

On The Margins of Health Care Provision: Delivering at Home in Harare, Zimbabwe

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Abstract: This paper analyses the phenomenon of home deliveries by pregnant women in an urban setting in Zimbabwe. It argues that, though home deliveries are commonly practiced in the rural areas, they have now found their way into and are even proliferating in the urban areas. Social cultural values, religious belief and economic status/resources determine women's place of birth. Whilst government policies expounded through the Ministry of Health (MoH) programs and policies denounce home deliveries, the frail health care system characterized by mass exodus of qualified personnel, in availability of drugs and understaffing of healthcare centres do little to lure pregnant women to deliver in hospitals. Furthermore, the high levels of poverty among the populace entail that people cannot afford either public or private hospital services; and thus resort to home-based healthcare and subsequently home deliveries. The paper explores the factors fuelling home deliveries and the challenges associated with this practice in Harare, Zimbabwe.

Keywords: Home deliveries, policy, urban, urban poor, Zimbabwe.

1. INTRODUCTION AND BACKGROUND

The purpose of this paper is to highlight the reasons for home deliveries (socio-cultural and economic dimensions home deliveries) in Zimbabwe. Home birth remains a strong preference, and often the only option, for many women in low income countries. The World Health Organization (1997) estimates that, 60% of births in the group of low income countries occur outside a health facility. Literature shows that women who deliver at home are more likely to experience perinatal mortality than those delivering in health institutions and there is an increased risk of neonatal infections and hypothermia in home delivered especially preterm babies. These home deliveries are often conducted by untrained birth attendants and sometimes in unsanitary conditions. These factors are known risk factors for perinatal mortality (Weeks 1995). Traditionally, deliveries occurred at home under the supervision of birth attendants or elderly women in the community. However, in view of the global efforts to lower maternal mortality ratios in developing countries, it is argued that one important aspect in efforts to reduce the health risks of mothers and children is to increase the proportion of babies delivered under medical supervision.

In the medical literature, "planned home birth" refers to delivery by qualified birth attendants in the home setting. These births are planned during the prenatal course, when the women have met screening criteria for low perinatal risk. Standard labor and delivery equipment and medications, access to hospitalization, are included in the delivery plan. Women can only exercise the right to choose a birth place if they are offered a range of settings and have access to qualified providers in each setting. Researchers have described the factors affecting women's choice of planned home birth and satisfaction with home birth as the perceived differences in women's ability to control the environment and process of care. Women describe an increased sense of safety at planned home births as facilitated by increased privacy, comfort, and convenience; greater cultural and spiritual congruency; an improved power balance with medical providers; and the ability to facilitate family involvement in a relaxed, peaceful atmosphere. They also appreciate the documented decrease

in the rates of medical interventions care (Birthplace in England Collaborative Group, 2011; Janssen, Henderson, & Vedam, 2009;).

However, most of the home deliveries in the developing countries do not follow this standard. The home deliveries in Harare are occurring under the supervision of traditional birth attendants (TBAs). The TBA and her appropriate role in Safe Motherhood Initiatives have been hotly debated for decades (Bergström & Goodburn, 2001; Sibley & Sipe, 2006; Velimirovic & Velimirovic, 1978). Prior to the 1990s, international maternal child health policy focused on training TBAs in practicing hygienic delivery methods and referring complications. The strategy was aimed at reducing maternal infections and postpartum hemorrhage, the two leading causes of maternal mortality worldwide (Kruske & Barclay, 2004). In the 1990s, however, when arguably the TBA training strategy did not result in significant drops in maternal mortality, international policy shifted to supporting initiatives encouraging deliveries with skilled birth attendants, defined as health professionals who have been trained to proficiency in midwifery skills (Starrs, 1998). The effort to ensure skilled attendance has taken many forms. In Nepal and Guatemala, existing traditional birth attendants are trained to employ sterile technique (Freedman, 2007; Goldman, 2003). The Ministry of Health in Mozambique's has trained and deployed non-physician surgical technicians to rural areas to perform obstetric surgeries in the event of complications during childbirth (Freedman, 2007). In Afghanistan, an extensive competency-based midwifery training program has more than doubled the midwifery workforce to date since 2002 (Currie, 2007). Malawi has begun to provide training in midwifery skills to a proportion of its community health workers, known as District Health Officers (Fauveau, 2008). In Zimbabwe, however, there has been a general disregard for TBAs and their practice and calls for institutional birthing under the supervision of trained health professionals have been made. The country is defined by policy ambivalence regarding the use of TBAs, despite having trained more than 15 000 TBAs under the Safe motherhood initiative. Policies and programs have since then been designed disregarding TBAs and or their practice. In the decade since this policy shift, evidence shows that achieving safe motherhood is not merely a question of having skilled attendants at birth, but also of the quality of the services provided and access to emergency care (Van Lerberghe & De Brouwere, 2001; Bergström, 2001; Buekens, 2001). The major underlying causes of maternal mortality are related to maternal health care (antenatal care, supervised deliveries, and post natal care). In this paper home delivery refers to an attended (TBA, family and relatives) or unattended child birth in a non-clinical setting.

