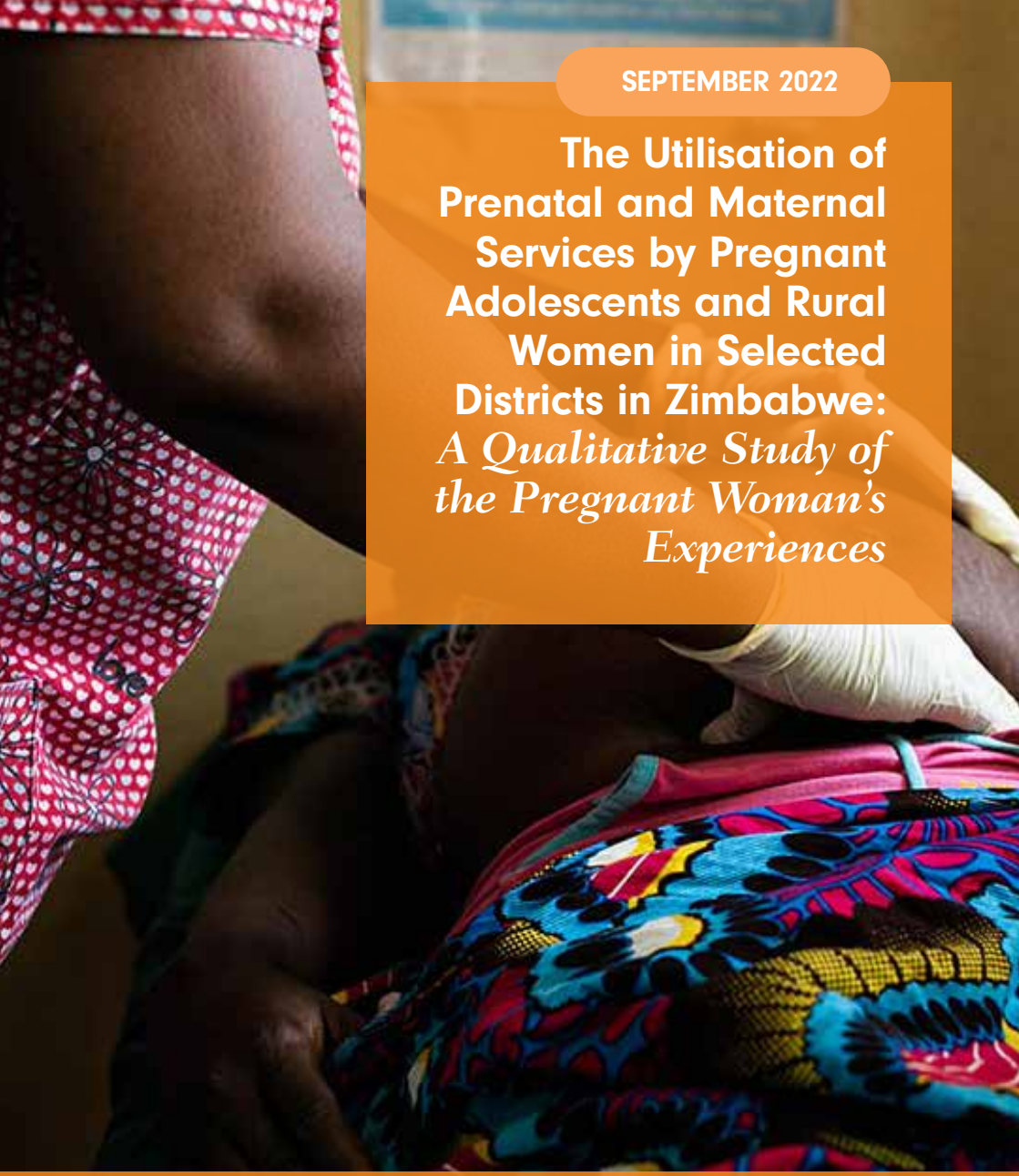

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The Utilisation of Prenatal and Maternal Services by Pregnant Adolescents and Rural Women in Selected Districts in Zimbabwe: *A Qualitative Study of the Pregnant Woman's Experiences*

AWDF AFRICAN WOMEN'S DEVELOPMENT FUND

WLSA Women and Law in Southern Africa Zimbabwe

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Contents

List of Acronyms

ABR	Adolescent Birth Rate
AGYW	Adolescent Girls and Young Women
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
FGD	Focus Group Discussion
GBV	Gender Based Violence
HTC	HIV Testing and Counseling
IEC	Information Education Communication
ILO	International Labour Organization
KII	Key Informant Interview
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MOHC	Ministry of Health and Child Care
MWACSMED	Ministry of Women Affairs, Community, Small and Medium Enterprise Development
NGO	Non Governmental Organisation
NDS	National Development Strategy
PNC	Postnatal Care
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-Based Violence
SRHR	Sexual and Reproductive Health Rights
TSP	Transitional Stabilisation Programme
UDACIZA	Union for Development of Apostolic and Zionist Churches in Zimbabwe
UNFPA	United Nations Population Fund
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic and Health Survey
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZWLA	Zimbabwe Women Lawyers Association

About WLSA Zimbabwe

Formed in 1989, Women and Law in Southern African Research and Education Trust (WLSA) Zimbabwe is a local Chapter of a sub-regional network - member countries are Botswana, Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe - seeking to contribute to sustained well-being of women and girl children in Southern Africa through action-oriented research in the socio-legal field and advocating women's rights.

By action-oriented research we mean research which is intended to inform and influence action being taken to improve the socio-legal situation of women and girl children. WLSA work incorporates action into research by questioning and challenging the law, instigating campaigns for changes in law and in policies, educating women about their rights, providing legal advice and gender sensitising communities and leadership during the course of the research.

Vision

A society where justice is equitably accessed claimed and enjoyed by women and girls in all spheres of life.

Mission

WLSA Zimbabwe aims to be a renowned Southern Africa feminist and human rights organisation that coordinates and supports evidence based interventions to promote and protect women and girl's rights through legal and policy reform and changes to discriminatory socio-cultural practices.

Values

WLSA Zimbabwe is guided by the following values:

- Good governance (professionalism, transparency, accountability and integrity)
- Solidarity
- Ownership

1. Introduction

Zimbabwe's high maternal mortality ratio which in 2017 led to the country being one of the 15 countries that were considered to be 'very high alert' or 'high alert' with MMRs ranging from 31 to 1150 on the Fragile States Index. Despite a reduction in the Maternal Mortality Ratio (MMR) per 100,000 live births from 651 in 2015 to 462 in 2019,[1] MMR in Zimbabwe remains high. Benchmarking regionally, East and Southern Africa Region's MMR in 2017 was much lower than that of Zimbabwe at 384. The major causes of maternal deaths in Zimbabwe include haemorrhage (22%), eclampsia (16%) and infections (14%). Among adolescent and young women aged 15-24 years, the major causes of maternal deaths are puerperal sepsis (16%), eclampsia/ PIH (16%) and post-partum haemorrhage (14%).[2] There are other factors as well contributing to the high maternal mortality in Zimbabwe that include negative labels attached to health facilities, high costs of services, poor attitudes of health service providers, extended waiting times, and distances to health facilities.

