, nothing had been written on it. She was fearful of asking about the purpose of the card as she was anxious that the staff would shout and embarrass her in front of the other

mothers. Sarudzai said she did not even know what to ask. She was afraid that if she asked she would be seen as telling the staff how to do their job. Even after the loss of her first child she was still afraid to ask about her health in her second pregnancy ...

This story illustrates one of many stories of the 25 women who participated in this study. All of the women have been given pseudonyms.

4.2 Study context of research participants

The demographic details of the research participants are in chapter three. The research community depends on their own farming products or vegetable gardens for their everyday needs. Barter trade is the system practised for exchange of goods or services. The currency of Zimbabwe experienced a rapid decline in value and in 2009 the government introduced multiple currencies. The United States dollar (US\$) is the dominant currency. Because the government cannot print out the US\$, the availability of this currency is very scarce. At the time of the study, even though there were seven mining companies operating in the district, jobs in the mining industry are very limited.

Mutare rural district is divided in to 38 wards. Each ward has one health facility which serves seven to twelve villages or a total of 7000 people. These health facilities which are normally referred to as rural health clinics (RHC) offer basic maternity care which includes care for low-risk pregnancy and a few beds for childbirth and postpartum care. Some RHC also provide maternity waiting shelters for women closer to their delivery dates. Dirt roads connect the villages with the RHC and part of the way to the district hospital. Public transportation however is very scarce, unreliable or too expensive. Women therefore would walk for hours to reach the nearest RHC or pay handsomely for transport to go to the district hospital in the city.

Emergency care services appear to be not functional. In a case of an emergency, a mother is referred to the district hospital. The woman would be transported by an ambulance at a cost. Often a woman or her family is not ready with cash on hand. Generally no clinic staff accompanies a woman to the district hospital. Either she is sent alone or accompanied by her relatives. The distance between a RHC and the district hospital is between 17 and 140 kilometers. If travelling by an ambulance it would take between 20 minutes and three and a half hours.

The rural health facilities have an establishment of at least two primary care nurses; one of whom must have trained in midwifery. They are cadres who were trained at Primary Care Nursing schools throughout the country to mitigate the human resource issues. Initially the training was run for 18 months without any midwifery training. In 2008 the curriculum was revised and now includes two years of training inclusive of six month midwifery training. All the primary care nurses who took up the old curriculum have been required to up-skill and take the six month midwifery training. There are also Registered General Nurses who have a diploma in nursing degree. It is a three-year nursing training, post secondary school. Some clinics may have State Certified Nurses who were trained in the early 1980s. They were trained for only six months and most of them were assistant medics during the war.

Regardless of their qualifications or training components, all of these nurses provide various health services to the communities, ranging from maternal health, family planning, immunisation, and treatment for infectious diseases and accidents. They can also prescribe some medication (Provincial Epidemiology and Disease Control Officer, Provincial Medical Directorate, Interview, 03/09/13).

4.3 Women's experiences of maternal health care

Chapter three explained that interviews were conducted in the clinics. Hence, women approached the interview questions carefully. The researcher observed that women were very careful in choosing their language and expression. A few of them were very cautious and may have been selective in their answers. Words were carefully chosen as if women did not want to insult or criticize their health clinics or the nurses. The researcher was also made aware that women would refer to 'other clinics' when explaining their experiences of 'bad' services whilst comparing them with current clinics. This may suggest that women did not want to be seen as being critical or being difficult.

Women categorised their experiences of maternal health care into categories of 'ideal', 'good' or 'bad' services. Kudzai (age 30), a mother of four children, highlighted her expectation towards her nurse rather than describe her own experiences on 21/08/2013. She believed that a nurse should be a good support system for a woman during labour by providing comfort: *'It is all about being given a nice place to recover. The nurses*

should be funny in the labour room to ease us from pain.’ Another mother, Danai (age 25) in an interview on 15 August 2013 also focused on her childbirth experiences as an important event to reflect on her maternal health experience. Like Kudzai, she believed that a woman needed to be nursed and comforted during childbirth: *‘...a pregnant woman is not supposed to be over worked. Come delivery they would already be very tired to push the baby out. Even the baby itself would be tired after a long labour’*.

The conversations suggested that women viewed childbirth as an illness, possibly implying that the idea of giving birth in hospital is linked with an ill-health condition. Women might see themselves a patient needing a special care and treatment. Whilst it is true that a pregnant woman needs comfort and support during labour, pregnancy is not an illness or a disease. The thought of going to a hospital or a health clinic for childbirth also appears to relate to the belief that the hospital and clinic has the power and resources to prevent maternal deaths (see also section 4.6.3).

Women expressed their fears to ask the healthcare nurses questions. In the beginning of this chapter, Sarudzai (age 19) had lost her first baby before deciding to move to another clinic during her second pregnancy. Like other pregnant women, she was given a health card supposedly to record her antenatal visits and treatment received; yet her card was blank. Later she explained that she did not know the reason she had been given that card or the purpose of the card exactly. When asked why she did not ask the nurse, Sarudzai said *‘even what I know now from you [researcher] and what the purpose of this card is, it is not going to make a difference because we are still afraid to question those nurses’*.

Another teenage mother, Tsitsi (age 16) shared the same account in her interview on 10 August 2013 when receiving pills without knowing why: *‘Ha, just like the pills they gave us, we were just told to drink them, and we just did what the nurses told us without asking’*. Reasons given for women being fearful or anxious to ask the practicing nurses questions were that: *‘some of the nurses were not approachable. If you tried to exercise your rights it appeared as if you were going too forward ahead of the nurses’* (Bertha, age 23, interview, 08/08/2013). Therefore *‘no one went that far to complain and people just left it like that’*. (Tendai, age 26, interview, 07/08/2013)

A clinic usually has a suggestion box, yet women were still afraid to give feedback on the services. Maidei and Rudo explained that clinic patients were still afraid to put any

suggestions in the suggestion box because there was no confidentiality. The box was either put in the nurse's hub or in a place where the nurses had a full view of the box.

We were told that there is a suggestion box where we would write our complaints on paper then put the paper in the box. No one has ever gone that far to use the suggestion box. Even when people had complaints, people would just leave it like that. (Madei, age 18, interview, 10/08/2013)

Rudo (age 19) was doubtful if reporting a nurse would do her a favour:

You know what happens Auntie [the researcher]? For instance here at the clinic, there is just one sister. If I expressed disgruntlement of the services here, it would appear as if I was reporting her inability to do her duties. It would then backfire on me, if one day I got sick, and I did not have money. Would you think she would help me if she heard I had once ill-spoken about her? (Interview, 07/08/2013)

Women's experiences of fears, anxieties of asking any questions to the nurses created a circle of learned-hopelessness on the women's part. In this situation, women perceive the nurse practitioners as figure of authorities needing no women to question their practice. Further, women deliberately choose to be silent and muted, believing that silence is their best and safest option.

4.4 Quality of maternal health care.

Quality of care is a concept that include people's access to effective healthcare structures and processes of care when needed (WHO, 2006). Two important domains of measuring the quality of care are the accessibility and effectiveness of the care (Donabedian, 1988). In assessing the quality of care received, women respondents explained access to health facilities to influence quality of care. Women also saw effectiveness of care given to determine quality of maternal care, namely: 1) the effectiveness of clinical care encompassing skills and expertise of the healthcare staff and the effectiveness of the delivery of the service and; 2) the effectiveness of interpersonal care. This component was with reference to relations between the women and their healthcare providers; and the staff attitudes and work ethics.

4.4.1 Staff attitudes and work ethics

All of the respondents mentioned that a crucial element comprising good maternal healthcare is the friendly care of the nurses. Women were afraid to ask questions of their

nurses. They described the health staff's interpersonal skills, communication styles, attitudes and behaviour in during ANC visits and whilst assisting women during labour as unfriendly, inappropriate and unprofessional. Some women were certain that the nurses were accountable for their conduct. Rudo, a teenage mother (age 19) explaining to the researcher on 7 August 2013 said that nurses had put their own interest above the needs of women and it was unprofessional:

At times they had boyfriends in the houses and they did not want to be bothered. The moment you cried for help, it had to be that the baby was on its way for real. False alarm came with a scolding. They told you to call them when the baby was at the entrance. They said it was not good to keep putting the hand inside to check how far off the baby was.