2. METHODOLOGY AND SOURCES OF INFORMATION

To achieve that objective this paper utilizes three major sources of information. That is, a literature review, FGDs and interviews held with key informants such as TBAs. The literature review concentrated on literature related to the following five topics with a heavy bias towards the urban context:

- Zimbabwe women's experience and perspectives of access to maternal health services or any other assistance
- Linkages between gendered causes of maternal mortality and other women's health issues
- Implications of current health system characteristics for access to maternal health services
- Role of Traditional Births Attendants (TBAs) and other key actors at community level
- Evaluations of innovative community based interventions (Zimbabwe and elsewhere) to reduce maternal mortality.

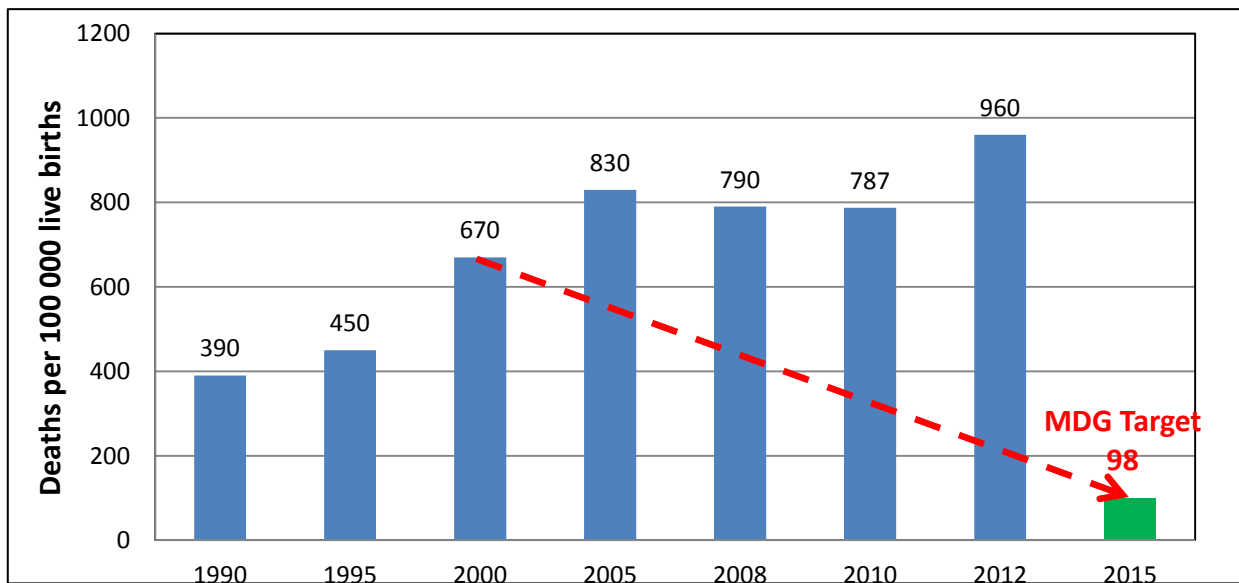
Using the above criteria, over 100 articles and reports were reviewed which included peer reviewed publications, organizational reports, case studies and other sources of information including media reports.

The Zimbabwean Context

The year 2007 marked the world's transition from a primarily rural sphere to a largely urban domain. Despite its status as the world's least urbanized region, SSA currently has the fastest rate of urban growth in the world at between 3 and 4 % per annum, with urban population in the region projected to increase from 37 % in 2011 to about 57 % by 2050 (UN 2012). Urban poverty as has been linked to substantial deterioration of key urban health and social indicators. The new face of urban poverty has been linked to adverse SRH outcomes for the urban poor such as high rates of unwanted pregnancies, higher fertility, sexually transmitted infections (STIs), and poor maternal and child health outcomes. There is

need to take into cognizance the socio-environmental and economic conditions that heighten vulnerability to poor health in urban contexts (Tipping et al 2005). Poverty, in particular, must be recognized as a key hindrance to sexual and reproductive health in urban poor communities. In Sub-Saharan African (SSA) countries many child bearing women are still being attended by TBAs and relatives at deliveries (Jamison *et al.*, 2006; Crowe *et al.*, 2012). Literature shows that births without skilled personnel and without access to life-saving drugs are the commonest practice for millions of mothers in the poorest countries where mortality rates and morbidity of the mothers are highest (Crowe *et al.*, 2012; WHO, 2012). In Zimbabwe, at least ten women die every day of pregnancy-related complications (ZDHS 2010/2011). Moreover, 7-10 million women and girls the world over suffer severe or long lasting illnesses caused by pregnancy and childbirth complications (WHO, 2012). The use of unskilled personnel (including TBAs) is argued to be among the reasons for the high maternal and infant mortality rates in SSA. However, despite the expansion of interventions, including construction of more health facilities close to the community, increased use of antenatal clinic, and increased coverage of immunisation (MoH, 2003) the problem of home deliveries has persisted. A situational analysis study in established that 28.8% of women delivered at home, 1.7% at the TBA's home and 0.3 % at Faith healer's home (ZMPMS 2007) The proportion of home deliveries without a skilled birth attendant stood at 69 percent in 2009 (UNICEF, MoH 2010 Country Analysis Report). The institutional deliveries rate was 66%, which implies that 34% of pregnant women deliver at home (World Bank 2013). This paper argues that rather than condemning the practice of home deliveries there is need to understand the rationale and or factors fuelling the practice in order to develop meaningful interventions for positive maternal health outcomes.