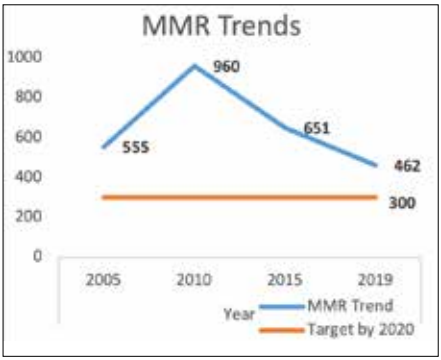


Figure 1: Trends in maternal mortality rate 2005-2019

Adolescent pregnancy remains a major contributor to maternal and child mortality. Zimbabwe's Adolescent Birth Rate (ABR) remains high, at 108 live births per 1000 women against a national target of 99 by 2020 and a global average of 44.[3] A downward trend has been observed from 2010 where ABR was 118. Rural ABR of 136 was double that of urbans'. Education is the factor most strongly associated with inequalities in ABR. With pregnancy and childbirth complications being the leading cause of death among girls aged 15-19 years globally, more needs to be done to further reduce the adolescent birth rate.

1 Ministry of Health and Child Care Zimbabwe (2020). 2019 Annual Family Health Programme Report.
2 Maternal Death Surveillance and Response, 2017 Annual Report.
3 Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019). Zimbabwe Multiple Indicator Cluster Survey 2019, Survey Findings Report. Harare, Zimbabwe: ZIMSTAT and UNICEF.

The main purpose of this study is to describe the utilisation of antenatal and maternal services in selected districts in Zimbabwe, identify the factors that affect the utilisation of antenatal and maternal services by pregnant adolescents and rural women as well as describe factors that will promote the utilisation of antenatal and maternal services by pregnant adolescents and rural women in these districts. This information will be used to recommend ways in which the antenatal and maternal services in selected districts in Zimbabwe will become more accessible to pregnant adolescents and rural women.

1.1 Objectives of the study

The objectives of the study are to:

1. Describe the policy and legal framework and related gaps that support the utilisation of prenatal and maternal services by pregnant adolescents and rural women in selected districts in Zimbabwe.
2. Describe the utilisation of prenatal and maternal services by pregnant adolescents and rural women in selected districts in Zimbabwe.
3. Document the obstacles adolescent girls and women face in seeking pre-natal and maternal care.
4. Identify possible barriers that may prevent pregnant adolescents and rural women from utilising the antenatal services.
5. Document the barriers that keep health practitioners from adequately caring for pregnant women. Document the factors that keep women from advocating for maternal health
6. Proffer recommendations and strategies that will promote antenatal and maternal service usage by pregnant adolescents- and rural women in selected districts in Zimbabwe.

1.2 Research Questions

The following research questions will direct this study:

1. What is the policy and legal framework, opportunities, entry points and gaps regarding the utilisation of prenatal and maternal services by pregnant adolescents and rural women in selected districts in Zimbabwe?
2. What are the factors that promote adequate utilisation of antenatal and maternal services by pregnant adolescents and rural women in Zimbabwe?
3. What have been the experiences in accessing adequate utilisation of antenatal and maternal services by pregnant adolescents and rural women in Zimbabwe?
4. What are the barriers that prevent pregnant adolescents and rural women from utilising the antenatal services?
5. What are the challenges faced by pregnant adolescents and rural women in advocating for adequate access to antenatal and maternal services?
6. What are experiences and the barriers that keep health practitioners from adequately caring for pregnant women?
7. What strategies could be developed will promote antenatal usage by pregnant adolescents?

2. Methodology

The study employed a participatory mixed-method or a pluralist method approach to integrate data from different data gathering methods, such as desk review, focus group discussions and key informant interviews, through engaging appropriate stakeholders. Use of mixed methods not only offers diverse perspectives to the research issue. It also promotes participation of different groups of stakeholders, allows multiple voices to be heard, provides a more holistic picture of the research issue being investigated and allows for triangulation of data for reliability and validity. Data from multiple sources provide means to develop defendable conclusions about the assessment. A participatory ethos was adopted in this study to ensure participation of all the key stakeholders. Participation ensures ownership of the results and facilitates adoption of proposed recommendations. The consultant played a crucial role in creating the space, environment and opportunity for conversations to happen where all opinions are accepted as valid and respected. Group discussions comprised of respondents with almost similar demographic and social characteristics, to provide liberating experiences for women and adolescent girls, by giving them an opportunity to voice their lived experiences.

The research also adopted feminist centred principles. The Feminist research–quantitative or otherwise – "deliberately and purposefully challenges existing power structures, and actively embeds feminism into every element and phase of the research process more specifically. In line with the feminist approaches to research, the research deliberately brings about structural challenges in access to prenatal and maternal services for rural women and adolescent mothers highlighting issues that women themselves identify as critical to their influencing policy and securing their rights. The study also amplified women's voices by strategically placing them at the centre of the study by ensuring that all the data on women's experiences is collected from women only Focus Group Discussions (FGDs). Men's voices were heard through key informant interviews (KIIs) with stakeholders.

The study relied on desk review of policy and legal framework as well as other research and government reports; focus group discussions with pregnant adolescents and rural women as well as health promoters in Marange and Murewa and in-depth interviews with key informants drawn from government ministries that include the Ministry of Health and Child Care and the Ministry of Women Affairs, Community, Small and Medium Enterprise Development (MWACSMED) as well as civil society organisations that deal with SRHR and women's legal issues that include Katswe Sistahood, Roots, and Zimbabwe Women Lawyers Association (ZWLA). The purpose of the interviews was to solicit stakeholders' views on factors that affect pregnant adolescent girls and rural women from accessing prenatal and maternal services, the policy and legal framework governing this, gaps, opportunities and entry points as well as recommended interventions to ensure women's access prenatal and maternal services. Observation was a key data collection tool for this study. The consultant observed selected rural health facilities using an observation checklist that is aimed at generating information on the quality of services targeting the following issues among others: visible IEC materials on prenatal and maternal health in high-traffic areas, location of the facility, privacy, availability of essential infrastructure, furniture, equipment, supplies, documents, and commodities.

3. Context Setting

Prenatal and maternal health services in Zimbabwe

Preventing problems for mothers and babies depends on an operational continuum of care with accessible, high quality care before and during pregnancy, childbirth, and the postnatal period. It also depends on the support available to help pregnant women reach services, particularly when complications occur. The prenatal and maternal services in Zimbabwe are categorised into 3 that is the antenatal/ prenatal care, delivery care and post-natal care (Kifle, Azale, Gelaw and Melsew, 2017).

