‘A JOURNEY THROUGH MATERNITY’: AN ANALYSIS OF INTERVENTIONS FOR REDUCING MATERNAL MORTALITY IN RURAL ZIMBABWE: A CASE STUDY OF MURAMBINDA MISSION HOSPITAL AND SURROUNDING CLINICS

BY

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ABSTRACT

The maternal mortality ratio in Zimbabwe sits at 960 deaths per 100,000 live births which is a far cry from the targeted 174 deaths per 100,000 live births by 2015 envisaged in line with its Millennium Development Goals. Despite the various international human rights provisions dealing directly with women's reproductive and maternal health, the situation seems to be deteriorating. The writer does not attempt to investigate maternal mortality with its varying and complex causes, contributory factors and reduction methods but investigates one intervention, namely the maternity waiting home (MWH) concept. She focuses on one maternity waiting home at Murambinda Mission Hospital where she is able to use the unique women's law approach and grounded theory to gather empirical data on the realities of the women who are actually making use of the maternity waiting home. She uses various other methodological approaches, including the human rights and constitutional interpretation, in investigating the extent of Zimbabwe's compliance with provisions dealing with maternal health care. The new Zimbabwean Constitution which for the first time contains the right to health, provides the opportunity to ask the question, 'What does basic health care as provided for in the Constitution mean for a pregnant woman in rural Zimbabwe?' She finds that though the maternity waiting home was designed to cater for the rural woman and is a free service, the costs associated with the resultant birth that must take place at the district level hospital proves too costly for many women. It is thus proposed that clinics take up the responsibility of housing these maternity waiting homes to make it a feasible intervention for women. The writer also explores the budgetary challenges that have seen maternal health care at national level not being allocated enough of the national budget to ensure that women get the best levels of care. In the midst of this, she finds however that women in rural areas have an alternative which, though discouraged both at international and national level, is both more affordable for them and at times the only acceptable option because of religious and other factors – the traditional birth attendant. She interrogates whether room can be found in the present health care system which encourages the use of skilled birth attendants for traditional birth attendants to perform a role that does not see them sidelined and their years of experience and their unique role in rural communities, in particular, going to waste.

Declaration

I, Vimbainashe Njovana, certify that this dissertation is my original work; it is an honest and true effort of my personal research. I certify that the work has not been presented anywhere else before for any other thesis.

Signed……

Date……

This dissertation was submitted for examination with my approval as the University Supervisor

Signed…….

Date…….

Dedication

This piece of work is dedicated to my husband, Tinashe. Thank you for all the support and for being the 'soldier' that I needed towards the end of this process. Thanks for driving me to Buhera countless times and just being there for me. I appreciate you!

To my family, thank you for being the greatest cheerleaders and for believing in me. Your support meant so much throughout this whole Masters programme. I love you all.

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Acronyms

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
HTF	Health Transition Fund
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MoHCC	Ministry of Health and Child Care
MoHCW	Ministry of Health and Child Welfare
MoWAGCD	Ministry of Women Affairs, Gender and Community Development
MSF	Medicins Sans Frontieres
MWH	Maternity Waiting Home
SADC	Southern African Development Community
SEARCWL	Southern and Eastern Regional Centre for Women's Law
STERP	Short Term Economic Recovery Programme
ZIM ASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation

Definitions of key terms

A maternity waiting home (MWH) is a facility within easy reach of a hospital or health centre where a pregnant woman can stay towards the end of her pregnancy and await labour.

Traditional birth attendant (TBA) is a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or through an apprenticeship to other TBAs.

An *mbuya* (grandmother) is also a term that is used to refer to a traditional birth attendant (TBA). It is an abbreviation for ***mbuya nyamukuta***.

List of human rights instruments

Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. Doc. A/811 (1948)

International Covenant on Economic Social and Cultural Rights, G.A. Res. 2200A (XXI), (1966/1976)

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), December 18, 1979, 1249 U.N.T.S 13

African Charter on Human and Peoples Rights (African Charter), G.A. Dec. 115 (XVI) (1981/1986)

SADC Protocol on Gender and Development

List of legislation

Births and Deaths Registration Act Chapter 5:02

The Constitution of Zimbabwe

Medical Services Act Chapter 15:13

Traditional Medical Practitioners Act Chapter 27:14

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Executive summary

Zimbabwe has recently enacted its new Constitution which for the first time provides for a right to health by providing that everyone has the right to have access to basic health care services including reproductive health care services. This has been seen as an extremely positive step for Zimbabwe in line with its international obligations relating to the health of citizens and in particular as far as it relates to maternal health care.

This Constitution come at a time where there are unacceptably high levels of maternal mortality in Zimbabwe, there have been various interventions put in place to reduce this ratio to the target set in the Millenium Development Goals. With the current maternal mortality ratio sitting at 960 deaths per 100 000 live births, the target to reach by 2015 is 174 deaths per 100 000 live births. In order to reach this target the government has encouraged that women make use of services such as maternity waiting homes where they can wait for their delivery date within the hospital facility, in cases where there is a history of complications or a high risk pregnancy. Recently the Ministry of Health has embarked on an initiative to revitalize and refurbish several maternity waiting homes across the country to ensure they are of a higher standard than they have been in recent years. However, the acceptability and accessibility for the users is not explored by that initiative which is what the research paper aims to uncover. In exploring the maternity waiting home initiative, it becomes clear that other initiatives aimed at reducing maternal mortality need to be examined in discussing affordability, acceptability and accessibility of the various initiatives.

Amongst the main findings of the research, it emerged that budgetary issues have had major impact on the use of maternal health services particularly for women in rural Zimbabwe. No budget from the Ministry of Health is reaching district level at the moment. From the Health Transition Fund, clinics receive US$2,250 per quarter to cover issues to do with maternal and neonatal health while hospital receives US$4,500. No budget at all comes from the Ministry of Women Affairs, Gender and Community Development towards maternal health issues.

In focusing on Buhera District it emerged that the only functional maternity waiting home is at Murambinda Mission Hospital servicing the whole district with a population of 245,878 (Census, 2012). Out of 27 clinics in the district, five had maternity waiting homes but

because of shortages of staff accommodation these facilities are now being used to house staff.

The Ministry of Health and Child Care discourages the use of Traditional Birth Attendants in its policies as well as in its programmes yet women continue to use them. Religion plays a major role in why some of the population of pregnant women cannot access the MWH, clinic and hospital particularly the Apostolic Sect members – during election campaigns, some politicians would tell people that in Zimbabwe we have freedom of religion therefore they can refuse to go to hospitals. This is clearly detrimental to the wellbeing and life of many women belonging to those sects.

The cost associated with travelling to the hospital at Murambinda (up to US$30 one way), the requirements a woman is meant to bring to the MWH (food, blankets, firewood, toiletries, bucket and cooking utensils), the baby layette (costing an average of US$60) and the maternity fee at the hospital (minimum US$28 and maximum US$168) is deterrent to women and they end up making use of traditional birth attendants who have very few requirements (no charge, a goat or chicken, string and soap).

Many women make use of both the formal health care system and the informal – if they go to register only about half will go back and deliver there but the other half will deliver with a traditional birth attendant.

There is therefore need for a definite place for traditional birth attendants to be carved out in the formal health delivery system as they are already playing the role of skilled attendants such as nurses at primary care level. They need to be equipped with the appropriate referral equipment such as cell phones and reliable transportation to link them with the formal health system for those cases that would need referral instead of being totally sidelined from the system. It is important that whatever maternal health service is provided for women be appropriate for them at all levels to ensure universal access to maternal health care.

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CHAPTER ONE

1.0 INTRODUCING THE RESEARCH

Figure 1: Photograph of an old village ox-drawn ambulance parked outside Murambinda Mission Hospital

1.1 Introduction

The story of maternal health care in Zimbabwe seems to be well represented by the ox-drawn ambulance (see the above photograph) used in days gone by to ensure women, men and children in the rural areas were able to access health care. It was operated by ordinary community members who came together to ensure the health and safety of fellow community members, so the story goes. In its day this ox-drawn ambulance doubtless saved many lives but has been rendered obsolete and redundant by new and supposedly better ways of doing things. However the key question that this research seeks to explore is, 'Are the current interventions to reduce maternal mortality working?' This study does not attempt to engage with the multiple and complex facets that contribute to maternal death but zones in on one intervention, namely the maternity waiting home (MWH) concept in order to assess whether or not this is yielding the best possible results that it could for the nation.

To put this in context, Zimbabwe was once among the countries with the best maternal mortality rates in the world with an MMR as low as 283 deaths per 100 000 live births in 1990, but this figure has since fallen and is now one of the worst with the current maternal mortality rate being 960 per 100 000 live births according to UNICEF and the Zimbabwe Demographic Health Survey 2010/2011. This figure is an increase from the last MMR which was recorded as being 725 per 100 000 live births.

Studies on maternal health care have identified the following three delays as being the major barriers to pregnant women accessing obstetric services. They are:

(1) The delay in pregnant women recognizing danger signs in the pregnancy and deciding to go to seek help at a health facility.
(2) The delay in getting to the health facility due to transport or communication challenges.
(3) The delay in getting treatment once at the health facility due to high user fees, lack of skilled personnel or shortages in medicines.

In order to address the second delay, maternity waiting homes have been used to ensure that pregnant women who are at risk of complications that could pose a risk to their lives and that of the baby are accommodated near a health facility. Having no prior experience working in the area of maternal health care, my interest in this topic was sparked by a visit that I had made to Murambinda Mission Hospital not to visit but when it was being used as the venue for one of our regular meetings with the Gender Forum in my work with Musasa. When I saw the maternity waiting home, quite literally as I passed it by, I asked myself whether it was being used, as it looked rather quiet. Giving no further thought as to the possible reasons why it was not apparently being used, I began my journey into this area of research and choice of topic.

The Ministry of Health and Child Welfare's support of the use of maternity waiting homes as a practical intervention is because they are designed to improve access to health institutions, skilled and emergency care to reduce morbidity and mortality for mothers and neonates in the face of complications. A maternity home is defined as a facility within easy reach of a hospital or health centre where a pregnant woman can stay towards the end of her pregnancy

and await labour.[1] It has been stipulated that the following categories of women are eligible and must be referred to a maternity waiting home by a primary health care worker:

- Every first time mother
- Every fifth pregnancy onwards
- Every pregnant woman who is 18 years old and below or 35 years old and above
- Every pregnant woman with a history of complications such as high blood pressure or anaemia as well as multiple pregnancy (twins, triplets or more)

The maternity home therefore is specifically designed to address the delays that women normally face in reaching a health care facility by ensuring that they are housed within the hospital property prior to any problems developing. In 2010 the Ministry of Health and Child Welfare set standards that the maternity waiting homes should adhere to, to ensure the best level of care for expectant mothers. Needless to say with the various challenges that Zimbabwe has faced with electricity supply, water and other service delivery, some of the waiting homes have become compromised, dilapidated and some abandoned and taken up for other uses. The research does not primarily seek to focus on the conditions of these MWH as this is adequately covered by a MoHCC study but seeks to focus on whether or not such a facility is feasible for potential users in terms of both the social and financial cost associated with using it. The research also unearthed the fact that women have alternatives in the face of various barriers that hinder their use of the recommended facilities.

1.2 Location of the study

'Buhera is fit for animals, not for human beings.'

(D.A. Zidya)

This statement was made by the District Administrator of Buhera in an interview held in his office about 30km from Murambinda town. He made this remark when describing the conditions in which many of the inhabitants of Buhera live with very little rainfall and hunger being prevalent as a result. I was taken aback by this statement as it would have been

[1] Maternity Waiting Homes Operational Guidelines, Ministry of Health and Child Welfare, Zimbabwe, March 2010.

expected that the D.A. would speak highly of his district but this spurred me on to want to discover more about the area.

I have worked in Buhera district for the duration of my employment with Musasa[2] since 2011. Having worked in four wards in the district I was not exposed to any of the other wards in which I was to carry out my research. To an extent then it was new territory for me which was a bit daunting in the beginning. I realized I could not make much use of the community structures that we had set up as Musasa to get into the community where I needed to meet with community members. However this was not to prove detrimental to my research as being thrown into the deep end was the most exciting aspect of my journey.