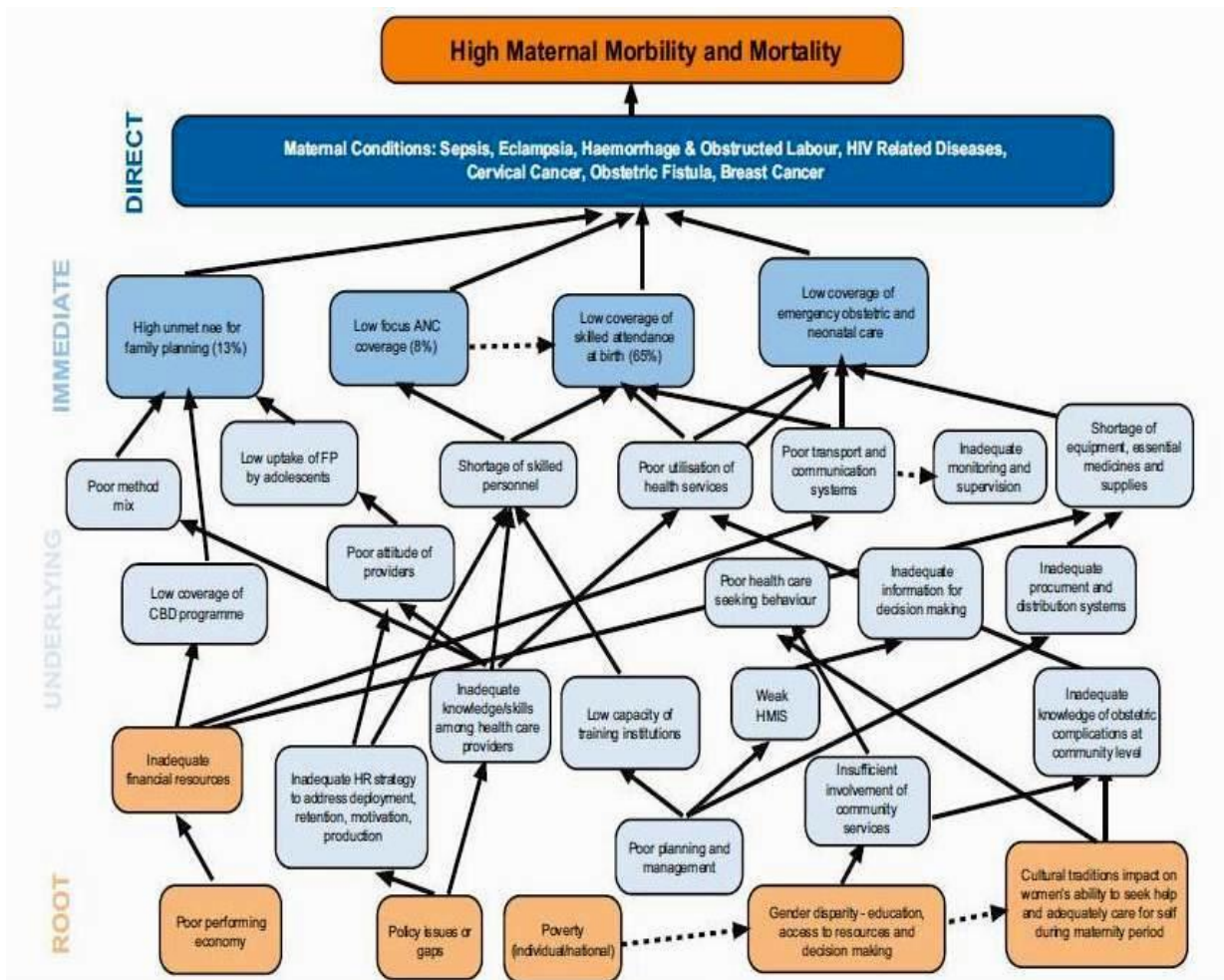
Zimbabwe is a land locked country in Southern Africa with ten administrative provinces. In 2007, out of the 12, 4 million people, 47 per cent were urban and 53 per cent were rural (UNDP, 2008). In line with the Millennium Development Goals, Zimbabwe is aimed at reducing by three-quarters, between 2000 and 2015, the maternal mortality ratio. The indicators for monitoring progress are maternal mortality ratio and proportion of births attended by skilled health personnel. Zimbabwe's progress report regarding the two indicators is appalling, characterized by a skyrocketing maternal mortality ratio and a decline in skilled attendants at birth. Zimbabwe is one of the countries with the highest maternal mortality ratios in the world. Health care in Zimbabwe has been categorized as pluralistic due to the existence of both traditional and biomedical systems (Dahlin, 2002; Hansson, 1996; Mutambirwa, 1989). The country's health system is dominated by the public sector, providing an estimated 65% of health care services in the country. Some facilities are operated by municipalities and receive block grants from government. The Zimbabwean government claims that it has done good work by reducing distance to healthcare facilities through the construction of healthcare facilities around the country. The average distance to the nearest healthcare facility is between eight to ten kilometers (MHCWZ, 1999). The Access to Health Care Services Study of 2007 found that most communities live within a 5 km radius from their nearest health facilities, whilst 23% live between 5 to 10 km and 17% are over 10 km from their nearest health centre (Makuto 2007). Generally, the Ministry of Health and Child Welfare has focused on Primary Health Care, with a strong emphasis on community-based approaches, complemented by robust referral systems and facilities. In the 1980s and early 1990s these health centres were adequately manned with a doctor to patient ratio of on average 1: 6000 in public institutions Auret (1990). The 1980s showed a general improvement in most of the major health indicators and service utilization, attributable to the expansion and improvements in the area of primary health care however, signs of deterioration were evident in the 1990s. By the year 2000, Zimbabwe's well-organized public service delivery system fell into steady decline toward near-collapse in 2008. The trends were a reversal of the gains made in the previous decade for example infant mortality rate (IMR) rose from 77 and 53 per 1,000 live births in 1992 to 94 and 67 in 2009. The infant mortality rate had decreased by 50 percent between 1980 and 1990, from 100/1,000 live births to 50/1,000 live births UNICEF (2010). On the hand, maternal mortality increased dramatically from 283 per 100,000 live births in 1994 to 390 per 100,000 births in 1990 to 578 in 1999 to 830 in 2005/6 and 790 in 2008. This sharp rise in maternal mortality is largely explained by the rapid spread of the HIV and AIDS epidemic. The Maternal & Perinatal Mortality Study of 2007 shows that the maternal mortality was pegged at 725 per 100 000 live birth, with HIV&AIDS related deaths accounting for 25.5% of all maternal deaths. Currently MMR has risen further to 960/100 000. The maternal mortality ratio estimate from the 2010/2011 ZDHS is 960 per 100,000 births, one of the highest in the world (World Bank, 2013). This rise in MMR is against the backdrop of government commitment and intention to reduce MMR by three quarters by 2015