Antenatal care, also referred to as prenatal care refers to the routine health control of presumed healthy pregnant women without symptoms (screening), in order to diagnose diseases or complicating obstetric conditions without symptoms, and to provide information about lifestyle, pregnancy and delivery. ANC is the initial constituent in maternal health care (McNellan et al 2019). It comprises of processes and health arrangements that function during the pregnancy phase. During this phase the pregnant woman is provided with medical and maternal attention (Kiogora, 2016). According to WHO (2015) these steps include; booking a pregnancy at a clinic, going for four ANC visits, going for birth check-ups, birth scans and birth preparedness. Davis et al (2016) add that other steps in the process include; blood donation in the case of excessive blood loss during delivery, birth preparedness, healthy eating, identification of danger signs during pregnancy and the healthy delivery of a baby. ANC is also a chance to use professional attendants at birth and in the education of healthy behaviours such as breastfeeding and planning for ideal pregnancy spacing (Lincetto et al, 2013). Other crucial services offered include HIV testing, amniocentesis, chorionic villus sampling, ultrasound and ANC counselling sessions are also crucial. Current antenatal care (ANC) guidelines recommend that pregnant women attend their first ANC visit in the first trimester, followed by two visits in the second trimester and five visits in the third trimester (WHO,2016).

According to Kiogora (2016) the goal of the ANC is to prepare for birth and parenthood as well as prevent, detect, alleviate, or manage the three types of health problems during pregnancy that affect mothers and babies that is, complications of pregnancy itself, pre-existing conditions that worsen during pregnancy and effects of unhealthy lifestyles.

Postnatal care (PNC) on the other hand is the period or days for mother and child's care after childbirth. It is a critical stage in the lives of mothers and new-born babies (Khanal, 2014). Most women in Zimbabwe within the first 6 months of delivery are prone to post-partum depression. This is mainly prompted by the labour pains and in some cases obstetric injuries sustained during birth. This therefore, means that, post-natal services are very crucial and should never be taken for granted.

Ditekemena et al (2012) assert that the regular care routines for mothers with new babies include; check-ups for blood loss, body temperature regulation, breastfeeding, checking the breasts to prevent mastitis, managing anaemia, promoting healthy eating, giving vitamin A, completing tetanus immunisation, providing counselling, referring complications such as infections, or postpartum depression and counselling on danger signs. Vital postnatal care for babies include assessments for danger signs, measuring and recording weight, temperature checks and feeding, exclusive breastfeeding, promoting hygiene and good cord and skin care, optic care, promoting clean, dry cord care and regular immunisations (Khanal et al, 2014).

It is the health personnel's duty to ensure that the mother is recovering at the same time the child is developing normally. At this stage, immunisation is a must and the children are expected to be regularly attending the hospitals at the booked time for immunisation. Counselling sessions are also given to both the father and mother on reproductive health. Family planning options are shared during the counselling sessions (Khanak et al, 2014). Research conducted in Mashonaland west province showed that 29.6% of men were well-informed about family planning methods accessible to their partners, yet there were knowledge gaps among men on the vitality of using family planning (OPHID, 2015). Kaida, Kipp, and Konde-Lule, (2005) also established that male participation in family planning procedures in Zimbabwe is low. A study by Comrie-Thomson et al (2015), showed that 33% of men participated in ANC and only 14% of the men engaged in utilisation of PNC services. This was attributed to the fact that males frequent the clinic less when their wives have given birth than they do when their wives are still pregnant mainly because of the vulnerability and fragility of women during pregnancy.

4. Study Findings

4.1 *Legal and Policy Framework and Access to Prenatal and Postnatal Services in Zimbabwe*

Zimbabwe like other countries ratified several treaties that require State parties to ensure that all everyone including rural women and adolescents have access to sexual and reproductive health services and information, and comprehensive sexuality education, free from barriers and discrimination. Section 76:1 of the Constitution of Zimbabwe states that every citizen has a right to access basic healthcare services. This includes sexual and reproductive health services. Section 81:1f affirms children's health rights. The constitutional provisions are given effect through national policies, strategies and programs. These constitutional, policy and legal provisions are implemented under the leadership of the Ministry of Health and Child Care responsible for health and child care, local authorities, civil society and private sector health service providers. The Adolescent Sexual and Reproductive Health strategy highlights the need for a multi-sectoral and participatory approach that also recognizes the participation of youth of both sexes at all levels of SRHR programming. The strategy is aimed at ensuring that adolescents have unlimited access to SRHR services both in school and out of school. Key documents include:

- The 2016-2020 National Health Strategy (GoZ, 2016).
- The National ASRH Strategy for 2016-2020: The ASRH Strategy I (2010-2015) had four interconnected streams for service delivery. These were; (i) community-based youth centres offering counselling, recreation, IEC materials and health consumables like condoms. However, this approach failed to achieve the intended purpose because the youth centres were not cost effective and was used for recreational purposes limiting girls' access to ASRH services. (ii) health facility-based, that is onsite youth-friendly corners facility that offer voluntary counselling and testing as well as IEC materials, health consumables and family planning services. This approach had weak referral systems and most young people could not afford to access the centres. (iii) school-based services including life skills training and counselling, and (iv) the peer education model: Although this was a promising approach, it was affected by lack of resources and limited support. To address these challenges and

also improve ASRH services and delivery for young people, the Government of Zimbabwe revised the ASRH strategy in 2015 and now is focusing on (i) increased safe SRH and HIV practices among Adolescents and Young People with emphasis on increasing correct and comprehensive knowledge of HIV/STIs and pregnancies and improving life skills among AYP, (ii) increased uptake of quality youth friendly integrated SRH/HIV services and (iii) strengthening protective environment for adolescent and youth through improving increased community support for ASRH and adolescent HIV programmes and improved parent to child communication on SRH and HIV services. The strategy however still fails to clarify adolescents' rights to access sexual and reproductive health services and information without imposing limitations based on age, marital status and the consent of a third party.

- The National Health Strategic Plan (2016-2020) seeks to strengthen ASRH through improving provisions of integrated youth friendly services using appropriate and evidence based inclusive models, strengthening school health programme to include Comprehensive Sexuality Education and awareness of ASRH among others.
- Zimbabwe Maternal and Neonatal Health Strategy (2017-2021).
- Section 35 of The Public Health Act of 2018 has been read to provide that children under 18 require parental or adult consent to access medical health services.
- Access by adolescents to contraceptive services is governed by Zimbabwe's National Guidelines on Clinical Adolescent and Youth-Friendly Sexual and Reproductive Health Service Provision, 2016 (Clinical YFSP Guidelines).
- The Termination of Pregnancy Act (No. 29 of 1977) (as amended in 2001), allows abortion when it is necessary to save the life of the woman, to preserve her physical health, when there is foetal impairment and when the conception is the result of rape or incest. Anything outside that is criminalised.
- The Criminal Law Codification Act also set limited conditions under which abortion can be conducted. Any abortion done outside these provisions is an offence.
- The School Re-entry Policy, to 'protect' pregnant learners. The Policy Circular 35, provides that when a girl gets pregnant in school she can go for maternity leave and be re-enrolled at the same school, in the same grade/ form in which she was before she took leave.

- The School Health Policy and the amended Education Act which alignment with the constitutional provision on education and international best practice as stipulated in the Convention on the Rights of the Child and the African Charter. The mended Act addresses issues of access to sexual and reproductive health services. Section 3 subsection (1a) provides for the provision of sanitary wear and other menstrual health facilities to girls in all schools to promote menstrual health.
- The National HIV Testing Guidelines of 2014 which states that a child under the age of 16 is unable to consent to HIV Testing and Counselling (HTC).
- The Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III, 2015-2018) supports efforts that will consolidate mainstreaming of human rights and gender responsive approaches in AIDS planning and service delivery mechanisms.
- The National Family Planning Strategy and the National Family Planning Costed Implementation Plan. The two goals of the Zimbabwe National Planning Strategy are to increase the contraceptive prevalence rate from 59% to 68% by 2020 and to reduce teenage pregnancy rate from 24% to 12% by 2020.