On the contrary a few other women defended the 'unfriendly' attitudes of the nurses explaining that the nurses 'were always correct' and that these nurses had valid reasons to be scolding or shouting at the 'disobedient' women:

Ah, they did not shout. But there were cases when they did shout to women who registered late. Ideally one should register within three months of knowing that she was pregnant. Those who did not register in time, they got shouted at. Others came when they were six months pregnant or when they were in labour. (Tendai, age 26, interview, 07/08/2013)

So when the nurses shouted, it was simply because the women had not followed protocol that would have saved their own lives and that of their babies. (Rumbidzai, age 23, interview, 08/08/2013)

What happened is that you were told that your due date was on the 30th but then delayed in coming to the clinic; you could not blame the sister for shouting at you. (Anna, age 17, interview, 08/08/2013)

Interestingly, a few women also saw themselves as deserving blame or a scolding by the nurses for not doing what they were told to do. Women were quick to self-blame for missing out on important information because they were not attentive during the education session or came for antenatal check-ups not well-groomed. Others, like Martha (age 23), Susan (age 25) and Bertha (age 23) insisted that a woman needed to take care of her own hygiene like having a bath before coming for antenatal check-ups or else the nurses would scold them. '*...one would never go wrong with the nurses if they came for their check-ups well groomed*' (Bertha, interview, 08/08/2013).

Women also explained the staff's reproachable attitudes might relate to low work motivation. Tendai (age 26) believed that the nurses were not well paid. Rudo (19) explained that being a nurse is highly regarded by the community. A nurse will always get a job and that she can provide a financial support for her family. Many nurses therefore, have been forced into the profession by families. Rudo once heard one nurse complaining: *'this was not my job of choice...I was forced by my mother to be a nurse'*.

Women also recognised 'exceptionally' kind hearted and friendly nurses yet they were rare: *'some shouted at us, some did not. There were those that had a very good heart that you would get shocked that the person was a nurse'* (Sarudzai, age 19, interview, 10/08/2013).

The appearance and cleanliness of the women predicted the quality of the service they received from their nurses. Women who were well groomed would receive positive remarks from the nurses. Young mothers were viewed as naïve, inexperienced or ignorant. Chenai (aged 17) in her interview on 9 August 2013 said: *'I did not have much understanding of the programme. I was a first time mother so I didn't know about many things back then. Neither did the nurses tell me much'*. Therefore the nurses' conduct was much influenced by the nurses' subjective perceptions of the women's social status.

4.4.2 Staff's skills and experiences

Women believed that the quality of maternal health care was largely influenced by the skills and experiences of the nurse. Women explained that taking mother's weight and checking the baby's position was the only thing the nurses at the RHC were capable of. The nurses did not have sufficient training or skills to correct a breech presentation. Bertha (age 23) and Susan (age 25) who were individually interviewed on 18/08/2013 confirmed:

Bertha: The nurses here did not have the capacity to do so. I never saw the nurses here attending to women with pregnancy complications.

Susan: Once the nurse told me that my baby was not in its right position, she referred me to go to the district hospital. The nurses in the city were able to help me.

Young mothers expressed fears and anxieties about going to the rural clinics. They had heard from other women in their villages, that compared to other mothers, first time or

teenage mothers were more likely to be referred to the district hospital. Rudo (age 19) relayed her anxieties and fears to have her baby delivered at a rural clinic on 7 August 2013: *'In some cases, these nurses were scared to deliver women with first time pregnancies. Only a few nurses would deliver only on the condition that all was well. Otherwise, women were referred to the city most of the time'*.

Referring a teenage mother to a district hospital might be the standard of practice the nurses learnt from the nursing training. Rural women however, saw this as a nurse having poor skills or experience. At the same time, women might not be well aware that if a breech presentation was not corrected, the mother might have to undergo a caesarean section at the district hospital. The risk of having maternal morbidities (for example, haemorrhage, transfusion, injury to other organs, anaesthesia complications) and maternal deaths are between two and four times greater during a caesarean section than in a normal childbirth (Liu et al., 2007).

4.4.3 Effectiveness of service delivery care

Effectiveness of service delivery largely depends on the availability of trained health workers coupled with an enabling environment for early detection and management of complications, and a safe delivery (Inam & Khan, 2002; Lincetto, et al., 2006). Unfortunately, in Zimbabwe, the ratio of nurses/midwives for the number of population is low, at 0.72:1000 (World Bank, 2010). Most doctors or midwives prefer to work in big cities. Consequently, a rural health clinic is manned by two primary care nurses, one with midwifery skills. If the one nurse is sick or unavailable, the other nurse is left on her own to serve the entire community.

Women reported waiting for long waiting hours due to lack of staff and others, staffs' inability to provide medically appropriate care. Chipso (age 17) often had to wait for seven hours before her turn for a check-up. She often felt hungry during those long waiting times. When she was given an iron tablet she had to take it on an empty stomach which made her feel sick and nauseated.

The problem with them was that they would make us wait for a long time in the queue without being served. They opened at 0800Hrs and I only left between 1400-1500hrs after being served because they were few of them. They would give you those brown pills [iron tablets] to drink on an empty stomach causing nausea if you took them on an empty stomach. I had to sit down for a while for the nausea to go before I made my way home. (Interview, 11/08/2013)

Women also explained the unavailability of transport to contribute to delays in women reaching emergencies care services. According to the women, it is necessary for good quality maternal healthcare to provide for free transportation in an emergency situation. The ambulance is not free and it is usually stationed at the district hospital. Whilst conducting this field research, the researcher observed that there were no ambulances at the clinic sites as it was reported they had either broken down or had no fuel.

4.4.4 Accessibility of maternity health facilities

Many women in this study chose to deliver at the health facilities. Women's accessibility were however, influenced by the cost associated in using the RHC. On 29 August 2013, the researcher conducted a FGD with women who were staying at a MWH which was a rural hospital. Women bemoaned the fact that even though the bed and the delivery cost was free they still found it very expensive to stay at a waiting home.

All of the group members explained that they were required to bring their own sanitary pads, gloves for the nurses to use, razors to cut the umbilical cord, methylated spirit and pin to treat and hold the baby's navel. They had to incur extra cost for transportation and to buy those items in the city. Women found it hard to understand why the facilities did not provide those items when they had normally provided them. Home deliveries were seen to be more convenient and less expensive than giving birth in a health facility.

Vimbayi (age 21): ...we did not have money to buy cotton and the clinic wanted cotton wool. So the best way was to give birth at home because I did not have the cotton. In addition, we were required to bring money for ambulance transport, money I did not have. They also wanted us to bring pins to hold the baby's navel but when you gave birth at homes, you just tied it. Now here, they required that pin but I did not have money to buy it so it was better to give birth at home. Gloves, I was told to buy, it also needs money.

Tecla (age 22): ...yes even if there were gloves in the clinics, women were told to still come with them just in case the clinic ran out of them. Razor, I did not have and all those things needed money which I did not have. So I saw it better to give birth at home because we did not need to use a pin. Cotton, I put cloths, so no need to have cotton wool. As for methylated spirit, ashes were used ... so no money was involved.

Women commented that having a MWH is a good thing as a woman would receive timely and adequate care when needed. In Zimbabwe, it is recommended that all rural women should be offered to stay at a waiting home between three weeks before and three days after delivery (UNFPA, 2012b). Staying at a waiting home however, added financial burden to women and their families. Women were also required to bring their own food and firewood. In reality, women would not go to a waiting home until they started to feel some labour pain. Women made this conscious decision to avoid financial burden to their family. Tatenda (age 18) and Netsai (age 25) explained:

Tatenda: Another issue is about food. What also happened was that I only had 2 gallons of mealie-meal at home and I needed food to eat whilst I was waiting to deliver. Honestly, was it proper to get a share of that two gallons? How about meals for my family? It is a really big issue.

Netsai: Some women told me that it was better to just go when they felt labour pains to avoid these other needs. Problem is, by the time they reached the clinic; the unborn baby was obviously tired.

A woman's decision to stay at a waiting home was also associated with support from her husband or whether she was single or an orphan.

If the shelter provided some food, it would have been much better because other women really did not have. Some women were just dumped straight after getting pregnant; some were orphans and some just had husbands who did not care. Some women were just told to go the shelter by their husbands and they were told that after delivery, 'call me and I will come pick you up'. He would not even have any interest in seeing the place. So you see, these are some of the reasons women delayed or just did not utilize the mothers' shelters. (Tinashe, aged 23)

Further, without support from her husband and family, a woman would be left alone to prepare for the childbirth: *'There are men who really do not care... as the woman you know what you needed to prepare for the childbirth ... you are required to bring in items so you had to work to buy those things'* said Tino (age 20).

Mildred (age 21) explained that poor women found it difficult to stay at the waiting shelter together with other women who were financially able. It was easier for those who had little, to choose home deliveries instead. The nurses at the homes often shamed women who did not bring things: *'When you went to the clinic without proper preparation, you heard the nurses saying 'Come all of you and see this woman coming to the clinic to give birth but not well prepared''* recalled Florence (age 18).