The research was mainly carried out in Murambinda which is in Buhera District, Manicaland Province. Murambinda acquired its town status in 2012 and previously had been a growth point. It is about 250km outside of Zimbabwe's capital city, Harare. Below is a map of the distribution of the health centres that are found within the district which also gives a picture of the whole district. Birchenough Bridge (highlighted in green) is the furthest point from Murambinda and is 125km away. The two clinics highlighted in yellow and blue are the clinics that I visited during my research. Munyanyi clinic is 18km away from Murambinda along the tarred road while Mombeyarara is slightly further at 22km away from Murambinda but along a dirt road. This distance, though seemingly short, unearthed a world of difference for the women in need of accessing services in Murambinda particularly with regards to transport. In an interview with the District Administrator for Buhera District, it was found that although Birchenough Bridge is 125km from Murambinda, it takes 5 hours by motor vehicle because of the poor state of the road. I was also able to visit Buhera Rural Hospital which is about 30km from Murambinda.

[2] Musasa is a non-governmental organization which works primarily in the areas of gender based violence with its main thrusts in service provision such as counselling, temporary shelter and legal advice, peace building, advocacy and information dissemination.

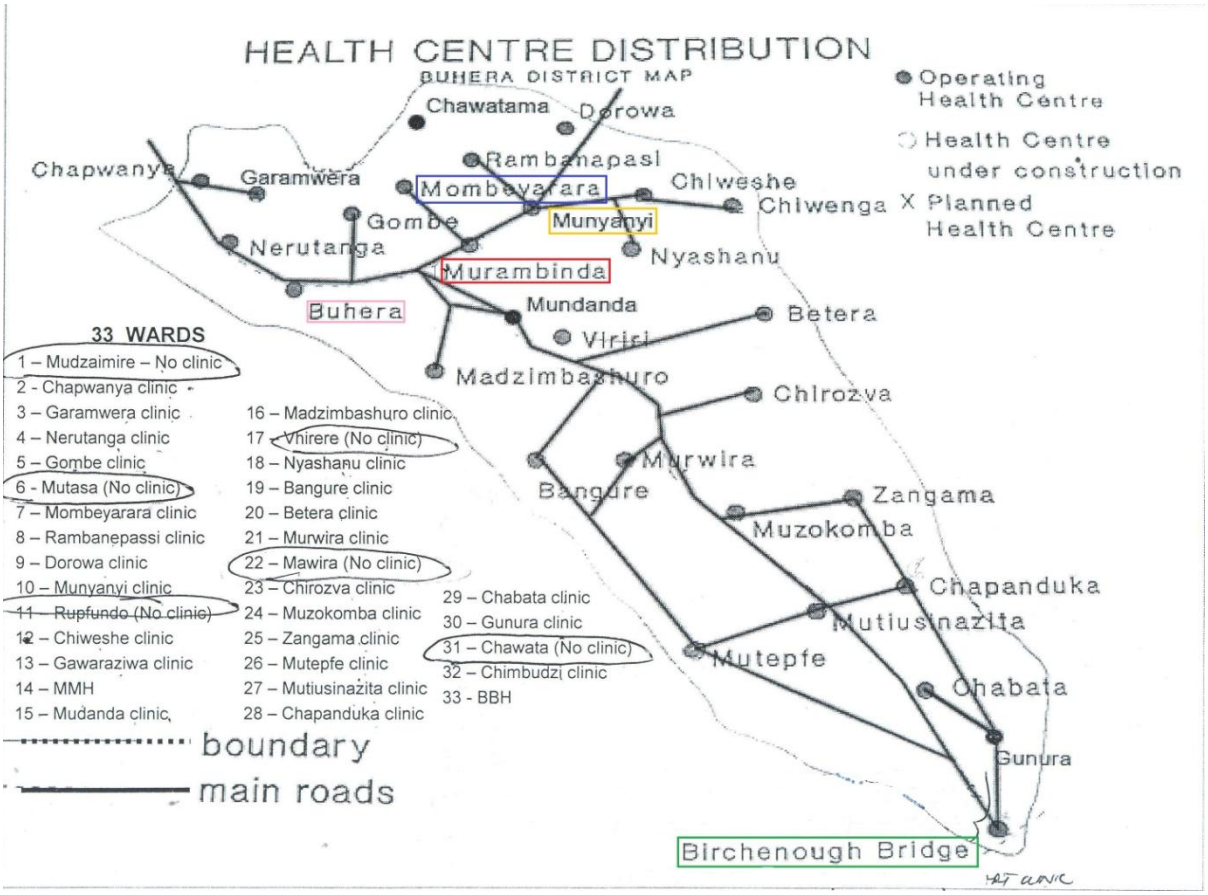

Figure 2: Map of Buhera district and the distribution of its clinics (Source: Courtesy of Medicins Sans Frontieres Murambinda, January 2014)

Distances from Murambinda Mission Hospital:

Munyanyi Clinic	18 kilometres
Mombeyarara Clinic	22 kilometres
Buhera Clinic	30 kilometres
Birchenough Bridge	125 kilometres

1.3 Objectives of the research

The overarching objectives of the research were as follows:

1. To investigate whether Zimbabwe has made enough effort to ensure that pregnant women have access to basic health care services including reproductive health services in Buhera District.

2. To assess whether health and gender budgeting has been adequate to make maternity waiting homes effective.
3. To find out whether the standard operating procedure for maternity waiting homes are being adhered to.
3. To assess whether maternity waiting homes are a feasible option for expectant mothers in rural areas.
4. To investigate the impact that the requirements for admission have on potential users of the maternity waiting home.

1.4 Research assumptions

The research was guided by the following assumptions:

1. Zimbabwe has not made necessary efforts to ensure that pregnant women have access to basic health care services including reproductive health services in Buhera District.
2. State response in gender and health budgeting has been inadequate to make maternity waiting homes an effective intervention to reduce maternal mortality.
3. Maternity waiting homes are not a feasible option for some expectant mothers in rural areas because of socio-cultural factors.
4. Requirements for admission are a deterrent to potential users of the maternity waiting home.
5. Standard operating procedures for maternity waiting homes are not adhered to.

1.5 Research questions

1. Has Zimbabwe made the necessary efforts to ensure that pregnant women have access to basic health care services including reproductive health services in Buhera District?
2. Is the state response in gender and health budgeting adequate to make maternity waiting homes an effective intervention to reduce maternal mortality?
3. Are maternity waiting homes a feasible option for some expectant mothers in rural areas because of socio-cultural factors?
4. Are the requirements for admission a deterrent to potential users of the maternity waiting home?
5. Are standard operating procedures for maternity waiting homes being adhered to?

1.6 Limitations of the study

The primary limitation of the study was that it focused only on one maternity waiting home which is in Murambinda, Buhera. The challenges faced there by women making use of the MWH were assumed not to be unique to that area but able to provide some sort of standard experience for women in rural Zimbabwe. I would have wanted to visit communities and especially clinics further away from Murambinda but I was advised that there are some very politically charged communities which view with suspicion any activities taking place in their areas, particularly involving the assembling of people and it would not have been safe for me to go there. For other areas further away from Murambinda I was advised that as the roads were bad I was likely to get stranded there as the research was largely taking place during the rainy season and there were no tarred roads in the places that I would have had to go. Though disappointing for me, it was even more troubling to think that if I could not get there then it meant a pregnant woman needing to be referred to Murambinda Mission or to Mutare Hospital could not be transported there.

CHAPTER TWO

2.0 THEORETICAL AND CONCEPTUAL FRAMEWORK

2.1 Introduction

A range of literature sources both national and international have been examined in order to establish the status of maternal mortality but also zeroing in on the intervention that is specifically tackled in this research – maternity waiting homes. The case is made that Zimbabwe has taken a leap forward in its compliance with international human rights obligations by including in its new Constitution the right to health. This is new terrain for Zimbabwe and an opportunity to begin dialogue on what this right will translate into in the lives of ordinary women in rural Zimbabwe.

2.2 The right to maternal health care and safe motherhood – The human rights framework

Zimbabwe is not short of ratifications to key human rights instruments that guarantee the rights of women to health particularly focusing on maternal health. The first human rights instrument, the Universal Declaration on Human Rights (UDHR) stipulates that everyone, without discrimination, has the right to a standard of living adequate for the health and wellbeing of himself and his family including access to medical care and necessary social services. Building upon this foundation, both the United Nations International Covenants on Civil and Political Rights as well as on Economic, Social and Cultural Rights stipulate that State Parties recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The SADC Protocol on Gender and Development stipulates that in line with the SADC Protocol on Health and other regional[3] and international commitments made by Member States on health, governments must adopt and implement legislative framework, policies, programmes and services to enhance sex and gender sensitive appropriate and affordable quality health care to reduce the maternal mortality ratio by 75% by 2015. Article 16 of the African Charter on Human and People's Rights also guarantees every individual the right to enjoy the best attainable state of physical and mental health.

[3] Article 26 of the SADC Protocol on Gender and Development.

Critical to this research was to focus on the conceptualization of the provision on health care found in CEDAW. Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women provides that:

> '1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, *on a basis of equality of men and women*, access to health care services, including those related to family planning.
>
> 2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women *appropriate services* in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.' (own emphasis)

To say that health care shall be accorded on the basis of equality between men and women raises the question of how reproductive health can be provided equally to man and women. Cook *et al*. argue that though reproductive health is an important component of health for both men and women, it is much more critical for women. Women are more likely to die as a result of their natural role in the survival of mankind and the roles associated with it while men are prone to die as a result of their own vices. The fact that women biologically are designed to carry children and give birth to them means that there can be no equality in this regard. The risk that women can lose their lives in this process means they bear a disproportionate burden in this regard (Cook *et al*., 2003).

General Recommendation 24 of the Committee on the Elimination of all Forms of Discrimination against Women (the CEDAW Committee) in expanding Article 12 states that State Parties should report on the measures they have taken to eliminate barriers that women face in access to health care services and what measures they have taken to ensure women's timely and affordable access to such services. The committee noted that some of these barriers many include requirements or conditions that prejudice women's access, such as high fees for health care services, consent from spouse, parent or hospital authority, distance from health facilities and lack of affordable public transport.[4] Some of these barriers could also include religious and social factors as this research unearthed. Article 14 of CEDAW pays particular attention to the challenges faced by rural women. It stipulates that state parties need

[4] Paragraph 21 of General Recommendation No 24 of the CEDAW Committee.

to eliminate discrimination against women in rural areas by ensuring they have access to adequate health care facilities including information, counselling and services in family planning. This being the critical focus group of my research, this right to information pertaining to matters related to maternal health care emerged as being very important because I found that women themselves without adequate information provided to them may among themselves share information that may discourage the use of critical maternal health services such as maternity waiting homes.

In August 2011, the Committee on the Elimination of All Forms of Violence against Women became the first United Nations human rights body to issue a decision on maternal mortality as regards a States obligation under Article 12 of CEDAW. The Committee found that State Parties have an obligation under human rights to ensure that women of all racial and economic backgrounds have timely and non-discriminatory access to appropriate maternal health services. The communication brought before the Committee was that of *Alyne de Silva Pimentel v Brazil* in which one Ms Pimentel died as a result of a complication in childbirth after she gave birth to a stillborn baby having complained of abdominal pain and vomiting at six months in her pregnancy. After some delayed interventions by the health institution, she died just after being referred to a more specialized facility. The Committee found that Brazil had failed in its obligation as laid out in terms of Article 12 of CEDAW. It was stated that 'the lack of appropriate maternal health services in the State party that clearly failed to meet the specific, distinctive health needs and interests of women not only constituted a violation of article 12, paragraph 2, of the Convention, but also discrimination against women under article 12, paragraph 1, and article 2 of the Convention.' It was also found in this case that a neglect of issues such as maternal health care that relate specifically to women is a form of discrimination against women.

In speaking of maternal mortality as a human rights concern, the critical issue of accountability lies at the centre. In Zimbabwe for instance it has been very easy to blame the economic meltdown and sanctions on the deterioration in service provision but the fact remains that nobody is made or held accountable for the lives of those women that are lost in childbirth. This decision about Brazil made by the CEDAW Committee was thus an indication that this matter is indeed a matter of gross human rights violations that leave women dead and the state must account for the policies and services that are in place to deal with maternal mortality.