The strategic priorities include improving availability and access to comprehensive family planning services, expansion of other SRHR services including cervical cancer screening and increased safe sexual and reproductive health and HIV prevention amongst adolescents and young people, increasing uptake of quality youth friendly integrated SRH and HIV services and strengthening protective environment for adolescents and young people. All of these policies emphasize that heath care delivery should be appropriate to the age of youth being served.

The shortfalls of these legal and policy provisions are not limited to the following:

i. Zimbabwe's constitution has a strong anti-abortion stance

Terminating an unwanted pregnancy is prohibited and can attract a prison sentence up to five years, as per the Termination of Pregnancy Act of 1977 [Chapter 15:10]. Exceptions are in cases of rape, incest, when the mother's life is at risk, or when the child may be born with serious disabilities. In the latest concluding observations of the Committee on the Rights of the Child on Zimbabwe, the Committee expressed concern over the high rate of sexual violence experienced by adolescent girls and stated that the abortion law in Zimbabwe was restrictive and that the extensive procedures for authorizing an abortion resulted in "illegal and unsafe abortions". **The Committee urged the Government to "ensure children's access to safe abortion and post-abortion care services in law and in practice".**

ii. Zimbabwe does not have a specific law to govern the age at which children may consent to medical procedures, including services related to SRHR

Zimbabwe does not have an expressed age for seeking medical procedure including accessing sexual and reproductive health services, such as seeking contraception or termination of pregnancy. The Public Health Act of 2018 [Chapter 15:17] defines a child as anyone under the age of 18 years, and states that "informed consent" can only be given by a person who has legal capacity to do so. The Act is silent on sexual and reproductive health services, which leaves the provision of such services to children unclear and up to the health care worker to interpret whether or not a child can receive such services without a guardian present. In such a legal environment, medical providers base decisions on personal opinions around the appropriate age, rather than following a stipulated framework. **There is need to amend the law to ensure adolescents can access sexual health services universally.**

iii. The age of consent to sex

The Age of consent to sexual activity has been raised to 18 from 16 under the Kawenda v Minister of Justice Legal and Parliamentary Affairs constitutional ruling of 2022 to align it to the age of consent to marriage. However, even though children need to be protected from sexual abuse and exploitation, it

needs to be acknowledged that adolescents start exploring their sexuality and engage in consensual sexual activity with their peers before they turn 18. This was clear during the COVID-19 lockdown period where just between January and 5 February 2021, the country recorded 4959 teenage pregnancies and 1774 child marriages (Parliament of Zimbabwe Hansard, 2021). The age of consent creates barriers in accessing sexual and reproductive health services, leading to higher levels of unsafe abortions, sexually transmitted infections and unwanted pregnancies. In addition, research shows that promoting sexual abstinence, as is often the case in jurisdictions with high ages of consent to sexual activity, does not actually lead to a delayed sexual debut. It rather gives adolescents the option to make safe decisions about their health. The higher the age of sexual consent, the more barriers exist in accessing sexual health services before that age.

The age at which a person is considered mature enough to consent to receiving health services related to sex and reproduction without a guardian is in many countries tied to the age of sexual consent. Having to obtain consent from a guardian or a parent to access services related to sexual health is a hurdle many adolescents will choose to avoid. Research shows that the better access adolescents have to sexual health services, the more likely they are to be empowered to express full, free and informed consent to sex. This increases overall health and wellbeing. In this regard, the Committee on the Rights of the Child has encouraged States to recognize a "presumption of capacity" for adolescents to access sexual and reproductive health services.

iv. Lack of translation of constitutional and legal provisions into rights that people enjoy

The other challenge in Zimbabwe is translation of constitutional and legal provisions into rights that people actually enjoy due to a number of factors including lack of understanding and knowledge of rights by the rights holders, inadequate alignment and implementation of the existing legal and policy framework on gender equality and women's rights law, and persistence of patriarchal norms. Women and girls remain second class citizens due to patriarchy which is often perpetuated under the guise of culture and religion. The dual legal system in the country complicates matters for women and girls. For example, the Roman Dutch law and Customary Law define the child differently and hence the expectations

of children also differ.[4] Women and girls thus find themselves subject to overlapping and potentially contradictory obligations, emanating from different systems of law. The CEDAW Committee at the 2012 review meeting recognised the important progress Zimbabwe has made in adopting a series of legislative and policy measures but however lamented the lack of implementation of the same. In February 2020, Zimbabwe underwent another review before the CEDAW committee and the committee called on Zimbabwe to ensure effective implementation of its laws on gender equality and women empowerment and the elimination of all forms of discrimination and to take measures to enhance the implementation of gender equality laws and policies through effective enforcement mechanisms. The enactment of the gender equality law is critical for the delivery of gender equality provisions in the constitution. The gender equality law includes sanctions for non-compliance.

The lack of policy implementation and enforcement in the country is furthered by lack of adequate allocation of resources to advance the laws and policies in place.

4.2 *Barriers to Access Prenatal and Maternal Health Services by Pregnant Adolescents and Rural Women*

There is a plethora of barriers to accessing prenatal and maternal health services by pregnant adolescents and rural women in Zimbabwe. WILD (2020) summarises the challenges that women in general face in relation to access to health as absence of waiting mothers' shelters, poor road infrastructure, long distances to get to the nearest medical services, lack of medication and qualified health personnel. These barriers have immensely contributed to maternal morbidity and mortality, postpartum depression and obstetric related cases. This section details the barriers.

- **Cultural and Religious Beliefs and Practices**

The health care system in Zimbabwe is characterised as pluralistic because of the co-existence and concurrent use of traditional and biomedical practitioners.

4 For instance, the definition of a child in most cultures in the Southern African region are linked to the child's ability to carry out certain tasks, attainment of marital status, on puberty, on procreation or on circumcision. In terms of civil law a child is defined according to biological age.

Cultural and religious beliefs have a strong effect on the responsiveness of pregnant women towards accessing maternal health. Women in Marange cited the influence of religion on access to prenatal and maternal health services. They cited an example of a girl from the area named Memory Machaya whose story went viral across all forms of media, who died at the Johane Marange religious shrine giving birth. This was given as an example of religious beliefs being practised by some apostolic sects in Zimbabwe shunning the use of medically approved maternal services. In Murehwa, a health promoter remarked,

> *"Some of the adolescent mothers from the apostolic sects are very rude, I don't know why. I suspect they are taught to be rude. I met a pregnant adolescent from Johane Marange and started a conversation with her regarding registering her pregnancy and everything about prenatal and postnatal care. She responded, "handipindi mazviri izvozvo, tinozvipedzera kuchurch kwedu" (I will not do that, we get the necessary support from our church)."*

A rural woman who belongs to the Johane Marange Apostolic sect also remarked,

> *"The problem is with the birth attendants in various Apostolic sects. They claim to have been trained so the adolescent mothers and rural women have developed confidence in the service they offer; and yet some of them have not undergone any training. They use salt and oil. There are however some rural women from these sects like myself who clandestinely visit health centres for prenatal and postnatal care. The health promoters know us and they assist us to be assisted privately and quickly for us not to be discovered by our spouses, relatives and church mates."*

In Murewa, female FGD participants reported that there were no family planning tablets at the local hospital due to religious reasons. Musami hospital which is Catholic owned is the only hospital and does not offer family planning services because of the Catholic belief against family planning.