Women therefore had at least two places of delivery options. Whilst some chose giving birth at home, others like Madei (age 18) and Kudzai (age 30) chose to stay at a MWH to give birth at the RHC. They both believed that giving birth at the RHC would provide them with good modern care:

I am very happy with the way I had my safe delivery at the clinic here. I would not have experienced the same if I had delivered at home. There is no way that a traditional birth attendant would tell me to hold my baby like this, or weigh my baby to see if she got the right amount of kilograms. My baby was too big so I had to be cut for the baby to come out. If I were at home, I do not think I would have been cut and the baby would have then died inside. If the nurse was not there, who would have stitched me up? (Kudzai, Interview, 21/08/2013)

Madei when interviewed on 10 August 2013 was happy with the service at her clinic:

They have been treating me well so far. They told me how to breast feed the baby; they checked if the baby was okay, how to handle the baby. Especially us new mothers, the nurses showed us how to best handle the baby in the arms. At home, no one seems to care.

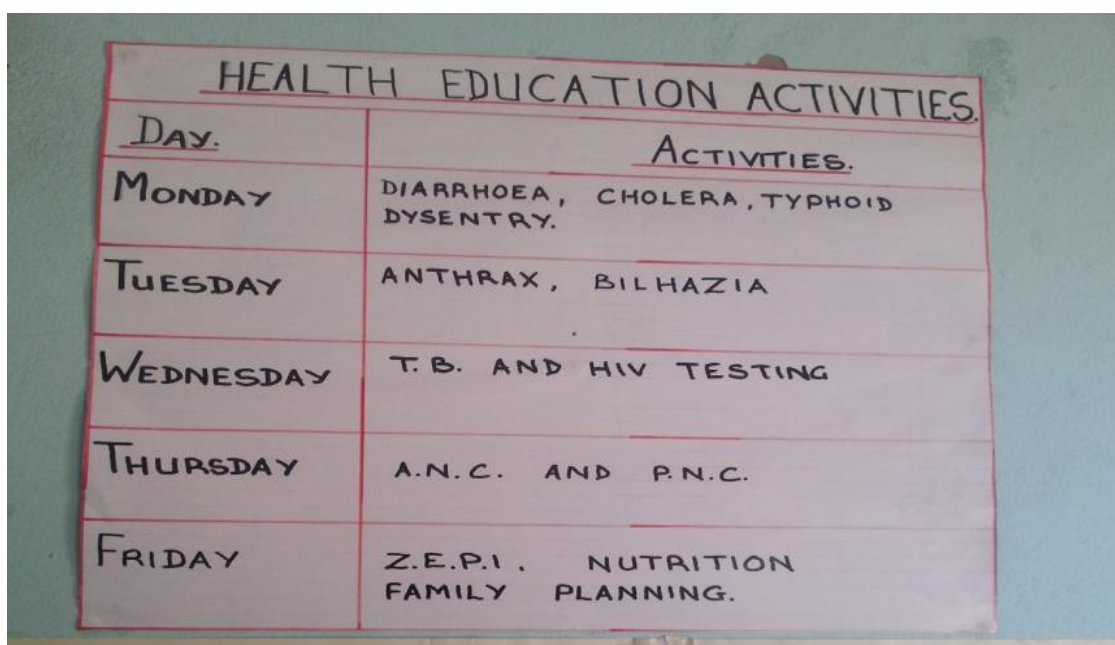
4.5 Women's knowledge of maternal health Care: Kuscero and bed rest

Maternal health education features prominently in literature as a mechanism employed during ANC visits to enhance women's maternal knowledge thereby increasing service use and consequently positive maternal health outcomes (Levine, et al., 2004; Schultz et al., 1994).

4.5.1 Kuscero - measuring women's weights

In Zimbabwe, a pregnant woman is recommended to have at least four antenatal (ANC) visits. These include one visit each during the first and second trimester and two visits during the third trimester (at 32 weeks and between 36 and 40 weeks of pregnancy) (Zimstat, 2012a). During ANC visits, women would be expected to receive some of the

following: regular health check-ups, tetanus injections, education on dangerous signs in pregnancy, iron supplements, screening and treatment of STIs and HIV counselling and testing (USAID, 2005). In addition, the Zimbabwe health services policy stipulates that every health facility should have a health education activity plan displayed and visible to inform visitors of which particular activity fall on a particular day. See Figure 4.1.



DAY.	ACTIVITIES.
MONDAY	DIARRHOEA, CHOLERA, TYPHOID DYSENTRY.
TUESDAY	ANTHRAX, BILHAZIA
WEDNESDAY	T.B. AND HIV TESTING
THURSDAY	A.N.C. AND P.N.C.
FRIDAY	Z.E.P.I. NUTRITION FAMILY PLANNING.

Figure 4.1: Health Education Activity Chart

Source: Picture taken by researcher at one of the study clinics

Although the days may vary across different health clinics, each clinic generally runs at least a session on antenatal and postpartum care. As a matter of interest, the majority of the women respondents were not able to give detailed accounts in relation to the health information or services they received during ANC visits nor were they able to give the closest local term to explain antenatal care. Women used a local term *scero* (English: scale) to refer to a woman being asked to stand on a weight scale for the nurse to note her weight. Whereas a few of the women mentioned receiving an iron supplement or tetanus injections only as some of the activities done during ANC, one woman mentioned a syphilis screening programme. All of the women spoke about HIV counselling and testing yet the depth of their knowledge with respect to the activity varied amongst them. A few women including Chenai (age 17) and Kudzai (age 30) said the procedure was voluntary and explained if the first test result was negative, they would be advised to take another test in three months to confirm the initial result.

Tendai (age 26), the only person who was able to give a detailed description of the steps involved in the HIV testing, was enrolled in a local Prevention of Mother to Child Transmission (PMTCT) programme.

...the moment you discovered that you were pregnant; you had to register at the clinic. At the clinic the nurses tested for HIV. Those who tested positive were given drugs to prevent transmission of the virus to their unborn baby. It was followed by a day per week of training on how antiretroviral drugs should be taken to prevent mother to child transmission. Come delivery, we were told to come and stay at a mother waiting home. There is a pill that we took just before we got into the delivery room (Tendai, age 26, interview, 07/08/2013).

Hypertension (pre-eclampsia and eclampsia) and haemorrhage are significant causes of maternal deaths in Zimbabwe (Ministry of Health and Child Welfare, 2012). To prevent maternal deaths, women should know the dangerous signs in pregnancies and what they need to do in emergencies. Women's understanding of dangerous signs in pregnancy included 'feeling unusual' or 'feeling something is wrong'. They were not able to give further details. Only those who had personal experiences were able to correctly explain dangerous signs in pregnancy to include: *'stomach pain, bleeding, high blood pressure, diarrhoea, uncontrolled vomiting and premature labour'* (Madei, age 18, interview, 10/08/2013).

A few women thought that a breech position and 'water leaks' were dangerous signs in pregnancy. Danai (aged 25) on 15 August 2013 explained that women identifying 'water leaks' as a dangerous sign in pregnancy was due to women giving incorrect dates of conception causing the nurses to miscalculate their respective estimated delivery dates. The given estimated delivery dates would likely not fall on the expected dates, prompting women to mistake 'water leaks' as a dangerous sign yet it will be the onset of labour.

Women's lack of knowledge of dangerous signs in pregnancy can also be explained by the days for antenatal checkups coinciding with days women receiving health education. Tendai (age 26) explained that as women did not attend any education sessions they were likely to miss out on important health information. On the other hand, women's awareness of HIV counselling, testing, preventing and treatment programmes, was foreseeable as women were advised on the importance of getting HIV tested once they register for ANC (Ministry of Health and Child Welfare, 2007).

4.5.2 Kupihwa mubhedha - giving a woman a bed rest

During the first six weeks after childbirth, postpartum care is critical to the health and survival of a mother. Recommended postpartum care includes monitoring and referral of complications such as excessive bleeding, pain and infections; counselling on breast care and breast feeding; education on healthy nutrition; newborn care and family planning (Sinces et al., 2007; WHO, 1998a).

To examine women's knowledge on postpartum care, they were asked if they had received any health services just after childbirth. All participants explained that it was common sense that one should rest after childbirth. Women referred to postpartum care as kupihwa mubhedha (English translation: being given a bed). Martha (aged 23) during the interview on 12 August 2013 explained: *'I did not know that kupihwa mubhedha was to monitor my health and the health of my baby. I just assumed that it was just for resting'*.

The length of time women stayed in hospital after childbirth varied from a few hours to three days. Some clinics discharged women within a few hours after delivery. First time mothers like Nyarai (age 17) and Rudo (age 19) were given a bed for three days. Tendai (age 26) who had given birth to her third child was told to rest in bed for three days. During this time, she and her newborn would be monitored. The nurses explained to her that they would mainly check on the baby, *'whether the baby was warm or being fed properly'* and *'the nurses would check on the mother only when it was needed'* (Rumbidzai, aged 23, interview 08/08/2013). Generally women were told by their nurses to visit the clinic with their newborns after 10 days, at 2 weeks, 6 weeks, 12 weeks and 14 weeks postpartum.