Sources: World Bank 2011, 2013, Gonda 2012

FIGURE 1: MATERNAL MORTALITY TREND IN ZIMBABWE

Problem Tree of High Maternal Morbidity and Mortality in Zimbabwe: Source: Country Analysis of Zimbabwe 2010



Factors Affecting Maternal Health in Zimbabwe:

Barriers against using reproductive and maternal health services include costs and distance to health facility, time, poverty, quality of services, limited decision making power of women, lack of permission by their families to utilise the health facilities as well as fear of side effects. These barriers are explored in detail below.

Availability of Resources, and Services Utilisation:

Focus on access constraints is one way of explaining barriers in the utilisation of health services. The commonly applied measure of access to health care is availability of services, measured in terms of physical distance, travel time, availability of transport, or even the nature of roads. However, the term quality care is multifaceted and value laden. Literature has shown that what constitutes quality care differs for clients and health service providers. Findings by Galaa & Abu (1994) show that the lay perception of quality care relates more to the attitude of health professionals in the care process than the availability of institutional inputs and standards of care delivery. For health services clients, quality refers to their reception by health professionals, rapport between clients and professionals, integrated care, conveniences, flexibility and the extent to which clients are able to influence the treatment process. Health professionals however, view quality having to do more with maintaining technical standards such as diagnostic and treatment regimes; professional skills requirements; use of equipment including laboratory and x-ray services and supervision. Thus these differing views interface in the clinical setting defining the health outcomes for many.

Whilst utilisation of health services is evidence that access is achieved, access cannot be equated with the use of services. This is because, before a person can use or will use health services s/he must be aware of his/her condition, and feel it warrants medical intervention, the appropriate services must be available (within reasonable time/distance); the services must be acceptable he/she should have confidence in the technical competence and 'humanness' of the facility and the providers; and the person should have the ability to obtain the services (money and or insurance). Each of these prerequisites comprises a potential barrier to utilisation and it is the existence of these potential barriers that differentiates the study of 'access' from that of 'utilisation'. It can therefore be argued that access to medical care is the function of two sets of factors: characteristics of the health delivery system and the characteristics of the population at risk - its perceived needs and morbidity, age distribution, sex, level of education and other background factors. Any of these factors can serve as barrier to the utilisation of modern health care services. For Zimbabwean urban poor women, a mixture of these barriers in varying degrees are intricately woven to present formidable barriers for maternal health services utilization.