It also emerged from the interviews that cultural and traditional influences on access to maternal health services is predominant in rural settings.

Seeking early maternal care was viewed as not necessary as women are socialised to endure pain. There are adults who are believed to be good at diagnosing pregnancy with eyes and who can also conclude that one is carrying a healthy baby and subsequently discourage the need to visit the antenatal clinic (Dodzo and Mhloyi, 2017).

Gender norms demanding that girls should remain shy and innocent about sexual matters limit their access to information on sexuality, contraception, pregnancy and related services. This also extends to health care personnel who may then stigmatize and disrespect pregnant adolescents. Health-seeking behaviour for these adolescent mothers is therefore mainly affected by norms and values in a particular society. This study revealed that contraceptives were available but there was a gap in their use especially by women from the Johane Marange sect due to their religious beliefs. Female condom use was also not popular. Young women indicated that suggesting use of a female condom may mean that you are promiscuous, and men will lose trust. Interviews with elderly women also indicated that the Zimbabwean culture does not expect a female to initiate sex, let alone the use of contraception.

It was also noted that parents do not talk about use of contraception with school going children, yet they are the most at risk of early and unplanned pregnancies from the age of 12. These social norms are reducing the use of contraception among the adolescents which is contributing to limited access to prenatal and postnatal services among adolescent mothers.

- **Lack of financial resources and shortage of health facilities and services**

One of the major challenges in the rural setup is the shortage of health facilities. Most rural clinics do not have all prenatal and maternal services and in most cases, accessibility remains a challenge due to transport costs as the facilities are located very far. In general, in addition to $10 registration fee, local clinics demand that one brings their own sanitary pads, bed sheets, a bucket of water, a razor to cut the baby's umbilical cord, gloves for the nurses and candles for lighting which would add up to $20. If one is transferred to a hospital they would pay at least $70 more and a blood transfusion if needed would cost $120/unit (RBF Health 2019). This is a lot of money and beyond the reach of pregnant adolescents and rural women. Although, the Rural Based Financing Program subsidizes health care services for

pregnant women and children under five in rural areas, unavailability of some of the services at the facilities hinders women from utilising this facility. Pregnant women have to gamble with their lives by opting for home delivery due to underfunded and under-resourced government hospitals or because they cannot afford the costs of care. The study revealed that some women even give birth at religious shrines owing to high costs of accessing services at health centres. Of late, high exodus of staff and shortage of essential drugs, have also forced many women to seek traditional care. To this end, economic challenges have not only affected households but even the community since some clinics in rural areas are community owned; they are built using locally available resources with the help of local government (Rural District Councils Act, Chapter 29:13). There is therefore shortage of health facilities. Distance to health care facilities therefore becomes a major challenge for remote locations and communities inhibiting access to health care services[5]. The current health facilities profile in Zimbabwe indicate that there are 214 hospitals and 1634 primary health facilities countrywide.

There have been initiatives by the government of Zimbabwe to have waiting mothers' shelters in some rural areas to deal with the challenge of distance to health facilities.

Where few clinics exist, they are usually ill-resourced and the conditions of health care staff are considered as poor thereby affecting their discharge of quality services to patients.

Table 1: Health Facilities Profile in Zimbabwe

Hospital	Number	Primary Health Facilities	Number
Central hospitals	6	Clinics	1122
Provincial hospitals	8	Polyclinics	15
District hospitals	44	Mission clinics	25
Mission hospitals	62	City council/municipal clinics	96
Rural hospitals	62	Rural health centres	307
-	-	Private clinics	69
Total	**214**		**1634**

Source: Ministry of Health and Child Care 2016-2020 National Health Strategy for Zimbabwe

5 Ray, S and Masuka, N (2017) Factors and Barriers to Effective Primary Health Care in Zimbabwe.

Due to financial challenges, rural women are left with home delivery as an option since transport cost can go beyond their financial capacities coupled with poor road networks. Failure to have resources to construct more clinics becomes a challenge and to those who have the facilities, failure to cater for service costs such as caesarean section during delivery and other maternal services becomes a great barrier to accessing medical care.

The challenge for adolescent mothers is compounded by the fact that local clinics are not allowed to attend to them; instead they are referred to general hospitals, where specialised care is available, thereby increasing the costs of accessing services for this category of patients. Owing to the age of the mother, there are risks of perinatal mortality for the child and prolonged labour for the young mother hence the need for them to be attended to at general hospitals.

Most of the rural women and pregnant adolescents interviewed initiated antenatal care late, despite most of the women having secondary education and access to ANC services. They all mentioned high costs of antenatal care as a barrier to utilisation. Women reported that they did not initiate early antenatal care because of transport challenges and myriad of problems with the quality of the healthcare services. There are serious gaps affecting quality of health care especially.

The following key indicators clearly portray the situation:

- Health facility density, an indicator of outpatient service access was 1.1 facilities per 10,000 population, below the Service Readiness and Availability Assessment (SARA) benchmark of 2 facilities per 10,000 population. Across all provinces, facility densities ranged from less than 1 health facility per 10,000 population to 1.7 per 10,000 population.
- Zimbabwe's national in-patient bed density is 18 in-patient beds per 10,000 against SARA target of 25 in-patient beds per 10,000 population.
- National maternity bed density is 8 per 1,000 pregnant women against the SARA target of 10 maternity beds per 1000 pregnant women.
- The overall health infrastructure index score (average of health facility density, in-patient bed density and maternity bed density) is 69% of the respective target values.
- Zimbabwe's overall density of core health care workers per 10,000 population is 8, about a third of the recommended target of 23 per 10,000 population by the World Health Organisation (WHO).

