

**MATERNAL HEALTH CARE SERVICES IN WAITING MOTHERS'
SHELTERS: THE CASE OF MAWADZA VILLAGE IN BONDA,
MANICALAND, ZIMBABWE**

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ABSTRACT

This study explores the experiences and perceptions of expectant mothers during prenatal, intra-, and postpartum care. It focuses on expectant mother's use or non-use of a waiting mothers' shelter within a medical pluralistic village within a context where hospitals and maternal health care facilities are not proximate. Special focus was on Mawadza village in the Mutasa district in Manicaland Province of Zimbabwe. A sample of 48 participants was used for collecting data in this study. The sample consisted of 15 women some of whom were expectant mothers in the waiting mothers' shelter (11) and others had used (4) the shelter once or twice since 2015. Participants were drawn mainly from Mawadza village and Bonda Mission Hospital while others were from the district and provincial offices of the Ministry of Health and Child Care of Zimbabwe.

The study adopted a qualitative research methodology, which employed in-depth interviews; key informant interviews (KIIs) and focus group discussions (FGDs) as the main data gathering strategies. In-depth interviews were conducted with the expectant mothers and those who had formerly used the shelter since 2015, while, key informant interviews were conducted with the hospital staff members, traditional healers and the midwives from Mawadza village. Focus group discussions were also conducted with both male and female community members from Mawadza village. The study carried out face to face interviews and notes were handwritten and transcribed at the end of each day. Data coding was used to analyse data. The paradigms and theoretical underpinnings of the study were influenced by the symbolic interactionist theory. The theory made it possible to understand the social processes of pregnancy and childbirth in the waiting mothers' shelter due to its interpretive approach to social research and the legitimacy it places on the social interaction and meanings that social actors place on interactions in their environments.

The study documented the ways pregnancy and childbirth are perceived, understood, and experienced in Mawadza village within the context of medical pluralism. In Mawadza village, pregnancy and childbirth are highly embedded in the cultural beliefs of the local people, hence, treated with importance and assumed important symbolic meanings. On the contrary, the waiting mothers' shelter as a biomedical facility handles pregnancy and childbirth from a biomedical approach, basing its practices and operations on pure science. Expectant mothers who

await labour in this facility are therefore involved in several biomedical activities during prenatal, intra- and post-partum care in the waiting mothers' shelter.

The need to access skilled birth attendants and the criminalisation of home births in Mawadza village have been the major reasons that influence the expectant mothers to use the waiting mothers' shelter. Nevertheless, factors such as medical pluralism, child care, and family commitments, lack of understanding of the importance of the waiting mothers' shelter, lack of privacy in the shelter, and cost of food and utilities during the expectant mothers' stay in this facility among others are factors that deter expectant mothers from using the waiting mothers' shelter. Lack of practice of bodily agency where practices common in preparation for childbirth such as opening the birth canal which is not accepted was also reported among common problems that discourage expectant mothers from preferring use of the shelters. The study also revealed that the community is involved in the operations of the waiting mothers' shelter, although, the involvement is gendered since there are more women involved as compared to men.

The study concluded that even biological processes such as pregnancy and childbirth can only be fully understood within a social context given the different meanings which are attached to the various aspects of the childbirth process by the various actors such as expectant mothers, mothers, biomedical practitioners, traditional healers and communities in Mawadza village. Also, in a medical pluralistic village, the different health care providers who deal with pregnant women do not necessarily conflict as evidenced by the complementary role of these two (complementary insofar as they achieve collectively desired outcomes, albeit in parallel and (mutually) exclusive means) in caring for women during pregnancy and childbirth.

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LIST OF ABBREVIATIONS AND ACRONYMS

ART:	Antiretroviral Therapy
MCH:	Maternal and Child Health
MMR:	Maternal Mortality Ratio
ATR:	African Traditional Religion
DMO:	District Medical Officer
FBCG:	Faith Based Community Organisation
FHI 360:	Family Health International 360
GO:	Government Organisation
GoZ:	Government of Zimbabwe
HIV/AIDS:	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
IKS:	Indigenous Knowledge Systems
MCAZ:	Medical Control Authority of Zimbabwe
MoHCC:	Ministry of Health and Child Care
MoHCW:	Ministry of Health and Child Welfare
MRCZ:	Medical Research Council of Zimbabwe
MRDC:	Mutasa Rural District Council
NGO:	Non-Governmental Organisation
NNRTI:	Non-Nucleoside Reverse Transcription Inhibitors
PMD:	Provincial Medical Director
PPCT:	Prevention of Parent to Child Transmission
SBA:	Spiritual Birth Attendant
STI:	Sexually Transmitted Infection
TBA:	Traditional Birth Attendant
TH:	Traditional Healer
TM:	Traditional Medicine
UNDP:	United Nations Development Programme
UNFPA:	United Nation Fund for Population Activities
UNICEF:	United Nations International Children's Emergency Fund
UNPF:	United Nation Population Fund

WHO: World Health Organisation
ZDHS: Zimbabwe Demographic Health Survey
ZESA: Zimbabwe Electricity Supply Authority
ZIMSTAT: Zimbabwe National Statistics Agency
ZINATHA: Zimbabwe National Traditional Healers Association

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CHAPTER ONE

INTRODUCTION

1.1 Introduction

It is trivial to raise the point that birth takes place somewhere, be it in the bush, in a hut in the jungle, or in a modern hospital. What is not quite so trivial is to consider that birth, by the mere fact that it is located somewhere, inevitably takes place on some-body's territory". [Jordan 1993(1978): 67]

Notwithstanding efforts to improve prenatal and post-partum health care in developing countries across sub-Saharan Africa, childbirth remains hazardous for both the mother and new-born. Expectant mothers anticipate a successful delivery of their new-borns. Nonetheless, maternal mortality remains a highly likely inescapable danger in rural communities. In many cases, pregnancies end in fatalities, of either mother, the new-born or both. Owing to the aforementioned factors, maternal health care is also an issue of on-going concern in Zimbabwe. This is shown by maternal mortality having unprecedentedly risen over the last two and half decades, although, a decline has been noted in the past few years (Dodzo & Mhloyi 2017). On one hand, the recent decline has been attributed to health systems strengthening through a multi-donor pooled funding mechanism. On the other hand, the proportion of community deliveries without the supervision of qualified and skilled birth attendants has been growing steadily. Non-hospitalised deliveries are the major reasons why birthing mothers and their new-borns are susceptible to fatalities (Kanengoni *et al.*, 2019, Mafaune *et al.*, 2020). Some of the factors that have been attributed to the rising trend include deliveries without skilled care, in places without appropriate or adequate facilities to handle complications and emergencies should they arise (Maguranyanga 2011: 1, Kangengoni *et al.*, 2019).

Two critical reasons for non-hospitalised deliveries in this study are that of long distances between the houses of the expectant mothers and the health care institution; and the practise of medical pluralism by a considerable populace in rural Zimbabwe (Chandramoham 1994, Lonkhuijzen *et al.*, 2012, Kajawu & Chingarande 2016, Moshabela *et al.*, 2017, Togarasei 2019). As a result of these factors, several measures have been initiated to mitigate maternal and perinatal morbidity and mortality in rural communities where health care facilities are not

proximate in Zimbabwe. One such measure is the establishment of facilities called waiting mothers' shelters. The waiting mothers' shelters are usually located close to hospitals where expectant mothers can await labour and transfer to the hospital wards for management and safe delivery where they are attended to by qualified and skilled birth attendants. Waiting mothers' shelters were established to reduce the risk of leaving it too late to traverse the distance between the house of the expectant mothers and the nearest health care facility to ensure expectant mothers are attended to by more skilled- births attendants (Murray *et al.*, 1990).

As a result of establishment of waiting mothers' shelters in rural Zimbabwe, expectant mothers are usually expected to report to the nearest health care facility, often a rural health centre, early in pregnancy. Those found to have risk factors are referred to the district hospital. According to Lonkhuijzen *et al.*, (2011), because health care facilities are not so proximate, the main direct causes of maternal deaths in rural communities in Zimbabwe are delays in seeking care during delivery, unsafe abortion, eclampsia, haemorrhage, obstructed labour, infections and sepsis among other factors. Lonkhuijzen *et al.*, (2011) further highlight that it is well recognised that most of these maternal deaths can be prevented with early identification, early diagnosis, when appropriate treatment is started in time and given by a trained health professional in an adequate environment. Hence, rural health facilities have established waiting mothers' shelters designed to allow expectant mothers living far away and those who have complications or risk factors to await labour whilst close to a hospital facility.

The establishment of waiting mothers' shelters has been considered useful because it emphasises the importance of giving birth in a hospital under the supervision of qualified skilled birth attendants where there is access to emergency facilities should any complications arise (Nhindiri *et al.*, 2018: 67). In order to fully understand the maternal health care services offered in waiting mothers shelters in Zimbabwe, I decided to explore the experiences and perceptions of expectant mothers during prenatal, intra-, and postpartum care in relation to their use or non-use of a waiting mothers' shelter in the context of medical pluralism where hospitals and maternal health care facilities are not proximate. My study, which is a case study, specifically focused on Mawadza village in Mutasa district in the Manicaland Province of Zimbabwe.

This introductory chapter commences by introducing the case study area of this particular research study. This is followed by the presentation of the motivation and rationale of the research, statement of the problem, research significance, goal and sub-goals of this study. The chapter ends with the synopsis of the structure of the entire thesis.

1.2 Socio-Economic Geography of the Case Study Area: Mawadza Village

Mawadza communal village which is the case study area for this study is located in Mutasa district in Manicaland. Manicaland Province is located in the eastern region of Zimbabwe and is the third most densely populated province in Zimbabwe. Manicaland Province is estimated to have a population of 1,755,000 according to the (ZIMSTAT 2012: 213). Manicaland Province is subdivided into six districts, namely, Mutare, Chipinge, Chimanimani, Buhera, Makoni and Mutasa. Mutasa district is located thirty kilometres from, Mutare which is the provincial capital city (ZDHS 2011: 2016).

Mawadza village falls under Mutasa Rural District Council (MRDC), which is a body corporate local authority. It was previously known as Chitepo district. It is the home of the late Second Chimurenga liberation war veteran, Cde Hebert Chitepo (Mudodo 2001, Chikovha 2015). MRDC is one of the seven local authorities in the Manicaland Province of Zimbabwe, divided into 31 wards with a population of 169,756, that is, 79,825 males and 89,931 females, as of the last census held in 2012 (ZNSA, 2012: 300). Its head offices are situated 58 kilometres from the City of Mutare and the district stretches up to the Honde Valley which is about 100 km northeast of Mutare. It borders with Nyanga Rural District (NRD) in the north, Mozambique in the east, City of Mutare in the south and Makoni Rural District (MRD) in the west (Mudodo 2001). The district council area is also home to one of the first three mission centres in Zimbabwe, namely, St. Augustine's Mission of the Anglican Church, Triashill Mission of the Roman Catholic Church and Old Mutare Mission of the United Methodist Church (Ranger 1980).

Mutasa is occupied mainly by the *Manyika* people (Ranger 1984: 4). The *Manyika* ethnic cluster is a Shona people with their own dialect, known as *ChiManyika*. According to Ranger (1984: 4) & Mundondo (2001: 15), the *Manyika* people under chief Mutasa were close to the Portuguese, thus, there is a quite considerable population of in-migrants from Mozambique in Mutasa. Mawadza village was originally occupied by the Mawadza clan of the warthog (*Humba*) totem (Beach 1980, Bourdillion 1987). With the passage of time, other people who were not the

original Mawadza people of the *Manyika* dialect also joined the village due to migration. The original inhabitants of the village have maintained chieftainship in this particular village. The village is largely a patriarchal community. Christianity is the dominant religion in Mutasa, but, African traditional beliefs also claim some level of dominance as most people practise Christianity along with their traditional beliefs (Bourdillion 1987: 96). Some villagers go to the Anglican Diocese church whereas others practice other forms of religion such as the African Traditional Religion (ATR) and *Chipostori* (various Apostolic Sects) where the most popular sect in the area is the Johane Marange Apostolic Sect and *vaPostori vekwa Mwazha* (the Mwazha Apostolic Sect) (ZDHIS 2012, Jaravaza 2013).

Mawadza village has a population of approximately four hundred and six (406) people (ZIMSTAT 2012: 232). There are approximately 145 households in Mawadza village, and the village has an agro-based economy where villagers practise semi-commercial agriculture. Villagers grow maize, groundnuts, sugarcane and herding cattle, goats and producing poultry. Some of the villages are small holder growers of coffee, tea and banana plantations. The district has several plantations and estates that provide employment. Large scale commercial plantations produce timber, coffee and tea estates. The settlement pattern in Mawadza village is communal settlement (ZIMSTAT 2012: 233). The village is structured into households for the villagers, cattle kraals, dipping areas and the fields for crop production; other pieces of land are used as tea plantations.

According to Mundondo (2001: 15), land is usually owned by men, and women access it through customary or legal marriages and in some cases inheritance. However, women do participate in crop production in Mawadza village. With the continued economic disparities faced in Zimbabwe, there has been deterioration in the amount of crops produced and the profits gained by most village members. As a result, some men in the village have migrated to other countries such as the neighbouring Mozambique and South Africa in search of greener pastures, leaving their wives and families under the care of elderly male members of their families (ZIMSTAT 2012). Infrastructural development is not at its best due to economic challenges faced in Zimbabwe, as most buildings such as schools built before independence are still the ones in use. In terms of sanitation, most households use Blair toilets. The closest health care facility to

Mawadza village is Bonda Mission Hospital, which is a referral centre located in Sanyatwe Village (UNDP 2014).

1.2.1 Bonda Mission Hospital

Bonda Mission Hospital is a mission hospital run by the Anglican Church in Mutasa, Manicaland Province. This hospital has been chosen for this study because it is the largest hospital in Mutasa district with a threshold that goes beyond Mutasa district. In addition, Bonda Mission Hospital, although not quite proximate, remains the only option for villagers in Mawadza which is the case study area for this study. According to ZIMSTAT (2012) and the ZDHIS (2016), Bonda Mission Hospital is a district hospital with approximately 200 beds. , It provides medical care to approximately 170,000 inhabitants of Mutasa district which is a 6,112km² rural area in Zimbabwe, and located near the border with Mozambique (ZDHIS 2016: 300). The hospital is an Anglican Mission hospital that has an associated school of Nursing and Midwifery. Bonda Mission has 50 nurses and 10 doctors (ZDHIS 2016: 300). The waiting mothers' shelter is located within the hospital premises and there are houses where expectant mothers await delivery. The waiting mothers' shelter at Bonda Mission is in a fenced area to provide protection for women from passers-by since the hospital is close to the main road. As part of the amenities at the shelter, there are two houses, Blair toilets and water tanks to ensure access to clean water. One of the houses accommodates those who are awaiting labour and the other accommodates those receiving post-partum care after childbirth. Generally, health care facilities, including maternal health care services are not proximate for village members in Mawadza.

Furthermore a hospital team, including doctors, nurses, and midwives, regularly visits the 40 rural clinics in the district to supervise the staff and follow-up on patients (ZDHIS 2016: 301). During such visits, they also encourage pregnant women to register their pregnancies in the first month. Referral facilities from Bonda Mission Hospital are sent to Mutare Provincial Hospital, the provincial capital (50km) which has a maternity ward but no waiting mothers' shelters since it is located in an urban space. In setting up the maternity ward, patients, beds, nurses, and medication were moved to some rooms that were no longer in use: a consultation room, a room for group activities, and two rooms with nine beds were created (ZDHIS 2016: 301). The provincial authorities did not allow facilities for a patients' maternity waiting unit.

1.2.2 Case Study Area: Mawadza Village

Mawadza village was chosen for my study due to a combination of factors. It is a multi-ethnic community with a large population of immigrants, and community members practise medical pluralism. Mawadza village consists of members of different ethnic origins who hold different traditional and religious belief systems due to different origins of inhabitants (Ranger 1980: 58). The original inhabitants of the area were the *Manyika* people under chief Mutasa. However, due to the strong ties chief Mutasa had with the Portuguese some in-migrants from Mozambique, especially, the Sena ethnic group from Tete Mozambique settled in Mutasa, particularly, in Mawadza (Ranger 1980, Bourdillion 1990, Mudodo 2001). Although, immigrants from Mozambique are also located in other villages, Mawadza comprises a greater population of Mozambiquan immigrants since it is a considerably larger village (ZIMSTAT 2012: 200).

Differences in ethnicity and diversity in Mawadza village translate into different healthcare systems although the biomedical healthcare system seems to be more predominant. The Anglican Diocese has been the dominant healthcare provider in this area through Bonda Mission Hospital since the colonial era and other community members have converted to Christianity and are affiliated to the biomedical health care systems (Mundondo 2001). Other community members practice the African Traditional Religion and still find relevance in the Indigenous Knowledge Systems (IKS) (Jaravaza 2013); hence, they prefer traditional medical systems. Also, other community members practice both systems, mainly, being Christian while also consulting the traditional healers. Moreover, although mission stations seem to be dominant in Mutasa district, other village members have joined apostolic sects that have grown popular in the district over the years (UNFPA 2014: 67). The most common apostolic sects in this area are the Johane Marange apostolic sect and the Vapostori Vekwa Mwazha (the Mwazha apostolic sect) (UNDP 2014: 67 & Kenneth et al., 2014). The diversity that Mawadza village offers in terms of ethnicity, religious practices and choice of health care systems (medical pluralism) made it a suitable case study to explore the experiences and perceptions of expectant mothers in waiting mothers' shelters during prenatal, childbirth and post-natal care. This is because rich data were obtained from different people of different backgrounds. In addition, the socio-economic status of women in this community made Mawadza village a suitable case study. Women take a passive role when it comes to accessing resources. Mawadza village is a patriarchal society and men are the owners of the means of production and women access this mostly through marriage (UNFPA 2015: 76).