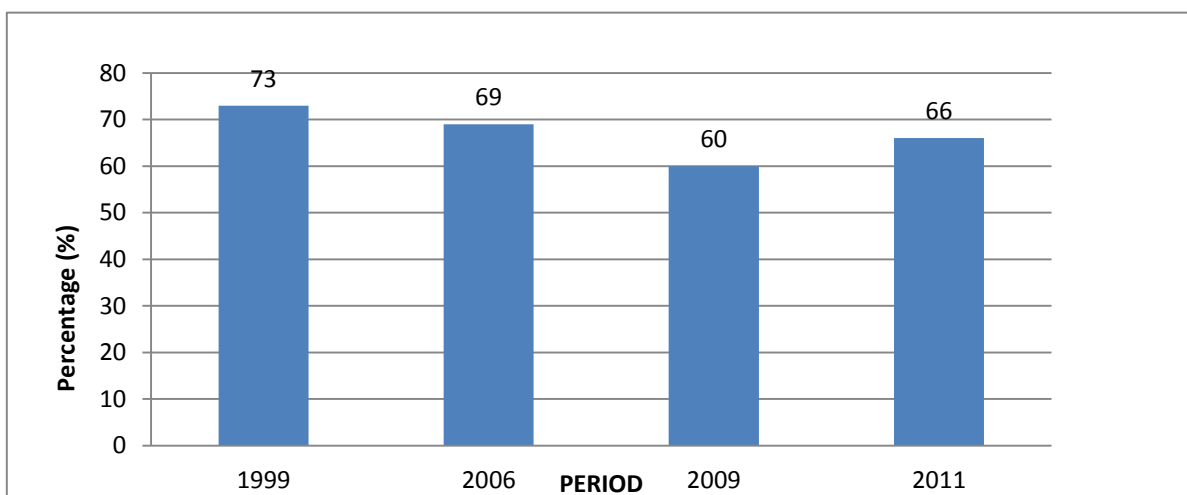
3. QUALITY OF SERVICE & PATIENT MANAGEMENT

Post independent Zimbabwe has been embroiled in a protracted multifaceted crisis which has had detrimental effects for social service provision in the country particularly health and education sectors. The country's health system has been in decline since defined by a systematic decrease in coverage of most basic services and a rising maternal and child mortality rate. Rural –urban disparities in access to health care continue to grow. The increasing exodus of staff, high hospital fees, and shortage of essential drugs have forced many more people to seek traditional health care sometimes with the acceptance and encouragement of medical doctors (Chimhete, 2003; Mukumbura, 2000; Ncube, 2003) and to self-medicate.

The government policy targets in 2007 were to achieve 80 per cent coverage of essential health personnel and to reduce vacancy rates to 10 per cent (HSB, 2007). However, in 2009 physician and nurse density was no better than it had been in 2004, with an overall density of 12.3 health staff per 10,000. The WHO recommended levels are at least 25 doctors, nurses and midwives per 10, 000 (GoZ, 2009). A massive internal and external brain and skills drain has led to a loss of experienced, qualified health professionals from the public health sector in particular and the country at large. Some institutions, particularly at district level, were found to be staffed by untrained or junior cadres (MoHCW, 2009; Makuto, 2007). With the proportion of home deliveries without a skilled birth attendant recorded to be 69 % in 2009, the target of universal access to skilled attendance at delivery by 2015 is unlikely to be achieved. There is need for more effort and investment towards strengthening the healthcare system and into scaling up coverage of maternity waiting homes as well as putting in place predictable and enhanced health financing policies and mechanisms.

Attendance at antenatal care (ANC) was relatively high between 1994 and 2005 but antenatal care bookings and numbers of women delivering at health facilities decreased by 30–50 per cent in 2005. This was attributed to shrinking incomes

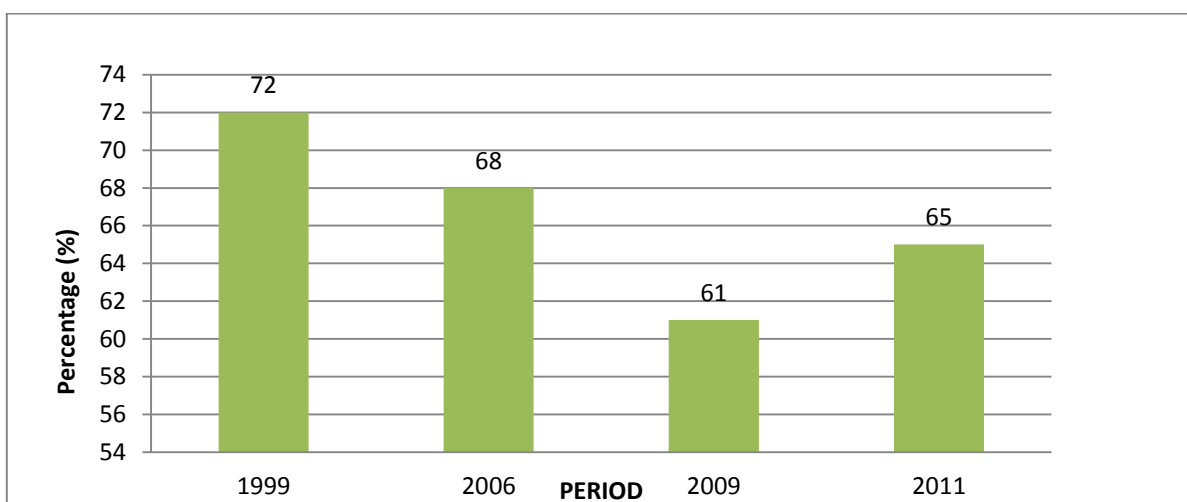
and increases in service fees (MoHCW, 2006, 2007). The share of women making four or more antenatal visits fell between 1994 and 1999. There was a significant increase in assistance by skilled birth attendants between 1994 and 1999, and a similarly significant decline between 1999 and 2005. By 2005, assisted deliveries were below the Millennium Development Goal target of 80 per cent, although this level had nearly been attained in 1999 (Loewenson and Shamu, 2008). Whilst over 90% of pregnant women reportedly attend formal health facilities for antenatal care (Nhindiri et al, 1996), more than 30% of deliveries take place outside the formal system (WHO 2007, ZDHS 2005/6). The Zimbabwe Demographic and Health Survey (ZDHS) (2006) results also showed a decline from 73% in 1999 to 69% in 2006 in skilled attendance at delivery and in 2009 the Multiple Indicator Monitoring Survey in Zimbabwe (MIMS) reported a further decline to 60%.