2.3 The state of health care in Zimbabwe in the current political and economic context

The Government of Zimbabwe has in recent years made efforts to improve the health care system that had fallen below acceptable levels and evidenced by a maternal mortality rate of 960 deaths per 100 000 live births. The introduction of the Health Transition Fund (HTF) is one such stride. The HTF is a pool of multi-donor funds including the European Commission, UNFPA and UNICEF as the grant manager aimed at revitalizing the health care system. For the period 2011-2015, these donors have pledged US$435 million for the health care system in Zimbabwe. So far there has be evidence of some of these monies being used to buy ambulances for health centres including at district health centres across the country.

In 2010 the European Union (EU) launched the 1 billion Euro Millennium Development Goals (MDG) initiative to support maternal health, contribute to the fight against child mortality and hunger and improve the supply of water and sanitation. Under this initiative the EU is supporting the Ministry of Health and Child Welfare (MOHCW) and the United Nations Population Fund (UNFPA) to foster progress towards achieving MDG 5 on improving maternal health with a focus on promoting institutional deliveries. The programme which is covering the period 2012 – 2015 has a total budget of EUR 9.9 million (US$ 12.4 million).

Zimbabwe has also launched Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIM ASSET) which is its blueprint for economic recovery and to guide national development. ZIM ASSET has as one of its clusters, a cluster on Social Services and Poverty Reduction which is where issues of health delivery are found. This document basically lays out in great detail what the ruling government has set as goals to be achieved within the period from October 2013- December 2018. One of the projected outcomes of this cluster is the reduction of the maternal mortality rate in Zimbabwe. In order to do this it sets out various outputs that will lead to that outcome. 90% of all pregnant women are expected to receive at least four antenatal care visits while at least 85% of deliveries are expected to be done in health facilities. Of the most significance for this study is the goal to have fully functional MWHs available in every district hospital by 2015. This will all be put in place with the aim that Zimbabwe accelerates its MDG 5 target which stipulates that the MMR

should go down to 174 deaths per 100 000 live births by 2015. These targets were agreed upon at the setting of the MDGs to ensure that governments are working at a specific, clearly articulated goal within the period 1990-2015.

ZIM ASSET can be seen as a follow on from the Short Term Emergency Recovery Programme (STERP) which was less detailed but also laid out the plans of the Inclusive Government. Once the Global Political Agreement was signed on 15 September 2008, the inclusive government put in place this programme in order to resuscitate an economy that was in need of intense rehabilitation. As an emergency strategy it was put in place between February and December 2009. One of the key priority areas under STERP was Social Protection under which the health sector fell. It was acknowledged that the challenges plaguing the health sector including lack of adequate funding for health, infrastructure deterioration, loss of experienced health professionals have led to a drastic decline in the quality of public health services. According to the Ministry of Health and Child Welfare, in 2011 69% of doctor positions and 80% of midwife posts were vacant. For STERP to be operationalized as far its health targets were concerned, it was estimated that US$300 million would be needed.

The total budget allocated to health in 2014 is US$339 million. This is out of a total national budget of US$4.4 billion. The percentage that has been allocated to health is therefore 8.2% which is less than the 9.87% that was allocated in 2013. This is short of the recommended 15% of the total budget that the Abuja Declaration of 2001, to which Zimbabwe is a signatory, stipulates. However a budget is just the guiding frame which the respective Ministers can only access if and when the actual funds become available. As a result, in the 2013 budget, Maternal and Child Health specifically had been allocated US$6 million from the total health budget but only got only US$2.6 million from that budgeted amount. In the 2014 budget, Maternal and Child Health have been allocated US$1 million dollars less at US$5 million and time will tell how much will be received in real terms.

Organizations such as the Zimbabwe Doctors for Human Rights have come out stating that corruption and fiscal mismanagement in public health facilities have limited maternal health services. The Board Chairperson of the organization states that clients needs have not been prioritized but rather the preservation of the funds and those who benefit from them. She identified the emigration of health professionals caused by poor working conditions and the

lack of budgetary support to public health institutions as contributing factors to poor maternal health services for women. She rightly states that our health care system is still heavily dependent on donors. This is evidenced by the number of funds and initiatives being supported by donors. Because of the high levels of unemployment and poverty, women have reduced health seeking behaviour (The Crisis Report, 2014).

2.4 The national legal and policy framework

Prior to the enactment of the new constitution which provides for a right to health, the laws and policies on health in Zimbabwe had no guidance from a supreme law. The previous constitution stipulated that international law did not automatically become domestic law once ratified or acceded to by the state. Therefore as regards health in Zimbabwe, the laws pertaining particularly to maternal or reproductive health were virtually non-existent. The Medical Services Act Chapter 15:13 makes no particular mention of maternal or reproductive health care. It simply mandates the Minister to provide and maintain comprehensive and constantly developing medical services and to encourage local authorities and other persons to provide such services.[5] The approach implied by this Act is one of progressive realization as is the case with social, economic and cultural rights even at international level. The constant development of medical services at the level of national authorities as well local authorities requires attempts to reach accepted international standards pertaining to health care services.

The National Reproductive Health Policy states that in improving maternal health there is evidence that the training of TBAs and the provision of simple kits are ineffective. It stipulates that pregnant women should be provided with waiting mothers' shelters and access to skilled personnel at delivery. It highlights the need to establish effective referral systems and transport as well as dealing with the social barriers to access to ensure that safe motherhood services are affordable and accessible to women. As an activity the policy speaks to the upgrading of skills and facilities of TBAs and primary level health staff to improve detection, treatment and referral of obstetric problems.

Traditional Birth Attendants may be provided for in the Traditional Medical Practitioners Act which provides for the registration of traditional medical practitioners should they be found

[5] Section 3 of the Medical Services Act Chapter 15:13.

to possess the necessary skills, have the ability to practice and be of good character. Section 1(2) of the Act defines the practice of medical practitioners as follows:

> '"practice of traditional medical practitioners" means every act, the object of which is to treat, identify, analyse or diagnose, without the application of operative surgery, any illness of body or mind by traditional methods.'

It is not easy to tell from this definition whether traditional birth attendants would fit into this category in totality but part of what they do is to identify certain complications in pregnancy and diagnose them. Some may refer to health care facilities or treat, depending on the condition. This would mean that there is requirement that they be registered with the Council and pay a registration fee. With the registration comes the payment of a registration fee which may be slightly problematic for most TBAs who hardly earn any money from what they do. The requirement that they register may present as a deterrent factor. However, the advantage of TBAs being registered as traditional medical practitioners would be that there would be a channel for complaints that can be used by patients or users of their services. As it stands when a TBA is not registered and therefore is not covered by this complaints body, there exists no mechanism for patients to tender their complaints to anybody regarding the service they have received from a TBA. This would perhaps contribute to the unease that many have felt regarding using a service that would for all intents and purposes be ungoverned.

In 2012 the Government of Zimbabwe issued a mandatory policy aimed at reducing and eliminating user fees for certain groups of people. The then Minister of Health and Child Welfare, Dr Henry Madzorera, stated that they had received enough funding as a Ministry to scrap user fees. As part of the STERP the then inclusive government had identified what were termed vulnerable groups who were meant to have user fees scrapped for them. Pregnant mothers were among them. Free health care is available for pregnant mothers at rural clinic level and the policy is yet to reach district level hospitals where Murambinda Mission falls (Banda, 2010). This policy is in essence a very good one but as far as maternity waiting homes are concerned, the fact that they are housed at district level hospitals means that pregnant women who need to make use of the MWHs must pay fees equivalent to hospital fees and more costs in many cases are incurred because of their stay in the MWH.

2.5 Maternity Waiting Homes (MWHs) as a safe motherhood strategy

The time when maternity waiting homes came into existence and began to be used in Zimbabwe dates back as far as the 1960s or even beyond. Some were known as maternity villages which were constructed by communities for use by pregnant mothers. In my quest find out how far back these facilities were in existence, it became necessary to ask one of the staff members at the Women's Law Centre to gather information from her mother who she had indicated had made use of a maternity waiting home as far back as the 60s. it was discovered that in the mid-60s to early 70s, there was no requirement that the pregnancy be a high risk pregnancy in order of the women to be admitted into a MWH. She had had three children being accommodated in a MWH in Plumtree in 1965, 1968 and 1970. It was compulsory for every pregnant woman when she got to eight months in her pregnancy to be admitted. Those with the high risk pregnancies and a history of complications were admitted into the MWH from the time that they were four months pregnant. By way of utensils to be used while in the MWH, the women were required to bring a plate, a cup, a spoon and a towel. This clearly indicates that they had food provided for them while they stayed in the MWH. They were also required to bring a baby layette, for which they were provided with a list of what this should comprise of. She could not recall if there was a requirement that they service be paid for but she stated that if there was then the amount could not have been something out of reach in those days. Almost everyone she knows used the MWH because as she described them, the conditions were very relaxed. She lived near the Plumtree Hospital and recalled how even when if she wanted to leave to go and spend the day at home, she could and only needed to be back at the hospital at night to sleep there. During their stay in the facility, they had regular check-ups by the doctor and stayed very active.

In October 2013, the Ministry of Health and Child Care issued a draft baseline assessment report on a study conducted on the strengthening of MWHs in Zimbabwe. In that report it is acknowledged that MWH have been in existence dating back to the pre-independence period but the re-launching of them in 2010 was part of the broader initiative of revitalizing them and improving the uptake the bid to meet the 2015 MDG target of reducing maternal mortality.

With the support of UNFPA, the Reproductive Health Unit in the MoHCC carried out the baseline study to assess MWHs in Zimbabwe and therefore devise a plan to strengthen these

facilities in selected locations across the country. The overall target since 2010 has been to provide 125 MWHs at district, mission and rural hospitals with revamping and revitalization. To date 62 have benefited from this initiative. The study looked into services and facilities that are available at the MWH such as transport, communication, provision of nutritional support, facilities such as water supply and ablution facilities. In light of the fast approaching 2015 deadline when the Millennium Development Goals should be achieved, this MWH strategy aims at building on the existing facilities to revitalize MWH as a tool to reduce MMR.

Some of the recommendations from the baseline study were:

1. The MoHCC needs to consider providing nutritional support to pregnant women admitted in MWHs.
2. In order to help pregnant women in the MWH, there is need to consider assigning a general hand to oversee general maintenance of the MWH with special emphasis on infection control.
3. Ensure that all MWH have a readily accessible source of clean and safe water for functions such as infection prevention and patience use. There is also need to use solar lamps at those facilities (mostly rural health centres/clinics) not connected to the national grid.
4. MoHCC should consider strengthening transport and communication system for easy of referral of women in labour from the MWH to the ward, and also to the next level of care.
5. Ensure that essential structural components of the MWH are revitalized in accordance with the MWH operational guidelines.
6. Print and disseminate MWH guidelines.

However, in light of the baseline assessment, my research which initially would have taken a similar direction digressed from this and sought to discuss the feasibility and accessibility for women who need to use the service. In the initial discussions with my supervisor, it emerged that the gap that my research ought to explore rather is the community response to the facility based on women's lived realities as opposed to just assessing if the facilities are of a certain standard. It may make no difference if the facility is in tip top condition and yet nobody is using it because of barriers at community or family level.

The recent focus on strengthening MWHs is critical though for all intents and purposes a bit late in the quest to reduce the maternal mortality ratio by 2015 but even beyond being late, the report does not attempt to answer the question of whether it is as a service acceptable for the people who need it. The report mentions that the users of the maternity waiting homes noted that beds, clean environment as well as clean water are positives but negatives have to do with ablution facilities. It however does not enquire into for example the cost incurred by the users to be there and even the social cost that might be being incurred.

2.6 A look back at the provision of health care in Zimbabwe since Independence

Zimbabwe post Independence was one of the countries with the best health delivery systems with very low MMR. The GoZ of the time sought to correct the injustices of the colonial past by setting out a policy called 'Growth with Equity: An Economic Policy Statement' in 1981. This saw the major gains in expanded health programmes and the setting of minimum wages. (UNICEF and Zimbabwe, 2011). It this period, the government introduced policies such as free health care for all those who earned less that Z$150 with the minimum wage set at Z$182. During the period post Independence, the National Village Health Worker programme was launched in November 1981 in order to train multi-purpose basic health workers who were based in their villages. Related to this programme was the Traditional Midwives Programme (TMP) designed to upgrade the skills of household level women in identifying at risk pregnancies. They were trained in basic midwifery and elementary hygiene among other skills (Sanders, 1990). In this period also, the focus was on ensuring that the general populace was able to access basic primary level health care and it was during this time that many doctors and nurses were trained to service the broader black majority population so that they could better access the medical care that had previously not been readily available. When the Economic Structural Adjustment Programme was introduced in 1991, things took a turn for the worst with the resultant introduction of user fees resulting in a seven times increase in the cost of healthcare. With many having lost their jobs in the failed structural adjustment programme, health care was way out of reach for the poor and unemployed (UNICEF and Zimbabwe, 2011).