Women in Mawadza village account for a great proportion of the agricultural labour force and produce the majority of food grown for subsistence purposes and perform most of the unpaid care work. Women in this village are farmers and landless workers (UNDP 2017: 22). Women's activities have been mainly confined to the home, hence, emphasis on the *Musha mukadzi* (a home is a home because of the woman) concept for women to learn more about family care. Kenneth *et al.*, (2007: 245) note that women in Mawadza also face more difficulties than men in accessing public services, social protection, formal employment and markets due to the patriarchal nature of the community, lack of proper education and lack of proper identity documents. For example, recent studies by the UNDP (2017: 23) reveal that the proportion of women without identity documents is as high as 40% in most villages in Mutasa district and this hampers their access to education, pensions, application for property or title deeds, and other social and health care services. According to the UNDP (2017: 24), most women in most villages in Mutasa district fail to access health care facilities due to a lack of proper identification and this has been a contributing factor to some of the non-hospitalised deliveries that occur in the district. In a village where women take the subordinate position in most aspects, it is prudent to acknowledge that women have little agency. They lack the decision making power to choose health care system they want to use, hence, they end up using health care systems they are advised to by the families or spouses in this context of medical pluralism and this also affect the maternal health care seeking behaviours of expectant mothers in this village. Owing to the contestations and gender power imbalances that are evident in this village in terms of access to resources, education and most importantly choice of preferred healthcare system, Mawadza village presented itself as an appropriate case study area.

Furthermore, Manicaland province was considered suitable for this study because it recorded the highest number of perinatal deaths in the country in 2013, that is, 960 deaths per 100 000 (Chaibva 2014: 49). This is not improving due to non-institutionalised deliveries that are attended by unskilled birth attendants. Chaibva (2014) and ZDHIS (2014) note that the province recorded 1,540 perinatal deaths against 44,610 due to non-institutional deliveries. Increasing the number of women who deliver in health facilities is an important factor in reducing health risks to the mother and the new-born child. Proper medical attention and hygienic conditions during delivery can reduce the risks of complications and infections that can cause morbidity and mortality to either the mother or the infant (ZDHIS 2014: 113). Manicaland continues to pose a

challenge in terms of maternal health due to non-institutional deliveries and this is mainly due to religious beliefs (Njovana, 2014). According to the statistics provided by ZDHIS (2014: 112), 37.5% of women in Manicaland give birth at home. Manicaland is home to the headquarters of the Johane Marange Apostolic sect and the larger percentage of the population 39% belong to the sect (Mukonyora2019). Seeking biomedical healthcare, including for maternity purposes is not encouraged due to the availability of SBAs in the sects. Mukonyora (2019) further states that this has had a net effect on the maternal health outcomes of the province. The Johane Marange apostolic sect members are significantly populated in *Bocha* in the Marange area and a considerable population is also in Mutasa district (ZDHIS 2015, Msevenzi 2017: 288).

Additionally, Manicaland Province has the lowest birth registration rate and this is indicative of the fact that there are a lot of non-institutionalised deliveries in the province (ZDHIS 2012: 55 & UNDP 2017: 115-116). Most women in rural areas do not have access to the means of production; hence, they live in poverty. The UNDP (2015) and the ZDHS (2012: 120) state that there is a strong correlation between household wealth and place of delivery. Mothers in the highest wealth quintile are nearly twice as likely to give birth in a health facility as mothers in the lowest wealth quintile (90% & 46%, respectively) (ZDHIS 2016: 120). According to the ZDHIS (2012: 138), as with education, wealth quintile is strongly associated with type of assistance at delivery. Births to women in the highest wealth quintile were more likely to get assistance at delivery from a skilled provider (91%) compared with births to women in the lowest wealth quintile (48%). Furthermore, births to women in the highest wealth quintile were five times more likely than births to women in the lowest wealth quintile to be assisted by a doctor (20% and 4%, respectively) (ZDHIS 2016: 120). Birth registration is still a problem in Mutasa district, this is shown by a number of people without identification documents, and hence, I considered Manicaland as a suitable province for this study due to low birth registration in the province, associated with non-institutionalised births.

Some of the Johane Marange Apostolic sect members reside in Mutasa and they are growing in numbers due to the apparent miraculous healing ability of the sect (Maguranyanga 2010; UNDP 2014 & Njovana 2014). Several studies have been conducted on the apostolic sects in Zimbabwe and it has been revealed that in Manicaland, a considerable cross section of the population have joined the Johan Marange Apostolic sect which discourages its numbers from seeking

biomedical healthcare while encouraging their own birthing systems as a sect. This ultimately had an effect on maternal mortality in the province at large (Maguranyanga 2010, UNDP 2014, Njovana 2014, Kenneth *et al.*, 2016). In addition, studies have been specifically conducted on maternal health by scholars such as Maguranyanga (2010) and Njovana (2014), and they have highlighted that *vapostori* (the Apostolic sect members) who are found in large populations in Manicaland have contributed to the maternal deaths in the province over the years. Maternal health care management also continues to be a matter of on-going concern in Manicaland; hence I considered it a relevant province to conduct my study.

In addition, Mawadza village is located further from the nearest maternal health care facility and waiting mothers' shelter compared to other villages serviced by Bonda Mission Hospital. It is quite a large village with with a significant population of village members and households that are scarcely spaced in terms of settlement; hence, it is not easy for some village members to access the health care facility.

1.3 Motivation and Rationale

A profound interest in the welfare of expectant mothers/mothers has motivated me to carry out this study to understand the experiences of expectant mothers in a waiting mothers' shelter during prenatal, intra-partum and post-partum care in a village that practises medical pluralism. The motivation for this research also stems from the concern that although knowledge has been developing continuously for over a century within the field of maternal health, and sound knowledge now exists on how to prevent the majority of maternal deaths, there remains an extremely high prevalence of maternal mortality in many countries, all of which are developing countries (Human Rights Watch 2011). Carrying out this research assisted me as the researcher to establish the quality of maternal health service provided in waiting mothers' shelters in rural Zimbabwe. It also assisted the researcher to explore the reasons why Zimbabwe struggles in reducing maternal mortality especially in rural areas (Mathole *et al.*, 2006, Dodzo & Mhloyi 2017, Choguya 2018, Mafaune *et al.*, 2020). Expectant mothers should not die from preventable causes and these women need to be afforded a birth territory and an environment conducive to giving birth that is well equipped and leaves both the mother and baby safe, and healthy because it is part of their basic right to health (WHO 2013: 1; 2016: 1; WHO 2017: 1). This qualitative study was therefore undertaken in connection with Sustainable Development Goal (SDG3),

(Sections 3.1 and 3.2) which aims to reduce the global maternal mortality ratios to 70 per 100 000 live births.

1.4 Maternal Health: Unpacking Nuances of Accessibility and Perceptions of Care

Research shows that 90% of maternal deaths occur in developing countries and the highest rates are found across sub-Saharan Africa and Asia (WHO 2013; 2016; 2018). Zimbabwe, being part of sub-Saharan Africa had a maternal mortality rate of 614 deaths per 100 000 live births in 2014 (WHO 2014: 86). In Zimbabwe, expectant mothers in rural areas continue to die as a result of obstetric complications that can be prevented or avoided if diagnosed and treated in time. Maternal mortality, however, remains a challenge and a major concern in Zimbabwe as it is highly skewed towards the young and poorest of Zimbabwean expectant mothers and mostly those from rural communities (Mathole *et al.*, 2006, Mafaune *et al.*, 2020). There are a number of challenges that have contributed to this high maternal mortality rates. These include delays caused by distances from the houses of the expectant mothers to the health care facilities and poor road networks that are in rural areas. This is also exacerbated by the existence of rivers which makes it difficult for the expectant mothers to reach hospitals in time especially during intra-partum transfers. Considering the aforementioned factors, it is conceivable to claim that the delays caused by long distances to health care institutions and poor road networks in rural communities continues to be a domineering challenge in Zimbabwe that needs to be solved.

In addition, in a country that has been burdened with continually high maternal mortality rates for over a decade due to delays caused by distance; literature has shown that waiting mothers' shelters remain underutilised facilities in rural Zimbabwe although these facilities have proven helpful in bridging the gap between houses of the expectant mothers and health care facilities (MoHCC 2016: 87). Previous research and statistics show that only 31% of expectant mothers use the waiting mothers' shelter to await delivery during the last phases of their pregnancies (ZDHS 2015, MoHCC 2016). In Zimbabwe, these facilities were introduced during the colonial era, and their relevance in the provision of maternal health care has been revamped via various policies; including the Maternal and Neo Natal Health Road map 2007-2015 to support the utilisation of these facilities by women in rural communities where health care institutions are not easily accessible. Although, the Zimbabwean government through the MoHCC has adopted a primary health care (PHC) approach in order to ensure health for all and accessibility to health

services, the country continues to face challenges especially with regards to the improvement of maternal health outcomes due to underutilisation of these facilities especially in rural communities (Sebiya 2020).

Apart from long distances to maternal health care facilities as a major deterrence to the utilisation of waiting mothers' shelters, medical pluralism also plays a crucial role in hindering women to utilise waiting mothers' shelters. This is because of the presence of alternative health care in local communities that easily available to expectant mothers in rural communities (Mathole *et al.*, 2006). It still remains a challenge to establish how the childbirth practises in alternative health care are done by skilled birth attendance or are in a position to handle complications should they arise or to transfer complications to the nearest hospital (intra-partum transfers) (Dodzi & Mhloyi 2017). Therefore, the underutilisation of the waiting mothers' shelters by rural women in Zimbabwe remains a major cause of concern considering that the country is burdened by skyrocketing rates of maternal mortality. It is against this problem that the researcher was compelled to explore the experiences and perceptions of expectant mothers during prenatal, intra-, and postpartum care in relation to their use or non-use of a waiting mothers' shelter; within a medical pluralistic village where hospitals and maternal health care facilities are not proximate.

In addition, in the sociology of medicine, issues of pregnancy and childbirth remain understudied and if studied researchers fall in the unresolved controversies. At this introductory juncture, the thesis recognises the most domineering controversy, that is, the never ending debates between proponents of hospital and proponents of home delivery. On one hand, proponents of the hospital births argue that there is always the possibility of unforeseen complications, hence, expectant mothers should always give birth in a hospital facility where they are attended by skilled birth attendants and have access to emergency facilities should the need arise (Zadoroznyj 1999, Room *et al.*, 2016, Williams 2020, Reis 2020). For these scholars, childbirth should be managed due to its susceptibility to pathology. On the other hand, proponents of the births outside hospital facilities also suggest the childbirth process is a process that is natural and part of human physiology and should be treated with normalcy. This entails that it does not require any medical supervision (McCourt 1986, Pike *et al.*, 1997, Berry 2005, Kennare *et al.*, 2010, Slutsky 2012, Cheyney & Davis-Floyd 2020).

A cross examination of literature shows that proponents of hospital births tend to dismiss the arguments from proponents of births outside hospital facilities (Williams 2020, Cheyney & Davis- Floyd 2020). The contradictions in literature have resulted in long running unresolved disputes on studies on childbirth that researchers are likely to be trapped in if they do not consider these controversies in academia before they embark on their researches. The debates constitute issues of hospital births over non hospitalised births. It is after a careful consideration of these controversies that I explore the experiences and perceptions of expectant mothers during prenatal, intra and postpartum care in relation to their use or non-use of a waiting mothers' shelter within a medical pluralistic village.

1.5 Significance of the Study

This thesis contributes intensively towards maternal health and broader social science literature principally in sociology of medicine. It does so by providing empirical data and advancing theoretical insights and extension of scholarly perspectives and ultimately informing maternal health care policies not only in Zimbabwe but further afield.

The thesis further expands the understanding of pregnancy and childbirth by bringing a sociological dimension to the understanding of how expectant mothers experience pregnancy and childbirth within medical pluralistic villages in contemporary rural Zimbabwe. The thesis' theoretical contributions are founded on the view that symbolic interactionism has scarcely been used in sociological analyses of issues to do with women's health, particularly, pregnancy and childbirth in marginalised communities of developing countries such as Zimbabwe. The thesis argues that even a biological process such as pregnancy and child birth can only be fully understood within a social context, given the different meanings which are attached to the various aspects of the child birth process by the various actors (Davis- Floyd 1994, Filder 1996). Symbolic interactionism makes a novel contribution to the inquiries on pregnancy and childbirth since it affords a comprehensive understanding of pregnancy and childbirth experiences of women in Mawadza village. Furthermore, the thesis expands our understanding of symbolic interactionism to formerly uncharted domains, that is, it includes the dimension that humans are actors interacting with information drawn from the interactions. Under such circumstances, actors derive subjective meanings based on the symbols and meanings that they attach to the interactions (Blumer 2004, Charon 2007, Conrad 2012, Redmond 2015).

In addition, this thesis is a qualitative, micro-level empirical study of pregnancy and childbirth experiences of expectant mothers that relates to their use and non-use of the waiting mothers' shelter in a medical pluralist village, in Manicaland, Zimbabwe. The thesis expands on studies conducted by scholars such as Eckermann (2008) and Lonkhuijzen *et al.*, (2012), Nhindiri 2018 and Mafaune *et al.*, 2020 among others. On one hand, this thesis highlights how pregnancy and childbirth are experienced by expectant mothers and establishes their reasons for possible continual use of the waiting mothers' shelter. On the other hand, it captures the experiences of expectant mothers and establishes reasons for their non-use of the facility in the context of medical pluralism. Whilst some studies have portrayed experiences of pregnancy and childbirth as a universal physiological process (Davis- Floyd 1996), this thesis reveals the differentiated experiences and fractured responses exhibited by some expectant mothers in Mawadza village. The study captures a broader perspective on different experiences from women starting from prenatal, inter-partum and post-partum care in the waiting mothers' shelter.

Most importantly, the study generates new and empirical knowledge on birth territories and the environments under which women give birth in, in medical pluralist societies. This is an extension of the works of Jordan (1993), Davis- Floyd (1994), and Fielder (1996) as well as Cheyney (2008; 2020) who are medical anthropologists who also looked at the importance of studying birth territories and environments under which expectant mothers give birth in. These scholars were motivated by the fact that birth territories are not only physical environments where childbirth takes place, but, they are in every ways socially constructed and shaped by the culture of the indigenous people. This study therefore becomes one of the few studies in the sociology of medicine to look at birth territories. This has been a field congested with medical anthropologist (Davis-Floyd 1994, Fielder 1996, Cheyney 2008; 2020) who conducted ethnographical studies to study birth territories of different indigenous cultures. My study shows the possibility of studying birth territories in medical sociology without necessarily using ethnography as my data gathering strategy like the majority of the previous researchers have done.

In this regard, the thesis also contributes significantly by addressing some of the methodological challenges and errors that have been noted in literature as far as studies on pregnancy and childbirth are concerned, especially, in the sociology of medicine. The study took heed of

Oakley's (1988) pertinent concerns of the importance of conducting women's pregnancy and childbirth studies by women themselves to ensure proper representation of narratives on pregnancy and childbirth, and to capture women's voices in the texts of medical sociology. The aspect of the voice of the expectant mothers in research is very pertinent because it does not only provide empirical data, but, also gives women the voice to provide clear insights into their experiences and perceptions.

At policy level, this thesis has yielded insightful knowledge which could be of practical relevance and importance in the field of maternal health. The findings in this thesis can inform the responses and actions of practitioners with regards to the circumstances faced by expectant mothers during pregnancy and childbirth, especially, for the expectant mothers who live in medical pluralist communities. The findings of this thesis can enable the practitioners to build the maternal health care systems for better resilience of women during pregnancy and childbirth, given the circumstances that they face. I have illuminated the understanding of pregnancy and childbirth in a medical pluralist village in order to assist practitioners to construct meaningful and informed ways of providing maternal healthcare services for women in these circumstances.

At policy level, empirical evidence is provided by this thesis. This evidence supports novel approaches to maternal healthcare policy and practice in Zimbabwe, premised on the centrality of women's views, experiences and practices. In this thesis, I highlight the implications of some of the maternal health care assessments, some of which can entrench misguided conceptions of maternal healthcare in medical pluralist societies. These can in turn, lead to misguided maternal health care policies that do not take into consideration the experiences and perceptions of women with regards to pregnancy and childbirth. This thesis, therefore, advocates for a more open-minded approach that are not blind to the concerns raised in the narratives of expectant mothers. These approaches should be more inclusive of women's strategies of coping with pregnancy and childbirth.