The nurses checked me too but it depended with who needed the most attention. If you told them that something was wrong with you, they looked at you and treated you accordingly. After delivery, they told me about the injections that my baby should get. Nowadays there is no such thing as check-ups after 1 month, 2 months. There is 10 days, 2 weeks, 6 weeks, 12 weeks and 14 weeks. These services are mostly for the babies (Tendai, age 26, interview, 07/08/2013).

4.5.3 Sources and quality of knowledge

In general, health knowledge in health care services is often characterised as imperfect where knowledge of healthcare is structurally unequal between the patients and

providers (Wonderling, Gruen, & Black, 2005). To be able to make informed decisions regarding healthcare, a woman needs to have adequate health information.

Women got information on maternal health from both health clinic staff and their close social networks. Kudzai (age 30), like Anna (age 17), Madei (age 18) and Rumbidzai (age 23) agreed that information they got from the communities was useful. Such knowledge about pregnancy or maternal care was gathered through daily conversations with acquaintances and with female friends or relatives. However, women were uncertain of the quality of the knowledge gathered in communities. They believed that clinics were the best place to get correct health information.

With the way I saw it; I think being taught at a clinic was ideal because the information was adequate. Unlike in the community, some of the information contradicted what we heard at the clinic. But sometimes the information we got in the community was similar to what we got at the clinic (Kudzai, age 30, interview, 21/08/2013).

Although some young or first time mothers were not entirely sure that the health knowledge they got from the nurses was sufficient, they were afraid to ask the nurse: *'we have had doubts that what we were being taught was adequate but we were afraid to ask. I think the problem we didn't have enough information is because of the staff. They should have informed us, especially us, who were first time mothers'* (Sarudzai, age 19). Others, like Chenai (age 17) thought the health staff did not educate them at all.

4.6 Priority areas of improvement

The researcher conducted two focus group discussions aimed to capture women's thoughts and ideas on priority areas of improvement in maternal health care and policies. Women were aware that their health and well-being had been influenced by factors that were often beyond their control. Some of these factors included the country's current health system, women's status in the society, and the absence of education and economic opportunities for rural girls and young women.

4.6.1 The health systems

Women observed that different elements in the health system affected health and well-being. For Rudo (age 19) the most important was the attitudes and work ethics of the nurses. She also felt that women's concerns and ideas needed to be heard. Women

needed to work together with local health authorities: *‘We would want an audience with the District Nurse Officer to tell them that they should recruit people who have the love to serve people because we are sick and tired of grumpy nurses who always tell us that being a nurse was not their initial calling’*. For Tendai (age 26), who was living with HIV/AIDs; the shortage of medicine was a problem: *‘What is needed to be improved is the shortage of medicine as no medicine is a very big issue. We were always told to go to the chemist and sometimes I do not have the money’*.

The majority of the respondents were adamant that nurses needed adequate trainings and education. Women noticed the lack of continuing education, training and supervision for local nurses. As such, Chipso (age 17) believed that a health clinic needed to have a health library providing women with pamphlets, books or brochures: *‘what I would want is for you to help us with books we can read for ourselves to enhance our knowledge because these nurses do not inform us, nor do they know what they do at times. It will prevent future problems that may result out of ignorance’*.

Another important issue raised by women was the cost for using maternal health clinics and maternal waiting homes. Women in both focus groups and individual interviews had hoped the government would review and recommend removing hidden expenses for example, women bringing their own cotton wool, pins and razors. These were not common things that women use regularly and women had to allocate some money to purchase them. Women suggested the use of traditional medicine or practice like recyclable pads or ash from firewood as an antiseptic to treat the baby’s navel. Kudzai (age 30) in her interview on 21 August 2013 offered a solution:

We were asked to bring our cotton wool, pin to hold the navel, and a razor to cut the umbilical cord. We were told to bring all of these items when we come to delivery. Things like diapers, we can provide for our babies but they should provide the rest. If provision of these items is very difficult, we might as well use other means like recycle cloths/pads or ash from firewood to treat the baby’s navel.

For many women, like Tatenda (age 18) and Melody (age 24) their worst fears were to have maternal complications and no access to free transportation when needed. In the event of emergency, a family having no money to pay an ambulance would put a woman’s life at risk.

Even when I rushed to the clinic, I was told to pay for the ambulance which I did not have the money for. So while my family was busy looking around for money for transport, my health deteriorated to a stage where I was dying. To prevent cases like this, women should not be asked to pay for the ambulance (Tatenda, age 18, FGD, 29/08/2013).

...Yes, because last time there was a case of a woman who gave birth at home and her uterus obstructed. Initially, she was reluctant to go to the clinic as she was poor. Her condition deteriorated and they started running around to seek care for her. They had to look for their own transport to go to the city as there was no ambulance nearby. I do not know how it ended. If the government addresses this transport issue, it would be very good for us (Melody, age 24, FGD, 29/08/2013).

Women agreed that the government needed to guarantee free ambulance services and that one ambulance needed to be on a standby in a local health clinic.

Women were aware that they were often blamed for not using a rural clinic or a MWH. Barriers to women's access to maternity facilities included costs, for example, bringing food and firewood at their own expense.

Providing all the basic necessities including food is the solution. That will make us know that we are going to a maternity waiting home where we will be taken care of and in turn, the government will be also taking care of our newborn baby. Let us say a woman gets pregnant, she will come to register her pregnancy at three months as we are encouraged to do without any burden of future expenses. Come delivery, it is a matter of just taking one's bag and her baby's preparation only. If that is being offered, women would be happy to come and stay here well in advance before delivery. That is what we desire (Tino, age 20, FGD, 29/08/2013).

Other barriers include lack of support from husband and lack of helpful or positive attitude from healthcare personnel and staff. They requested the government's assistance to remove these barriers. Husband support was a huge topic of debate as will be discussed next.

Husband support and economic opportunities

African women are custodians of their children's well-being. A mother is expected to provide for her children ensuring they are healthy. Women are the homemakers and housekeepers, responsible for providing food, water and education for their children. On average, according to Food Agriculture Organization (2011), women in rural Zimbabwe spend about 16-18 hours every day looking after their children, fetching water and

firewood. Women spend nearly half of that time on agricultural activities. They do not have the luxury of a washing machine or a vacuum cleaner to ease up their domestic tasks. It is such a context they live in that women highlighted the importance of support from their husbands.

Husband support

Women said men wanted them to keep giving birth to more children amidst the lack of finances to take care of the children. Some women were not allowed to take contraceptives by their husbands. In Zimbabwe, having children is seen as a symbol of male masculinity and virility (Howard, 2013). This explains why some men forbid their wives to take contraceptive pills. Although women saw the link of a miserable circle of poverty with the increase in number of children, they had no choice. Because the institution of marriage occupies a key link in the configuration of women's identity and status, subsequently, women's position of submission towards her husband requires them to obey their husbands. Bertha (age 23) when interviewed on 8 August 2013 explained that a woman's fear to reject having more children was that '*...you cannot dispute their request for more children as he is the head of the house, otherwise he will send you packing*'.

Even if one had the option to leave her marriage and get married to a responsible man, that new man would still expect her to bear children. With the social stigma attached to a woman having children with multiple partners as being immoral, a woman is therefore forced to stay in the current marriage and fulfil her duty to her husband. Mildred (age 21) explained: '*It is then better to just keep getting pregnant for the same man to preserve your marriage and keep your status untarnished*'. This was nodded by Mellissa (age 22):

...yes then you ended up doing what he wanted but he would leave you with the burden of taking care of the baby. Whilst pregnant, you would walk very long distances selling things for you to be able to provide for the other children. Ha! It is amazing how these men do not provide for their children but they love having many of them.

Many other women also said that they did not feel that they had the power to decide the number of children and when to have children. Failure to obey their husbands might result in domestic violence. Vimbayi (age 21) noted: '*There is no equal power in these*

marriages. It can easily turn out to be a domestic violence. Refusing to have children for them, you would get a beating of your life'. She narrated an incident of a woman's acquaintance which had gone against her husband's wish:

There was this woman who got an implant straight after giving birth. When she got home, the husband told her to go back to the clinic and get it removed or else he would beat her up and the nurse too. When she went back to the clinic, the nurses were surprised that she was already back to get the implant removed when she had it for two days only. She asked the nurse to remove it because she got beaten by her husband at home. (FGD, 29/08/2013)

Women acknowledged their vulnerability and how their lives were at the mercy of their husbands. Their inability to access family planning and control over their reproductive health reflected the practice of patriarchal ideology. Members of the group discussions argued for the need to reinforce the existing law or a regulation that makes it compulsory for men to be financially responsible for his family and children. As a matter of interest, women did not appear to consider the need for the reinforcement of the anti-domestic-violence law. Perhaps the practice of wife battering was seen as an 'acceptable' form of punishment for a wife who failed to obey her husband. Women were rather concerned with how best to meet the financial needs for raising their children.