It is during those days that the maternal mortality began to rise, never to come down again in spite of all the interventions that have been put in place. During that period, traditional birth attendants were well accepted in the community as part of the primary health care system as they had been trained by the Ministry of Health and other players such as NGOs. However global calls were made in the late 1990s by the WHO, World Bank, UNICEF and UNFPA to ensure that ALL women, regardless of circumstances access skilled care during pregnancy, while giving birth and in the post-natal period (WHO, 2004). These calls did not have any regard to the economic challenges, social barriers and other inhibiting factors that women in different circumstances face. Rural women in particular as a group were known to be users of TBAs because of various challenges like accessibility and equity of maternal health care.

2.7 Hope for the future – The right to health under the new Constitution

The new Zimbabwean Constitution has brought hope for many women and men alike with regards to the inclusion of socio-economic rights within its Bill of Rights. The introduction of this right to health was one of the primary motivations for this study to create a dialogue on how this right could to be interpreted in order for it to have real meaning for as many Zimbabweans as possible. Of note is that the inclusion of the right to health in this context has brought Zimbabwe into compliance with its human rights obligations that require legislation to be put in place to ensure that the right to health is provided for.[6]

Section 76 of the Constitution provides that every citizen of Zimbabwe has the right to have access to basic health care including reproductive health care services. The National Objectives in the Constitution also stipulate in section 29 that the State must take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe. In developing a conceptual understanding of this right to health, it was important to understand what basic health care really means for the rural Zimbabwean woman.

Matsuura (2007) suggests that the right to health in a national constitution could play two roles – one of being an aspirational goal to which the state is working towards or it could be a legal instrument that is used to attain real improvements in health policy and translates into actual outcomes. However for the latter to be true it is argued that there has to be a conducive environment for citizens to claim and assert their rights. One of the key elements of this type

[6] General Recommendation 24.

of environment is a system of checks and balances where citizens can actually use the court system without fear or favour. The government does not necessarily have to wait for citizens to run to the courts but should ready itself to fulfil the obligations set out by having a right to health. In the Brazilian case discussed above which was brought before the CEDAW Committee, the Committee made the statement below:

> 'The distinction between obligations of conduct and obligations of result is critical to understanding the right to health. When States act to implement this right, they not only need to create policies designed to realize the right (an obligation of conduct), but must also ensure that those policies actually achieve the desired results (an obligation of result).'

It is hoped that the government of Zimbabwe has not just succumbed to pressure from various quarters to put the right words in the Constitution but will actually ensure that the right yields the desired result for the most vulnerable in society, including rural women.

2.8 Traditional Midwives v Skilled Birth Attendants – A place for traditional midwives in present day Zimbabwe?

Many scholars have written on the role of traditional birth attendants/traditional midwives in assisting women to deliver especially in rural communities. The key issues in the discussion on TBAs to be tackled by my research are raised by Stella Nyanzi in her description of the Gambian experience. She refers to the 'politics of health care in which bio-medicine takes supremacy needing to be addressed through sensitization about the need for mutual existence, support and collaboration so as to enhance the active participation of TBAs' (Nyanzi, 2008: 231). She states that the traditional midwife plays multiple roles in society, both socially and culturally and that it is important to recognize their position in the communities that they operate in, at times as part of community leadership. Perhaps TBAs in the Zimbabwean context may not hold a similar position but they are certainly esteemed highly in the society. In the field I was able to observe interaction between a local TBA and other women in the community. Because of her age as well as the nature of the work she does, she was revered as a mother figure in the community.

> 'According to WHO, skilled care refers to the care provided to a woman and her newborn during pregnancy, childbirth and immediately after birth by an accredited and competent health care provider who has at her/his disposal the

> necessary equipment and the support of a functioning health system, including transport and referral facilities for emergency obstetric care' (WHO, 2004).

In order for the package called skilled care to be possible, it is not enough that there just be a skilled birth attendant present but there are further resource implications. The existence of necessary equipment noted as well as a functioning health system. This could mean specialist doctors in the case of complications that this primary skilled attendant would not be able to handle and amenities such as beds that are relevant. In addition to this, the transport and referral facilities must be functional and available. In order to make all this available there needs to be allocation of resources that will make all this possible.

On one of my visits to a Buhera Rural Hospital which is a clinic not far from Murambinda Mission, I was taken on a tour of the facilities that are available in the maternity ward and the delivery room. The standard was by far higher than what I had expected and it was perhaps because the government is indeed aiming at improving standards at the primary care level.

Figure 3: Photograph of the delivery room at Buhera Rural Clinic

Upon seeing this room, the question still lingered pertaining to where traditional birth attendants would fit into this system even at this primary level of care. It is acknowledged by

the WHO that pregnant women need a fully functional continuum of care from the time of early pregnancy right up to the time of delivery. In this continuum therefore, it has been argues that the best role of the TBA in the skilled care strategy is to serve as advocate who encourage women to seek care from skilled attendants (WHO, 2004). The unique role of the TBA would therefore to not actually perform any deliveries but at the community level encourage women and facilitate their use of skilled care by providing them with information, for example.

In the course of my research I began to carve in my mind a possible place for TBAs as skilled attendants in the present day Zimbabwe as part of the primary health care provision in line with the WHO definition above. I would go as far as to say that they are already performing this role whether it is recognized or not. In light of this, I sought to establish what the views of those in the community are concerning my potentially controversial propositions. To start the trail of my enquiry, I followed a lead that took me to the Murambinda School of Midwifrey and enquired about the course that was offered there in a bid to see if TBAs could perhaps also be included in the trainees. The tutor there informed me that it is a one year Diploma in Midwifery where they admit nurses who already have a General Nursing qualification and have two years working experience preferably with exposure to a maternity unit. Each intake has 20-24 students with two intakes per year. In addition to covering issues of pregnancy and delivery, the course also has an applied psychosocial component which covers issues like the economic situation of the mother and its impact on maternal health, issues of religion as well as culture.

When I asked what she thought would be the best approach with the TBAs she said that the most important thing is to give information to them and teach them. There is need to identify the malpractices that were being done by TBAs and the harm that they are causing but it is also important to acknowledge the good. She said that the fact that TBAs do not have a scientific background is what compromises them. There are some things like anaemia or HIV which need to be detected so that mother and baby are kept safe. For them the answers are in prophesy and exorcisms. At times women are told through prophesy that the baby is not in the right position for delivery and that if they then try to seek help from a hospital then they will die or the baby will die. One major challenge she highlighted with TBAs is that they do not have a hierarchy so that if that TBA encounters a complication that is too difficult for

them there is no superior to refer to. She said TBAs should only assist with emergencies but otherwise leave it to health professionals.

This view did not dissuade me from my opinion that was slowly taking stronger and stronger root in my mind. I do not put forward the position that TBAs need to come in to replace primary health care workers but there is a definite place for them as evidenced by the fact that women continue to use them. Looking at the 'grocery' lists of skills that the WHO provides that a skilled attendant should have, it became important to divide this list into what TBAs can do and in many cases are already doing and what they would need to be able to contact primary care nurses or doctors for. With the right support from government and the donor community by way of clean huts to perform their duties and basic telecommunication devices such as cell phones to communicate with the next level in the chain, TBAs would be able to fit in well within the formal health care system. With a clear line of communication, even over a simple device such as a cell phone which is widely used in rural Zimbabwe, a TBA could be guided by a primary care nurse or doctor over the phone and conduct safe deliveries.

What TBAs can and are already doing:

- Communicate effectively 'cross-culturally'[7] in order to be able to provide holistic 'women-centred' care. To provide such care skilled attendants will need to cultivate effective interpersonal communication skills and an attitude of respect for the woman's right to be a full partner in the management of her pregnancy, childbirth and the postnatal period.
- Assist pregnant women and their families in making a plan for birth (i.e., where the delivery will take place, who will be present and, in case of a complication, how timely referral will be arranged).
- Educate women (and their families and others supporting pregnant women) in self-care during pregnancy, childbirth and the postnatal period.
- Perform vaginal examination, ensuring the woman's and her/his own safety.
- Identify the onset of labour.
- Identify delayed progress in labour and take appropriate action, including referral where appropriate.

[7] Cross-cultural communication in the case like we have in rural Zimbabwe where Traditional Birth Attendants provide services to women within their own communities may not even be relevant.

- Manage a normal vaginal delivery.
- Manage the third stage of labour actively
- Assess the newborn at birth and give immediate care.
- Assist women and their newborns in initiating and establishing exclusive breastfeeding, including educating women and their families and other helpers in maintaining successful breastfeeding.
- Provide advice on postpartum family planning and birth spacing.
- Educate women (and their families) on how to prevent sexually transmitted infections including HIV.
- Collect and report relevant data and collaborate in data analysis and case audits.
- Promote an ethos of shared responsibility and partnership with individual women, their family members/supporters and the community for the care of women and newborns throughout pregnancy, childbirth and the postnatal period.

What they would be able to do assisted by primary care nurse or doctor:

- In pregnancy care, take a detailed history by asking relevant questions, assess individual needs, give appropriate advice and guidance, calculate the expected date of delivery and perform specific screening tests as required, including voluntary counselling and testing for HIV.
- Identify illnesses and conditions detrimental to health during pregnancy, perform first-line management (including performance of life-saving procedures when needed) and make arrangements for effective referral.[8]
- Monitor maternal and foetal well-being during labour and provide supportive care.
- Record maternal and foetal well-being on a partograph and identify maternal and foetal distress and take appropriate action, including referral where required.
- Identify any life threatening conditions in the newborn and take essential life-saving measures, including, where necessary, active resuscitation as a

[8] For TBAs to be able to do this, it should be clearly defined that transport from primary or even secondary health care facilities will be made available to the centres from which TBAs will be operating.

component of the management of birth asphyxia, and referral where appropriate.

- Identify haemorrhage and hypertension in labour, provide first-line management (including lifesaving skills in emergency obstetric care where needed) and, if required, make an effective referral.
- Provide postnatal care to women and their newborn infants and post-abortion care where necessary.
- Identify illnesses and conditions detrimental to the health of women and/or their newborns in the postnatal period, apply first-line management (including the performance of life-saving procedures when needed) and, if required, make arrangements for effective referral.

The skills that are required by skilled attendants could be made available to TBAs, for those which they do not already possess. The continued training of TBAs or even their integration into the midwifery programme at Murambinda Mission Hospital could be the first step in ensuring that the divide between TBAs and the formal health care system is eliminated.

CHAPTER THREE

3.0 FINDINGS ON FACTORS AFFECTING THE USE OF THE MATERNITY WAITING HOME (MWH)

3.1 Introduction

The findings from the research process have been divided into two sections. The first section tackles the findings that relate directly to the various factors that influence women's ability to make use of the maternity waiting home that is at the district hospital. These factors were found to be financial constraints, religious as well as social barriers. Women do make use of alternatives that are available to them such as traditional birth attendants and this is also explored as a major emerging issue in the research. The second section (chapter 4) focuses on how other players such as the government and NGOs/donor agencies play a role in women's use of these facilities.