Whilst dominant dispensations on maternal health suggest that pregnancy and childbirth in Zimbabwe are straightforward, this thesis reveals that pregnancy and childbirth experiences of expectant mothers are intricate. The thesis, thus, shifts the attention of scholars and policymakers to the fact that expectant mothers do not only experience pregnancy and childbirth but also

contest the disparities they encounter in medical pluralistic settings. Current policy emphasis should be placed on ensuring the improvement of pregnancy and childbirth experiences of expectant mothers; should factor into consideration the premise that expectant mothers are also constantly responding to socio-cultural factors that influence their experiences during pregnancy and childbirth. Discussions on maternal healthcare in Zimbabwe have revealed that there is weak appreciation of the comprehensive needs of expectant mothers, since the biomedical professionals' approach to pregnancy and childbirth does not fully take into consideration the social and cultural dimensions of pregnancy and childbirth that expectant mothers encounter. This attitude of medical professionals has led to their disdain of indigenous knowledge and traditional practices of caring for expectant mothers during pregnancy and at childbirth. The thesis reveals that women and local people are more informed about the comprehensive social, psychological, and physical conditions and needs of expectant mothers. They, therefore, construct comprehensive ways of ensuring that expectant mothers receive appropriate care – whether they are in waiting mothers' shelters or not. As such, there is a need to recognise local people's understanding and discourses on pregnancy and childbirth. Although my study was small-scale, which makes it inappropriate for me to generalise my findings, I argue that a qualitative enquiry into local people's understanding of pregnancy and childbirth provide rich ways of questioning pregnancy and childbirth experiences. This creates a more complex view of pregnancy and childbirth, than the imagined premises currently obtaining in existing studies (Millard 1991, Poovan *et al.*, 1990, Chandramoham 1994, Eckermann 2008, Lonkhuijzen *et al.*, 2012) and national policy framework.

1.6 Research Goals

The main goal of this study was to understand the experiences and perceptions of expectant mothers in waiting mothers' shelters during prenatal, childbirth and post-natal care, in relation to a waiting mothers' shelter at Bonda Mission Hospital. The goal of the study was achieved by responding to the following specific sub-goals:

- To explore the perceptions and experiences of expectant mothers in a waiting mothers' shelter before, during and after delivery;

- What are the determinants of utilisation of the waiting mothers' shelter by the expectant mothers in Mawadza village and identify factors that influence women's choices regarding use or non-use this facility;
- To examine the extent to which expectant mothers exercise their bodily agency and traditional birth practices during their waiting period in the waiting mothers' shelters;
- To examine the community members' involvement in supporting (or not) the operation of the waiting mothers shelter at Bonda Mission Hospital.

1.7 Thesis Synopsis

My thesis comprises of nine chapters, including the current first chapter. Chapter Two chronicles the development of waiting mothers' shelters and discusses important scholarship on maternal health, specifically on waiting mothers' shelters, their historical background, their purpose, functions and their contributions to maternal health care in rural communities. In doing so, it shifts from a global and regional perspective to Southern Africa and the Zimbabwean context. In addition, the concept of medical pluralism is conceptualised, contextualised and explored in detail. Essential debates as to how medical pluralism relates to, and affects the functions of maternal health care facilities such as waiting mothers' shelters in rural communities are discussed. In this chapter, I discuss one of the identified crucial subjects of my thesis, that is, the subject of long distances between the expectant mothers' homes and the health care institutions, together with how these distances cause delays in seeking maternal health care services. Furthermore, I demonstrate how distance and medical pluralism affect women's access to maternal health care institutions. I also ponder the different health care systems that Zimbabweans adhere to, that have affected the use of biomedical health care facilities such as waiting mothers' shelters. The scholarship review emphasises the relevance of the study as it highlights and clearly show how biomedical maternal health care facilities are under risk of not being used by expectant mothers due to long distances, medical pluralism, religious and cultural beliefs among other discussed factors.

Chapter Three discusses the paradigmatic and theoretical framework adopted in this study. The chapter begins by showing the nexus between the theory that influenced this study and the research methods I used in this study. The basic tenets of the symbolic interactionist theory are

well discussed showing the basic premises of this theory. In chapter, I also show the nexus between symbolic interactionism and medical systems, and how symbolic interaction is also evident in medical pluralistic societies leading to the social construction of medical knowledge. I deliberately discuss this to show how symbolic interactionist processes are evident even in medical systems in societies. I demonstrate that pregnancy and childbirth are culturally perceived processes as much as they are biological processes and medical systems are embedded in socio-cultural dimension.

Chapter Four is the methodology chapter. It describes how a qualitative research methodology was adopted to show the experiences of expectant mothers in a waiting mothers' shelter from a medical pluralistic Mawadza village. The chapter describes the methodology that was employed in my study. The study focuses on expectant mothers as the central unit of analysis. Moreover, the study takes a phenomenological approach for a research design, which is basically aimed at understanding social phenomena from the lived experiences of the expectant mothers. The second section of this chapter shows the data collection strategies that were used in my study. Qualitative data collection methods were useful in eliciting rich, in-depth and detailed experiences of study participants. They allowed for greater degree of flexibility that was compatible with the subject matter which requires subjectively told stories (experiences) in studying the in-depth childbirth experiences of expectant mothers in waiting mothers' shelters. In this chapter, the different data collection strategies, sampling, ethical considerations as well as ethical issues and methodological challenges that were encountered in the field are elaborated. The chapter closes by chronicling how I navigated through these challenges as the principal researcher. The challenges were mainly addressed in a manner that allowed the smooth continuation of the study while getting rich data.

Chapter Five is the first of the empirical chapters which begins by presenting the socio-demographic information of the participants in Mawadza village. This is motivated by the need to show the nature of socio-economic status of the research participants. I explain in detail how pregnancy and childbirth processes are understood in this particular society. In Mawadza village, medical pluralism plays a crucial role in the understanding of pregnancy and childbirth; hence, the processes have different meanings in this society depending on the health care system one is using. I have proceeded to show the experiences of expectant mothers in the waiting mothers'

shelter at Bonda Mission Hospital where pregnancy is handled from a biomedical approach. Experiences of expectant mothers during prenatal care and the preparation of childbirth in the shelter are explored. Expectant mothers with special conditions such as high blood pressure and HIV/ AIDS are treated and taken care of as they await labour in the waiting mothers' shelter. The importance of PPCT has also been shown since emphasis was placed on the B+ Option. In this chapter, the biomedical model of health in relation to pregnancy and its limitations in practice have also been showed. As a further point of analysis, I have deliberated on the Social Model of Health and how adopting this in conjunction is potentially holistic in providing maternal health care in indigenous communities such as Mawadza village.

Chapter Six builds on the topics raised in Chapter Five, to do with understanding the pregnancy and childbirth experiences of expectant mothers in Mawadza village. This chapter establishes the level of utilisation of the waiting mothers' shelter. It discusses the factors that influence use or non-use of this maternal health facility at Bonda Mission Hospital by the expectant mothers from Mawadza village. The respondents reveal that the waiting mothers' shelters is being utilised for two main reasons; that is the need to access skilled birth attendance and bylaws that support the criminalisation of home births in this village. This process has encouraged women to await labour in the waiting mothers' shelter so that they can give birth in the hospital where there are skilled birth attendants. Nonetheless, some of the factors that influence the use or non-use of the facility by expectant mothers apart from long distances to from maternal health care facilities and the houses of the expectant mothers and medical pluralism include religious factors, economic hardships and cultural issues, among others. A detailed analysis on these factors is undertaken in this chapter, leading to an appreciation of structural symbolic interactionist theory and its relevance in the context of Mawadza village. Social institutions such as religion have an influence in the development of the self through social interaction.

Chapter Seven examines the extent to which expectant mothers exercise their bodily agency and traditional birth practices during their waiting period in the waiting mothers' shelter. The chapter brings to the fore how pregnant women in this village view their bodies and develop a sense of identity. Expectant mothers view their bodies in relation to others in the society such as family members and other community members. Moreover, as part of the defining factor to the pregnancies of the expectant mothers, the community is involved in beliefs, ceremonies and

rituals to care for pregnancies as part of the indigenous knowledge systems (IKS) in this village. The three ceremonies that are common are the *taguta miriwo*, *masungiro* and *kuvhura nzira*. These ceremonies and practises are important in helping women conceptualise their bodies and in turn develop a sense of identity as pregnant women and family are important in the conceptualisation of pregnancy and ultimately how women view their bodies. Expectant mothers exercise body agency but not on their terms at all times because some traditional practices in the waiting mothers' shelter are prohibited. In addition adornments are viewed as problematic and a possible interference with one's pregnancy and can possibly harm the baby or the mother during the childbirth process. The important for the waiting mothers' shelter to embrace cultural sensitivity in all its operation so as to provide a holistic approach to maternal health care provision in Mawadza village is also deliberated in this chapter.

Chapter Eight analyses the involvement (or not) of the community in the operations of the waiting mothers' shelter. The community has been involved at different levels: women are involved through their group have made significant contribution to the operation of the shelter. They have also made donations such as blankets and detergents to assist the shelter. Nonetheless due to financial challenges the group has faced challenges in raising fund to assist like before. Men showed little knowledge about the proper function of the waiting mothers' shelter. However for those who have assisted, they have fetched firewood on a yearly basis to assist the expectant mothers and they have supported their spouses to use the facilities although this constitutes to a few men. In addition, the chapter shows how chiefs and people in positions of authority help to enforce people to await delivery and give birth in a hospital. In addition, other groups within the society such as FBCG have also contributed towards the operations of the shelter through prayer session. In light of the finding gathered, it can be noted that men in this community feel alienated in the operations of the waiting mothers' shelter. The programmes available in the village do little to involve men hence more has to be done to include men in the operations of the waiting mothers' shelter.

Chapter Nine is the last chapter of the thesis which reflects on the key topics and subjects of the study. In the chapter I reflect on the main ideas, findings and conclusions drawn from the entire thesis. I attempt to connect empirical findings to the theoretical concepts that have been used in the study. I discuss the theoretical and empirical contributions of my thesis as well as further

areas of research. This thesis began in this chapter with a background, justification of this study and objectives of the study.

CHAPTER TWO

SCHOLARSHIP REVIEW AND THE CONCEPTUAL FRAMEWORK: THE WAITING MOTHERS' SHELTERS-HISTORY, REGIONAL, GLOBAL CONTEXT, MEDICAL PLURALISM, CHILDBIRTH AND PRACTICES

2.1 Introduction

Reproductive health experiences such as pregnancy and childbirth (maternal health) are a major concept in the subfield of medical sociology. In this chapter, existing literature on maternal health is reviewed, specifically on waiting mothers' shelters; their historical background, purpose, functions as well as their contributions to maternal health care in rural communities. In doing so, I will start from a global and regional perspective and narrow down to Southern Africa and, finally, to the Zimbabwean context. In addition, the concept of medical pluralism is conceptualised and deliberated on in detail, insofar as it relates to and affects the functions of maternal health care facilities such as waiting mothers' shelters in rural communities. Furthermore, medical sociological literature on child-birth, birth territories and cultural factors that affect women's choices of birth territories in medical pluralistic rural communities is reviewed. In this chapter, historical and contemporary literature perspectives on cultural beliefs on childbirth in Africa and Zimbabwean *Manyika* people are also provided.

The literature review in this chapter takes a thematic approach. According to Labaree, (2009: 229), a thematic approach in literature review entails that the researcher organises and discusses existing literature based on themes and theoretical concept(s) that the researcher feels are important, in this case, the understanding of the experiences of expectant mothers from Mawadza village in a waiting mothers' shelter at Bonda Mission Hospital before, during and after delivery.

2.2 Waiting Mothers' Shelters: A Conceptualisation and Origins

The aim of the waiting mothers' shelter strategy in developing countries' maternal health systems is to reduce maternal and infant mortality during and soon after delivery by improving access to a skilled birth attendant and emergency obstetric care (WHO 1996a , Yustina 2020). Waiting mothers' shelters have been conceptualised as "housing facilities", located near a qualified medical facility (hospitals). In waiting mothers' shelters, expectant mothers who are

seen as “high risk”¹ can await their delivery and be transferred to a nearby medical facility shortly before delivery, or earlier should complications arise (WHO 1996a: 1, Yustina 2020). Lonkhuijzen *et al.*, (2011) have also defined a waiting mothers’ shelter as a facility that is within easy reach of a hospital or health centre that provides antenatal care with skilled birth attendants and emergency obstetric care. It is prudent to note that expectant mothers do not give birth at the waiting mothers’ shelter, but rather await delivery there in the weeks before they are due to give birth. They are transferred to the health facility when they go into labour (the stage when one is confirmed by the attending health care workers to be in labour).

Originally, waiting mothers’ shelters were developed across the globe for expectant mothers identified as having “high-risk” pregnancies (Lonkhuijzen *et al.*, 2011). Since the 1960s, waiting mothers’ shelters have been advocated to bridge the geographical gap - the difference in care received by expectant mothers living in remote areas compared to expectant mothers living in urban areas (AbouZahr 2018, Kambarami 2019 , WHO 2018: 342). In the 1960s the idea of waiting mothers’ shelters was also reenergised in mission centres and promoted in rural Zimbabwe as a potential intervention to decrease the physical gap that precludes rural women from receiving skilled maternal health care (Lonkhuijzen *et al.*, 2012). Even so, more recently waiting mothers’ shelters have been promoted as a strategy for increasing access to facility-based births for remote or dispersed rural populations (Koblinsky 2003, Kanengoni *et al.*, 2019 & Mafaune *et al.*, 2020). In some countries, in Europe, such as Finland, expectant mothers with social risk factors, such as adolescent pregnancy and those with inadequate living conditions are referred to the waiting mothers’ shelters (Figa-Talamanca 1996, Krasovec 2004, Melos *et al.*, 2018).

In most developing countries, particularly, across the sub-Saharan region, Zimbabwe included, waiting mothers shelters are continually in the process of being established though facility-based births are fewer. There has however been a move towards encouraging the use of the shelters by all expectant mothers in rural areas (Eckermann 2008, Kanengoni *et al.*, 2019, Mafaune *et al.*,

¹ According to Lonkhuijzen *et al.*, (2012), the concept of risk selection aims to select expectant mothers for referral to a waiting mothers’ shelter. Selection takes place during antenatal clinics by the attending health professional, either within the hospital or in health centres/clinics without labour facilities. Selecting women with risk factors such as a poor obstetric history, high parity or anaemia and advising them to stay near a hospital could prevent maternal or infant mortality during or immediately after delivery. Selection of women with high-risk pregnancies, however, has not always been successful (Lonkhuijzen *et al.*, 2012).

2020). In addition, in Zimbabwe, traditional huts (Millard 1991, Poovan *et al.*, 1990) modern houses with toilets, bathrooms and kitchen facilities (Cardoso 1986, Knowles 2000, UNPF 2019), old hospital wards (Wilson 2018) or houses on stilts may function as waiting mothers' shelters (Barss 1985, Milton 2018, Saunder 2019, Selbana *et al.*, 2020).

Ideally, expectant mothers can be referred to a waiting mothers' shelter by health workers at peripheral facilities and mobile clinics, traditional birth attendants (TBAs) and people working for NGOs (Figa-Talamanca 1996, Tumwine & Dungare 1996, van der Marel 2005, Eckermann 2008, Milton 2018, Saunder 2019). However, in the contemporary period where maternal and infant mortality remains high in rural communities, in particularly, in developing countries such as Zimbabwe, expectant mothers do not need referrals to go and await labour in a waiting mothers' shelter (Saunder 2019). Women typically spend two weeks at the waiting mothers' shelter, but this can vary from one day to three months (Otis 2001, van Geel 2005, van der Marel 2005, Saunder 2019). Expectant mothers are allowed to go to the waiting mothers shelter two weeks before delivery and in Zimbabwe, if one attends prenatal care at the hospital, one can await labour at the shelter and even in rare cases of those who do not attend prenatal care (Mafaune *et al.*, 2020). Waiting mothers' shelters are usually staffed by a manager and volunteers, with visits conducted by midwives or physicians from the affiliated health centre (Poovan *et al.*, 1990, Chandramohan *et al.*, 1995, Tumwine & Dungare 1996, van Geel 2005, Mathole *et al.*, 2006, Bekele *et al.*, 2019, Selbana *et al.*, 2020).

Educational activities and health promotion are also part of the fundamental services provided in the waiting mothers' shelters. Staff members in the facility also provide expectant mothers with health education about pregnancy, giving birth and infant care (Tirunek *et al.*, 2016, Scott *et al.*, 2018, Bekele *et al.*, 2019). When staying in a waiting mothers' shelter, women often have access to antenatal care. Expectant mothers may visit the routine antenatal care programme in the health facility, but more often the waiting mothers' shelter is visited regularly by a nurse, midwife or doctor (Henry *et al.*, 2017, Scott *et al.*, 2018). Other activities conducted in the waiting mothers' shelter include weaving, sewing, gardening and helping with the maintenance of the home (Wild & Kurji 2020). In these facilities, additional emphasis is put on education and counselling regarding pregnancy, delivery and care of the new-born infant and its family. Throughout Zimbabwe, lectures are given on a broad variety of topics including the development

of the foetus, infant development, labour/delivery, breast-feeding and care of the new-born, family planning, immunisation, HIV/ AIDS, alcohol abuse, and home accidents among other topics in waiting mothers' shelters. Sessions on relations within the family are especially appreciated by the women as shown by a study conducted by (Kanengoni *et al.* 2019).