- The national general service availability score is 42%.[6]

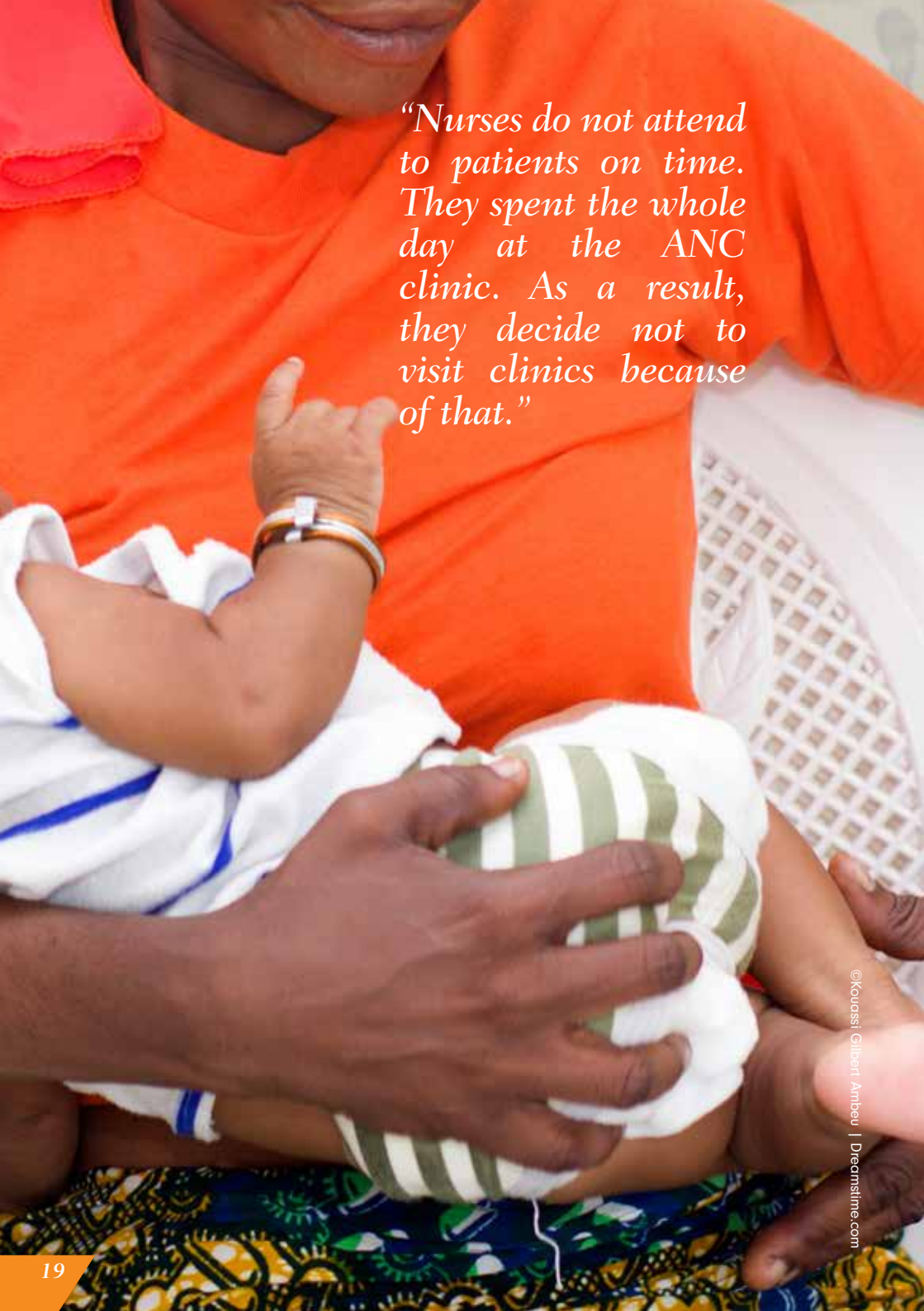
The health care sector in Zimbabwe is currently struggling to provide good health services (Mafukidze, 2018). Quality service delivery in Zimbabwe is being impeded by these factors competence, negligent, unfriendly attitudes of health service providers, physical environment and facilities, inadequate supply of drugs, inadequate providers, long waiting time and inappropriate referrals. Interviews revealed that in most cases, student interns are the ones who are being found on sight at clinics/ hospitals even during emergencies with no assistance from the qualified health personnel as qualified personnel opt to offer private services which give them more money. Zimbabwe continues to lose qualified health personnel due to brain drain. The exodus of most nurses and doctors to the UK continues every year. Approximately 4780 health personnel have left Zimbabwe to the UK as reported by the UK NHS staff from overseas report of March 2021 (Baker, 2021). The shortage has not gone unnoticed by people and women have tended to socialise themselves to conduct home deliveries using local natural means.

A study conducted by Mutowo et al (2021) in Mashonaland West revealed that shortages of resources such as skilled staff, drugs and essential equipment were some of the reasons why pregnant women did not see the need to seek health care services. Quality service delivery is crucial and if the service offered is poor, it can become a barrier to accessing prenatal and maternal health. Lack of sufficient support to the health sector remains a critical challenge affecting health service delivery in the country. The health sector budget allocation from treasury always falls short of the Abuja Declaration which requires 15% of the total budget to go towards health. The 2022 national budget allocated 12.7% of the budget to the health sector.

- **Attitudes of Health Care Providers towards Patients**

Types of attitudes and behaviours such as neglect, disrespect, verbal and physical abuse often take place at health facilities. This is despite the Patient's Charter that states that 'patients shall be interviewed, examined and treated in surroundings designed to ensure reasonable privacy and shall have the right to be accompanied during any physical examination or treatment if they so wish. A client has the right to have the

6 Ministry of Health 2015 Zimbabwe Service Availability and Readiness Assessment Survey



"Nurses do not attend to patients on time. They spent the whole day at the ANC clinic. As a result, they decide not to visit clinics because of that."

full details of patient's care (including the use of new technology) prognosis and all communication and other records relating to the patients care to be treated as confidential unless the release of such information is authorized in writing by the patient.' The Valerie Chibaya case is a typical example. In 2020, Valerie Chibaya, with WLSA's assistance sued the Vice President of Zimbabwe Constantino Chiwenga in his capacity as the Minister of Health and Child Care for neglecting to treat her as a medical emergency. Chibaya went to Sally Mugabe Central Hospital when she was 23 weeks pregnant after experiencing unusual abdominal pains. Upon arrival, the doctors and nurses did not take her temperature, blood pressure or sugar level nor a routine check. They instead insisted that she gets a scan first before they could treat her. Chibaya began to bleed without any treatment and went into premature labour and lost her baby without receiving any emergency medical care from the staff at the hospital. Chibaya then filed a lawsuit demanding $1,5 million for pain, suffering and contumelia damages after she lost her unborn baby. She won the law suit and the Minister of Health and Child Care was ordered to pay $900,000 in damages.

Blame has been apportioned to health care professionals as well as paraprofessional staff for failing to deliver quality services because of generally bad attitudes towards patients, more-so towards pregnant adolescents. Judgmental health personnel were reported to be preventing adolescent mothers from accessing contraception or sexual and reproductive information or services from health facilities. One health promoter in an FGD remarked,

> *"Kana mwana ari under age ndinomupirei ma contraceptives? (If the child is under age, why should I give her some contraceptives?)."*

Long queues and lack of privacy at the facilities were cited as additional barriers to access to prenatal and maternal services by adolescent girls and rural women. The purported lack of privacy and confidentiality mainly influenced by attitude of health workers in most health facilities therefore becomes a hindrance for pregnant adolescents and rural women especially first timers to then avoid seeking maternal health services. An adolescent mother remarked,

> *"As pregnant adolescents we are afraid of nurses' attitudes. Because sometimes when we arrive at the facility individual nurses may shout at us calling us names for early pregnancy.*

Getting pregnant as an adolescent is highly stigmatised by some health care personnel. In addition, we are afraid to visit health facilities because it exposes you; the health care personnel would want to know who impregnated you because in our country it is illegal to impregnate a minor."