3.2 Women's real choices

As the research process continued, it became very clear to me that the issues around maternal health and decisions pertaining to it such as where to give birth, who to assist with the birth or even how many children to have do not rest solely with the woman. According to health policies in Zimbabwe, a woman must make sure her births are attended to by a 'skilled attendant' either in a clinic or in a hospital. By scrapping maternity fees, the government has taken strides to ensure this happens, however these fees are only scrapped at the level of rural clinics. However there are other semi-autonomous social fields such as family and religion that have a huge bearing on women's choices. A report by UNICEF on the role of the Apostolic Sect and access to maternal and child health reveals that one's religious affiliation is a determinate of whether you are at risk of maternal death (Maguranyanga, 2011). In the course of this research it was found that perhaps that choice is not made by the woman herself but is made for her by the family. I greeted a man at the door of the Ministry of Health offices in Murambinda who had just jumped out of one of the Ministry ambulances. I asked him how work is and he said work was fine except that they are having problems with *mapostori* who are making their work difficult. I found this very interesting as I had not indicated that I was actually doing research in which this was emerging as a major issue. He said there are times where they can be called to attend to an emergency like a woman in

labour and at times they will have put the woman in the ambulance but when the husband arrives he demands that they let her off the ambulance. The husband tells the driver that they have been told that they have the freedom of religion therefore if their religion says their wives do not go to hospital then that is it. He gave a scenario where that happened but when they had already left and travelled some distance they were called back because the prayers had failed and they needed the woman to get help. In that situation he stated that the woman then gave birth in the ambulance. In this situation, the woman herself is silent and has absolutely no say in what is happening to her in such a critical moment where it is either life or death. Perhaps she did not even choose to be in the Apostolic Sect but was either married into it or born into it.

Over and above this, it would seem that the choice of where to give birth is made for the women by the high costs of associated with making use of safe motherhood interventions such as maternity waiting homes which are at par if not more than the cost of giving birth at a district hospital. On top of the requirements for maternity fees, her upkeep in terms of food and firewood while staying at the MWH pushes the costs way out of reach for most rural women, and thus the decision is made for them.

3.3 The violence of neglect – The state of the maternity waiting home in Murambinda

One of the objectives of the research was to investigate the conditions under which the women in the maternity waiting home were living. In the initial stages of the research planning process I had wanted to focus on an investigation whether the Operational Guidelines for Maternity Waiting Homes set by the Ministry of Health and Child Welfare in 2010 are being adhered to. However in deeper discussion with my supervisor it emerged that there would be a greater need instead to focus on the feasibility of the waiting home for the women who have to make use of it, thus grounding the study in the lived experiences of the women. I had never been inside one and I was anxious to see what it was like. In order to explore whether or not the standards set in the Operational Guidelines were being adhered to I decided to begin with interviews with pregnant mothers currently making use of the maternity waiting home.

Throughout the research, the *Shona* word that was being used to refer to the maternity waiting homes was *matumba* which from my knowledge means a shack. As nurses, pregnant women in the MWH, pregnant women in the community as well as some officials continuously referred to it in that manner, it created an impression that the conditions I was going to find there would be a reflection of that name.

The maternity home is located less that 100 metres from the maternity ward of the Murambinda Mission Hospital. On the first visit, women could be seen sitting on the rocks just outside of MWH, some holding babies and others just sitting outside. It was found that there is no dedicated staff for the MWH alone but one of the Sisters indicated that the maternity staff rotates the duty. She stated that there are 8 midwives in total who rotate – 2 on night duty, 2 on nights off, 4 on duty during the day attending to labour, post-natal care, ante-natal care, children as well as the MWH. The women in the MWH referred to a *sekuru* (meaning, a title of respect for an old man) they had heard of who was in charge of cleaning and manning the MWH but none of them had ever actually seen him. The women orient each other on the MWH as there is nobody who escorts them there or briefs them on what is expected of them or what will be happening during their stay once they have been registered at the maternity ward. I witnessed this soon after the women told me this. A woman walked into the MWH in the middle of our discussion and greeted everyone. She asked where she could put her bag, to which she got some mumbled response telling her there was space right by the door. It became evident that this was a new person as nobody really spoke to her after that. The young girl I was sitting next to in the circle then said, *'Aunty honai uyu munyowani arikutosvika izvezvi'* (meaning, 'Aunty, look, this lady is new and has just arrived.') I greeted her and introduced myself telling her what we were doing before proceeding with the discussion.

Figure 4: Photograph of the view of the MWH taken from the entrance of the maternity ward

Two focus group discussions were held with different groups of women in the MWH. On both visits there were new faces as the women do not spend very long periods of time there. In the groups that we interviewed, some had been there for three days and up to as long as four weeks. The women were there for various reasons, all reasons prescribed by the guidelines, including distance from the clinic or hospital, first pregnancy or fifth baby. Upon entering the room, I observed some of the women sitting on the floor, some on beds and others on mattresses. This was consistent with what the Sister at the maternity ward had said about there being only six beds in the MWH that could accommodate 30 women. The typical day for women in the MWH begins with waking up at 4am to clean their sleeping areas, the cooking area as well as the ablution facilities. They are then not permitted to cook before their pre-natal classes which normally begin between 0800hrs and 0900hrs. after these classes the women are free to come and cook and have their breakfast. If they have visitors, they are permitted to see them during the normal hospital visiting hours that are 0600hrs, 1300hrs and 1700hrs. For the rest of this time, they are seated, talking to each other. With no beds and for some no mattresses, it was hard to imagine how these women could spend the whole day just seated on a hard floor. When it comes time to cook, they go to the next room where the kitchen is found and each woman starts her own fire and prepares her meal. One of the women even stated that when one of them goes into labour and goes over to the hospital, she

is told by the nurses to ask her friends at the maternity waiting home to cook for her until such time as she gives birth, after which she would be provided with food by the hospital. Some women could also be seen cooking for their family members who would have spent several hours waiting for the next visiting hour to be able to see them.

Having seen this situation, it was possible to juxtapose what was observed with what is provided for in the Maternity Waiting Homes Operational Guidelines which the then Ministry of Health and Child Welfare (MoHCW) developed in 2010. The guidelines were developed through a participatory and consultative process to provide service providers at all levels of care with key information with standards on how MWHs ought to be run. The guidelines are designed to be used as reference material during service delivery. The guidelines outline key information pertaining to where a MWH should be located, the sitting of the MWH as well as providing tools for monitoring and evaluation. Of interest was that the infrastructure that should ideally be found in a MWH is laid out as follows:

Table 1: Showing essential infrastructure and equipment of a maternity waiting home

Area	Items	Numbers
Laundry Area	Sinks	4
	Washing lines	4x4 strands x 5 metres
	Ironing Slabs	5
	Electric Iron	1
	Charcoal iron	1
Recreational Room	TV Set	1
	Radio Set	1
	Easy Chairs	24
	Coffee Table	3
Bedrooms	Beds	4/room
	Lockable lockers	4/room
	Fitted Wardrobes	4/room
Kitchen/Dining Room	Tables	5
	Chairs	6 per table
Bathrooms	Hand washing basins	
Sundries	Gloves	
	Delivery Pack	1
Transport and Equipment	Stretcher	1
	Wheel Chair	1
	Bell system for rooms	1
	Blankets	3/bed
	Counter Panes	2/bed
	Pillows covered with polythene plastic	2/bed
	Mattresses covered with polythene plastic	4/room
Security	Lockable gate	
	Security fence	

Needless to say this is the entire ideal infrastructure as outlined in the guidelines but the MoHCC needs to allocate the necessary resources to this and other facilities of its kind to make it a reality. With the current MWH strengthening and revitalization intervention being carried out, Murambinda Mission Hospital is among the selected MWH set to be revitalized so it would be good to see it after the intervention.

Figure 5: Two snapshots of views inside the MWH in Murambinda

3.4 'I just can't afford it!' – The cost of using the Maternity Waiting Home in Murambinda

It became evident that the choices women have to make as far as where to give birth is concerned, boiled down to the issue of cost. The concept of the maternity waiting homes having been introduced to deal with delays in women getting to a birthing facility perhaps never initially considered the costs that would accrue by default. With a maternity waiting home being housed at the hospital it means a woman, though being admitted for free into the MWH will accrue all the other expenses associated with a hospital birth, often out of the reach of many.

When women are admitted into the MWH, they are required to bring in the following items:

- A baby layette
- Cooking utensils
- Blankets

- Bucket to bath in
- Toiletries
- Food
- Firewood

In one of the focus group discussions with pregnant women in the community, it was stated that the baby layette or what is popularly known as preparation can be a major deterrent because the nurses tell women that they want only brand new contents. One woman recounted her experience of going to the hospital where she was told that there was a requirement for 5 or 6 brand new nappies. She recounted how she did not have the required number but only had 3 brand new nappies that she had managed to acquire. She then made a decision not to go as she could not meet the requirements. One of the nurses at Munyanyi also told of a woman who had come to register at the clinic for free but then a few weeks after her due date, the nurse met her walking in the village with her baby. She asked her what had happened and she said she ended up giving birth at home because she did not have enough preparation for the baby. Not having had a baby before, it was necessary to find out more about the contents of this layette, which are as follows:

Table 2: Showing the contents and cost of items which make up an ideal layette

ITEM	COST (in US$)
Baby blanket	10
Wrapping towel	5
Hat	0.5
Socks	5
Trousers and jacket	10
Vest	1
Nappies x5	10
Methylated spirits	1
Cotton wool	2
Bucket	5
TOTAL	US$ 49.50

In addition to these requirements, every pregnant woman has to pay US$28 for a normal delivery. If there is need for stitches, an additional US$22 has to be paid. In the event that this same woman requires a blood transfusion, then she must pay US$80. If the woman needs to have a caesarian section then that will cost her US$60. These are the normal fees that must be

paid in a hospital and by virtue of the fact that the woman fits into the category of people that must use a maternity waiting home then these are the costs that she has to bear.

Over and above this, the transport costs that must be met also proved to be steep for mothers needing to access the hospital. Because of the state of the roads, it was found that women coming from about 25km away can pay as much as US$30 to hire a car from a member of the community as some public transport operators would not be willing to carry pregnant women on their way to the hospital. The normal cost of public transport could be between US$1 and US$2 but in emergency cases, a situation could even arise in the middle of the night that necessitates a woman rushing to the hospital when there is no public transport available. However these transport costs would be cheaper if the women were already at the maternity waiting home, in which case it would not be an emergency and they could pay the normal US$1 or US$2 for public transport.

With all these costs that women need to bear, the issue of access to information about these costs emerged during the course of this research. How women knew of all these requirements was an issue that came to me attention towards the end of a focus group discussion I conducted in ward 31 in Buhera with 25 pregnant women near Mombeyarara Clinic. One woman, after I had asked why she would not use the maternity waiting home facility stated that she had heard that there was a requirement for one to bring six brand new nappies for the new born baby and she simply did not have these. Upon further enquiry on this matter, I found this not to be true but with that type of information circulating amongst pregnant women in the community it was difficult to imagine what the impact had already been and the number of women who had been dissuaded by it.

In light of the user fee policy that excludes pregnant women from paying maternity fees, it is argued that it would make more sense economically if these maternity waiting homes were situated at a clinic rather than a hospital. This would at least eliminate the costs associated with giving birth at a hospital. As it stands, a woman who is a first time mother, on her fifth pregnancy and above, has some form of complication or lives far away from a health institution is by default expected to have enough money to give birth at a hospital. The elimination of maternity fees therefore does not seem to benefit women in rural areas who

need to make use of a maternity waiting home located at a district level government or mission hospital.[9]

3.5 Traditional midwives as a feasible alternative for pregnant mothers

Traditional midwives were one of the categories of potential interviewees that emerged through the grounded methodology. In one of my first interviews with the Ministry of Women Affairs official in Murambinda it emerged that there had been intense work to discourage women from making use of TBAs. Part of the form of the campaign was to threaten TBAs with arrest if they continued to assist women. As a result they were almost in hiding and getting them together was not very easy. However I was successful in getting the community facilitators within the Ministry of Women Affairs to identify a few that they were able to communicate with to come to a focus group discussion that we had organized for pregnant mothers and women from the Apostolic Sect which was another emerging category.

One of the highlights of my research was when I met *Mbuya* Musindo, a 77 year old traditional birth attendant. She said she began her career as a midwife in 1960 when she was around 30 years old. She described how people, normally women, learnt to be midwives by watching older women doing the job. She said on one occasion after she had been observing for a while a relative of hers was giving birth and there was nobody else around to help and people called on her. She said she had nothing, no gloves or any other equipment but she delivered the baby safely after she prayed for the girl. She could not remember when but said she had been trained in midwifery at the time when the Ministry was training midwives and she used to go to Murambinda Hospital once a month but that has since stopped. I asked her if she charges for her services and she said she does not really charge but some women pay with soap or anything they have but in cash she said she can get in the regions of US$3 to US$5. She had with her the book she has had from 1960, recording all the births she has attended since she started as a TBA.