The extent to which women are cared for in the shelter and the help that is available to them differs from shelter to shelter. Some facilities are completely self-catering and women provide their own food, water and firewood. Others are completely catered for and sometimes the economic status of the woman determines whether she is provided with food or not (Figa-Talamanca 1996, Tumwine & Dungare 1996, van der Marel 2005, Eckermann 2008, Milton 2018, Saunder 2019). The costs of a waiting mothers' shelter are covered in different ways. Communities have been involved in building huts, while, the Ministry of Health and Child Care (MoHCC) or Non-Governmental Organisations (NGOs) contribute to building costs. Running costs may be partly covered by user fees and by fundraising projects co-ordinated by the expectant mothers. Some waiting mothers' shelters are initiated by the community and women's groups (Wessel 1990, Mafaune *et al.*, 2020), while, many are established as vertical strategies by NGOs or organisations of health professionals (Sambe *et al.*, 1990; Chandramohan *et al.*, 1994, Gunara & Van Geertruyden 2021). More recently waiting mothers' shelters have become part of government health policy, the Maternal and Neo Natal Health Road map 2007-2015 backed by the Maputo Declaration, UN agencies and other large donors (Kanengoni *et al.*, 2019 & Mafaune *et al.*, 2020). Furthermore, in Zimbabwe, the resources available at waiting mothers' shelters differ depending on whether they are run by the government, district council, non-governmental organisation (NGO) or Christian missions. Mission hospitals have played a crucial role since the pre-independence era providing and running waiting mothers' shelters for expecting mothers (Green *et al.*, 2005, Togarasei 2017, Mureyo *et al.*, 2020). In the pre-independence era, mission hospitals were for rural communities as urban hospitals were tailored for the white people (Zvobgo 1982, Dodzo & Mhloyi 2017).

2.3 Dissemination of the Waiting Mothers' Shelter Concept

2.3.1 Early Influences

The early idea for waiting mothers' shelters/ maternity waiting homes or maternity villages in "developing" countries may have originated from similar strategies as Northern Europe, Canada and the United States of America used at the beginning of the twentieth century (WHO 1996: 2). It has been documented in scientific literature since the 1960s that doctors, particularly, obstetricians and gynaecologists took an early role in advocating the establishment of waiting mothers' shelters (Stewart & Lawson 1967, Cardoso 1986). Stewart and Lawson (1967: 309) state that Cuba was also one of the first countries to develop a waiting mothers' shelter in Baren district which is located in Pinar del Rio Province in the 1940s. In Africa, the idea of waiting mothers' shelters also became popular around 1945 with the earliest being recorded in countries such as Ethiopia in 1950, Nigeria in 1955 and the DRC (Zaire) in 1956. Since the 1960s, maternity waiting homes (MWH) (waiting mothers' shelters) have been advocated to bridge the geographical gap which is the difference in care received by women living in remote areas compared to women living in urban areas. Expectant mothers have been encouraged to go and stay close to the clinic toward the end of their pregnancy (AbouZahr 1998, Fawcus 1996, Greenwood 1987, Kambarami 1999, Mahony 1995, Stewart 1968, WHO 1991, Scott *et al.*, 2018, Lori *et al.*, 2020, Girma *et al.*, 2021).

2.3.2 Waiting Mothers' Shelters in Zimbabwe

The first waiting mothers' shelter in Zimbabwe was established in 1960 at Mt Selinda Mission Station in Manicaland Province, which was one of the first mission centres built in (Rhodesia) Zimbabwe (Zvobgo 1982, Bekele *et al.*, 2020). The idea of waiting mothers' shelters spread to other mission stations in Manicaland, including Old Mutare Mission Centre in Mutasa and Mutambara Mission Centre in Chimanimani. In the late 1960s, the idea spread to other provinces such as Mashonaland is Karanda Mission Centre is located. The idea of constructing shelters for expectant mothers to await labour in (Rhodesia) Zimbabwe was popularised by medical missionaries who viewed home delivery by the traditional birth attendants (TBAs)² /traditional midwives as dangerous. In the pre-independence era, mission hospitals were for rural communities as urban hospitals were tailored for the white people (Zvobgo 1982, Bekele *et al.*,

² *Vanambuya nyamukuta.*

2020). Huts were built that were easily accessible by community members in rural communities where expectant mothers on prenatal care would make routine visits for regular meetings. Expectant mothers would also get knowledge on how to handle pregnancy, pregnancy-related taboos, and prenatal care. Post-partum care was offered after follow up visits to the house of the new mother by the community health care workers. It was also in these shelters that expectant mothers under the supervision of white health care workers received free medical attention on ailments that were not only related to pregnancy.

Nonetheless, inasmuch as the medical missionaries placed emphasis on the importance of utilising waiting mothers' shelters, the idea was not easily accepted by villagers in different regions across Rhodesia. Literature shows that the strategies that were used by the early medical missionaries to encourage women to use these facilities conflicted with the medical systems of the indigenous Shona culture and its sub-dialect groupings, including the *Manyika* people (Gelfand 1979, Mutambirwa 1985, Kaiser *et al.*, 2019). In addition, the structure of the waiting mothers' shelters was not habitable for the expectant mothers. The waiting mothers' shelters were initially referred to as tents³, and some provinces such as the Masvingo province in Zimbabwe still use the term. A tent in the vernacular language- Shona is a term that refers to any temporary structure that has been built without expertise due to its temporary nature. These structures were not habitable for the expectant mothers, especially, during seasons of harsh weather conditions (cold winters and rainy seasons). The structures were initially overcrowded and there were not enough provisions for women to use and more often than not those who went to await labour had to bear the burden of securing provisions such as firewood and food and this discouraged many women from awaiting labour in these facilities (Gelfand 1979). Other expectant mothers were discouraged by their husbands from awaiting labour at the shelters as they opted for TBA when their wives were due (Zvobgo 1982: 68, Mutambara 1985).

With the passage of time to the early 1970s, during the second liberation war⁴, medical missionaries improved structures of waiting mothers' shelters to dormitories (Sander 1995). There was the introduction of old or abandoned hospital wards to function as facilities that expectant mothers could use to await delivery as they received prenatal care from skilled

³ *Misasa/Matumba.*

⁴ *Chimurenga.*

personnel. Karanda Mission in Mashonaland completed dorms that were fenced-in and expectant mothers referred to them as dorms or keeping areas⁵ (Sander 1995: 286). The waiting mothers' shelters were referred to as keeping areas due to the strategy used by the medical missionaries to keep expectant mothers in the shelters; this was a reminiscent of the "keeps" that were used as fenced security areas/ open prisons for political prisoners during the war (Mutambirwa 1985). The terms that were used to refer to waiting mothers' shelters vary from province to province, depending on the dialects or languages used in that area. Thus, this thesis synonymously employs all the identified native terms used to refer to a waiting mothers' shelter (*misasa/ matumba/ madhomu/ makipi*). In different rural communities in Rhodesia (Zimbabwe), health workers – with the help of the black elites (those who had managed to get white settler education and speak English) from the village would identify all pregnant women in villages and mandate them to go and await delivery (Zvobgo 1982: 63). Expectant mothers were not allowed visitors at these facilities and were only discharged after delivery. The facilities were also overcrowded since the number of the people in the shelters had increased. There was no privacy and expectant mothers could be attended by male doctors due to shortage of staff members at the hospitals, and this was against the cultural beliefs of the Shona people (Sander 1995: 286).

At this stage, the waiting mothers' shelters became very unpopular with community members/villagers across the country. Zvobgo (1982: 66) states that there were reports of abuse in those shelters in cases where some expectant mothers suspected to have husbands actively involved in the war would face abuse in the shelters. Pregnancy began to be treated with confidentiality in villages to avoid one being forced to go to "keeps" (waiting mothers' shelters). TBAs would assist expectant mothers who were about to deliver in secrecy. As Zimbabwe gained independence, some of the stringent rules that were practised in waiting mothers' shelters during the second liberation struggle were eased by the MoHCC. Expectant mothers could now receive visitors and were free to move from one point to another as long as it was safe to do so (Sander 1995: 287). The idea of waiting mothers' shelters has been developing and these facilities are still present in present-day Zimbabwe.

Zimbabwe currently has 1335 health facilities, with waiting mothers' shelters available in or close to 255 of these facilities (ZIMSTAT 2012: 82, MoHCC 2015: 33). Additional shelters are

⁵ *Madhomu or Makipi.*

being built near rural hospitals following the government mandate to establish a shelter at every hospital in rural Zimbabwe (under The Zimbabwe National Maternal and Neonatal Health Roadmap Policy of 2015, introduced by the MoHCC). According to Loewenson *et al.*, (2015) and MoHCC (2016: 59), one in every six referral hospitals has a waiting mothers' shelter and only 31% of the expectant mothers in rural areas use these facilities. Chandramohan (2005) evaluated waiting mothers' shelters in rural Zimbabwe over a two-year period and observed that non-users were more likely to have obstructed labour (1% versus 0.06%). Non-users were also less likely to have a caesarean section (15% versus 18%). Among the non-users, complications were common, compared to the facility users. The perinatal death rate per 1000 births was 19.1 in the users group, compared to 32.2 amongst the non-users (Risk Ratio [RR] 1.7, 95% CI 1.1 to 2.6). Waiting mothers' shelters have demonstrated to be effective in facilitating deliveries under the supervision of skilled birth attendants in hospital over the past decade for rural women in Zimbabwe (Bhutta *et al.*, 2019, Lee *et al.*, 2019).

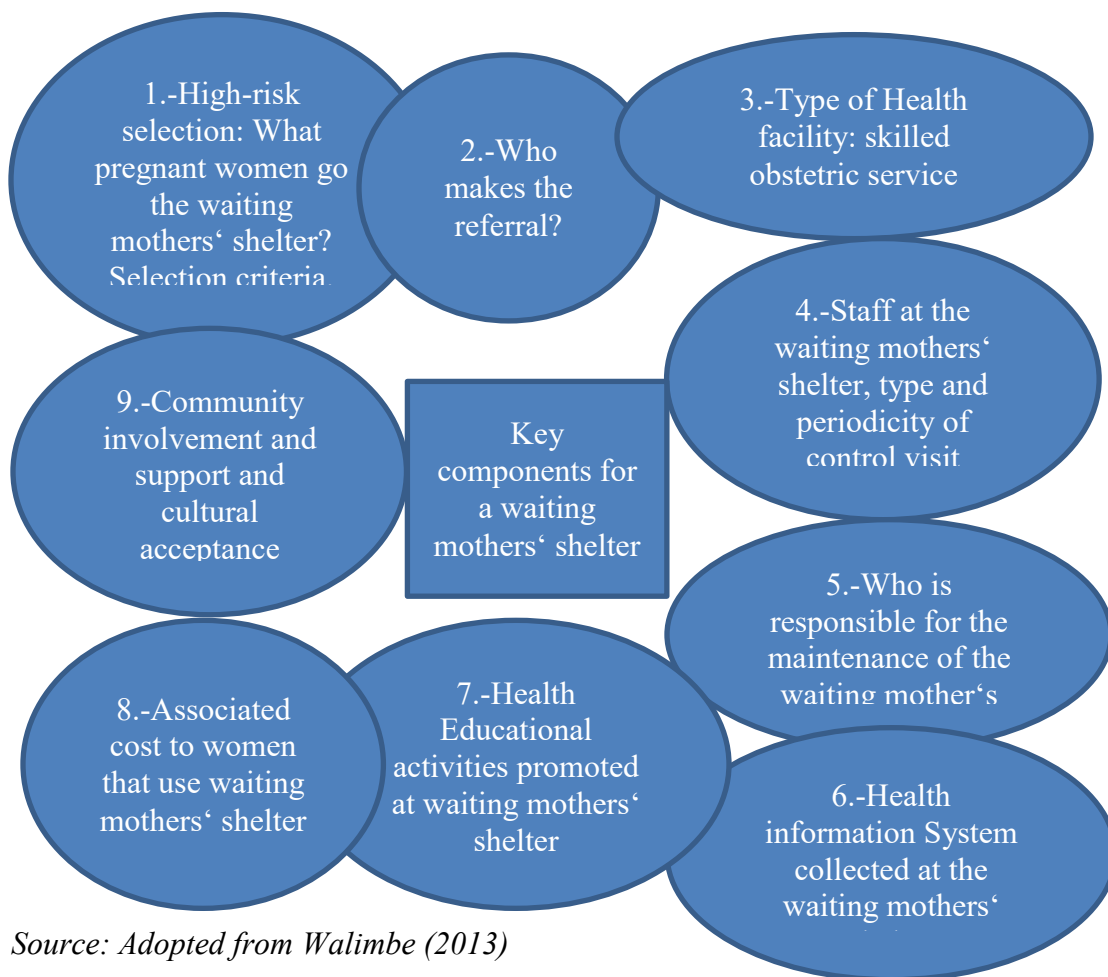
2.4 Key Elements of Waiting Mothers' Shelter Management and Functioning

Initial guidelines regarding waiting mothers' shelters were published by WHO in 1996 in Zimbabwe in collaboration with the MoHCC in the document "*Maternity Waiting Homes: A Review of Experiences*" (WHO 1996, Scott *et al.*, 2018). These guidelines highlighted the importance of considering waiting mothers' shelters as a part of the continuum of maternal care, and not just as a facility that exists in a vacuum. In fact, the experiences detailed at that time focused on several aspects that suggest that crucial aspects affecting the success of waiting mothers' shelters occur outside the facility. WHO (1996: 7) and Scott *et al.*, (2018) state that waiting mothers' shelters should be understood as part of a complex chain of factors which affect the maternal health status of expectant mothers. Considering the WHO guidelines and also lessons from empirical experiences, the diagram below (Fig. 2) shows the key elements affecting the level of success of waiting mothers' shelters in reducing maternal (and neonatal mortality) in Zimbabwe as suggested by (WHO 1996 , Scott *et al.*, 2018).

Related to the high-risk selection, there are three approaches: (i) a high-risk medical approach to identifying pregnancies likely to develop complications and refer them to a waiting mothers' shelter; (ii) a high-risk multifactor approach that promotes a broader concept based on a combination of distance, socioeconomic and medical risk factors and (iii) an open access

approach that understands waiting mothers' shelters as a proxy for institutional deliveries. In order to define the best approach, it is vital to assess, firstly, the capacity of the National Health System to correctly identify high risk cases and, secondly, if the health system is able to provide care to the identified women. This analysis should be locally evaluated and depend on available resources (Walimbe 2013).

Fig.2: Crucial Aspects Influencing a Waiting Mothers' Shelter



Source: Adopted from Walimbe (2013)

Referring women to a waiting mothers' shelter is a key factor, especially, in Zimbabwe. Involvement of the community and TBAs appears to be the best solution if antenatal care visits present a low rate (Walimbe 2013). However, in rural communities where the continuity of care is more stable, the involvement of health services is crucial for referring. As has been noted

previously, in systems in which the family physician has a relevant role, the involvement of this person appears as the best option.

The purpose of waiting mothers' shelters is to provide expectant mothers, especially, those with obstetric risk, access to qualified obstetric care. In this sense, waiting mothers' shelters can be set up near a health facility with Basic Obstetric Care (BOC) or a health facility with Complete Obstetric Care (operating theatre) (Walimbe 2013). In the first case, it is indispensable to ensure rapid transferral for complicated situations. However, in developing countries, this is also a problem. The options depend on the local situation regarding the resources and on the characteristics of the community (Walimbe 2013, Mafaune *et al.*, 2020).

Related to this point, it is crucial to analyse the human resources available in the health facility. Again, the capacity of the National Health System will be a determinant, although – obviously, skilled staff is strongly recommended. The presence of an obstetric specialist in each waiting mothers' shelter is strongly recommended (Mafaune *et al.*, 2020). In any case, in countries where human resources are scarce and no specialists are available in each facility, it is important to reinforce the visits to the waiting mothers' shelters, establishing at least, periodical daily rounds in order to detect complications.

The maintenance of the waiting mothers' shelters is a critical issue. Available literature indicates several experiences where lack of maintenance is identified as a factor that limits the success of the strategy (Mann *et al.*, 2006, Walimbe 2013, Mafaune *et al.*, 2020). Several options can however, be implemented if the health system is sufficiently strong. It is recommended that the maintenance of the service is assumed by the state in order to ensure long-term continuity. Other options focus on self-maintenance by women users, or community involvement towards the proper functioning of the waiting mothers' shelter. Other options include trying to generate income by small economic activities, in order to guarantee funds. Most of the cases promote a mix of these options in order to ensure community involvement. No information about success in self-maintenance has been found. Clinical records and other relevant information should be collected in waiting mothers' shelters in order to evaluate the services. It is strongly recommended that waiting mothers' shelters registers, data and indicators should be incorporated into the routine health information system. However, with special incidence in developing

countries, records are non-existent, making proper assessments difficult (Chandramohan *et al.*, 2005, van Lonkhuijzen *et al.*, 2003: 66 , Girma *et al.*, 2021).

The location of women in waiting mothers' shelters is an important opportunity to promote educational activities with a focus on maternal and neonatal care, family planning, Sexually Transmitted Infections (STIs), HIV and other critical health conditions (Mafaune *et al.*, 2020). Community health workers can play a relevant role, although, clinical staff involvement is also suggested. Several studies (Wilson *et al.*, 2017, Talamanca 2018, Eckerman & Deodato 2008) identify the associated cost for expectant mothers using waiting mothers' shelters as the main barrier to access. This critical point can be overcome by promoting economic incentives for users, but, this may seriously hamper sustainability. In some cases, women are allowed to stay with their family in the facility (Mafaune *et al.*, 2020). However, this approach may also lead to complications. The associated cost is the most complicated and crucial aspect, and definitively is intrinsically linked to the economic and social status of expectant mothers in developing countries (Makandwa *et al.*, 2017). Finally, the success of waiting mothers' shelters depends on community involvement, support, approval and cultural acceptance. It is necessary to adapt cultural aspects such as the sex of those responsible for carrying out visits (in most developing countries, it is recommended that these are women and not men), or the promotion of some cultural practices and traditions such as performing rites and rituals at the facility in accordance with local beliefs and other strategies to increase population acceptance of the service (Mafaune *et al.*, 2020).