SOURCE: ZDHS, 2011

FIGURE 2: SKILLED ATTENDANCE AT BIRTH IN ZIMBABWE

Institutional deliveries also declined from 72% in 1999 to 68% in 2006 (ZDHS, 2006) and in 2009 MIMS reported a 7% decline to 61%.



SOURCE: ZDHS, 2011

FIGURE 3: INSTITUTIONAL DELIVERIES IN ZIMBABWE

The 2007 Maternal And Perinatal Mortality Study found a number of barriers to access and uptake of maternal health services, including delayed reporting, failure to recognise danger signs, high fees at district hospitals, first use of traditional healers, service barriers (communication facilities, inadequate transport and communications, social barriers, lack of drugs and skilled staff shortage) (GoZ MoHCW, 2009). Among mobile and vulnerable pregnant women only 58

per cent reported being assisted by a skilled health worker (NEDICO, 2008). The most significant social differential for coverage of maternal health services has consistently been mothers' education as well as wealth disparities.

In 2009, disruptions in communications and supplies were reported to have limited outreach activities and contributed to adverse outcomes, particularly for maternity, acute and emergencies care (GoZ, 2009). The referral chain was reported to be largely dysfunctional due to a critical shortage of ambulances at district level (GoZ MoHCW, 2010). These supply constraints reportedly affected particular groups more. Women were more affected by numerous barriers, including treatment fees, drug availability, transport and distance to facilities (CSO, Macro Int., 2007). A number of studies identified that the decision to seek care is influenced by perceptions of physical accessibility, access to transport, distance, insecure roads and inability to afford transport (Bartlett et al 2005). However, even where there is availability, there are access barriers. Financial barriers were cited by 75 percent of women in the lowest income quintile compared to 35 per cent in the highest income quintile (CSO; Macro Int., 2007). The low use of clinic services amongst some social groups has been attributed in national planning to lack of knowledge, religious and cultural barriers, user fees and poor male involvement (GoZ MoHCW, 2010). Generally, in Zimbabwe, women still have limited control over their sexuality and reproductive rights. The challenge is to improve education for women and to reduce the gender inequity that prevents women from making reproductive choices.

The Better Birth Initiative, a WHO strategy, specifically identifies continuous companionship during labor as a key, evidence-based component of improving quality of care in low and middle-income countries (WHO, 2002). Despite a large body of evidence supporting the benefits of continuous labor support, public hospital protocol in Zimbabwe and in much of the developing world continue to isolate women during labor and delivery, a practice that has been described as a violation of women's rights (d'Oliveira, Diniz, & Schraiber, 2002). The preference for home birthing is influenced by the fact that the woman in labour can get the much needed support from the spouse and family members present. Additionally, the health professionals are accused of not giving the women the attention they need and do not have respect for their clients. The set up of the maternity wards is further dehumanizing as everyone gets to see these women's naked bodies.

4. POVERTY & THE COST FACTOR IN THE UTILIZATION OF SERVICES

The Economic Structural Adjustmnet Program (ESAP) and the post 2000 economic decline brought hardship for the poor majority, with shortfalls in a range of basic needs and declining employment and income security. Poverty increased between 1995 and 2003, both in terms of the food poverty line and the total consumption poverty line (Equinet 2011). Total consumption poverty was higher in urban households than in rural households and in female-headed households than in male-headed households (MPSLSW, 2006). Between 1990 and 2005, 56 per cent of people were living on under US\$1 a day and poverty tripled in Mashonaland Central (Harare), Bulawayo, Manicaland and Matabeleland South (GoZ/UNICEF, 2007). Though poverty levels have not been measured in household surveys since 2005, the substantial post 2000 economic problems, hyperinflation that eroded purchasing power and periodic droughts are reported to have deepened poverty (Bracking and Sachikonye, 2006). There is evidence that urban poverty has increased for example the 2009 ZimVAC urban food security assessment found 33 per cent of the assessed households to be food insecure compared to 24 per cent in November 2006, (ZIMVAC 2009). Evidence suggests that urban poverty may have risen since 2009 at a time formal safety nets have not adequately addressed vulnerability. One assessment of ten select urban areas revealed a Total Consumption Line poverty rate of 70% (ZimVac 2012).