One respondent in an FGD in Murewa remarked,

"The consultations given at the local clinics are not confidential because the rooms are not sound proof and the consultations do not afford one a chance to ask as many questions as possible because the health staff will be in a hurry to serve other clients due to long queues."

Health service providers in all the studied districts confirmed some of the challenges cited by the adolescent mothers. One nurse remarked,

"It's quite possible for other people to hear our counseling sessions although we have separate rooms; the rooms are few so we end up cutting short our counselling sessions so as to attend to more clients."

Adolescent mothers reported that they were reluctant to seek prenatal and ANC services because of long waiting times. A participant in Murewa reported that the nurses wait until there are many women to treat before they open the ANC clinic. She remarked,

"Nurses do not attend to patients on time. They spent the whole day at the ANC clinic. As a result they decide not to visit clinics because of that."

Staff disrespect towards pregnant women have been associated with an increase in home deliveries and a subsequent increase in maternal and neonatal morbidity and mortality as observed by Mannava, Durrant, Fisher, Chersich and Luchters (2015).

This was despite the fact that staff were aware of the World Health Organisation's guidelines and protocols regarding sexual and reproductive health services for adolescents. The eight guidelines include adolescents' health literacy, community support to SRHR services, appropriate package of services, health care providers' competencies, facility characteristics, equity and non-discrimination, data and quality improvement and finally adolescents' participation.

Some of the guidelines that they mentioned are captured below.

Health care Protocols and Guidelines mentioned by Health Service Providers:

- Do not ask clients, even young clients, to get someone else's permission to use family planning or a certain family planning method.
- Explain family planning methods clearly, including how to use them, how effective they are, and what side effects they may have, if any.
- Make sure that the health care facility is accessible to including those with physical disability.
- Do not discuss your clients with others except with permission and as needed for their care.There is the non-disclosure policy which ensures the privacy and confidentiality of adolescent clients, basically it hammers on the health staff maintaining privacy at all times, whatever the client shares with the nurse/doctor must remain between the two of them and this should be followed at all times, no circumstances should allow this code to be breeched.

- **Lack of family support**

The study established that pregnant adolescents and rural women face immense challenges in accessing prenatal and maternal health services because of lack of family support. Lack of acceptance of a pregnant adolescent by her in-laws can be a cause for reluctance to advise the adolescent to seek prenatal and maternal health services. Even the biological parents of the pregnant adolescent out of disappointment may fail to give support to the pregnant girl for her to seek maternal services and resultantly making lack of family support a barrier to accessing prenatal and maternal health. A key informant remarked,

"Due to lack of family support, some pregnant adolescents choose to abort, so because of that option, they do not want to register the pregnancy. Registering it is declaring that the pregnancy exists, it is therefore safe for the pregnancy to remain unknown if one intends to abort it."

A health promoter in Murewa also remarked,

> *"Vabereki vanotadza kuzvigamuchira kuti mwana amitiswa, ndiro dambudziko guru rekutanga. Zvinozokonzera kuti vabereki vasada kuti vanhu vazive nezvedumbu yemwana wavo vobatsira mwana kuibvisa. (Parents fail to come to terms with the fact that their adolescent girl is pregnant. This is the most serious challenge. This causes them to avoid public knowledge of the pregnancy to facilitate its abortion)."*

In addition, rural women are personified as strong and any complain of ill health is seen as laziness. This prompts both pregnant adolescent and rural women to desist from accessing medical care not on voluntary basis but because of no support from the family (Dodzo and Mhloyi, 2017).

- **Disasters and Emergencies**

Disasters generally disrupt access to services. In recent years Zimbabwe has experienced an increase in short term shocks or disasters that have had an impact on access to sexual and reproductive health services in general. In the study districts, participants cited COVID-19 as having had the greatest impact on access to prenatal and postnatal services. It was reported that measures taken by the government to contain and reduce the spread of coronavirus affected access to these services. The national lockdown resulted in the disruption of access to the full scope of health services as health facilities concentrated on emergency cases, with most of the cases being referred to provincial hospitals due to limited or no capacity to handle COVID-19 related cases. At these hospitals, women reported that they were being made to wait outside the health centres and were called in batches of a maximum of 5 people which was frustrating and discouraging.

Participants reported that during COVID-19 lockdown, due to mobility restrictions, access health services was limited by a number of factors, namely, the unavailability of transport services, the closure of some health facilities to other cases except COVID-19 related cases as well as the fear by health care workers to contract COVID-19 from people that were walking in from communities. In some cases clinics and hospitals were demanding COVID-19 results for one to access health services, and PCR tests were being charged US$65, which was beyond the reach of many adolescent girls and rural women.

The other challenges were staff shortages as a result of a strike by health personnel and unavailability of essential drugs from clinics and hospitals which meant that women were supposed to procure these from pharmacies which had stipulated opening hours (8am-3pm). Pharmacies ended up charging exorbitant prices for drugs.

In Murewa one female respondent remarked,

> *"During COVID-19 it was difficult to access prenatal and postnatal services because there was a time when the police officers demanded an exemption letter for one to move around and the majority of us did not have those letters because we are unemployed."*

Health service providers reported that that due to mobility restrictions there was low turn out for routine services such as immunisations, antenatal care, family planning services and HIV treatment and care services. OCHA reports that as of 3 December 2020, access and utilisation of essential services including preventive, curative and rehabilitation services declined in the period April to October 2020, compared to the same period in 2019. Outpatient consultation declined by 49% and attendance of pregnant women at the fourth antenatal care visit declined by 55% and this resulted in an increase in unsafe home deliveries in a country that had witnessed progress in reduction of mortality ratios from 651 in 2015 (2015 ZDHS) to 462 in 2019 (2019 MICS). The number of live births in health facilities fell by 21% while new clients on combined birth control dropped by 90%. Female participants reported being turned away from health institutions as priority shifted to the fight against COVID-19. They also reported limited access to family planning services and to modern contraceptives, leading to a rise in unwanted pregnancies. Currently, the unmet need for contraceptives in Zimbabwe is 8.6%.[7]

In the studied districts, women and girls reported that they had limited access to information due to limited access to public spaces, group gatherings and outreach activities.

7 Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019). Zimbabwe Multiple Indicator Cluster Survey 2019, Survey Findings Report. Harare, Zimbabwe: ZIMSTAT and UNICEF.

4.3 *Factors Promoting Access to Prenatal and Maternal Health Services by Pregnant Adolescents and Rural Women*

Various factors were cited as promoting access to prenatal and maternal health services in the studied districts.

- **Awareness and access to services**

Both health care personnel and adolescent mothers and women reported that access to services including information is key to promoting access to prenatal and postnatal services. They advocated for inclusive approached to access to information and other critical services.

- **Male involvement in prenatal and maternal health**

Male involvement in maternal and child health is recognised as a valuable health promotion strategy in low- and middle-income country settings (Mavhu etal, 2019). It has been seen as increasing maternal health seeking behaviour by pregnant adolescents and pregnant rural women. Health facilities are encouraging pregnant women to bring their husbands during pregnancy period, delivery and post-natal visits. Studies have shown that involving male partners in maternal healthcare has the potential to improve uptake of maternal healthcare services, as well as reduce delay in seeking care and maternal stress, thus contributing to improvement in maternal health outcomes (Mullany et al, 2006). Some of the activities to be conducted together can be HIV tests and counselling.