2.5 The Role of the Church in Health Care Delivery

For over a century, medical missionaries have played a significant role in the development and provision of health care in many African countries. Historically, the process of Christian mission and the provision of health care were not always seen as related activities. Indeed, notwithstanding devastating levels of mortality amongst both their own workers and the local population, most missionary societies were slow to recognise the need for trained medical people. Some missions actively resisted the involvement of medical workers. Nevertheless, from the beginning of the twentieth century and even much earlier, mission personnel were often the sole source of allopathic medical care in many African countries, particularly, in rural areas (Green *et al.*, 2002).

In Rhodesia⁶, church-based medical care developed as part of the Christian mission “to proclaim the Kingdom of God and to heal” (*Luke 9:2*), and the traditional mission station included a church, a school and a hospital. There were different reasons that led to the establishment of mission stations. Schulpen (1975: 100) suggests that these included:

- Compassion for the people in need, out of pure Christian charity;
- Contact with the population, especially where verbal communication was difficult;
- To look after the health of their own missionaries;
- As a prestige object for the church;
- To help build the ‘Kingdom of God’ and to establish “visible signs of God’s presence”;
- As a source of income to finance other missionary activities.

In Rhodesia, there were notable variations between Christian missionary societies in the precise motivation to develop their medical work. Some considered the provision of medical services to be merely a practical expression of their Christian faith and, as such, sought no specific returns for their altruism (Zvogbo 1982, Green *et al.*, 2002, Kaiser *et al.*, 2019). Others held the view that medical care could be used as a method of evangelism to bring individuals and communities to believe in Christ. Since health care was seen as a means of promoting the faith, many missions required all staff to be professing Christians and prayers would be offered in the wards as well as in the chapel or church (Green, *et al.*, 2002). Furthermore, the power of medicine to defeat demons and bad spirits was an argument for the power of the Christian God and a strong motivational force for conversion; surgery and “miracle” drugs were, therefore, the preferred mode of care, rather than preventive health work. Finally, some mission hospitals, many of which are still involved in relief and development work today, considered it a social duty to meet medical or social needs, viewing health as a human right (Masawi 2014, Kaiser *et al.*, 2019).

The developing medical infrastructure in Rhodesia was intimately tied to missionaries, hospitals being linked to the main mission of a particular area and clinics to minor mission stations.

⁶ Rhodesia refers to the Pre-independent Zimbabwe in the period before 1980.

Missions provided one or two completely equipped medical centres at the main mission stations with qualified (European) doctors and African personnel; male medical assistants (usually African) and/or nuns (also referred to as ‘sisters’) staffed rural outposts (Rugwiji 2019). These facilities proved to be a powerful socialising tool, both in preparation for Christian doctrine as well as incorporation into the evolving cash and moral economy of the colony. Mission hospitals (and perhaps more specifically, mission doctors), like local traditional healers, embodied both the sacred and the secular worlds (Ranger 1980). By the turn of the century, Rhodesia had developed an efficient infrastructure: in the form of telephone lines, as well as the railway system, linked urban centres; and the institutionalisation and increasing secularisation – of a medical system was well advanced. Hospitals, for example, were then constructed with brick and iron, as opposed to the rather flimsily constructed tents of a few years before (Gelfand 1980). Trained nurses replaced Dominican (and other) nuns at many of the major hospitals. Medical scientific knowledge and education began to spread in Rhodesia with the expansion of mission stations in different regions in the country (Rugwiji 2019).

The training of medical orderlies, nurses and auxiliary health staff was also an important service provided by some mission hospitals (Gelfand 1986). In Rhodesia, mission stations grew significantly during the early part of the twentieth century and, by the time of independence, were a significant part of the health care services. Matomora (1995: 222) notes that “in 1971, protestant churches alone operated medical programmes in 51 hospitals in Rhodesia”. Standard missionary medical training consisted of a six-month internship at a hospital to learn the basics of diagnosis and treatment of disease, simple surgery and maternity work. However, it is probable that little of this training could prepare missionaries for the unique and geographically specific types of diseases they would meet while in Rhodesia (Mazowa *et al.*, 2019). What medical knowledge missionaries did have was the by-product of rapidly changing and competing European conceptions of disease and its causation and prevention. Underlying this range of approaches, however, was a humoral economy where bodily functions were thought to be mediated by geography, climate, gender, race and moral disposition (Mazowa *et al.*, 2019). In this vein, recording and ordering empirical biological reality generated medical knowledge. Diseases may have varied from culture to culture, but medical knowledge, based as it were on the “facts” of nature and the causal-functional integration of biological systems did not (Rugwiji 2019).

At first glance, the medical worlds of Europeans and Africans in Rhodesia seem to be apart (Ranger 1980). On one hand, European medical orthodoxies constructed on the supposed firm ground of rationalism and the developing natural sciences, enjoyed the legitimacy of medical —knowledge”. On the other hand, indigenous medical beliefs and practices steeped as they were in presumed superstition and fetishism enjoyed the dubious title of native —beliefs.” This apparent dichotomy, however, masks fundamental similarities in both medical systems, particularly, as they intersect with religion and religious practices. Medicine and religion are indeed inseparably intertwined when looking at the development of medical healthcare in Zimbabwe (Gelfand 1986, Chavhunduka 1994, Mawoza *et al.*, 2019, Rugwiji 2019).

Rhodesia and missionary belief systems diverged, however, in their construal – both of the moral universe and of the individual’s place within it. For missionaries, as Chirongoma Masakure (2020) argue, the physical illnesses from which Africans suffered were symptomatic of a greater spiritual disease and a deeper illness of the soul. Such explanations rested on a paradoxical logic that viewed sin as the cause of illness at least historically amongst (Christian) Europeans, as the responsibility of the individual, while simultaneously holding Africans as a population collectively responsible for apparent sin and illness. In this vein, healing of the body was predicated upon and seen in conjunction with, the parallel healing of the soul through conversion to Christianity. Africa and Africans were therefore —viewed as pathological and polluted in their natural‘ state, the only antidote being the civilising mission” (Masakure 2020: 300). Moreover, it was not enough for individual members of say a compound to convert for individuals could be quickly incorporated back into the collective pathological body. Nothing less than collective conversion would suffice (Chirongoma 2020, Masakure 2020).

Today, in Zimbabwe, mission hospitals continue to play an important role in health care delivery with three significant changes from their original foundation. First, they are part of a more complex array of health care providers including central government, local authorities, private-for-profit providers, secular NGOs and traditional practitioners (Green *et al.*, 2002, Strohmayer 2019, Chirongoma 2020 , Masakure 2020). This has implications for their role, both as providers and as policy influencers and for their relations with other agencies. Secondly, most of the mission hospitals in Zimbabwe are no longer owned, managed and staffed by international missionary organisations, but, by a national church body called Zimbabwe Association of

Church Related Hospitals (ZACH) (Chirongoma 2020). This makes it possible to address the local health needs of rural societies not from imposed policies but from a context-based approach. Lastly, sources of funding have also changed with a shift away from a structure where the majority of external income comes from those motivated to promote religious activities to one where there is a greater contribution from secular sources such as bilateral and multilateral donors, international NGOs and national government as well as user charges (Green *et al.*, 2002, Chirongoma & Dube 2020). Although such changes have been accepted as inevitable by many organisations, they can be challenging to the autonomy of churches and, in particular, individual missions are often still reluctant to align themselves with government. This may be for a variety of reasons including a mistrust of government, a desire to retain autonomy or a belief that medical care remains an important evangelistic tool (Dube 2020). Inasmuch as mission hospitals are no longer isolated and autonomous institutions representing the sole source of allopathic medical care, many retain their erstwhile (though often untested) reputation for quality care, despite the struggle to maintain previous standards with diminishing resources (Bishi 2020, Dube 2020).

2.6 Mission Hospitals and the Provision of Maternal Health in Manicaland: A Historical Background

The development of maternal and infant health care as an exclusive unit within medicine can be credited to the establishment of mission hospitals in Zimbabwe. This came as a result of “civilising” Africa by spreading the medicalisation of childbirth to the African continent since Europe had already passed the stage (Gelfand 1980: 88). In Europe, during the First World War, movements developed against the midwifery approach of childbirth to a more medicalised system and the same criteria was transferred to Rhodesia by the advent of the medical missionaries in the country (Wiley 1994; Gelfand 1980, Muzuro 1980). The medical missionary believed it was important to support a medical approach to childbirth and discourage the traditional midwifery approach that was practised by indigenous Shona people (Prevost 2017). Medical missionaries at the turn of the century defined and controlled the medicalisation of the childbirth process, although, this came with contestations from the locals. Part of the tactics used by the medical missionaries involved constructing ever more elaborate distinctions between “normal” and “abnormal” childbirth which, when accepted, resulted in a progressive deskilling of the traditional midwife as responsibility shifted from her domain to that of the nurses and

doctors (Chuhna 2018). In many places in Rhodesia, substantial parts of the midwife's role became incorporated into the field of obstetrics, the preserve of qualified medical practitioners (Chuhna 2018).

The first mission hospital to be established by the Anglican Diocese in Manicaland was St. Augustine in Mutasa district followed by Bonda Mission Hospital (Ela 1989, Chirongoma 2020). Both Mission stations were established in Mutasa district as a result of the evangelical activities of the Anglican Church. The mission stations had both a school and a hospital, and maternal health services were not an exception. The activities of medical missionaries in provision of maternal health care to women in rural Manicaland did not go unquestioned by the local traditional midwives. Ideologies relating to illness and childbirth were different between the Europeans and the Africans. For the Africans, childbirth was a sacred process that needed an appeasement of the ancestors and God⁷ for it to go well. In cases of complications, it was clear God or the ancestors were not pleased and it would result in the death of the mother or the infant, disability or albinism (Gelfand 1980, Chavhunduka 1982, Chirongoma 2019, Dube 2020).

After the process of delivery, the family to which the new-born had been delivered had to send a chicken or a goat to thank the TBA for the delivery (Chavhunduka 1982, Mutambirwa 1985). It is very important to acknowledge that in the Shona culture *Manyika* included, the TBAs was regarded as a very important practitioner and it was considered unwise to engage in an argument with them if one is a woman who might need their services in the future (Chavhunduka 1982). In the *Manyika* culture, proverbs were there to warn expectant mothers to respect the traditional midwives in their communities, for example, do not exasperate the midwife if you are still of child-bearing age⁸. The belief, although not confirmed, was that the midwife would strangle your baby during delivery and this would hurt the mother of the baby (Mutambirwa 1985). In present day societies, this belief continues to exist as some women still use the services of midwives in home births. Even in maternity hospitals in contemporary in both rural and urban societies, lots of women are extremely afraid that the midwives might do a number of negative things, including stealing the child or baby swapping (sometimes with a dead new-born from somebody else in the ward), killing the baby for ritualistic/ satanic purposes, or initiating the infant into

⁷ *Musikavanhu*.

⁸ *Kuchenjedza nyamukuta kuzvara uchada*.

dark arts. As a result, nowadays, many spouses are usually present when their wives are giving birth in the maternity ward. It is not necessarily about being supportive, but often also ensuring the security of their child.

The view that the Africans hold towards the midwives is different for European medical missionaries who believed in science and a rational approach to reality. The medical missionaries viewed childbirth as a process that was moving towards institutional delivery. In Manicaland province, “institutions” took many forms, that is, from the great lying-in hospitals to tiny maternity clinics run by local doctors. For centuries, the woman’s home had been the midwife’s chief workplace, but by the advent of the medical missionaries and their medical interpretation of childbirth, this situation changed and midwives became alarmed by the erosion of the practice of home birth. The question of control was an issue here, in the woman’s home; the midwife was in a unique position of power, albeit still an invited guest. Unless complications set in, she would normally conduct her work single-handedly and, of significance, collect her fee at the completion of her work. However, the medical missionary found it important for expectant mothers to mingle and keep each other company in hospitals (although, this has been criticised for denying women privacy in maternity unity) and the services provided were free of charge (Gelfand 1996).

Services provided by mission hospitals to expectant mothers in rural communities included education on antenatal care. Expectant mothers received education on the importance of delivering in the hospitals and they received treatment on other diseases that affect women during pregnancy, including thrush and even Sexually Transmitted Infections (STIs). Gelfand (1996) states that the activities of the mission hospitals to encourage the medicalisation of the birth process in Rhodesia were highly contested by the African community who saw a threat to and a potential erosion of their culture. Societies remained sceptical of the benefits of hospital deliveries. With time, positive results were observed in several hospitals due to the practice of hospital delivery. According to the ZDHS (1990: 334), Mt. Selinda Mission Hospital, Mutambara Mission Hospital, Old Mutare Mission Hospital and Bonda Mission Hospital, all in Manicaland, recorded a significant rise in the number of women who delivered in these hospitals from 1970 to 1988. This was mainly due to free health care services provided and the presence of

health care community workers to identify pregnant women and encourage them to deliver in any mission hospital within the locale (ZDHS 1990: 338).

In order to execute the need for women to deliver in the hospitals, waiting mothers' shelters were established as formal structures at every mission hospital in Zimbabwe since 1960. In Manicaland, the first waiting mothers' shelter was at Mt. Selinda Mission Hospital, which is in Chipinge. In Mutasa district, mission hospitals such as Old Mutare also had waiting mothers' shelters built as part of an agenda to improve maternal health care in rural areas. International organisations and church-based international donors have also played a role in funding the establishment of waiting mothers' shelters. During the pre-independence era in Zimbabwe, especially, in the 1970s, the Christian international community played a major role in financing the establishment of waiting mothers' shelters. Green *et al.*, (2002) further observe that mission stations have played a crucial role in health care delivery, even during the liberation struggle, and maternal health care remained a priority in mission hospitals regardless of the activities of the second liberation war.

In present day Zimbabwe, although mission hospitals fall under ZACH, their operations are now guided by the MoHCC. However, scholars indicate that some mission hospitals still have international funding from Christian-based international organisations and this makes them better providers than the government (Green *et al.*, 2002, Strohmayer 2019, Chirongoma 2020, Masakure 2020). Mission hospitals also offer midwifery training schools for nurses and this shows the importance they place on maternal health care, not only for rural communities, but, for Zimbabwe at large, since the trained midwives upon completion of studies will be deployed to any hospital in Zimbabwe, whether government, private or mission hospital. Mission hospitals in Manicaland have worked with other international organisations to improve the operations and care provided in waiting mothers' shelters. The organisations include WHO and UNICEF, who make donations of items like bed linen, blankets and other utilities needed in waiting mothers' shelters (ZIMSTAT 2015: 300). This has been done with the aim of improving access to maternal health care facilities and improving the chances of women delivering in health care institutions in rural communities.

2.7 The Role of the Ministry of Health and Child Care (MoHCC)

The government of Zimbabwe, through the MoHCC has played and still continues to play a crucial role in the operation of waiting mothers' shelters in rural communities. The MoHCC currently runs all hospitals in Zimbabwe, including mission hospitals. There is no question that ZACH manages mission hospitals as a separate board, but all hospitals in Zimbabwe currently belong to the government and are governed by government policies (Green *et al.*, 2018). Policies and interventions have been formulated to improve the operations of waiting mothers' shelters and to build more shelters in hospitals so that every hospital in rural communities has a waiting mothers' shelter as a facility. Additional shelters are being built near rural hospitals following the government mandate to establish a shelter at every hospital in rural Zimbabwe (under the Zimbabwe National Maternal and Neonatal Health Road Map Policy of 2015, introduced by the MoHCC as part of the Maputo Declaration). The MoHCC has done this to encourage expectant mothers in rural areas to deliver in health care institutions where there are skilled birth attendants and, resultantly, reduce the risk of mother or infant dying during delivery (MoHCC 2016: 300).

In 2010, Partners in Health (PIH) partnered with the MoHCC in Zimbabwe to renovate and support rural health centres in some of the remotest, underserved areas of Zimbabwe. The development of waiting mothers' shelters is an essential part of a comprehensive maternal mortality reduction programme that aims to have all expectant mothers give birth in an adequately staffed and equipped health facility. The MoHCC (2016: 382) states that –waiting mothers' shelters can be an extremely effective intervention, but only if they are part of a larger, comprehensive strategy to increase access to maternal health services.” To implement this strategy, the government through the MoHCC has worked towards decentralising primary health care services to bring skilled obstetric care closer to women in rural areas as well as to make use of community health workers to identify expectant mothers and accompany them to the facility for care. In PIH/Zimbabwe, the maternity waiting mothers' shelters are one component of a comprehensive maternal health programme called the Maternal Mortality Reduction Programme (MMRP). The goal of the Maternal Mortality Reduction Programme is –to ensure that 100% of women in the PIH catchment area deliver at a health facility that is adequately staffed and resourced to provide high quality basic obstetrical care and can refer to a higher level of care for emergencies” (MoHCC 2016: 308).