The National Health Strategy 1997–2007 aimed at all households being less than 10 kms from a health centre. By 1997, 85 per cent of the population lived within 8 kms of a primary care facility (MoHCW, 2009). However, by 2003, 25 per cent of all households and 30 per cent of the poorest households were further than 10 kms from facilities (MPSLSW, 2006). The population movements in the land redistribution exercise meant that more people moved into the previous large-scale farming areas, characterized by distant health facilities. Nonetheless there was evidence of improving access as reported use of facilities for illness rose from 62 to 71 per cent between 1994 and 2004 in both urban and rural areas. However, in 2004, 23 per cent of those not visiting services when they needed to cited cost as the reason (CSO, 2006). Use of private sector facilities was higher in urban than in rural areas in 1994 (with 25 percentage points difference) and 1999 (with 18 percentage points difference) but fell significantly by 2004 (to 9 percentage points difference) with cost a barrier for urban users. The share of households more than 10 kms from a facility had reduced to 17 per cent by 2007, although 40 per cent were still more than 5 kms away. However population movement, as a result of the agrarian reform

programme and natural population growth, reduced geographic access in some parts of the country (MoHCW, 2009). In 2007, shortages of medicines, ambulances, water, electricity and sanitation at health institutions led to people using more distant facilities, increasing household transport, medicine and fee costs (Makuto and James, 2007).

The cost of medical care is an important variable in determining the utilization of services. Until the introduction of user fees, cost of health facilities was relatively small. The introduction of user charges for health services meant that some people were automatically excluded by reasons of poverty and or unwillingness to pay. In 1980 free health care was introduced for those on low incomes (below Z\$150, equivalent to US\$220). The policy position on user fees has been that those who can afford to pay for services should do so but implementation of the principle has been mixed. Managing exemption from fees has been difficult and costly, with some consequent injustices in who is exempted. In 1990, emphasis was placed on fee collection. However, after evidence of high dropout rates from services, user fees in rural primary care services were suspended in 1995. The National Health Strategy for Zimbabwe 1997–2007 targeted at free treatment for the majority but stated that the policy of free health ‘creates a disincentive for people to join medical insurance schemes’. Poor people thus faced a variety of *de facto* cost barriers: the falling real value of the threshold for free care; transport costs; private purchases of medicines due to drug stockouts; and poorly functioning exemption schemes (MoHCW, 1999).

Though there are provisions for pregnant mothers, children under five years and adults over 65 years to be exempted from fees, in 2008, 59 per cent of respondents were found to have been charged for health care services, especially in urban, large-scale farming and mining areas. Of these, 36 per cent reported being unable to pay the fees (Makuto and James, 2007; Parl. of Zimbabwe, 2007). Private sector medical fees have risen sharply and government has not succeeded in regulating them. User fee collection varies between and within the public and private institutions, depending on the level of subsidies the facilities can secure from other sources. City clinics typically collect US\$25 for a normal delivery while central hospitals collect US\$80 for a normal delivery and US\$450 for a C-section. In the private facilities, the fees can range from US\$400-500 for a normal delivery and US\$1050-\$1400 for a C-section—costs that are prohibitive given prevailing household poverty and low coverage by insurance schemes (World Bank 2013). The Maternal and Perinatal Mortality Study of 2007 documented that among cases referred for childbirth complications, 14% of patients did not follow through with the referral for financial reasons, despite the fact that professional care for complications during pregnancy and childbirth is crucial in preventing maternal mortality. Thus a number of surveys such as the Maternal And Perinatal Mortality Study (2007), the Health Services Study (2008) and the Assessment Of Primary Health Care In Zimbabwe (2009) all report that communities considered user fees for services unaffordable. This contributed to reduced access to services, especially for poor and vulnerable communities (MoHCW, 2009). User fees were the most commonly mentioned reason for lack of access, especially for maternal health services (MoHCW, 2009). User charges are thus a major deterrent to accessing health care, a major cause of delay in seeking treatment, and cause for many to turn to traditional medicine and self-medication. Related to the issue of user charges were the issues of unofficial charges, multiple payment points and inappropriate prescriptions (Martinez, 1992). These inflated the cost of treatment and further aggravated the plight of the poor. The cost factor in health care is a crosscutting issue as the cost of health care to a patient and family is not only the user charges, it also includes the access cost (transport, waiting time). The cost of health services is a great inhibiting factor to health facility utilization.