- **Infrastructural development**

The availability of community infrastructure promotes access to prenatal and maternal health services by adolescent girls and rural women (Construction review online, 14 August 2021). Respondents pointed out that construction of good road networks and bridges in rural areas and building clinics observing a fair distance of 5km at most from residential areas promote access to prenatal and maternal health services by pregnant adolescents and rural women. Construction of waiting mothers' shelters also aids access to maternal health. It means pregnant women get shelter at the facility until day of delivery and at the same time receiving close monitoring of the pregnancy to reduce complications during delivery (Mangundu, Roets, and Rensberg, 2021).

- **Parent to Child Communication (PCC)**

Zimbabwe pioneered the PCC programme to provide a platform for open communication between parents and adolescents on SRHR issues and this has been seen to be an effective tool in the promotion of access to prenatal and maternal services particularly by adolescent mothers. The PCC programme was designed to enhance parents and adolescents' skills to initiate and maintain SRHR discussions. Parents/ guardians and their adolescent children are recruited through door to door approach and meet in groups facilitated by mentors. The PCC curriculum has 11 units delivered over 2 months with the 3rd month being for support and mentoring visits.[8]

- **Comprehensive Sexuality Education (CSE) for youth**

CSE is a community-based intervention targeting both in school and out of school youths regardless of gender. The CSE programme aimed at increasing knowledge and utilisation of integrated HIV prevention, SRHR and SGBV services among adolescents and youths.[9] The intervention provides adolescents and youth with correct information, helping them to develop the skills to adopt safe sexual behaviours. Adolescents and youth are recruited door to door by a trained community-based mentor. The module has 11 units delivered over 31 weeks for adolescents and youth organized by age, grouping girls ages 10-14 years, 15-24 years. These group meetings provide an environment for open dialogue and communication on issues affecting youth today; the growing numbers of teenage pregnancies, school dropouts, drug abuse, social, SRH problems, SGBV, STIs and HIV.

8 Parent Child Communication Mentors Manual final 2017.

9 Comprehensive Sexuality Education for out of school young people in Zimbabwe, community facilitators manual.

5. Conclusion and Recommendations

From the foregoing, it is evident that pregnant adolescent mothers and rural women face a number of challenges regarding access to prenatal and maternal services. This calls for multi-pronged and sustained engagement with multiple stakeholders, including addressing underlying risk factors such as social norms regarding marriage, women's economic empowerment and policy gaps, alignment and implementation of existing progressive legal instruments. It also calls for economic empowerment interventions, awareness of women's rights as well as adolescent sexual and reproductive health rights, interventions that address religious and cultural practices that perpetuate sexual violations as well as engagement of relevant stakeholders to ensure enforcement of the laws. The following recommendations are proffered:

a. Advocacy for legislative review and implementation of laws

In light of a number of advocacy issues that are prominent in the findings, it is important that the following advocacy issues be pursued:

- Review of the 1977 Termination of Pregnancy Act to expand conditions under which termination of pregnancy is allowed to include pregnancy of minors. This will ensure children's access to safe abortion and post-abortion care services in law and in practice.
- Considering that Zimbabwe does not have an expressed age for seeking medical procedure including accessing sexual and reproductive health services, such as seeking contraception there is need to advocate for a review of the Public Health Act of 2018 [Chapter 15:17] to incorporate this.
- There is need to advocate for adequate financing of the health sector by the government in line with the Abuja Declaration. This will ensure improved conditions of service for health care professionals as well as construction of more health facilities and better equipping of the same.
- Gender equality legislation is the missing link on implementation of progressive constitutional provisions. This calls for CSOs to push for the gender equality law which would penalise institutions for lack of implementation the progressive constitutional provisions.

b. Capacity strengthening of independent commissions

There is need to strengthen the capacity of independent commissions such as the Zimbabwe Gender Commission to monitor implementation of laws, to hold the government to account to its gender equality commitments under CEDAW, and to push for the gender equality law which would penalise institutions for lack of implementation the progressive constitutional provisions.

c. Intensification of mobile and digital services during emergencies

To ensure wider access to services including during emergencies, there is need to roll out of mobile clinics in communities for basic health services that remained a concern in communities. There is further need for community engagement to improve health information and access to essential services. These could be complimented by toll free and hotline services. The hotlines should use all local mobile networks to enable everyone including those in remote areas to call for services.

d. Strengthen women and girls' agency

Social norms and values influence access to prenatal and postnatal services. Owing to this background, interventions that are aimed at strengthening rural women and adolescent mothers' agency are critical. Lessons can be drawn from a successful Tariro Youth Centre operating under almost similar circumstances in Hopley.

Supporting adolescent mothers and rural women's business development, including through business and life skills training and financial inclusion is critical for the promotion of access to prenatal and postnatal services. Development of entrepreneurship skills for women and adolescent mothers as well as increasing their access to finance addresses idiosyncratic barriers to economic progress and in turn can address economic barriers to access to services. Economic empowerment of women and adolescent mothers is likely to improve their agency.

e. Establish Accountability Platforms

Adolescent mothers' agency and voice appears to be undermined by all-inclusive community platforms. There is need for accountability platforms bringing together duty bearers and adolescent mothers and rural women. These could be complimented by development of social accountability tools such as scorecards to enhance adolescent mothers and rural women's participation as well as measure prenatal and postnatal service delivery.

f. Partner with UDACIZA and other relevant religious umbrella bodies

To meaningfully tackle the religious factors contributing to limited access to prenatal and postnatal services, especially within the Apostolic sects, strategic partnership with UDACIZA at national level to influence change is critical.

g. National Inquiry

Considering that the study that informed the development of this policy brief was from a few selected districts, there is need for a Parliamentary Committee national Inquiry into the Status of Maternal Health and ASRH in Zimbabwe to give a comprehensive picture of the status of maternal health and ASRH in the country.

The Tariro Youth Centre

UNFPA in partnership with ILO, Lafarge Holcim Cement Zimbabwe and the City of Harare, complemented by other UN agencies, such as UNDP, supported the building of the Tariro youth centre and the clinic in Hopley. Hopley is semi-formal settlement in Harare South District with a population of approximately 200,000, out of which about 65,000 are between 10-24 years. The suburb has high levels of migration, poor infrastructure, weak social services, low education, early marriages and high teenage pregnancies, high unemployment and informality. Prevalence of child marriages and teenage pregnancies are at 18 percent and 21 percent respectively, while at least 70 percent of women are mothers by age 24 years. The Tariro Clinic and Youth Centre were constructed to improve sexual reproductive health outcomes and reduce vulnerability through skills development and economic empowerment of young people. The facility is expected to help impart life skills and values to the 65,000 young people aged between 10-24 years, of which 18% are in child marriages and 13% are school drop outs. The Youth Centre and Clinic serve as a community facility and provides a safe space for young people to access youth development programs. UNFPA, with its collaborating partners, supported the construction and equipment of the youth centre and training of young people in livelihood/ entrepreneurship skill and life skills.

Source: 7th UNFPA Country Programme Evaluation, 2020

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