Economic opportunities for women

Income generating projects have been seen as a solution to improve the income of families and communities (Rafiqul, 2011). In this study community, a number of income generating projects included gardening and poultry farming. According to Rafiqul (2011), most income-generating activities have encouraged women to participate, as women are seen to be better at managing money and using money wisely for the benefit of all family members.

The group discussions however revealed that current income-generating projects had not been able to bring sufficient money for women to pay for health services. Projects of growing vegetables did not work for many women as it had been hard to sell. Women practiced barter trading for other goods and services with their produce. Women were contemplating the possibility of local health clinics accepting farm products as a form of payment.

We are based in the rural and our lives are totally different from those who live in the city. Here, there are no jobs. Even if you want to improve yourself by growing vegetables to sell, who will buy when everyone is struggling to get money? We survive by exchanging farm products. If you want a rooster, all you do is take your vegetables in exchange for it with your neighbour. For you to get hold of any money, it will be very difficult. Unfortunately, the clinic will not accept your vegetables as a form of payment (Netsai, age 25, FGD, 29/08/2013).

Women also observed lack of employment opportunities in their communities. Although there were a number of mining companies operating locally they preferred to employ men. This frustration and difficulties in getting a job was expressed by Vimbayi (age 21): *'Some of us have had the privilege to go to school but as we speak now, my qualifications are kept on top of the wardrobe gathering dust. I am not allowed to use them to look for a job; neither do the companies also employ us'*.

Chiadzwa, a ward in Mutare district is currently ranked as the largest diamond producing deposit on earth ranging over 300 square miles (Zimnisky, 2014). Seven mining companies are currently operating in this area. Women acknowledged that having a low educational status had made it hard for them to get a job. Yet they believed that women should be given an equal opportunity to work at the mines.

In Chiadzwa, there is a company that recruited women to do jobs in line with their strengths and abilities. But because women are too many, the company was not able to give every woman a job. So if we have other companies that are willing to employ women, we can also get jobs and look after our children we keep giving birth to that our husbands are failing to take care of. (Vimbayi, age 21, FGD, 29/08/13)

A few women thought that women should not work outside the home. Melody (age 24) and Lydia (age 17) believed that a wife should stay at home and look after her family. Women working outside the home were seen as a threat to their marital relationship leading to a marriage break-up.

Melody: At the time we were growing up, we were taught that a wife should stay at home and do house chores. The husband should go out to work for his family. It is only recently that women are trying to adopt the western culture and complaining that they want to also have jobs. A woman gets a job, the husband gets one too and that is where the problem starts. So we do not want people to encourage women to seek for jobs because it causes problems in the family. So men should just be given jobs to take care of us.

Lydia: Ha! For women to earn more than their husbands or that issue of 50- 50 we do not want. This 50-50 business will make women be authoritative towards their husbands because they feel financially strong. We do not want it. When a man says he wants a child, you will have power to say 'no' because of money. We do not want that. Husband and wife should just know their roles, positions and different authority they have.

Tino (age 20) closed off the argument by bring back the women to reality.

Tino: Yes, things have changed. We may continue to argue about this till sunset but we all know that 50-50 does not work in our marriage; neither do us women embrace it with open arms. Even though we want formal jobs to solve our financial problems, it is better that men be prioritized first for job allocations. It is also good for a woman to be given an opportunity to work to be able to feed her family as it is a reality that our husbands would still fail to support the family as they would misuse the finances.

Finally the members of this particular group discussion agreed with Tino explaining that the social and economic changes in the last two decades had placed an ever huge burden on women than before. Yet the attitudes of both men and women had not changed much. Centuries of socialisation in the fundamental tenets of patriarchal systems which continue to discriminate against women remain unchallenged. Males were born to be superior to females. Families still preferred sending boys rather than girls to school. Women thus, identified education for young girls as a pre-requisite for women's well-being. A young girl with a good education is likely to get good employment and is more confident to participate in other economic or social development.

Education for young girls

Investing in girls' education was an undisputable topic of discussion. Some women argued that being poor represented the main determinant resulting in poor maternal health outcome. Women observed that poor families continue to privilege boys' education over girls. *'My mother did not go to school. I was fortunate enough to complete my primary schooling but my father chose to further my brothers' education when things started becoming difficult in the country. Now I cannot get a job to provide for my children'*, said Mildred (age 21). Florence (age 18) explained that education for girls was considered to be a waste as girls would marry and leave her paternal family. Others said that a good education for a girl was equally important to improve women's health outcomes.

According to Tinashe (age 23) not going to school reduced her ability to understand health information:

I did not even go to school...even if you ask me how old I am, I cannot tell you because I do not even know. Now here at the clinic, I was asked when I got pregnant. I was not even able to tell them when because I have no knowledge of anything. How I knew I was pregnant was simply because of what I have heard others talking about when they got pregnant.

Chipso (age 17) agreed with Tinashe as she believed that knowledge was power and it would be best to be educated than leave their lives in the hands of nurses who might not be competent enough. Women in the FGD unanimously agreed for a free education for all especially the rural girl child to improve the health and well-being of women in their communities. With regard to education in Zimbabwe, people are required to pay tuition fees and development levies, which is an impediment to the provision of free education (Mapako & Mareva, 2013).

4.7 Summary

The broad themes explored here include the quality of care and women's experience of the healthcare they receive. Women also revealed that the negative maternal health outcomes were just not only the product of the quality of services they received but were a result of their social circumstances. The findings from these women's stories are important in learning that maternal health policies and programmes need to also focus on these social determinants of maternal health. Women are very able to give valuable contributions as they are experts with respect to what will work and what may not work in their context. They have solutions that hold the key in promoting maternal health. This awareness should be the starting point to deliberately engage women in policy and programme formulation to ensure positive outcomes for the result-oriented policy makers and programme planners.

CHAPTER 5

DISCUSSION AND RECOMMENDATION

5.1 Introduction

This chapter discusses the key research findings with regard to women's understanding and experiences of maternal and obstetric emergency care and the implications of these findings in relation to maternal health policies, practices and research for rural women in Zimbabwe. The sections are as follows: section 5.1 introduces the chapter outline; section 5.2 summarises and discusses the key research findings. It appears that women's understanding and experiences of maternal and or obstetric emergency care were influenced by their level of education and the context of their cultural, economic and domestic lives. Women perceived that the quality of maternal health care they receive is associated with their quality of their maternal health outcomes. Section 5.3 highlights the implications of the study findings in policies, programmes, or research in safe motherhood areas. The results of this study challenges policy and programme makers and those who care for women to critically reappraise the present situation of maternal health in rural Zimbabwe. It argues for the need to advocate for improvement in maternal health by promoting gender-sensitive programme in maternal health; providing skilled birth attendants or nurses with midwifery training in each rural clinic; affordable or free maternal and emergency obstetric health services; and for free ambulance transport at every rural clinic. The researcher argues for the adoption and implementation of women's human rights across different sexual and reproductive health service provisions. For instance, all women should be guaranteed equal access to local maternity waiting shelters regardless of their financial, social, or education status.

5.2 Summary of key research findings

This study began with a passion to capture rural women's perceptions and understanding of maternal health services in Mutare, east of Zimbabwe. Six research questions were developed prior to the field work (Refer to chapters one and three). A summary of the research questions follows. The first question '*what is women's knowledge of maternal health care?*' examined women's knowledge and perception of different type of services offered at their RHC. The second question aimed to capture women's experiences whilst accessing care during pregnancy, childbirth and postpartum.

The third question examined women's subjective perceptions of the quality of care they received. The fourth and fifth questions explored women's understanding of the dangerous signs in pregnancy and their ability to explain them. The last question explored women's collective ideas and thoughts on the priorities for improvement of maternal and emergency obstetrics care services at the rural or district area. This question was developed specifically to guide the women's focus group discussions.

5.2.1 Women's knowledge of maternal health care services

Women believed that a maternal health clinic is the most appropriate place to get correct health information. It appeared that rural women's knowledge of antenatal care, safe pregnancy, childbirth and postpartum was minimal. A summary of the results follows.

1. None of the women respondents was able to correctly explain the acronyms ANC or PNC or its purposes. Women used local terms like 'scero' to refer to ANC which referred to the most common activity of 'scaling' women's weight and 'kupihwa mubhedha' for PNC which meant women having a bed rest after childbirth.
2. Many women correctly explained the reasons and processes for having an HIV test during ANC. This shows that PMTCT programmes has been integrated in Zimbabwe's maternal and child health programme (National AIDS Council of Zimbabwe, 2010).
3. Women seemed to regard childbirth as a medical rather than a social event. Some women regarded 'modernised' childbirth as superior. Homebirth or indigenous systems of birth knowledge on the other hand was considered as inferior to the imported techno-medical practices and knowledge. The techno-medical take-over in the knowledge and experiences of childbirth is not a new phenomenon in developing countries. Undeniably modern childbirth knowledge has been moving closer toward the western super-valuation or high medical technologies found in many developing worlds (Buekens, 2001; Robbie & Sargent, 1997).