[9] Murambinda Mission Hospital is a Roman Catholic Mission which is partially supported by the government of Zimbabwe. It also receives some support from an association of nurses called the Little Company of Mary which collects donations for the hospital.

Figure 6: Photograph of a page from *Mbuya* Musindo's record of the births she has attended

As we discussed the issue of her book and the way she keeps her records, it became evident that this is work that *Mbuya* Musindo takes great pride in. She took hold of the book and at some point recalled some of the individual women she had assisted. She stated how her husband had constructed an outbuilding for her in the form of a round hut which was dedicated for her deliveries. She had been able to get a bed to use and she still makes use of it today.

It emerged that there are different types of TBAs that operate in Buhera. Some are religious, meaning they are aligned to a particular sect and thus normally assist women within that sect as well. As they assist women they will also pray for them and prophesy over them and they believe that every complication in pregnancy or childbirth is a result of some sin that has been committed therefore once the pregnant woman confesses it will be rectified. There are then the midwives who are not aligned to any religion and these may use herbs or other traditional medicines to assist women in childbirth. The nurse at the Murambinda School of Midwifery gave an example of an incident where there were three maternal deaths consecutively because a n'anga had come in as a visitor but had started giving the women

there some herbs which she claimed were to speed up labour. She stated that pregnant women are in a real dilemma caught between what the nurses are saying to them and what culture or religion says to them.

It was also found that in circumstances where women have sought medical attention within the formal health care system, they will also make use of TBAs for the herbs and other things that they can offer them, as well as for prayer. An informal and impromptu interview I had with the wife of the owner of the lodge where I was staying in Murambinda revealed that even though some women can afford to access the hospital and they give birth there, during the course of their pregnancy they will look for a TBA for prayer so that whatever complication has been found can be dealt with. Some will also visit the non-religious TBAs who will give them herbs to speed up labour and open the pathway for the baby to come out. One of the nurses indicated that because these substances are not tested or their properties not fully known, they may cause a risk to the life of the mother and the child.

Due to the fact that all these services that may be offered by TBAs are virtually free of charge, women are left with no real choice but to do what they can afford. From discussion with pregnant women in the community it emerged that these are women often with no income of their own and sometimes need to rely on their husbands borrowing money in order for them to be able to access health care. They may go and work in other peoples' fields in order to get second hand baby clothes and a few dollars that are needed. One girl who struck me in discussion within a group of pregnant women was a 17 year old expecting mother who remained very quiet during the discussion about where people in the group would be going to give birth and why. When it came her turn she bluntly said she would be going to a TBA from her church because she cannot afford to go to the MWH. The way in which she responded brought up the question of choices for pregnant women in those circumstances.

Aside from the obvious advantage of affordability associated with giving birth assisted by a TBA, respondents identified the major challenge as being that of getting a birth certificate for the child. Due to the fact that TBAs are not able to give a birth record as can be acquired in a clinic or hospital, it was found that many mothers are then not able to get birth certificates for their children. TBAs noted that in some circumstances they have tried to escort mothers who have given birth under their care to the nearest clinic to get a birth record but they are denied because the baby was not actually born in the clinic.

However, the Births and Deaths Registration Act Chapter 5:02 is unambiguous on this matter. Section 10 of the Act makes it compulsory for every birth that occurs within the territory of Zimbabwe to be registered. The following section, section 11(1), lists the various persons who may be responsible for registering a birth as follows:

> ‘(a) the occupier of the house in which the birth or still-birth occurred, where he had knowledge of such birth or still-birth; or
>
> (b) the person in charge of any hospital or other institution in which the birth or still-birth occurred; or
>
> (c) the headman appointed in terms of section 8 of the Chiefs and Headmen Act [Chapter 29:01] for the community in which the birth or still-birth occurred, where he had knowledge of such birth or still-birth; or
>
> (d) any person who has attained the age of eighteen years present at the birth or still-birth; or
>
> (e) in the case of a birth, any person who has attained the age of eighteen years having charge of the child; or
>
> (f) such other person as may be prescribed; to give notice of the birth or still-birth in the prescribed form to the registrar of the district in which the birth or still-birth, as the case may be, occurred.’

Nowhere in this section or any other part of this Act is reference made to the fact that the registration of a baby needs to go through a clinic. If anything, the Act actually recognizes that some babies may be born in houses or other places other than hospitals or clinics. The ability of TBAs to give notice of the birth of a baby is also clear from this Act as they are the ones who would have attended to the birth. There is no indication in this law either that there must be birth record coming from a clinic. It is acknowledged that the headman may also be able to give notice of the birth of the baby. This indicates that the law is cognizant of the fact that births do take place outside of the formal health care system, particularly in rural areas where women would on those circumstances have access to the headman who can assist them to register the births of their children. It therefore was a case of misinformation of community members perhaps with community members sharing information amongst themselves which is detrimental and results in many children being unable to obtain birth certificates. This then

leads to cycle where that baby then grows into a child of school going age without any form of identification, barring the ability of that child to access an education and then eventually they are not able to get an National Identification Card. This may then be the same woman who will not make use of the clinic of hospital because she has no means of identifying herself and then will opt to give birth with a TBA and the cycle continues.

Chief imposes hefty fines for home deliveries

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HOME deliveries have gone down in Wedza as traditional leaders fine mothers giving birth in unsafe conditions at home, a village head claims.

Village Head Simon Musanhu said the move is meant to promote the uptake of antenatal care services in line with the country's target to eliminate mother to child HIV transmission in 24 months.

"The traditional midwives you (government) trained had become the problem and stumbling block to antenatal care," Musanhu said at an Organisation for Public Health Interventions and Development (Ophid) strategic meeting called to brainstorm ways to overcome gender-based barriers to Elimination of Mother To Child Transmission (EMTCT) last week.

"If a midwife goes against that, then the chief gets a goat.

"The mother parts with a cock and a goat because you would have aided and abetted a crime," he said, adding that cases have gone down from seven last year to zero this year.

Musanhu, who represented 67 villages under Chief Svosve, said a community health committee manages the implementation of a cocktail of measures to fight HIV.

Mash East hosts 208 health institutions, according to Mash East provincial medical director Simukai Zizhou.

The village head said the traditional midwives in his area have assumed a new role in fighting the epidemic.

"They have been helping mothers to deliver babies from pregnancies they do not have medical history on but now they are propagators and supervisors of mothers in their sub-communities," he said.

Ophid country director, Barbra Engelsmann, said field experience has shown that in some cases, gender can create barriers for the uptake of health services, and as a result can limit uptake of EMTCT or HIV prevention services.

United Nations human rights chief Navi Pillay said during her inaugural UN human rights fact-finding mission to Zimbabwe, in May last year, that sanctions were responsible for the high number of home deliveries.

"My call for the lifting of sanctions was on the basis that I found that from talking to ordinary people on the ground that sanctions were affecting ordinary people," she said.

National Aids Council estimates that Zimbabwe has about 64 000 mothers in need of EMTC services but the number could be much higher now, with the newly-adopted WHO guidelines which require all HIV positive pregnant mothers to be immediately put on ARVs

Traditional leaders in Wedza say imposition of heavy fines has reduced the number of home deliveries.

Daily News, 17 December 2013

Figure 7: Article in the Daily News, 17 December 2013, 'Chief imposes heavy fines for home deliveries'

The article above from a local daily newspaper, Daily News, was published towards the end of my time in the field. Having seen all I had seen in Buhera and having spoken to women particularly about the financial challenges they face in trying to access skilled birth attendants, this article provoked varying emotions in me. It states how TBAs that were once trained by government have become a problem in that they are seen as a stumbling block to

women accessing ante natal care. This line of reasoning was problematic in that by fining women a goat or a cock, then that is counter-intuitive as that woman has most likely not been able to go to a clinic or hospital due to financial constraints. Penalizing the TBA also does not come across as being very helpful as this is a woman who possesses skills and knowledge that is most accessible to the community and is helping this woman through the process of childbirth that she cannot do on her own. However the major question was what are these resources that are collected used for. When the traditional leader collects these resources from the community women, it is most probable that they remain in his possession for his personal consumption. Perhaps if those resources were pooled together in order to create a fund that would assist pregnant mothers to access all the necessary health care, it could be beneficial to the community. It should rather be the role of these chiefs in line with the Births and Deaths Registration Act Chapter 5:02 to play an active role in ensuring that births taking place within their communities are registered.

3.6 The social and religious factors affecting use of the Maternity Waiting Home

The very first interview I had was with the District Development Officer with the Ministry of Women Affairs in Buhera. He was to be my entry point into almost all the offices I need to access in order for my research to be a success. Working with Musasa we were essentially under their guidance and leadership in the community and thus meeting him in my new shoes as a researcher was not very difficult. He stated that in the work that they do in communities, they encourage women to go and give birth at health institutions. He indicated that they encounter challenges with the Johanne Marange Apostolic sect whose members do not want to give birth at health institutions. He gave the example of a woman whom he had to go and collect who had complications while giving birth. The traditional midwives attending to her were convinced that her complications had to do with evil spirits. When they had failed to help her, someone present suggested that the Ministry be called. This is when they took her to the hospital. He emphasized that as a Ministry they held a campaign which began in 2011 discouraging the use of traditional birth attendants in conjunction with the Ministry of Health. He indicated that he was happy with their progress that the campaign was yielding but it was very hard to break the religious wall. The intention that women access skilled birth attendants as a result of this campaign could have been good but it was equally important that an alternative be provided which the Ministry did not seem to be doing through this campaign. If

there was no provision financially for women to access a clinic or hospital then it would have been driving home deliveries further under ground, thus the country would continue to lose vital statistics on births that take place under such circumstances. One of the key issues that came out was whether as Zimbabwe we really have an accurate maternal mortality range as home deliveries that lead to death are very difficult to account for.

A sister at Munyanyi Clinic highlighted an issue with the Apostolic sects as being a hindrance to women who are in there accessing maternity services or any other medical assistance. One of the main challenges is the fact that they hold spiritual beliefs about pregnant women being seen in public after a certain point in the pregnancy because she may be bewitched. This belief therefore immediately excludes the possibility of such women accessing facilities like MWHs that can be accessed only in the very advanced stages of pregnancy. She said that pregnant women are taken through exorcisms and are prophesied over during the pregnancy and birth experience and are told statements like *'kuenda kuchipatara kun'ora'* (meaning, 'going to the hospital is an abomination or unclean'). In some of the sessions they are then told that if they go to the hospital or clinic they will die.

The sister at the Murambinda School of Midwifrey described the experience that she had had with the Johane Marange Apostolic Sect during the cholera outbreak. Health workers went to the homes of church members as part of a response programme and the *vapostori* were hiding sick people and acting like nobody was ill and then the sick person would be heard calling for help in a faint voice in a room or outside where they were hidden from health workers.

In an interview with the Ministry of Health Official in Murambinda, we discussed the issue of women in the Apostolic Sect and he said they are very many in Buhera area and they have been classified as health objectors i.e. those who do not use health facilities. When I asked what they have tried to do as the Ministry to address this he said besides awareness they have not done much else because it is a very political matter. He stated that especially during election period, politicians sought to get votes from that large constituency of *vapostori* and therefore many began to say *'Vakuru vakati'* (meaning, ' it's your right to refuse') referring to a person's right to refuse to make use of health facilities. He recounted an experience they had had with a road traffic accident involving a lorry or combi (a mini bus) full of *vapostori*. A passerby called an ambulance and when they got there, they refused to get onto the ambulance or get any assistance. They got very aggressive and threatened the ambulance staff

saying they would call *'vakuru'* ('the elders'; *vakuru* is the plulral of *sekuru*) who had said they had a right to refuse. He however stated that now there are younger *mapostori* who are more willing to come to clinics and the hospital. He said that even in their awareness raising and community work they had difficulties because *mapostori* refuse to be gathered alone. This point came up after I had enquired what they are the MoHCC were doing to reach this population of the Apostolic Sect. He indicated that in order to address their specific issues, one could not call for a meeting with them alone but amongst others. The dilemma was however that they did not show up for many of the community meetings that take place as they fear that it may be a ploy to get them arrested once they come out into open meetings.