Prior to the Maternal Mortality Reduction Programme by the MoHCC, most women in the rural areas delivered at home with the assistance of traditional birth attendants. Traditional birth attendants in Zimbabwe and in many other countries are compensated by their clients with money or bartered goods. A traditional birth attendant, therefore, has a financial disincentive if they refer pregnant women to health facilities (MoHCC 2016, Kanengoni *et al.*, 2019). Safe motherhood initiatives in many countries have attempted to provide traditional birth attendants with training to conduct safer deliveries while continuing the informal economy of home delivery. In contrast, the Maternal Mortality Reduction Programme has retrained traditional birth attendants to become Maternal Mortality Reduction Programme Assistants (MMRPA) under the MoHCC in Zimbabwe (MoHCC 2016). MMRPAs are directly compensated by MoHCC to accompany expectant mothers to health centres for antenatal care, facility-based delivery, postpartum care, and new-born/child health care. Since it is important that the community understands the importance of facility-based delivery, this is the main focus of the education they provide during community gatherings. They also work to address traditional beliefs and other cultural barriers that might prevent an expectant mother from receiving care at the facility (MoHCC 2016, Kanengoni *et al.*, 2019).

Initially, waiting mothers' shelters were usually intended for expectant mothers with high risk pregnancies, although this was not closely adhered to. The MoHCC has made it a mandate under this programme that the admission protocol of waiting mothers covers not only expectant mothers identified as high risk but also women who live far from the health centre or face other geographic barriers such as rivers during the rainy season. According to the MoHCC (2016: 300), any expectant mother is eligible to stay in the waiting homes, but priority is given to women from rural areas (for example, living more than two hours from the facility by walking) and expectant mothers with risk factors for complications (for example age less than 16 or more than 40 years, first birth, more than six births).

In Zimbabwe, the waiting mothers' shelters are part of a comprehensive care strategy for antenatal care, labour and delivery, and postpartum care (Kanengoni *et al.*, 2019). The other integral components of this strategy are trained health personnel, uninterrupted supplies for safe delivery, referral and transport protocols to ensure that expectant mothers benefit from staying in the waiting mothers' shelter. The nurse-midwife lives in staff housing on the grounds of the

health facility and is on call regardless of the time of day (ZDHS 2015). Mafaune *et al.*, (2020) share the same view with MoHCC (2016) and Kanengoni *et al.* (2020) that when an expectant mothers staying at the waiting mothers' shelter goes into labour, the nurse-midwife is alerted and the expectant mother is transferred to the labour ward at the adjoining health centre. The nurse-midwife is capable of managing basic emergency complications, including administering antibiotics and oxytocin, actively managing the third stage of labour, and manually removing the placenta (MoHCC 2016: 314).

According to MoHCC (2016: 315), if an expectant mother is experiencing prolonged labour, severe postpartum haemorrhage, or another complication that requires a higher level of care and intervention not available at the health centre, such as caesarean section or blood transfusion, arrangements are made to transfer her to the district hospital. Each health centre (hospital) has an emergency transfer protocol that has been individualised to its particular geographical location (ZDHS, 2015: 134). Health centres located within several hours' drive to the district hospital have a car and driver on call for road transport. At sites without cars, the MoHCC/PIH has arranged in advance with people who live in nearby villages who have access to vans or trucks (Kanengoni *et al.*, 2019). For health centres that are located more than three hours by car from the nearest district hospital, health centre staff coordinate with the non-profit organisation in villages close to the mission hospitals to transport the women (ZDHS. 2015, Kanengoni *et al.*, 2019). For very high-risk women (for example, older expectant mothers, pregnant for the first time or expectant mothers with a previous caesarean section scar), delivery is not attempted at the health centre and a transfer to the district hospital is scheduled instead. Still, many of these expectant mothers will stay at the waiting mothers' shelter in preparation for transfer to the district hospital in advance of their expected delivery date (ZDHS 2015: 138). However, inasmuch as the government has been making efforts to ensure that waiting mothers' shelters operate well in Zimbabwe, challenges still continue to occur that hinder expectant mothers from accessing these facilities.

2.8 Waiting Mothers Shelters as Part of Maternal Health Care Policies in Zimbabwe

2.8.1 The Maternal and Neonatal Health Road Map 2007-2015

The Maternal and Neo Natal Health Road map 2007-2015 policy has been vibrant in refurbishing the existence and functions of the waiting mothers' shelters in rural Zimbabwe. It was due to this

policy that awaiting labour at the waiting mothers' shelter in rural communities was declared a mandate by the MoHCC in Zimbabwe; and every hospital in rural Zimbabwe was also mandated to have a waiting mothers' shelter close to/or in the hospital premises. The Zimbabwe government developed its Maternal and Neo Natal Health Road map 2007-2015 policy in line with the Africa Commission/Maputo Protocol which called for all governments in Africa to develop their country-specific road map in line with the Africa road map guiding governments to accelerate the attainment of MDG 5A (which aimed to reduce the maternal mortality ration by three quarters between 1990-2015). The main objective of the Maternal and Neo Natal Health Road map 2007-2015 policy was to ensure provision of skilled attendance during pregnancy, child birth and the post-natal period and to strengthen the capacity of individuals, families, communities and civil society organisations to improve maternal and new-born health, especially, in rural communities.

The main objective of the Maternal and Neo Natal Health Road map 2007-2015 was to facilitate the success of the four pillars of maternal and child care which are family planning, antenatal care, clean and safe delivery for the mother and the new-born, and essential obstetric care to all mothers in Zimbabwe (Zakeyo 2016). It emphasised the distribution of family planning services at the health facility and in the community; antenatal services including prevention from parent to child transmission (PPCT); and nutrition to be made available to all expectant mothers. Lastly, and mentioned as key to reducing maternal mortality in this policy, was the emphasis on the importance of a skilled health worker and quality obstetric care to take care of the expectant mothers, mothers and their new-borns. In ensuring that all these were strictly adhered to by both the healthcare professionals and the expectant mothers, the government mandated that every hospital in rural Zimbabwe should have a waiting mothers' shelter and every expectant mother should fulfil a mandatory obligation of awaiting labour in the waiting mothers shelter in order to receive the four pillars of maternal and child health as suggested by the MoHCC (MoHCC 2016: 200).

As part of implementation of this policy, the government of Zimbabwe took an action with regard to waiting mothers' shelters to make them fully functional and to ensure that all high-risk mothers and those living far away from health care facilities are in contact with health facilities for prenatal, intra-, and postpartum care (MoHCC 2016 and Mafaune *et al.*, 2020). The action

was taken in an effort to address the problem related to delays by permitting identification of intervention for life threatening complications for both mother and new-born. Key maternal and new-born health practices, for example, early initiation, new-born health practices, breastfeeding, thermal care and family planning, are key elements that were targeted to be improved and in the waiting mothers shelters under the Maternal and Neo Natal Health Road Map 2007-2015 policy. In order to ensure that waiting mothers' shelters are well equipped with qualified and skilled professionals, the government of Zimbabwe recruited registered nurses nationally to be trained in midwifery, and strengthened the capacity of the midwifery training school in order to have competency-based midwifery training (MoHCC 2016: 202). For this purpose, the midwifery training curriculum for registered nurses was revised to provide comprehensive midwifery education. The number of midwifery schools was increased from 13 to 20. Availability of five midwifery tutors for each school was ensured whilst policies for retention of midwives were strengthened. For example, bonding midwife nurses to an equivalent of number of years of training received so as that they would at least serve at waiting mothers' shelters as part of their training was introduced (MoHCC 2016: 200 , Zakeyo 2016).

2.9 Maternal Health Care Services in Zimbabwe: Service Accessibility

Dodzo and Muhloyi (2017) give a synopsis of the challenges that expectant mothers in Zimbabwe face generally in terms of access to maternal health care services. Dodzo & Muhloyi (2017) state that in Zimbabwe the ZDHS is one of the national surveys that attempts to look at factors of health care utilisation. It indicates that problems in accessing health care include lack of money to pay for treatment (50%), distance to health facility (34%), permission to seek health care (8%) and the desire for company (14%) among others. In this regard, scholars have agreed that access to good quality delivery care is a priority in the reduction of maternal mortality (Maguranyanga 2018: 1, Kangengoni *et al.*, 2019). There are several factors that can be considered to determine easy accessibility of maternal health care services. Firstly, the ratio of home to hospital deliveries can be used to determine the level of accessibility maternal health care institutions (Kanengoni *et al.*, 2019). More deliveries at home suggest that there is less accessibility to maternal health care services by the expectant mothers. Secondly, accessibility can also be determined by calculating the number of hospital admissions for maternity visits. Thirdly, other scholars have also suggested that issues of accessibility can be accessed from the

hospital setting itself, that is, the availability of a well-functioning transport system that includes the number of ambulances available for transporting patients (Kanengoni *et al.*, 2019).

In Zimbabwe, poor service accessibility, delay in seeking care and sub-standard care factors in health institutions have been identified as factors responsible for low use of public health institutions and the continually high maternal mortality (Stekelenburg *et al.*, 2004, Mathole *et al.*, 2006, Choguya 2015; 2018, Lori *et al.*, 2018, Dodzo & Mhloyi 2017). These scholars further state that distances from the houses of the expectant mothers to the health care facilities, financial expenses and perceived quality of care have also influenced the expectant mothers' decision not to seek maternal care. Failure to access adequate and quality maternal health services has resulted in expectant mothers using alternative care service because it is more accessible to them thereby giving birth alone at their homes with no supervision of a skilled birth attendant (Stekelenburg *et al.*, 2004). The aforementioned factors have been considered crucial in inhibiting access to maternal health care, hence, facilities such as waiting mothers' shelters have been made available to facilitate accessibility and ensure that expectant mothers are able to seek maternal health care at hospitals in time and give birth in health care institutions where they are supervised by skilled birth attendants. Service accessibility is explored below in terms of distance to the facility and cost of service.

It is a requirement of maternity facilities to have readily available transport in the form of ambulances that transport expectant mothers from their homes to the hospitals or from one hospital to another in case the expectant mother is referred to another hospital. Distance is a critical factor in getting to the hospital, because it inhibits accessibility to maternal health care. Cost, availability of transport and the condition of the roads have been major factors deterring expectant mothers from accessing maternal health care services especially in rural Zimbabwe (Stekelenburg *et al.*, 2004). Lohela *et al.*, (2012) argued that distances to health centres in developing countries are very long and ambulance transport for transporting expectant mothers is scarce. This is notwithstanding the fact that geographical access to delivery care and level of care offered at a health facility are key determinants of facility delivery.

One can argue that service accessibility in terms of user fees; distance and availability of transport are factors that influence access to maternal health facilities. Equally, the choice of using a hospital is determined by the accessibility of a facility. Mutseyekwa (2010) supports Stekelenburg *et al.*, (2004) and Lohela *et al.*, (2012) by arguing that lack of transport upon admission for referral purposes to major public hospitals contributes to inaccessibility of maternal health services by expectant mothers. He further mentions that in Mwenzezi district of Zimbabwe where there are 50 primary health facilities, only two ambulances are available to deal with emergencies. This shows that if maternity facilities do not have transport to fetch patients it results in expectant mothers travelling long distances to the facility using other means (donkies, bicycles, scotch carts among others). This may result in expectant mothers giving birth on their way to the facility or else giving birth at home with either no supervision or under the supervision of unskilled birth attendants who are not fully equipped to handle emergencies and obstetric complications should they arise.

Shortage of transport and long distances expectant mother may have to travel to maternal facilities may inhibit access to maternal health services. It has been argued that the timely access to emergency obstetric care plays an important role in saving the lives of expectant mothers experiencing complications at delivery (Stekelenburg *et al.*, 2004, Lohela *et al.*, 2012, Honda *et al.*, 2019). Apart from addressing the challenge of long distances to health care institutions, it has been emphasised that there should be a sound financial mechanism in health systems to ensure that expectant mothers access services and reduce out of pocket spending when they are about to deliver in health care institutions (Honda *et al.*, 2019). Non-medical costs involving transport and accommodation hinder access to emergency obstetric care by expectant mothers in particular those from low income settings in rural areas. Honda *et al.*, (2019) further add factors such as lack of knowledge and cultural barriers as well as inadequate antenatal care as other possible reasons influencing expectant mothers' access to health facilities.

However, a study conducted in Mberengwa district found that when the hospitals received aid from donors, affordability remained an issue because of the high cost of transport to the facility and the purchasing of items required for delivery (Dube, *et al.*, 2019). Furthermore, a study undertaken in Gutu rural villages in Zimbabwe, revealed that barriers to accessing health service

are extended beyond cost to include transportation, lodging in the waiting mothers' shelter, cost of services, payment for medicine in the hospital pharmacy, cotton sheets, fuel for ambulance, laundry service and food (Lori *et al.*, 2018). This shows that there are a number of factors besides user fees that affect access to maternal health services. In order to enhance access to maternal health services, there is a need to solve the problem of user fees, distance, and transport and ensure that resources needed for delivery are readily available for all expectant mothers.

It should be noted that differences in utilisation of maternal health care services between high- and low-income countries are enormous. However, differences are also encountered within countries where rural populations tend not to utilise maternal health care facilities as compared to the urban population (Eckermann & Deodato 2018). In rural Zimbabwe, areas with high maternal mortality ratios, utilisation of maternal health services is low. Low utilisation of maternal health services is mainly a result of barriers to access due to long distances to health care facilities and the availability of alternative care in villages due to alternative sources of care or poor access to biomedical facilities; and this has been considered important factors leading to high maternal mortality rate in rural area. Access to maternity health services is a key indicator of maternal mortality (Eckermann & Deodato 2018). Besides the per capita gross national product, access to maternal health services is the only important predictor. Therefore, reaching a health facility that can provide emergency obstetric care, is the best tool for reducing maternal mortality, and will also lead to a significant reduction of perinatal morbidity and mortality (Eckermann & Deodato 2018).

2.10 Healthcare Accessibility: Distance and Transportation Constrains

One of the major reasons why expectant mothers are encouraged to await labour in a waiting mothers' shelter in Zimbabwe is that of long distances between the houses of the expectant mothers and the health care facilities (Thaddeus 1994, Campbell 2009: 34, Figa-Talamanca 1996, Tumwine & Dungare 1996, van der Marel 2005, Eckermann 2008, Milton 2018, Saunder 2019). Geographical determinants include long distance between the community and the health facility; barriers such as rivers between the health facility and the community, the means and mode of transport to the health facilities in the event of an emergency. These geographical factors in many African countries such as Nigeria, the DRC, Zambia, Malawi and Zimbabwe contribute to delays in seeking maternal health care facilities in rural areas and this further places

mothers or new-borns at risk (Gabrysch *et al.*, 2011: 8, Keya *et al.*, 2013: 382). A review of the determinants of delivery services observed that greater distance to maternal health care facilities reduced the chances of skilled birth attendance at delivery in almost all studies (Moisi *et al.*, 2010; Schoeps *et al.*, 2011, Okwaraji *et al.*, 2012).

Studies conducted in Zambia and Bangladesh showed that health service utilisation decreases with distance (Kanengoni *et al.*, 2019 & Witter *et al.*, 2019). Further studies conducted in Vietnam, Burkina Faso and Ethiopia also confirmed that maternal and neonatal mortality increased with distance from the maternal health care service in most rural communities (Moisi 2010, Lohela 2012, Nyoni *et al.*, 2019 & Namurambi *et al.*, 2019). To reduce maternal mortality in rural areas, WHO suggested that waiting mothers' shelters can play an important role in reducing maternal and prenatal mortality for expectant mothers who live far from a health facility where transport networks are poor in cases of complications. Therefore, waiting mothers' shelters were established to reduce the risk of leaving it too late to traverse the distance between the house of the expectant mothers and the nearest health care facility to ensure more skilled-attended births. Different strategies were designed and employed to reduce such instances (UNFPA 2012; 2014). When access to care is difficult, women with high risk pregnancies should be admitted to a waiting mothers' shelter at 36 weeks of pregnancy (WHO 2012: 60, UNFPA 2012, UNDP 2014).

Maternal delays in utilisation of emergency obstetric care are the contributing factors for high maternal mortality in developing countries (Dodzo & Mhloyi, 2017: 4). Here "delay" refers to delays in arrival at a health facility, delays in receiving adequate treatment and delays in seeking health care. Two studies conducted in Zambia and Zimbabwe by van Lonkhuijzen *et al.*, (2003) assessed whether expectant mothers from remote areas were more likely to use a waiting mothers' shelter than other expectant mothers would. One study in Zambia showed the average distance to home for a waiting mothers' shelter users was 22km (range 2-80km) and 13km (range 0-66km) for those who went directly to hospital and none for non-facility users (van Lonkhuijzen *et al.*, 2003). In Zimbabwe, women who used the waiting mothers' shelter were more likely to live more than 40km away (48% versus 22%, $p > 0.001$) than those who went directly to hospital (van Lonkhuijzen *et al.*, 2003). The above studies provide evidence that the

issue of distance from the house of expectant mother to the health care facility is crucial yet inadequately studied. The “Three-Delays” model explained hereunder further explains the nature of delays in seeking obstetric care expectant mothers in rural communities usually experience.