5.2.2 Women's experience of maternal health care

It seemed that the majority of women in this study were not satisfied with the quality of care and those feelings were mostly related to nurses' negative or disrespectful attitudes towards women. Other studies also found a link between women's satisfaction of health care and the attitudes and behaviour of the health providers (Dias, Gama, & Rocha, 2010; Oladapo & Osiberu, 2009; Sorensen, Nielsen, Rasch, & Elsass, 2011). A friendly staff and safe environment were seen to be a vital element of good maternal health care.

Women's appearances, cleanliness, social classes, and age also influenced the quality of care or treatment they received. A similar study of South Asian descent in Britain for example, also found that midwives tended to use stereotyping schema to treat women, especially when they were overworked or under pressure (Bowler, 1993). The availability of skilled birth attendance is an important pillar in any safe motherhood programme worldwide (Jackson, 2012; Tuladhar & Dhakal, 2011; WHO et al., 2004). Women in this study expressed concern about the lack of competent and experienced nurses in rural clinics. It was also clear that lack of availability of free ambulance and the costs associated with using the maternity waiting homes, served as major deterrence in women's decision to use them. What follows is a summary and discussion of these findings.

1. Women's were fearful and anxious to ask questions or discuss their concerns with nurses. Women were also not confident to give feedback about the services. They chose to remain silent so as not to create a problem.
2. Women reported nurses to be unfriendly or unprofessional. The nurses looked down on women who were young, poor or badly groomed.
3. Women speculated that nurses were poorly paid. Women also explained the likelihood of nurses being forced by their families to attend nursing school. These situations might account for the nurses' low morale or motivation.
4. From word of mouth in their community, women believed that nurses at the rural clinic were not trained in dealing with complications in pregnancy. Women's observations were true to some extent as the primary care nurses in Zimbabwe are not trained in basic emergency obstetric care (MoHCW, 2009).

5. Women seemed to have had some misconception of what comprises a good childbirth experience and what they should expect from the health providers. Women expected that the nurses would be ready at any time they needed them. They had hoped the nurses would be cheerful, in good spirits, uplifting, funny or entertaining. These expectations however might be unrealistic. In fact, rural nurses are likely to be overworked and underpaid. A clinic in rural Zimbabwe generally only has one registered nurse and a primary health care nurse (see also chapter four). A rural clinic may also serve up to 7000 people. In addition to providing maternal health services, the nurses are also required to provide children's immunization, STI/HIV tests, amongst other services.
6. Women observed that the nurses were not confident to treat teenage pregnancy. This observation could be correct. Since the country's independence in 1980, as a part of promoting health equity, the Zimbabwe MoHCW requires rural health clinics to refer first time teenage mothers to the next higher level health care system, such as a district or city hospital (MoHCW, 2008). The Zimbabwe Confederation of Midwives (2013) and the Zimbabwe National Maternal and Neonatal Road Map: 2007-2015 (2007) also recognize that this referral is necessary due to lack of trained staff, essential drugs and equipment at rural clinics.
7. Ambulance transportation was not always available in every rural clinic and it was not free. The lack of availability of ambulance transport at each local health clinic hindered timely referral and promptness of care to prevent maternal or neonatal deaths (Echoka et al., 2014; MoHCW, 2009; Pfeiffer & Mwaipopo, 2013).
8. Women were concerned with the high unforeseen expenses (food, fire wood and other deliverable consumables items) when staying and giving birth at a maternity facility. It caused them to opt for home deliveries. This study concurs with other studies which found an association between free or affordable maternal and emergency obstetric care and a reduction in maternal and neonatal deaths (Kruk, Galea, Prescott, & Freedman, 2007; Parhurst et al., 2005; Saiti, McLaughlin, & Seung, 2013).

5.2.3 Women's awareness of dangerous signs in pregnancy.

This study confirms previous studies that the provision of antenatal education does not correlate with women's knowledge of dangerous signs in pregnancy (Nikiéma, Beninguisse, & Haggerty, 2009; Okour, Alkhateeb, & Amarin, 2012; Pembe et al., 2010). Women's understanding of dangerous signs in pregnancy is summarised below:

1. All mothers in this study reported wanting, yet not receiving, meaningful information on dangerous signs in pregnancy. This lack of information caused women to have incorrect assumptions, beliefs or understanding of signs of pregnancy complications. Although women knew that a breech presentation and water leaks (water rupture of the membrane) were dangerous, they could not explain the associated risks. For example, none of the women explained the association between having a breech presentation with the likelihood to have to undergo a caesarean section. Caesarean section poses medical risks to women, including infections, haemorrhage, possible injury to other organs, or complications due to anaesthesia and even death. Maternal mortality, due to caesarean section are two to four times greater than those in normal vaginal births (Liu et al., 2007). Although water leaks occur in many situations, and are part of a perfectly normal sign of the onset of labour, women also thought water leaks could point to a dangerous sign in pregnancy. These results may reflect the lack of training given to health workers in relation to the dangerous signs of pregnancy. The 2012 National Integrated Health Facility Assessment confirmed that only 12 percent of the health workers in Zimbabwe were competent to provide counseling on this matter (MoHCW, 2012).
2. Women explained that their lack of education had made it hard for them to understand and comprehend health information given at the clinics. Many women even found it difficult to know what questions to ask. A review of the literature suggests that compared to women with low level of education, educated women tend to have a better understanding of health issues and better exposure to information resources that will enable them to make a more well informed decision regarding health care (Karlsen et al., 2011; Levine et al., 2004; Okour et al., 2012).

3. Women may have found it difficult to find the time to attend educational sessions at the clinic due to their domestic responsibilities, for example, childcare, cooking, fetching water and working in the farms. A similar finding was reported elsewhere (FAO, 2011; Parkhurst, Rahman, & Ssengooba, 2006; Prah, 2013).
4. Women were not able to explain the purpose of postpartum care as a means to observe vaginal blood loss, uterine involution, blood pressure and possible infections following childbirth (WHO, 2010a). All women explained that the main aim of a postpartum care was to merely give a woman a bed rest after childbirth. The recent ZDHS (2012) showed that a majority of mothers (57%) did not receive any postpartum care.
5. Women were certain that the primary aim of postpartum care was for the purpose of checking the health and well-being of the newborn. The mother's health was a second-tier of importance. This echoes the same concern raised 30 years ago: "Where is the M in MCH?" by Rosenfield and Maine (1985). More recent research confirmed that PNC procedures have been largely dominated by efforts to alleviate neonatal deaths with little impact in lowering maternal mortality and morbidity (Atrash et al., 2008; Cohen, 2009; Khalafi et al., 2007).

5.2.4 Priorities areas of improvement in MH programmes and policies

In group discussion sessions, women were asked to identify priorities requiring improvement in maternal health programmes or policies. Women suggested priorities of improvement to include the provision of free ambulance, the reduction of unforeseen costs at maternity health facilities. Women explained that good education and work opportunities at local communities were needed to increase their capacities to have more control over their health and wellbeing. The list of priorities follows.

1. Women were adamant that nurses at rural clinics required up-skilling and ongoing training in obstetric care and supervision to improve services for women and their newborn. This has been reported by women in other studies (Gerein et al., 2006a; Harvey, Blandon, & McCaw-Binns, 2007).

2. Women wanted to see improvement of staff etiquette, interpersonal and communication skills, and conduct. The high association between patients' perception of quality of care and the attitudes of health providers have been reported in many studies (Gilson, et al., 1994; Grossmann-Kendall, et al., 2001; Nzama & Hofmeyr, 2005; van den Broek et al., 2003). The lack of friendly or compassionate attitudes of health providers often creates a social and psychological distance between women and institution that will limit women's utilisation of health care facilities. This explains the reason women were afraid to ask questions or discuss their health with their health providers (Lloyd et al., 2000; UNDP, 2011).
3. Women believed that food and consumable delivery items ought to be available free of charge at maternity facilities.
4. Women wanted the ambulance services to be free and available at rural clinics. Although the current maternal health policy had removed user fees to increase women's access to maternal care (Mhofu, 2012), women still needed to pay for an ambulance service. These circumstances are attributed to the lack of national health care funding. Even so, the Zimbabwe's 2014 health expenditure continues to be low at 8.2 of its GDP rather than the required 15 percent to build a good standard of national health care (Zimbabwe Minister of Finance, 2013)².
5. Women wanted the government to ensure a constant supply of medicine and medical equipment in rural clinics.
6. Surprisingly, women did not see travelling to health clinics as a barrier to maternal health. Other studies found that having a nearby maternal health clinic has been mentioned as favourable by women in other studies (Griffiths & Stephenson, 2001; Thaddeus & Maine, 1994; Wild et al., 2012). Neither did the women raise issues to do with domestic violence emanating from using family planning services. This is explained by the study participants who indicated that

² In 2001, the Zimbabwean Government and other Head of States of Africa Union countries were signatories of the Abuja Declaration which required the signatory member states to set a target of allocating at least 15% of their annual budget to improve their national health sector.

it was the way of rural and marital life and they said they did not know what to do or if anything could be done about the problem.