Politics had thus emerged as a new factor that I had not previously thought of as having an impact on women's access to health care services. Once politics and religion are put together in the mix of influences, they seem to have a bearing more on her male family members' views than they do on her personally. Thus one of the major weaknesses in the research was an inability to access members of this sect alone to engage with them.

At the level of the family it was found that a woman going to the MWH is not a challenge in the sense of leaving a gap in the family coping structure. During one focus group with pregnant women in the community, it became clear that my concept of the family set up that would have left a huge gap in the absence of this pregnant woman was not the reality. When women are married they often come into the man's homestead which is not only made up of him alone but includes his mother and his sisters who have not yet been married. Thus when his wife needs to be away in a place such as a maternity waiting home, his mother and sisters are there to care for him, the home and the other children if they are there. This focus group discussion was particularly interesting as my lack of experiential data in the area of childbirth proved to have an interesting effect. When we began the discussion, I indicated my age and that I had been married for four years and did not have children. Many of the women in the group were younger than me and had puzzled looks on their faces. Their first question was 'What is wrong?' Before I had opportunity to answer that question, one of the participants quickly said 'Well, you have something to do, you are busy with school but what do we have to occupy us here?' The fact that I was not yet a mother then became a point of sympathy for me and I could sense a feeling of pride in the young women while they 'schooled' me on the subject of childbirth which I knew nothing about. A part of one of my assumptions then did not hold up as I had initially assumed that this would be one of the major barriers to women

accessing the MWH. However, this assumption was not totally crushed as other barriers to access emerged.

Although the family does not struggle to cope, other social and family dynamics come into play. One woman remarked that if you ‘overstay’ at the MWH you can be accused of infidelity. This suggested that there is a perceived set time that a woman can reasonably stay in the MWH, after which she would be said to be overstaying. Perhaps this came from the community where women would use the experiences of others with childbirth to assess their own realities. Or perhaps their husbands because of a lack of understanding of how the expected date of delivery works as a mere guide and is not cast in stone, would use it to ensure that the woman accounts for her whereabouts after that date has passed. Nevertheless, it was raised as an influence on how the MWH may be used.

In discussion with one of the members of the men’s groups that is involved in encouraging other men to support their pregnant wives or partners, it emerged that some men were uncomfortable with their wives being attended to by male nurses and thus would not allow them near MWHs, clinics or hospitals.

CHAPTER FOUR

4.0 OTHER PLAYERS IN THE FIELD

4.1 Budgeting to make Maternity Waiting Homes work

The major challenges that have been highlighted with our health delivery system are centred around a shortage of trained professionals, dilapidated infrastructure and the shortage of appropriate machinery and supplies and all this can be traced back to inadequate financing as has been discussed above. Having looked at the budget allocations at national level, it was also necessary to see how these budgets were translated into reality at district level. This research also examined the third level in hierarchy of the MoHCC as illustrated by this diagram. As could be expected with the current economic situation, the MoHCC budget gets slimmer every year but I had not been prepared to hear that it may actually not reach the district level at all. A ministry official at head office level also stated that the Reproductive Health Unit under which the MWHs fell did not get much allocation from the total Ministry of Health budget. Though she said she was not at liberty to disclose an exact figure she stated that if the unit at head office received around US$100,000 it was a difficult task to allocate any money to the province, let alone the district level unit.

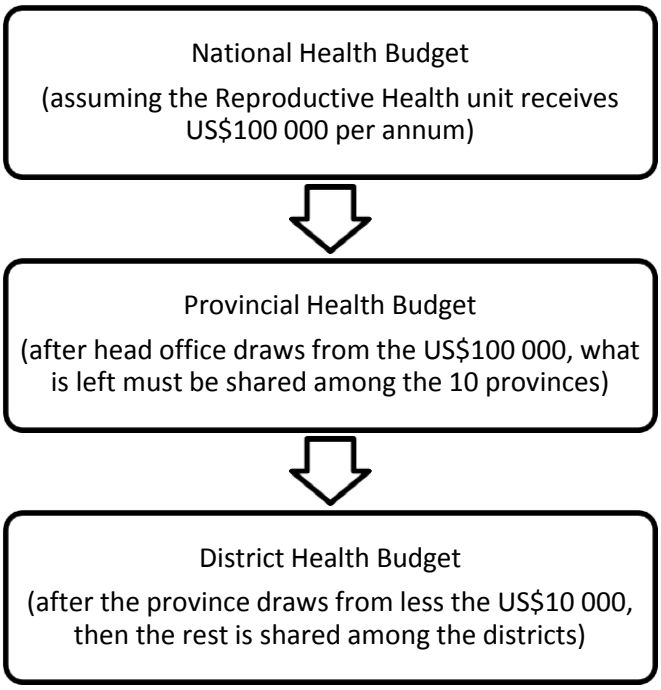

Figure 8: Diagram showing a breakdown of national, provincial and district health budgets

Using the Murambinda Mission Hospital at district level as an example and working with hypothetical figures, assuming the Reproductive Health Unit at Head Office receives its US$100,100 and keeps half of that for their own operations, each of the provinces would receive an equal share of the remainder, being US$5 000. Once Manicaland province receives its US$5 000 it can be assumed that it would divide this amongst its seven districts equally, leaving Buhera district with roughly US$710 for the whole district.

One component of the impact on budgeting that helped me to get a clear picture of the situation was that of the staff complement. At Buhera Rural Health Centre, the sister in charge informed me that they have two staff members trained in midwifery, excluding himself. He highlighted that the fact that he does not have a midwifery qualification is sometimes a challenge as he is in charge yet does not know how to assist in complicated cases. He stated however that he had taken a five day course in Basic Obstetric Emergency which had been helpful for him. The situation was not very different at Munyanyi Clinic where it emerged that there are three nurses and one nurse aide who operate on a rotational basis. This shortage of staff has detrimental consequences for pregnant mothers. The MoHCC official in Buhera noted that nurses are overwhelmed and thus may tell pregnant women not

to come to the clinic. He gave a scenario of a clinic which has one nurse and one nurse aide who both work from 0730hrs to 1700hrs. In those circumstances he said it is possible for nurses to tell pregnant mothers to go to the TBAs because they are exhausted.

In discussion with one of the sisters in the maternity department at Mruambinda Mission, I asked about the challenges that they face as a department including their role in overseeing the MWH and the top of the list was shortage of staff. She stated that there are 8 midwives in total who rotate – 2 on night duty, 2 on nights off, 4 on duty during the day attending to labour, post-natal care, ante-natal care, children as well as the MWH. Therefore during the day and after hours it is difficult to allocate one midwife to attend solely to the maternity waiting home. She said as far as the MWH is concerned, there are not enough beds so some of the pregnant mothers sleep on the floor with mattresses. I asked how many women it could accommodate in total and she said it was designed to fit in 30 women. She highlighted another challenge as the absence of shelving for storage. She stated that all these things require money which is just not available.

Once the staff is there, it then is a requirement that they be provided with accommodation within the vicinity of the hospital or clinic. The Sister in Charge at Buhera Rural Hospital noted that a major challenge for him in women's access to adequate maternal health care is the absence of a maternity waiting home at the clinic. He stated that at some point it used to be there but because of shortages of staff accommodation at the clinic, the facility was now being used as staff quarters.

Another indicator that I used to assess if budgets were reaching the district level was what equipment and vehicles were available. The district MoHCC official informed me that they had received two new ambulances through the Health Transition Fund. He stated that the mission had two ambulances which they use for referrals from Murambinda to Mutare. The mission does not want it's vehicles to go out into the rural areas because of the condition of the roads. The Ministry ambulances are the ones that do referrals in from clinics. He indicated that the Ministry has two other vehicles that are not ambulances which may be free but the challenges is the drivers. At times there is no fuel available and it is not possible for them to charge the patient. When I asked how much they as a district office were getting from the Ministry's main budget, he indicated that that budget is not reaching the district level. He said there was a Health Services Budget but it was being used for things like bottle store

licenses and inspection of meat. If the inspection of meat and allocation of bottle store licenses take precedence over maternal and child health issues it leads one to question what the priorities are and who sets the priorities in the health system. The lives of women and children are therefore seen as being of far less importance than meat and beer.

I indicated that I had heard about the Health Transition Fund and wanted to know what they were receiving at district level. He stated that it is a fund targeted at children 5 years and below and pregnant mothers. He stated that in the fourth quarter of 2013 they have received the funds – US$2,250 per quarter per clinic and US$4,500 per quarter per hospital. Of that amount it did not emerge exactly how much is going to the MWH as the budgets are still being worked on to be submitted. For a whole hospital over the period of three months, the budget of US$4,500 is expected to cover immunization for children and prevention of early childhood diseases as well women's pre and post natal care.

In an interview with the Monitoring and Evaluation Officer at the MoHCC headquarters I asked what the status of the operational guidelines was to which he replied that they were there but they had not really been operationalized. He stated that there was no evaluation or anything done on the guidelines because telling institutions they are not up to standard was not useful if the Ministry cannot do anything about it. 'What do we do *tisina mari*?' (meaning, 'What do we do *when we do not have the money*?') was his closing remark in our interview.

4.2 Filling in the gaps – The role of donors in delivery of health care

Figure 9: Photograph of a sign of MSF (Medicins Sans Frontiers, Doctors Without Borders), one of the major players in health care in Buhera District.

In almost every interview or other engagement I had with respondents in Buhera, Medicins Sans Frontieres (MSF) continuously came up as a key player in health care in the district. Proving to be a very difficult interview to secure, it became necessary for me to put on my professional jacket for this one and introduce the fact that I was a researcher once I was already through the door. I introduced myself as an employee of Musasa who was seeking some information necessary for a research project. Having failed twice already to secure time with the staff in the Patient Care department, I was finally successful on my third attempt. I was unaware that I had arrived on the best day of the week where they would not be going into the field. It had come to my attention that they would be leaving Buhera District in 2015 and this they had greatly scaled down their operations by the time the meeting happened.

In my interview with the MoHCC in Murambinda, it emerged that MSF had played a key role in the communication system between rural health centres and the referral hospital at Murambinda Mission. It was stated that at times cellphones are used at the nurses' own expense using their own airtime if the radio communication system was not working. MSF revitalized a radio system in 90% of clinics but because MSF is leaving they gave notice that they will no longer be able to service the radios so "if they die, they die!" Of those that were revitalized, 80% are still functional. This was a worrying point as the Ministry would have to pick up this responsibility which was there to begin with but had been taken up voluntarily by an aid agency that had seen a gap in health care delivery. It was worrying because the Ministry official had already indicated that they did not receive any budget from Ministry headquarters and they have to raise their own funds, therefore this seemed a mammoth task looking forward.

When I finally got an opportunity to engage with MSF directly, I began by asking what MSF's major role was as far as maternal health is concerned. They indicated that their major focus is on HIV/Aids therefore they provide anti-retroviral treatment as well as prevention of mother to child transmission including the equipment that is necessary. They also provide counselling services especially for HIV related issues. They also said they do a lot of work in the community encouraging women to deliver at health care facilities. I indicated that they had been mentioned by the Ministry of Health as having worked on the communication system. They stated that the radio communication system between clinics and the hospital had existed before but they had simply revived it. This has been done in Buhera, Gutu and Chikomba. They also described their role in providing transport that can be used to transport

pregnant women to the hospital. A situation was described where a woman had given birth by the road side and the MSF ambulance had been used to rush her to the hospital. Support groups are also established for pregnant women who are living with HIV.

One initiative that they mentioned which could be built on and carried forward by the Ministry was that of surveillance teams. These teams were described as teams of health professionals including doctors and nurses who would go into communities that are particularly resistant to accessing health care services. They would go and stay in those communities, not forcing community members to make use of their services, but just being there conducting awareness activities. At times they also have night classes where those who may not be comfortable to access services like voluntary testing and counselling during the day may do so at night. Perhaps this approach could also be used for access to maternal health services for women who may have been convinced to attend ante natal classes but may not be comfortable to be seen by their fellow community members or members of the extended family. They could thus even be transported to places like maternity waiting homes during the night so as not to be seen and then just be said to have travelled when others see that they are missing. However this may be work for emergencies like a woman who is already due to deliver as this could occur at any time, day or night.