2.11 Understanding Maternal Health Seeking Behaviours: The “Three Delays” Model

As described above, in Zimbabwe and other sub-Saharan countries, delays in seeking health care contribute to maternal mortality. However, the interval between the beginning of obstetric complication and its conclusion is one of the most critical aspects. The “Three Delays” model (Thaddeus & Deborah 1994) proposes that pregnancy-related mortality is mainly affected by: (1) delay in the decision to seek care, which means delay deciding to seek appropriate medical help for an obstetric emergency; (2) delay in arrival at a health facility, therefore delay reaching appropriate obstetric services and (3) on behalf of the health system, delay in the provision of adequate care when it is reached. The three delays model has been further used by scholars such as Nyarambi *et al.*, (2019) and Gladstone *et al.*, (2019) to discuss the delays that hinder expectant mothers from giving birth in health care facilities especially in rural communities. The above mentioned delays still remain the crucial delays in rural communities to date and they are the main hindrance to the access of maternal health care facilities (Manyika *et al.*, 2019, Mbuya *et al.*, 2019, Witter *et al.*, 2019).

The first delay stems from a failure to recognise danger signs. This is usually a result of the absence of skilled birth attendants in rural communities. It may also stem from reluctance within the family or community to send (or allow) expectant mothers to attend health facilities due to financial or cultural limitations. The second delay is caused by a lack of access to a health facility, a lack of available transport or a lack of knowledge of the existing services. The third delay relates to difficulties in the referral facility (including inadequate equipment, lack of available transport, and/ or a lack of trained personnel, emergency medicines or blood) (Teddius & Deborah 1994: 56).

Fig. 1: The Three Delays Model



Source: adapted from Taddeus and Deborah (1994)

All countries that have reduced maternal mortality have done it through an increase in hospital deliveries (Dodzo & Mhloyi 2017, Manyika *et al.*, 2019, Mbuya *et al.*, 2019, & Witter *et al.*, 2019). Therefore, maternal mortality reduction programmes should give priority to the availability, accessibility and quality of obstetric facilities (UNFPA 2018). It can be said that the first delay is related to the procurement of services, whereas the second and the third are related to the offer of services. Strategies to improve maternal health care should contemplate both, offer and demand, due to the multiple origins of causes. However, distance and cost are major obstacles in reaching appropriate obstetric facilities. As a result, the governments of most developing countries, including Zimbabwe, mainly try to increase access and reduce the second delay. Waiting mothers' shelters are therefore, one of the strategies most recommended as they are designed to reduce the gap between the community/villages and the biomedical health system (Nyati-Jokomo *et al.*, 2020). Waiting mothers' shelters attempt to reduce delays in treatment by moving expectant mothers into a waiting mothers' shelter located near hospitals. Waiting mothers' shelters, therefore, contribute especially to reducing the second delay of the "three delays" model.

2.12 Utilisation of Waiting Mothers' Shelters in Other Countries

The chances of women dying as a result of complications during pregnancy, delivery or the postpartum period remain high in many parts of the world. In 2005, the worldwide maternal mortality ratio was 402 deaths per 100,000 live births (confidence interval (CI) 216 to 654) (van Lonkhuijzen *et al.*, 2012: 3). Of the estimated 535,900 women who died that year, 50.5% (270,500) lived in sub-Saharan Africa. These numbers have remained essentially unchanged since 2000 (Hill 2014: 33). It is well recognised that most of the maternal deaths can be

prevented when appropriate treatment is started in time, and is given by a trained health professional in an adequate environment (WHO 2004). In areas with high maternal mortality ratios, utilisation of maternal health services is low (Dodzo & Mhloyi 2017). This low utilisation of maternal health services is mainly a result of barriers to access and leads to high maternal and perinatal mortality and morbidity. Differences in utilisation between high- and low-income countries are enormous, but, differences are also encountered within countries, for example, the level of utilisation of maternal health care services is higher in urban areas than in rural communities (Mathole 2006, Njovana 2014, Choguya 2015, Dodzo & Mhloyi 2017). Access to maternity health services is a key indicator of maternal mortality. Besides the per capita gross national product, access to maternal health services is the only other important predictor. Therefore, reaching a health facility that can provide emergency obstetric care is the best tool for reducing maternal mortality, and accessing that care will also lead to a significant reduction of perinatal morbidity and mortality (Bulatao 2018).

According to Endalew *et al.*, (2016: 32), evidence in Nigeria showed that waiting mothers' shelters reduced the maternal mortality ratio from 10 per 1000 to less than one per 1000 deliveries, and the stillbirth rate from 116 per 1000 deliveries to 20 per 1000 deliveries. Similarly, in Malawi (Nkhotakota, Dowa and Dedza Districts), waiting mothers' shelters reduced maternal mortality in the area to zero (Endalew *et al.*, 2016: 32). In Eritrea, there was a 49% increase in health centre births after the introduction of waiting mothers' shelters (Andemichael 2009, Kelly *et al.*, 2010, van Otsine & Stekelenburg 2012). A study done in Atat Hospital, Ethiopia, showed that disparity in food supplies among differing levels of family and social support, medical care including delivery, lack of facility at the waiting mothers' shelter where visiting relatives can stay, were the major challenges that women faced in waiting mothers' shelters. In present day Ethiopia, deliveries attended to by skilled health professionals is targeted to be 90% and to reduce the maternal mortality rate to be less than 1% in 2020 (Gaym *et al.*, 2012: 210, Berham & Berham 2014: 137, FDRE 2015: 31).

Other factors besides sustainability can lead waiting mothers' shelter services to fail. Shrestha *et al.*, (2007) described the failure experience of waiting mothers' shelters in Nepal, where out of the 27 waiting mothers' shelters available, not a single one had been utilised by all the expectant mothers (Shrestha *et al.*, 2007). The cross-sectional study was based on 18 pregnant women and

14 health workers interviews and focus groups. After the analysis of data, the authors concluded that many women were unaware of the service and that the community was not involved in the establishment of the waiting mothers' shelters, highlighting the need for information dissemination and promotional activities to increase the utilisation of waiting mothers' shelters. UNICEF (2010) describes the promotion of a waiting mothers' shelter set up in Afghanistan in 2008. A 17-bed facility became fully operational in 2008 located near Kandahar Hospital. The facility had a female medical team in order to conform to local customs. No information about usage was provided (UNICEF 2010). Notwithstanding studies that showed that utilisation of waiting mothers' shelters reduce maternal and neonatal mortality; there is scarcity of documented literature in the study area about experiences of women in waiting mothers' shelters on the use or non-use of these. Therefore, this study reduces this gap by studying the particular experiences of expectant mothers in these facilities before, during and after delivery in relation to their use or non-use of the facility.

2.13 Utilisation of Waiting Mothers' Shelters in Zimbabwe

Nhindiri *et al.* (2018) conducted a study to estimate the degree and pattern of utilisation of institutional maternity services in a rural area of Zimbabwe, a cross-sectional study was performed in Gutu district in Zimbabwe. In August 1991, 12 out of 43 wards in the district were randomly selected and, in each ward, about 40 expectant mothers (in total 520) who had delivered in the previous 12 months participated in the study. There was a high degree of utilization of institutional maternity services by the women (96%, 79% and 74%) for antepartum, intra-partum and post-partum care, respectively (Nhindiri *et al.*, 2018: 43). Expectant mothers sought this care from a multiplicity of sources depending on a variety of social, geographical and service factors. Very few expectant mothers (17%) had total pregnancy care at the rural health center. There was a significant association between the actual place of delivery and nulliparity⁹: whether the previous delivery took place at home, whether the family belonged to the Apostolic Faith sect, and whether the husband spent most time in urban area Nhindiri *et al.*, (2018). For nulliparity, previous delivery at home and belonging to the Apostolic Faith sect, the proportion of women delivering at home, or at the rural health center/urban maternity clinic, and at hospital

⁹ Refers to cases where a woman has never given birth before. It does not mean that a woman has never fallen pregnant before but the woman could have had miscarriages, still births or elective abortions hence never given birth to a live baby (Russel 2018:14).

was statistically significant. The waiting mothers' shelters that were available lacked basic amenities and were unattractive to the mothers, even though 65% either used them or could have done so if they were available (Ndindiri *et al.*, 2018).

In this same study, Nhindiri *et al.*, (2018) concluded that most expectant mothers stayed in a waiting mothers' shelter and institutional deliveries were preferred by the majority of expectant mothers, with hospital and clinic deliveries constituting 58% and 27% of deliveries, respectively, while 15% delivered at home. Long-term complications were few, and only 14 (1.6%) women reported a current health problem, which they related to previous pregnancies. Antenatal attendance rate was high. The majority of women preferred institutional deliveries. Few women reported complications, which were not taken care of in the health service. Long-term complications related to previous pregnancies were few.

Several authors including Dodzo and Mhloyi (2017), Nhindiri *et al.*, (2018) (van den Heuvel, 2018) have investigated the factors that play a role in the success of a waiting mothers' shelter. In Zimbabwe, a cluster survey (including 235 respondents) examined the use of maternal care services and found that nearly all (97%) women attended antenatal care during their last pregnancy at least once, and 66% gave birth in hospital (van den Heuvel 2018). The use of a waiting mothers' shelter increased the likelihood of hospital delivery nearly six-fold. Only one-third of all respondents, however, did use the waiting mothers' shelter. Complaints that were mentioned about the waiting mothers' shelters were that the houses were too small and crowded, the toilets needed improvement and there was a shortage of water and firewood (Van den Heuvel 2018). Five years earlier, in a survey in the same district, two thirds of the women stated that they would use a waiting mothers' shelter if one was provided. The other third mentioned the absence of food provision and that there was no help with cooking, the necessity to collect one's own water and firewood, poor hygiene and lack of transport for referrals as important factors for their refusal to use a waiting mothers' shelter (van den Heuvel 2018).

In addition, another crucial element in rural Zimbabwe that affects the utilisation of waiting mothers' shelters is the acceptance and participation of community in the operations of the facility. Waiting mothers' shelters are the maternal health service that is best organised by communities using their local resources, although, the government is taking the major role of

establishing these facilities in present day Zimbabwe. If a community does not accept a waiting mothers' shelter, the chances of it being utilised are low (Nhindiri *et al.*, 2018). Studies conducted by Mafaune *et al.*, (2020) and Nyati-Jokomo *et al.*, (2020) in rural Zimbabwe showed that some expectant mothers were discouraged from using waiting mothers' shelters by their husbands, who considered it inappropriate for women to stay away from home for too long. The government in Zimbabwe establishes the waiting mothers' shelters, but, the community is where local support is greater, and has been able to sustain their activities despite the reduction of government support in certain instances (Dodzo & Mhloyi 2017). Credibility of the waiting mothers' shelter is a critical factor because expectant mothers and their families may not be easily convinced to move away from home before their expected delivery date.

2.14 Effectiveness of Waiting Mothers' Shelters in Other Countries

The effectiveness of waiting mothers' shelters has been described in general terms and can be traced from history up to date. Cardoso (2018: 350), in his study, shows that Cuba has improved its national health system since 1961. According to Cordoso (2018: 352), waiting mothers' shelters were part of an extensive project to improve the care for women giving birth. The first waiting mothers' shelter opened in 1962, and by 1984 there were 85 facilities. In the same period, the proportion of deliveries in health institutions increased from 63% to 99%. A continuous audit of all cases of maternal death showed that between 1960 and 1984 maternal deaths from haemorrhage decreased from 32 per 100,000 births to 2 per 100,000 births (Cordoso 2018: 352).

In addition, the Cuban case study shows that there was a comprehensive register of waiting mothers' shelters services. Maternal mortality in the Caribbean country decreased between 1962 and 1989, from 118 to 29 per 100,000. In this period, institutional delivery experienced a considerable increase from 63% to 99%. It is considered that the set-up of waiting mothers' shelters that increased from 22 in 1970 to 148 in 1989 contributed significantly to these improvements (Wilson *et al.*, 2017: 244). The waiting mothers' shelter network in Cuba is completely integrated within the National Health System. Referrals to waiting mothers' shelters are assigned by the family physician who provides prenatal care to expectant mothers. Waiting mothers' shelters are built within the premises of a local hospital or at a reasonable distance. A particular characteristic of the Cuban experiences is the availability of national health workers in

waiting mothers' shelters, with an average of 0.8 full-time health workers (nurses, auxiliaries and labourers) per bed (Wilson *et al.*, 2017:244). In addition, the staff sometimes includes one or more full-time physician or midwife. Medical care includes daily vital signs and blood pressure measurements done by a nurse, as well as at least one obstetric check-up twice a week by the physician. All the activities required to maintain the infrastructure in a good condition, including day activities such as cooking and cleaning, are carried out by labourers. Educational and health promotion activities are offered to expectant mothers staying in the waiting mothers' shelters (Wilson *et al.*, 2017: 256).

The Cuban case study is characterised by a community service aspect. Several groups based at community level support the waiting mothers' shelter (agriculture cooperatives, women's organisations, and others). By 1990, there were 150 maternity homes distributed throughout the island, with a total of 2,365 beds (Talamanca: 1996: 1382). In 1989, nearly 30% of all deliveries incorporated waiting mothers' shelters. Although waiting mothers' shelters in Cuba have been assessed positively, empirically there is no definitive evaluation of the impact. Nevertheless, it is widely considered that they have undoubtedly contributed to raising the rate of institutional deliveries in Cuba (WHO 1996: 2-4, Talamanca 1996: 1382-1384).

In Honduras, the introduction of waiting mothers' shelters was part of a strategy to improve maternal health. According to Daniel and Rivera (2017), firstly, it consisted of improving the referral of obstetric emergencies through the training of traditional birth attendants. Secondly, it aimed to identify women with high-risk pregnancies and encourage them to give birth in hospital. Waiting mothers' shelters were built and maintained with help from the communities, to allow expectant mothers living far away to go and stay near the hospital. With this risk approach, hospitals with a waiting mothers' shelter (compared to hospitals without a waiting mothers' shelter) had more women who were older than 34 or who had had more than 4 deliveries (Daniel & Rivera 2017).

Knowles (2018: 388) suggests that all expectant mothers should be referred to a waiting mothers' shelter so that they may give birth in hospital. In Nigeria, the establishment of waiting mothers' shelters has contributed to reducing the maternal mortality ratio in hospital from 10 per 1000 deliveries to less than 1 per 1000 deliveries, and the stillbirth rate from 116 per 1000 deliveries to

20 per 1000 deliveries (Knowles 2018: 388). In Papua New Guinea, it was observed that many complications occurred in grand multiparas (Stewarts 2020). A grand multipara occurs when a woman has had five or more pregnancies (Stewarts 2020). A policy of early referral of these grand multiparas to a waiting mothers' shelter, combined with the advocacy of tubal ligation for these women after giving birth, has led to a reduction of emergency referrals by air from 25 to 9 per year (Stewarts 2020: 312). Nevertheless, Stewarts (2020) and Knowles (2018) also observed that fewer stillbirths have occurred among women staying in the waiting mothers' shelter when mothers failed to inform the nurses that their labour had started as compare to women who did not stay in the waiting mothers' shelter.

Studies shown above state that waiting mothers' shelters are facilities that have improved access to hospitals to expectant mothers and have increased the chances of women delivering in health care institutions, thus decreasing the risks of maternal mortality during delivery (Stewarts 2000, Knowles 2018, and Mafaune *et al.*, 2020). Nonetheless, in other studies, for example, by Stewarts (2000) & Knowles (2018), the effectiveness of waiting mothers' shelters is still questionable; hence there is need for more research to assess the effectiveness of these facilities in rural communities where health care facilities are not easily accessible.

2.15 Effectiveness of Waiting Mothers' Shelters in Zimbabwe

In Zimbabwe, Chandramohan *et al.*, (1994) evaluated a waiting mothers' shelter over a two-year period. This study compared the outcome of delivery for 1573 women who had stayed in the waiting mothers' shelter to 2915 women who had not. They found that non-users were more likely to have obstructed labour (1% versus 0.06%). Non-users were also less likely to have a caesarean section (15% versus 18%). Among the non-users, there were six craniotomies¹⁰ and four hysterectomies¹¹ compared to zero amongst the waiting mothers' shelter users (Chandramohan *et al.*, 1994). The authors found that only 31% of women had stayed in the waiting mothers' shelter. They concluded that the facility users are more likely to have safer delivery than non-facility users.

¹⁰ Craniotomy refers to a surgical operation in which a bone flap is temporarily removed from the skull in order to access the brain (Bick 2009:199).

¹¹ Hysterectomy is a surgical operation to remove a woman's uterus (Bick 2009:32).

In the same study population, the effect of waiting mothers' shelters on perinatal outcome was recorded. The perinatal death rate per 1000 births was 19.1 in the users group compared to 32.2 amongst the non-users (Risk Ratio (RR) 1.7, 95% CI 1.1 to 2.6) (Mbizvo 2019: 32). In the subgroup with antenatal high-risk pregnancies, the difference was 21 compared to 43 (RR 2.1, 95% CI 1.2 to 3.6) (Mbizvo 2019: 32). When adjusted for other risk factors, the RR was 1.9 (95% CI 1.1 to 3.9). In the group with low-risk pregnancies, that is, without any antenatal risk factors, no difference in perinatal deaths was found. Authors such as Knowles (2018), Mathole (2004), Chandramoham (2005) and Mudani (2010) also conclude that the waiting mothers' shelter improved access to hospital care.