Out of pocket expenses for MNCH care for Harare City: Source: Harare City Council: April 2013

Services	City of Harare	Government Central Hospitals	Private Clinics/Hospitals
Antenatal care	\$25	Seen at local Clinics	
Delivery		\$80	\$400-\$500
C-Section	Referred	\$450	\$1050-\$1400
Postnatal care	\$0.00	Referred to local clinics	\$20-\$30

5. CULTURAL BELIEFS AND GENDER RELATIONS

Culture and tradition have a significant influence on the decision to seek antenatal care. The challenge, therefore, is to empower women through information, education communications (IEC) to enable them to make informed decisions concerning their maternal and general health issues. Many families opt for the traditional birth attendant as their first line of call for delivery services unless they believe labour is not normal. They just are familiar to and have trust in homebirthing. Gendered barriers to education also have implications for health-related choices as the level of education is considered to have an effect on people's capacity to make good health choices. Women and adolescent girls' choices and ability to make choices in favor of their own health are jeopardized by the production and reproduction of gender inequality at household and community level. For instance, health seeking decisions are generally made by men (Olesen 2005). Moreover, lack of male knowledge and understanding (with which to make decisions) is recognised as a significant obstacle (Olesen et al 2005). Additionally, it is culturally unacceptable for women to receive midwifery/obstetrical care from a man and this can explain partly why home births vastly outnumber those occurring in health facilities.

A woman's education and wealth are strong determinants of whether or not deliveries happen in institutions. A woman can only exercise choice of birth site if she has unrestricted access to maternity providers in all settings. The odds of delivery at a healthcare facility are 17.7 and 2.9 times higher among women who attained higher education and up to secondary education respectively than among those who had no schooling at all both significant at the 1 percent level. The odds of delivery at a healthcare facility amongst women who belong to the middle, richer and richest societies are 2, 2.5 and 6.4 times higher than amongst those women from the poorest family settings all at 1 percent level of significance whilst the odds for women from the poor society utilising the same service are 1.3 times higher at the 5 percent significance level. The odds for delivery at a healthcare facility are 3.5 times higher among women from urban areas than among their rural counterparts at 1 percent level of significance. Women in polygamous households are 35 percent less likely to deliver at a healthcare facility compared to those from non-polygamous households also at 1 percent significance level. Women who cited distance as a big problem for getting to the nearest healthcare facility are 20 percent less likely to give birth at health centers, significant at 10 percent level. The fact that a woman attended antenatal sessions has also proved to be a significant determinant of delivery at health centers. The odds for delivery at a health centre are 2.1 times higher among women who attended antenatal sessions than amongst women who did not get antenatal care at 1 percent level of significance (Gregson et al 1999).

6. RELIGION

Religion is considered a significant constraint on demographic transition, and on fertility change, in particular, in a number of historical and contemporary populations and this constraint can operate at a national level (Cleland and Wilson 1987; Grada and Walsh, 1995). In some instances, minority groups tend to maintain strict and sometimes separate lifestyles, against backgrounds of widespread social, economic, and demographic change (Eaton and Mayer 1953; Hostetler 1993). Commonly held beliefs and norms that could be religious or cultural, shape individuals perceptions of their own health and the health services available. Religious and cultural beliefs have been found to be sources of exclusion from maternal healthcare utilisation in Zimbabwe and Africa at large (Stephenson et al., 2006; ZDHS 2005/6) Women from apostolic households and those that believe in traditional healing are less likely to make antenatal visits and deliver healthcare facilities than women from other religious affiliations. Religious affiliation is thus a strong and significant source of exclusion from antenatal care and delivery at healthcare facilities. The exclusion of women affiliated to apostolic sects and traditional practice from antenatal care and delivery services has also been documented elsewhere. In Zimbabwe, women affiliated to apostolic sects do not take medical services because they believe in faith healing and they prefer traditional midwives. Traditionalists do not believe in modern day medicine and they prefer cleansing and traditional herbs. Thus religious and cultural beliefs are a strong determinant of women's place of birth.

7. CONCLUSION

A link between poverty and maternal health has been clear for more than a century. Progress towards positive maternal health outcomes will ultimately be dependent on strong health systems ensuring high coverage of midwifery services supported by timely and competent hospital care, especially in the poorest countries in sub-Saharan Africa including Zimbabwe. The persistent emphasis on global differences and strategies for maternal health has often entailed a neglect of

biological, geographic, economic, and social differences in maternal mortality within populations. There is need to target interventions towards the most vulnerable groups (mostly rural populations and the urban poor); understand local practice and preferences. This in turn relies on the organisational and learning capacities of not just communities but also local health providers and policy makers. Zimbabwe's health service infrastructure could support universal access, although gaps need to be addressed in new resettlement areas. Improved uptake of services depends on overcoming shortages of drugs, staff and other supplies, as well as barriers to uptake. These include charges for services and medicines, as well as social factors. Women are having babies at home because of religious beliefs, influence of family members, culture, fear of hospital procedures and accessibility, affordability and user-friendliness of healthcare facilities. Zimbabwe has both geographical and income level fee exemption policies. The policy of free care at clinic level has not been applied uniformly. This together with informal charges, fees have raised cost barriers for poor households. The available information consistently points to the role of social and cultural factors in women's choice and ability to choose access to maternal health services. Gender inequality,

the low value put on women's health and men's accepted control of decisions over health service utilisation are among the identified key problems. In addition, there are barriers related to costs and physical access, both of which have a gendered dimension. All of these in turn influence decision-making and health seeking behaviour at household/community level.

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