7. Women realized that gender inequalities existed in all contexts of women's lives, for example, in health, education, or employment opportunities. Providing free education for young girls was deemed to be very important to improve women's social status. Women believed that a good education would increase their capacities to look after themselves and their families, to access health information, and to make correct decisions regarding care. A good education would also support a woman to get good employment and to be financially independent as had been confirmed by others (Hill, 2011; International Labour Organisation, 2012; Lumadi, 2012).
8. Although opportunities for employment were important to women's status, women preferred that jobs be created for men. Unfortunately the widespread cultural and economic practices often work to prevent women's empowerment and economic independence (Lumadi, 2012). For example, an African girl is generally taught to be a good wife and a mother; to serve her husband and her family; and leave formal jobs to the husbands. These norms are a reflection of the patriarchal ideology to which a woman is required to conform (Mintz & McNeil, 2013).
9. Women hoped for a law to make it mandatory for their husbands to be financially responsible to their families. Women explained that even though customarily a husband should be financially responsible to the family, it was not always the case. There are studies that note that women are largely to be responsible to provide meals for their families (FAO, 2011; Rafiqul, 2011).

5.3 Implication of this Study to MH Policy and Programme in Zimbabwe

This study concurs with the finding of the Zimbabwe national policy, specifically, the Maternal and Neonatal Health Road Map (MNH) (2009-2015). The latter argues for the government to start addressing the user fee policy and its connection to the availability of human resources and the quality of maternal health care. Another recommendation noted in the MNH included the need to adopt a multi-sectoral approach to improve

maternal health. It is essential to involve women's husbands as partners in MNH programme. Recommended improvements in maternal health care by women of this study included: improving staff attitudes and morale; skills and experience; effective clinical care; and lowering the high costs associated with the childbirth clinics. Women's recommendations for priority of improvement are summarised below:

5.3.1 Recommendation 1: The incorporation of human rights and sexual and reproductive rights in MH policy and programmes

The researcher believes that women's right to survive pregnancy and childbirth is a basic human right (Freedman et al., 2007; Hawkins, Newman, Thomas, & Carlson, 2004; Right to Maternal Health, 2008). Zimbabwe is a signatory to a number of international human rights instruments, including the Convention on the Elimination of Discrimination against Women (CEDAW) (Shizha & Kariwo, 2012). Article 14 of CEDAW specifically focuses on the situation of rural women. Article 14 2(d) commits States to ensure rural women have access to adequate health care facilities, including information, counselling and services in family planning (UN Committee on the CEDAW, 1992). These domains of human rights sit in well with requests of the women in this study to be treated with respect and to affordable or free health care. This suggests the lack of the government commitment to protect those rights.

To have a right is to have the power to enforce the duty bearers in providing the right or to discharge the duty bearers from the responsibility to do so (Williams, 2011). Women respondents in this study, in the researcher's view, have no power to impose the above aforementioned actions. The underplaying of oppression was observed with women choosing to be silent and to not question their health providers. Women did not feel comfortable asking questions or discussing their health with health providers. To enable women to understand and be confident in exercising their rights requires the State to address the broader social, cultural and economic determinants that are currently disadvantaging women.

Reduction in rural-urban health inequalities

It has emerged from this research that there has been a discrepancy in the health service provision between Mutare rural and Mutare urban of Zimbabwe. For example, the distribution of health personnel is skewed in favour of urban areas as most of the skilled

professionals are located in the city. Policies and measures need to be put in place to reduce these health inequalities which include staffing, trainings for health providers, medical equipment and drugs.

- Trainings and education programmes for nurses and midwives need to meet a minimum set of skills recommended by the WHO (WHO, ICM, FIGO, 2004b), including skills to provide proper treatment in relation to pregnancy complications, interpersonal and communication skills, professionalism and cultural competency. Literature suggests that for health providers to effectively deliver quality services, they should first understand the different social class, level of education, culture and traditions and age of their clients (Cham, Sundby, & Vangen, 2005; Flores & Falcoff, 2004). It is necessary for the government to therefore, ensure maternal health services to be guided by the needs of women and their life context.
- Women noted their health and well-being were associated with the social context of the community they live in. The social determinants concept looks beyond sectoral borders in order to create synergies across health, development, and human rights (UNICEF, 2008a). For instance, a good transport system will influence the health-seeking behaviours and the access to health services by addressing the availability and cost of transport while education and financial sectors expand women's and girls' access to education and economic independence. Economic independence may increase utilisation of maternity facilities of the women without the fear of financial implications. Thus, the research notes the importance of conducting a Health Impact Assessment. It enhances the policy-making process in collaboration with other sectors and stakeholders to help facilitate better policy-making that is based on evidence and focused on positive maternal health outcomes and distribution effects in the population (Brønnum-Hansen, 2009; Public Health Advisory Committee, 2005).

Women's participation in maternal health programmes.

This study concurs with others that recognise the importance of women's contribution to policy and programme formulation to improve women's favourable maternal health experiences (Hill, 2011; Neieburg, 2012; Pratihtha, 2012). None of the women in this

study had ever been invited or consulted by policy makers and programme developers. The 2007 ZMPM study suggests that even when women were consulted by policy or programme makers, women's recommendations were unlikely to be implemented (Munjanja, 2007). Seven years later after the 2007 ZMPM study, The 2011/12 Zimbabwe Demographic Health Survey shows that no significant improvement has been made to maternal health (Zimbabwe National Statistics Agency, 2012b). Instead of getting better, unfortunately maternal mortality and morbidity in Zimbabwe has gotten worse in the past decade.

- Women in this study were keen to participate in maternal health policies and programmes and any other activities for women's empowerment and development. The Safe Motherhood project in Kenya (Warren & Liambila, 2004) for example, had invited community participation to successfully reduce maternal deaths. Lessons learnt from this project informed that positive maternal health outcomes were associated with how well the programmes build on indigenous or community knowledge, solutions, and resources. For example, women in this study suggested the use of safe traditional practices such as using firewood ash to cure the baby's navel or using recycle cloths as substitutes for cotton pads that were easy to find and inexpensive.
- The benefits of having women's full participation would help programme planners to better understand local values, knowledge, and experience; obtain community support in programme implementation; and effectively utilise community resources (World Bank, 2003). Promoting gender equality in education and employment is the key to women's participation in community programmes (Smith et al., 2009; UNICEF, 2009; World Bank, 2003). Efforts to improve women's maternal health therefore can no longer ignore the gendered context that determines women's participation.

5.3.2 Recommendation 2: Revisit the national agenda in relation to equality and women's empowerment

Women acknowledged and recognised the need to address gender disparities in education, employment and health. Women were keen to see initiatives aimed at free education for young girls and poverty alleviation programmes to address health inequalities that arise from unequal power relationships between women and men.

Free education for the girl child

- When money was very scarce, women reported families deciding to allow their girl to leave school to allow her brothers to continue studying. Investing in a girl's education would not benefit that family as she would be married off to another family. Thus many families believe that education is more important for boys than girls. Therefore, women's plea is for education to be free for girls. Research shows that investment in girls' education has positive development effects for the girls and their families, communities and their nation (Nikiéma et al., 2009; Okour et al., 2012; Oladapo & Osiberu, 2009; Pembe et al., 2009).
- It is necessary for the Ministry of Education to consider the incorporation of the safe motherhood education into the school curriculum. Statistics on maternal mortality in Zimbabwe shows that young women between 15 and 19 years of age, represent twenty-five percent of the maternal mortality rate (MoHCW, 2012) In this study, nearly half of the respondents were teenage mothers. It is therefore important for education on safe motherhood to be integrated in the school curriculum to give young girls the correct information to enable them to make decisions related to their sexual and reproductive health and future motherhood.
- The government is also urged to protect young girls by passing an act that forbids child marriages, that is, getting married before 18 years of age. Child marriages will risk forfeiting their rights to education, economic independence and health, and also increase their health risk associated with early sexual activity and childbearing leading to high rates of maternal mortality, STIs including HIV.