Thus when a donor agency leaves, communities ought not to despair but rather harness some of the good initiatives that they have put in place and continue with them. It may call for a bit of money from the MoHCC and could have been a possibility with the pool of donor funds called the Health Transition Fund in order to save as many mothers as possible. However this budget a discussed above is just too small to meet even the critical needs of maternal and child health let alone engage in other activities. Perhaps initiatives could be started by communities themselves to encourage women to seek professional health in whatever form during pregnancy and childbirth using similar surveillance teams.

4.3 The role of men – The Lead Men Campaign

In the interview held with the District Development Officer in the Ministry of Women Affairs, Gender and Community Development, he mentioned that together with World Vision in Murambinda they had been working with a group of men called the Lead Men. As a women's law researcher pursuing the grounded theory, it is with confronting this group that I

was really challenged to keep an open mind about the role of men towards the goal of gender equality and not allow my preconceived ideas about this subject influence that data collection in this regard (Weis Bentzon, 1998). Had it not been for the presence of my supervisor in that particular interview, I may not have pursued an interview with this new emerging category but I soon discovered the value of that one interview I was to have with a Lead Man.

It emerged that this group of about 30 men in Ward 11 of Buhera district was making some headway in encouraging women to make use of facilities such was the maternity waiting home. Their activities include making presentations at community gatherings and targeting those places particularly where men can be found. They also make use of ward meetings, village meetings, school meetings and church meetings to speak to the community. They encourage men to encourage their wives to go and register their pregnancies at a clinic or hospital and also to make use of the maternity waiting home, particularly for first time mothers. As part of this initiative they encourage community members to visit the clinic as couples so that they can be tested for HIV together. Men and women alike are also taught about gender based violence and the negative impact that it has on the community. They however said their greatest challenge were the members of the Johanne Marange Apostolic Sect who they said were resistant to these teachings. He stated that they had had an encounter with a prophet who had been instructing women on where to go and give birth based on his visions about them. One community member heard about this and asked that the Lead Men come and talk to him about the risks to the lives of the mothers, especially those who were told that they should go and give birth at home. They were able to influence this prophet to change his behaviour and they recorded this as a great success in their work.

This initiative which is run by the community in conjunction with World Vision and the Ministry of Women Affairs, Gender and Community Development has begun to yield some results in the community. Prior to the intervention, the interviewee stated that they would go to Chiweshe Clinic in Ward 11 where they could find that out of 30 women who had registered, only 2 had given birth at the clinic. He stated that the majority would have then given birth at home which was risky for mothers. After their interventions they went back to the same clinic in 2013 where they found that out of 30 women who register, about half of them go and deliver there. When I enquired how they work with traditional birth attendants in the community to achieve their intended goals, he stated that they had been advised that TBAs ought not to be delivering babies because of the risks of diseases like HIV for the new

baby but that if women are in emergency situations, only then should TBAs be involved to quickly take the child and the mother to the hospital for further attention.

Some feminists have argued that men are the cause of women's oppression and thus could not possibly play a substantial role in achieving gender equality but this is an example that could illustrate how men could indeed play a 'lead' role in transforming the minds of fellow men to ensure the health and well-being of women in their communities.

CHAPTER FIVE

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 Recommendations

The recommendations made in this research are a combination of recommendations made by the researcher but also those made by the 'researched'. This is critical for the feminist researcher who must be able to recognize that she/he is not the only knower and the respondents themselves know exactly what they would want to see.

- For universal access to maternal health care services and safe motherhood strategies to become a reality, a mutually respectful and coordinated relationship must exist between the formal health delivery system and traditional birth attendants in rural Zimbabwe. I propose integrating TBAs into the formal system by recognizing them a first port of call for pregnant women in communities and equipping them with communication tools such as cellular phones that would allow them to communicate with primary health care providers at clinic level.

- A multi-sectoral approach to maternal health care. So far in Zimbabwe it would seem that the responsibility for maternal health care lies solely with the Ministry of Health but other line ministries such as the MoWAGCD ought to also take more responsibility to ensure that maternal health care standards improve.

- Clinics should also be supported to house maternity waiting homes as this will be considerably cheaper for users in need of MWHs.

- Continuous awareness raising and community education with appropriate IEC materials on the risks associated with home deliveries while encouraging women to make use of services such as maternity waiting homes.

5.2 Conclusions

In a workshop on reproductive health a few years ago, one woman said, 'Imagine if 13 buses drove out of the Road Port in Harare's Central Business District every year never to be heard of again.' The room was silent and it slowly dawned on me what she was trying to put across. The number of women who die in childbirth due to avoidable causes and the country is silent, is the equivalent of those 13 buses, assuming that one bus seats 75 passengers. The newspaper article (see Appendix 1) is centred on the death of a popular television presenter who died in childbirth at Parirenyatwa Hospital early this year. However it got me thinking of the thousands of others who die in similar and worse circumstances- circumstances that could have been avoided.

This research has attempted to show how vast the challenges are that women face in trying to access facilities such as maternity waiting homes, clinics or hospitals. Maternity waiting homes as a safe motherhood strategy are commendable and have many positive outcomes. However as the research revealed, it is not as easily accessible as may be thought. Women face varying challenges from economic challenges, religious barriers as well as other social factors that hinder them from making use of the maternity home. I propose a mutually beneficial relationship to be created between the formal health delivery system and the traditional birth attendants who have been discouraged though women continue to make use of them in different ways. I do not suggest that TBAs should come in to replace the health professionals such as nurses and doctors but I see benefit in not rushing to follow the global trends that encourage this and discourage that without grounding policies in women's lived experiences, particularly in areas most affected by them, like rural areas. Maternity waiting homes focused at clinic level as opposed to the level of district hospitals may be a more feasible option for pregnant women with high risk pregnancies.

Bibliography

Banda I. (2010) 'Zimbabwe Free Maternal Health Care Too Costly for Most'. Available online at www.globalissues.org/news/2010/07/26/6408. Accessed on 14 March 2014.

Bentzon A.W. *et al.* (1998) Pursuing Grounded Theory in Law: South-North Experiences in Developing Women's Law, Mond Books, Oslo. Tano Aschehough.

Cook R.J., Dickens B.M., Fathalla M.F. (2003) Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law. Text and materials. New York, Oxford University Press Inc.

Crisis Coalition in Zimbabwe (2014) Crisis Report Issue 257, 'Poor Governance fuels maternal deaths. Harare, Crisis Coalition in Zimbabwe.

Maguranyanga B. (2011) Apostolic religion, health and utilisation of maternal and child health services in Zimbabwe. Unpublished research report. Collaborating Centre for Operational Research and Evaluation, UNICEF and M Consulting Group. Available at www.unicef.org/zimbabwe/ZIM_resources_apostolicreligion.pdf Accessed on 21 March 2014.

Matsuura H. (2013) Effect of Constitutional Right to Health on Population Health in 157 countries, 1990-2007: The Role of Democratic Governance. Working Paper Series, Harvard Institute for Global Health. Available online at www.hsph.harvard.edu/pgda/working.htm Accessed on 23 March 2014.

Nyanzi S. (2008) "Empowering Traditional Birth Attendants in the Gambia: A Local Strategy to Redress Issues of Access, Equity and Sustainability". In: Sama, M.T. and Nguyen, V., eds. Governing Health Systems in Africa. Senegal, Council for the Development of Social Science Research in Africa.

Sanders D. (1989) "Equity in Health: Zimbabwe Nine Years On" In: Journal of Social Development in Africa, 5,1 (2010): 5-22.

UNICEF and Zimbabwe (2011) A Situational Analysis on the Status of Women's and Children's Rights in Zimbabwe 2005-2010. A Call for Reducing Disparities and Improving Equity. Harare, UNICEF, CASS and Government of Zimbabwe.

United Nations in Zimbabwe (2013) Maternal Mortaility in Zimbabwe: Evidence, Costs and Implications. Harare. Available at www.zw.one.un.org Accessed on 21 March 2014.

WHO (2004) Making Pregnancy Safer: the role of the skilled attendant. A joint statement by WHO, ICM and FIGO. Geneva, WHO. Available at http://whqlibdoc.who.int/publications/2004/9241591692.pdf?ua=1 Accessed on 21 March 2014.

WHO, Maternity Waiting Homes the experiences, Geneva, WHO.

Zimbabwe. Ministry of Health and Child Welfare, Reproductive Health Unit, National Reproductive Health Policy.

Appendix 1: Newspaper article entitled 'Health delivery system requires redress'

Enacy Mapakame
Features Writer

Health delivery system requires redre

The death of popular ZTV presenter Tendai Chitsinde during childbirth last week represents the epitome of a health delivery system gone awry; one that requires urgent redress.

CHITSINDE died at Parirenyatwa Hospital in Harare due to pregnancy complications. The child did not make it either, in a sad case that chastises Zimbabwe's maternal record as mortality has soared by 239 percent in the last two decades.

Deaths at childbirth have climbed from 283 per 100 000 live births in 1984 to 960 per 100 000 live births in 2010-2011.

No matter one's colour, tribe, profession or age, the fact is no woman should die while giving birth, or as a result of pregnancy-related difficulties.

It is appalling to note that in this day and age of vast improvements in medical science, Zimbabwe is still reporting escalating maternal deaths.

Such advances are generally expected to translate into improved service delivery. But the case of Chitsinde gives a different testimony.

Following her death, some social media networks were inundated with calls by different individuals for justice for her and many other women.

Others even advocated peaceful demonstrations against the health system to send the clear message that there is urgent need to look into the matter before many other women lose their lives.

It is not only Chitsinde who has lost her precious life while giving birth; there are many others who are unknown in big and smaller hospitals, private clinics and many other health facilities.

Her case is just a tip of the iceberg.

Chitsinde was a celebrity with access to better health facilities, which, in Zimbabwe, are found in Harare, where she resided. Despite all that, she died. What is the hope for those women in remote rural areas where the closest clinic can be 15km away and the fastest available modes of transport being scotchcarts, foot, wheelbarrows or a donkey?

The death of such a popular figure is an indictment on the country's health delivery system. It puts the system into question: how much longer can Zimbabwe wait before actively implementing functional strategies to reverse the problem of high maternal deaths?

The situation spells doom for aspiring mothers. Losing life while giving life is the biggest irony which should be avoided at all costs.

Pregnancy is an experience women should cherish dearly despite the labour pains that come accompany it.

But to be pregnant in these current times is a high risk and traumatic as one is uncertain whether they will come out of a maternity ward with a baby in their arms or come out lifeless, just like the television presenter.

The Holy Bible says women should endure pain at childbirth, but not death.

The maternal mortality rate (MMR) is the annual number of female deaths per 100 000 live births from any cause related to or caused by pregnancy or its management (excluding accidental or incidental causes).

This includes deaths during pregnancy, childbirth, or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, for a specified year.

According to the Zimbabwe Demographic Health Survey (ZDHS) 2010 / 2011, at least 10 women die everyday due to pregnancy-related complications, which is three times as high as the global average of 287 per 100 000 live births and almost double the average for sub-Saharan Africa with an average 500 per 100 000 live births.

The late Tendai Chitsinde

In 2012, the World Health Organisation reported that approximately 800 women worldwide lose their lives everyday from preventable pregnancy-related complications with 99 percent of all maternal deaths recorded in developing countries.

More than half of these happen in sub-Saharan Africa and a third in South Asia.

The major causes of MMR are pregnancy-induced hypertension, post-partum haemorrhage, puerperal sepsis, malaria, obstructed labour, lack of information and unsafe cultural practices.

The ZDHS reported that while there has been a decline of 34 percent in MMR from 1990 to 2008, Zimbabwe has continued to experience an increase in 1994 and 2010 / 2011.

According to the Zimbabwe Maternal and Prenatal Mortality Study of 2007, HIV and AIDS-related conditions contribute 25 percent of total maternal deaths.

Yet successful prevention and treatment of all the pregnancy complications could help cut MMR by 46 percent.

Poor quality care owing to different reasons among them high staff turnover and migration of skilled personnel to other countries and shortages of reproductive health commodities and decline in institutional deliveries also contributed to this gloomy picture.

The study also showed that about 66 percent of births are assisted by skilled professionals while 13 percent are assisted by a traditional attendant *(nyamukuta)* and another 13 percent by friends or relatives while the remaining three give birth unattended.

The Zimbabwe Agenda for Sustainable Socio-Economic Transformation