Poverty alleviation

Gender equality is as well as a matter of rights to economic benefits. The majority of women in this study lacked financial independence. They were often not in a strong position to decide about care due to lack of economic resources. Women explained that many community-based income generating projects had not been working effectively. Such programmes had yet to show its effectiveness to promote financial stability and economic dependence of the community as it was promised (FAO, 2011; Rafiqul,

2011). So far, income generating projects have relied heavily on the availability and production of cash as the medium of economic or trades exchange. They had overlooked the existing traditional trading structure which could be more relevant to local communities. This calls for the need to localise small business and entrepreneurship to work within the existing local structure to meet the local needs.

Access to quality maternal health care

Women reported that the lack of husbands' support served as a barrier to women's access to maternal health care and family planning services. The husbands did so by not providing adequate money to buy baby preparations and delivery of consumables to use at the clinic. Current efforts of the Zimbabwe government to encourage male involvement in MNH programme (MoHCW, 2007), have been criticized to only reinforcing norms relating to men's control over women (WHO, 2002). Rather than focusing on the role of the husband in the maternal health access of women, interventions may need to focus on accessing local networks and church groups or community based organisations to engage men and boys in MNH gender transformative programmes that promote collective and safe discussion to challenge masculinity norms. Studies have shown this approach to be effective in promoting more gender equitable relationships between men and women (Barker et al., 2007; Dworkin, Treves-Kagan, & Lippman, 2013; World Bank, 2012).

5.3.3 Recommendation 3: Further research on maternal health in rural Zimbabwe

This study was conducted with a passion to capture women's experiences and understanding of maternal health in Zimbabwe. Results of this study raise questions as to the reasons Zimbabwe has failed to reduce its maternal mortality and morbidity without taking into account the government's commitment to the MDGs. The epistemology and methodology that informed this study was selected based on the researcher's belief that women are the experts of their lives and whilst they are given the opportunities, women are specialists in solving their own problems. This study confirms and proves this belief. The researcher therefore, believes that it is necessary for future research in relation to women's health in Zimbabwe to continue, employing research methodologies that are participatory and empowering.

Building on this research, future research needs to focus on the examination of the potential use of traditional, indigenous or local knowledge and social structures to improve maternal well-being in rural communities. This research recommends the use of participatory action research to fully take advantage of women's knowledge and resourcefulness to participate in the design and efforts to improve community-based maternal health programmes.

Study Limitations

The data collection was conducted during a politically volatile situation at the time of the presidential election in Zimbabwe (August 2013). Access to the community of interest was limited, as the researcher had to rely on the transport of non-government health workers, thus followed their scheduled clinic visits. The researcher was therefore, not able to recruit women that were non-clinic users. Given that the participants were recruited from the health facilities, the findings of this study may only reflect the views of those who chose to use maternal health services and may not be applicable to those who do not use the rural clinic facilities for a variety of reasons. The study could have missed women who opt for more traditional or other means of maternal health.

In addition to the volatility of the political situation, being interviewed by a 'stranger' in a clinic setting, might have had some influence on how women approached the interview and shared their experiences with the researcher. To begin with, women might have been suspicious that the researcher was affiliated with a certain political party. Although in the introductions to the interviewees, it was made clear that the researcher was not attached to the clinics, some women might have approached the interview questions carefully and chosen not to disclose certain experiences. Other participants could have been less outspoken in giving their accounts of their experiences amidst fears that the information would be given to health staff. If this research had been conducted in women's place of reference and the political situation was stable, women might have been more confident with the research process. The researcher was also mindful that as it could have been the first time they were approached to tell their stories which could explain the hesitant of some of the women to answer the questions. Regardless of the limitations, without a belief in the importance of women's accounts, this study would have missed the detailed, contextualised pictures of the experiences of rural mothers and their aspirations.

APPENDIX A – ETHICAL APPROVAL



A U T E C
S E C R E T A R I A T

1 July 2013

Sari Andajani
Faculty of Health and Environmental Sciences

Dear Sari

Re Ethics Application: **13/71 Women's experience and perceptions of maternal health care: A qualitative participatory research to improve the quality of maternal health and emergency services in rural Zimbabwe.**

Thank you for providing evidence as requested, which satisfies the points raised by the AUT University Ethics Committee (AUTEC). Your ethics application has been approved for three years until 1 July 2016.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 1 July 2016;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 1 July 2016 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Blessing Kanengoni beekanengoni@yahoo.com

APPENDIX B – PARTICIPANT INFORMATION SHEET

Participant Information Sheet



Date Information Sheet Produced: 4 April, 2013

Project Title

Women's experience and perception of maternal health care: A qualitative participatory research to improve the quality of maternal health and emergency services in rural Zimbabwe.

An Invitation

Greetings to you all. My name is Blessing Kanengoni. I am a student at Auckland University of Technology studying a Master in Public Health. A research is conducted as part of the study. I would like to invite you to participate in this research project. I am conducting a research that explores women's perceptions on the quality of care being given by the maternal health services. Your participation in this research is completely voluntary and you may withdraw at any time.

What is the purpose of this research?

The purpose of this research is to contribute to the knowledge-base that exists from the understanding and perception of women on maternal health care. Policy makers and programme developers may also refer to this research to help guide in their respective line of work. This research may be used in the development of a paper and/or presented at a conference in the future.

How was I identified and why am I being invited to participate in this research?

You have been identified to be invited to participate in this research as this researcher focuses on maternal health services users of child bearing age with the minimum age being 16years of age.

What will happen in this research?

If you choose to participate, you will be asked some questions around your understanding and perception of maternal health care. This will be a one on one discussion which will take an hour. You will also be invited again to discuss on what could be done better so as to mitigate the number of maternal deaths occurring. All information collected, including your personal information will be kept private and confidential. The data collected will only be used for the purpose it was intended for.

What are the discomforts and risks?

There are no direct discomforts or risks involved. You will not be asked anything of a personal nature. If you feel that participating in the research would put you at risk, it is advisable that you do not participate.

How will these discomforts and risks be alleviated?

Shona will be used during our discussions to make you feel free to talk about your experience, understanding and perceptions of the services that are being offered to you. However, if you feel discomfort during the interviews, please let me know as soon as possible. If you feel that the research has caused you any discomfort, you will have access to free counselling sessions at the clinic.

What are the benefits?

There might not be any direct benefit to you but your involvement in this research will contribute to the current knowledge-base around maternal health care. This may in turn improve the lives of women who will use the services in Zimbabwe.

How will my privacy be protected?

Although I will know who you are, all your personal details will be kept confidential and locked in a filing cabinet in my supervisors' office. You may also ask for your personal information back at any time.

What are the costs of participating in this research?

There are no financial costs to you. If you require the reimbursement of travel costs, please let me know in advance and how much that will cost. The interview will take at a maximum of two hours to complete.

I would like to meet you prior to the interview to brief you on the research and answer any questions that you might have. You will be provided with refreshments at both the meeting and the interview.

What opportunity do I have to consider this invitation?

You will be invited to a meeting held by me to learn more about the research. You will be given 4 – 5 days to decide whether to take part in the study or not. I will contact you at the end of the week to re-confirm your participation, time and location for interview. Any questions that you have may be directed to the local clinic staff or you may contact me or my supervisors directly.

How do I agree to participate in this research?

If you agree to participate, you will need to fill out a consent form. I will provide this to you in our meeting.

Will I receive feedback on the results of this research?

Yes. You will receive a copy of the findings. I may return back to present the results, or the local clinic staff will do it on my behalf.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr. Sari Andanjani, sari.andajani@aut.ac.nz, 0064 9 921 9999 ext 7738 or Dr Maphios Siamuchembu, siamuchembu1@yahoo.co.uk: +263-772 137 035 /+263-714 841 972. Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Dr Kate O'Connor, kate.o'connor@aut.ac.nz , 0064 9 921 9999 ext 6938.

Whom do I contact for further information about this research?

Researcher: Blessing Kanengoni, beekanengoni@yahoo.com, +263 773 094 043.

Project Supervisor: Dr Sari Andanjani, sari.andajani@aut.ac.nz,

Zimbabwe Supervisor: Dr Maphios Siamuchembu, siamuchembu1@yahoo.co.uk

Approved by the Auckland University of Technology Ethics Committee on 1 July 2013, AUTECH Reference number 13/71.

APPENDIX C – CONSENT FORM

Consent Form



Project title: Women's perceptions and understanding of maternal health care: A qualitative participatory research to improve the quality of maternal health and emergency services in rural Zimbabwe.

Project Supervisors: Dr.Sari Andajan (NZ), Dr Maphios Siamuchembu (ZBWE)

Researcher: Blessing Kanengoni

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 4 April, 2013.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐
No ☐

Participant's signature and date:

Participant's name:

Participant's Contact Details (if appropriate):

.....

Approved by the Auckland University of Technology Ethics Committee on 1 July 2013 AUTEK Reference number 13/71

Note: The Participant should retain a copy of this form.

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