Mafaune *et al.*, (2020) note that despite efforts to improve prenatal and perinatal health care in Zimbabwe, childbirth remains hazardous for both mother and child. Several measures have been initiated to try to improve maternal and perinatal morbidity and mortality. One such measure is the establishment of waiting mothers' shelters at hospitals where mothers can wait so that, when they go into labour or develop antenatal complications, they can transfer to the hospital wards for management and safe delivery. From May 1987 to April 1996, Tumwine (1996) evaluated pregnancy outcomes among 280 women using such a shelter in Gutu rural district in Zimbabwe. Perinatal mortality was higher (29.8 per 1000) among 773 non-waiting mothers than among the waiting mothers (25.0 per 1000), although this was not statistically significant ($p > 0.05$) (Tumwine 1996). However, there were significantly more low birth weight babies (11.4%) among the non-waiting mothers than among the waiting mothers (4.3%) ($p < 0.01$) (Tumwine 1996). Fetal deaths were more common than early neonatal deaths, suggesting that maternal factors accounted for most of the perinatal deaths. Poor pregnancy outcome was associated more with primigravidae¹² and grand multigravidae¹³ than with those who had had one to four pregnancies. Tumwine (1996) concluded that waiting mothers' shelters can contribute to preventing low birth weight and improving perinatal outcome.

In addition, Chidakaya *et al.*, (2018) conducted a study on waiting mothers' shelters in Mberengwa district, in Zimbabwe. In their study, they note that waiting mothers' shelters have been proposed as a means to improve expectant mothers' access to hospital care. The study

¹² Primigravidae refers to a woman who is pregnant for the first time (Geily 2013).

¹³ Multigravidae refers to a woman or a female who is or who has been pregnant for the second time (Geily 2013).

investigates the use and effectiveness of waiting mothers' shelters through an analysis of all births in Zimbabwe's Mberengwa district during a 2-month period in 1994. Four of the five hospitals in the district had waiting mothers' shelters on site that are open to any woman at no charge. Of the total of 1041 births that were available for analysis in the study, 813 (78.1%) occurred in the hospital and 228 (21.9%) were home deliveries, (Chidakaya *et al.*, 2018: 24). Waiting mothers' shelters were used by 616 women (59.2%), for an average stay of 16 days. The majority of these women (85.9%) cited good access to medical care as their reason for using a waiting mothers' shelter, (Chidakaya *et al.*, 2018: 25). The perinatal mortality rate was 22/1000 for hospital deliveries and 39/1000 for home births. On one hand, women with a previous cesarean section and primiparous¹⁴ women gave birth in the hospital significantly more often than at home (Chikadaya *et al.*, 2018). On the other hand, women with at least four previous births and women not booked for antenatal care were significantly more likely to give birth at home than in the hospital. The number of women with a previous perinatal death, a previous postpartum hemorrhage, breech presentation, or a twin pregnancy did not differ significantly between the home and hospital groups (Chikadaya *et al.*, 2018). The findings of the study suggest that as long as access to emergency obstetric services is limited by poor transport, waiting mothers' shelters are effective as a means of improving pregnancy outcomes.

In different provinces in Zimbabwe, waiting mothers' shelters have demonstrated benefits such as an increased proportion of facility-based deliveries (Kanengoni *et al.*, 2019), improved maternal health (Kennethe *et al.*, 2016 & Makate *et al.*, 2017), a lower risk of perinatal death Makandwa *et al.*, (2017), decreased incidence of obstructed labour (Chandramohan 2005, Cutts, & Millard 2017), improved access to essential and emergency obstetric care (Spaans, van Roosmalen & van Wiechen, 2015), and the potential to decrease rates of stillbirths (Bhutta *et al.*, 2009; Chandramohan *et al.*, 1995; Lee *et al.*, 2009). Systematic reviews have concluded that waiting mothers' shelters have proven to be effective, but, the evidence is limited because of a lack of properly designed intervention studies (van Lonkhuijzen, Stekelenburg & van Roosmalen 2012).

While these studies only looked at institutional births, Makandwa *et al.*, (2017) also included home births in his analysis of 1041 deliveries in Zimbabwe. Of these, 22% occurred at home and

¹⁴ *Primipara* is basically a woman giving birth for the first time (Gaily 2013:19).

78% in hospital. Waiting mothers' shelters were used by 59% of all women. The two most frequent reasons for women delivering at home were lack of money (35%) and uncertain gestational age (26%), (Makandwa *et al.*, 2017: 17). Two women died at home due to postpartum haemorrhage and one died in hospital due to cerebral malaria. Primiparas and women with a previous caesarean section more frequently delivered in hospital. The authors concluded that the waiting mothers' shelters improved access to hospital care (Makandwa *et al.*, 2017).

Findings from a range of studies examining waiting mothers' shelters in terms of their acceptability to expectant mothers and their effects on maternal and infant outcomes in Zimbabwe have been considered in this section. Overall, findings were generally encouraging suggesting that waiting mothers' shelters are facilities that increase the number of expectant mothers accessing hospitals or health centres for the birth (Andemichael 2009, Mathole *et al.*, 2006, Choguya 2015, Mafaune *et al.*, 2020). Some studies reported improved outcomes for women, infants, or both (Chandramohan, 2005; Kelly *et al.*, 2010; & Mafaune *et al.*, 2020), or at least no worse outcomes even for women with complications during pregnancy (van Lonkhuijzen 2003). Notwithstanding these positive findings, the high risk of bias in studies means that results may be difficult to interpret and generalise, hence, there is need to continue carrying out studies in other rural communities since these cannot be generalised.

All of the retrospective cohort studies in Zimbabwe that I have mentioned above describing the effects of having a waiting mothers' shelter in a hospital were at high risk of selection bias. That is, expectant mothers using these facilities were different from those not using the facilities, and such differences mean that the results may not be generalised. Differences between women using or not using facilities may have been by design, for example, where expectant mothers with risk factors were specifically referred to the waiting mothers' shelter. Nevertheless, findings may well have been confounded by other selection factors. For example, Kelly (2010) reports large differences in maternal and perinatal mortality rates favouring expectant mothers using waiting mothers' shelters compared with expectant mothers admitted directly in labour. However, expectant mothers admitted during labour were less likely to have attended for any antenatal care (therefore, were less likely to have had antenatal risk factors detected), were younger and more

likely to be nulliparous¹⁵ and most importantly, in a context where most expectant mothers gave birth at home were often seeking admission because a problem had already developed.

Although the effect size in this study was large, it is difficult to know how much of the decreased mortality rate is accounted for by differences between expectant mothers in the two study groups rather than by attendance at the waiting mothers' shelter. Willis (2017) also highlights the possibility of selection bias, his study examined whether the introduction of waiting mothers' shelters in a rural area increased the number of expectant mothers who lived in remote areas accessing health facilities for the birth (as intended) and concluded that they did not. The further expectant mothers lived from healthcare facilities the less likely they were to access them (Willis 2017). This applied just the same before and after the introduction of waiting mothers' shelters, raising the possibility that expectant mothers who seek health care for the birth are the same ones that take up waiting mothers' shelters. These women are likely to be different from those that do not (Willis 2017). There is a strong likelihood that as well as the opportunity to 'wait' for the birth at a location with immediate or improved access to a hospital or health centre, other aspects of care were different for expectant mothers attending or not attending a waiting mothers' shelter.

A number of scholars have acknowledged that, in the Zimbabwean context, there was considerable variability in the amenities and care available at waiting mothers' shelters. Some waiting mothers' shelters provided basic shelter, while in other cases, the waiting mothers' shelter was part of a broader package of care including the provision of food, education and antenatal care (Makate *et al.*, 2017, Kanengoni *et al.*, 2019, & Mafaune *et al.*, 2020). Access to healthcare staff may have increased the likelihood of expectant mothers reporting problems and antenatal monitoring in the waiting mothers' shelter may in turn have increased the likelihood of complications being detected and provided for in the subsequent course of antenatal and intrapartum care (Kanengoni *et al.*, 2019). In the study by Makate *et al.*, (2017), comparisons were made between expectant mothers giving birth at home and those giving birth in hospital with most of the women in the latter group, reporting having used a waiting mothers' shelter. Women giving birth at home and in hospital are likely to have different care experiences (for both

¹⁵ Medical term used to describe a woman who has never given birth to a child. It doesn't necessarily mean that she has never been pregnant — someone who's had a miscarriage, stillbirth, or elective abortion but has never given birth to a live baby (Murray 2018: 48).

antenatal and intra-partum care) irrespective of whether or not they attended waiting mothers' shelters.

Other studies have examined community acceptability of waiting mothers' shelters in Zimbabwe. Expectant mothers praised the easy access to skilled attendance during delivery and the companionship of other women staying in the facility (Yaya *et al.*, 2017 and Nyoni 2019). However, Mhloyi (2017) has made recommendations on what should be available at waiting mothers' shelters, including privacy and separation from men and income-generating or skill-development activities embarked on by women whilst at the shelters. In Mberengwa district, prior to the establishment of waiting mothers' shelters, a community acceptability study revealed that there would be barriers to their use by minority ethnic groups (Chidakaya *et al.*, 2018). The programme was subsequently designed to address these potential barriers, including the integration of micro-credit and income-generating activities with maternal health services, and permission for non-harmful traditional birth practices to take place alongside modern medical practices (Chidakaya *et al.*, 2018).

The variation in waiting mothers' shelters, populations and areas served means that results from individual studies that have previously been conducted may not be easily generalised to other settings. Studies conducted by Chidakaya *et al.*, (2018) & Kanengoni *et al.*, (2019) also examined the limited uptake of waiting mothers' shelters in some settings underline the need to take account of local customs and practice, and the broader factors facilitating or inhibiting access. Kanengoni *et al.*, (2019) states that access to waiting mothers' shelters and to health care is not only affected by geography and distance or access to affordable and efficient transport links. Expectant mothers may have many factors to take into account when deciding where they spend the last weeks of their pregnancy and, indeed, where they give birth. These factors include the community engagement in support of the waiting mothers' shelters. According to Nyoni (2019), the fact that expectant mothers who develop a serious obstetric complication need appropriate care in order to survive is clear. From the literature reviewed, it is also clear that in many places, a large number of expectant mothers are unable to deliver in a healthcare facility. Antenatal care attendance might be good but when labour starts, many barriers may prevent women from reaching a hospital. So, building a waiting mothers' shelter may be a solution for expectant mothers (Nyoni 2019). If expectant mothers manage to stay in a waiting mothers'

shelter, immediate access to emergency obstetric care, if required, should be guaranteed. Therefore, there is an urgent need for more studies to provide evidence to assess the effect of a waiting mothers' shelter on pregnancy outcomes for women and neonates in low-resource rural communities placing emphasis on the community involvement in the functioning of the waiting mothers' shelters.

Although waiting mothers' shelters are effective facilities in rural communities, as shown above from a cross examination of literature, the facilities are not commonly used in rural Zimbabwe. One of the major reasons crucial to this study, apart from long distances to health care facilities, is that these facilities are situated in multi-ethnic communities that practise medical pluralism. Medical pluralism practised in rural Zimbabwean communities comprises western biomedicine, faith healing, patent medicine shops and traditional medicine; care-seekers make choices on these options to meet their health needs (Choguya 2015, Kajawu & Chingarande 2016, Moshabela *et al.*, 2017). According to Mathole *et al.*, (2006: 44), 60-80% of deliveries in rural areas in developing countries are assisted by traditional birth attendants. In general, rural Zimbabwe has entrusted the field of maternal health to traditional healers who usually perform traditional/home birth attendance methods (Choguya 2015). Jaravaza (2013: 1) also argues that although, health care systems co-exist, issues to do with contraceptives and childbirth in Mutasa district are biased towards traditional indigenous systems. Kajawu & Chingarande (2016) also state that traditional healers are usually consulted for any health problem occurring among expectant mothers until after delivery, and have knowledge on medicines used in managing pregnancy and childbirth. Expectant mothers are educated on pregnancy-related taboos and how to handle infants after birth. Traditional birth attendants and traditional healers are known to have some knowledge of risk signs during pregnancy (Mathole *et al.*, 2004, Jaravaza 2013 & Choguya 2015). Given the bias that rural communities have towards traditional birth attendants, it is important to explore the perceptions and experiences of expectant mothers in biomedical health care facilities and what influences their choices in use or none use of the facilities.

2.16 Medical Pluralism

Historically, medical sociologists have devoted considerable attention to the study of maternal health care amenities of different medical systems in indigenous or tribal societies, in peasant communities, and among sub-groups of urbanites in developing nations (Singer *et al.*, 2011).

Even before the emergence of medical sociology as a named area of specialisation within sociology, researchers recorded data about health beliefs and practices, including healing techniques in indigenous societies (Hughes 1978: 151). Studies of health-seeking behaviour have become increasingly popular over the past two decades in an attempt to explain the differential use of health care services, including maternal health services (Mackian *et al.*, 2004, Singer *et al.*, 2011, Amzat & Razum 2014, Kajawu & Chingarande 2016, Moshabela *et al.*, 2017). Medical pluralism is, therefore, a common phenomenon in reproductive health, including maternal health (Jaravaza 2013, Choguya 2015). It opens up important discussions on how cultural processes/ideologies and beliefs influence the maternal health care systems care seekers (expectant mothers) adhere to. Thus, the present study ponders on the concept of medical pluralism to establish how it relates to, and affects, women's choices on use or none use of biomedical health care facilities such as waiting mothers' shelters.

Medical Pluralism (MP) can be conceptualised as the employment of more than one medical system or the use of both conventional and Complementary and Alternative Medicine (CAM) for health and illness (Shih *et al.*, 2010). Seethamraju (2017) agrees with Shih *et al.*, (2010) that medical pluralism refers to the co-existence of different medical systems in any given society. Amzat and Razum (2014) further elaborate that the term "medical pluralism" is used to describe the co-existence of biomedicine and alternative medicine. Therefore, medical pluralism (MP) refers to "the coexistence in a society of differing medical traditions, grounded in different principles or based on different world-views" (Gabe *et al.*, 2004: 183). In other words, MP can be conceptualised as the adoption of more than one medical system or the use or integration of both conventional biomedicine and complementary and alternative medicine for health and illness. Medical sociological investigations of health care practices have demonstrated that medical pluralism, or the existence and use of many different health care alternatives within societies, (as has been defined above) is the rule and not the exception in indigenous societies the world over (Singer *et al.*, 2011, Amzat & Razum 2014, Mandizadza 2016, Chibanda *et al.*, 2017). Medically pluralistic societies offer a variety of treatment options (physician, spiritist, pharmacist, curandero, and so on) that health seekers may choose to utilise exclusively, successively, or simultaneously (Choguya 2015, Kajawu & Chingarande 2016, Mandizadza 2016, Mashabela *et al.*, 2017).

In all societies, there are alternative or complementary health care systems. Nevertheless, in modern societies, biomedicine that claims to be evidence-based dominates the health systems. Hence, other systems that are not from the biomedical approach are often referred to as complementary or alternative medicine. The so-called complementary and alternative medicine (CAM) often predates modern medicine; it comprises ways or practices used in medical care before the introduction of modern medicine, but outlive modernisation (Amzat & Razum 2014). Alternative medicine refers to a medical tradition often devoid of systematic and scientifically verifiable evidence, which people sometimes use in the treatment and prevention of diseases. Alternative medicine is usually derived from historical and cultural traditions. Complementary medicine is the phenomenon of the mix of modern and traditional medicines. In this case, traditional medicine is used alongside orthodox medicine. Conventional medicine (also herein called modern, western, orthodox, or allopathic medicine) is medicine as practiced by those who are formally trained in biomedical sciences. These people include the physicians, pharmacists, nurses, and other allied health professionals, such as physical therapists and psychologists.

Cultural variation or multiplicity accounts for the variety of alternative medicines which are mirrored in the country's pluralistic medical systems and beliefs surrounding the concepts of illness and health. The conception of health and illness often varies within medical systems. Han (2002) observed that in pluralistic medical systems there are divergent sickness labels and multiple interpretations of illness conditions. Therefore, pluralism results from heterogeneous cultures with differential traditional care patterns.

Many people identify with alternative medicine because its existence provides viable options in health care. There is still a preference for alternative medicine among many individuals in both developing and developed countries (Amzat & Razum 2014). In most societies, there is competition and antagonism between modern and alternative medicine in the care of the patients. Alternative medical practitioners often lay claim to expertise on various illness conditions. In most instances, they are closer to community members than the orthodox medical practitioners. And importantly, modern medicine has not been able to resolve all health problems, and alternative medicine often claims to fill the gap of medical possibilities. This is why they are still relevant. Like other societies in Africa, Zimbabwean societies are not left out. Medical pluralism is a major feature of the health care system. Alternative medicine is sometimes called traditional

medicine (TM). For the purpose of this study, the focus is on only three health care systems that affect childbirth and delivery in rural communities; that is the biomedical, traditional and faith healing systems. These health care systems have been chosen because they are the widely practised in Zimbabwe. Other medical systems have been deliberately excluded from this study due to their unpopularity in the case study area and the possible methodological challenges that they may pose.

2.17 Organisation of Health Care in Zimbabwe

According to Machinga (2011: 3), Zimbabwe has a three-tiered health system. Zimbabweans mainly consult the traditional healers, the prophets from –Churches of the Spirit,” and western style hospitals and clinics for health and healing, and this includes maternal health services too. In the traditional practices which include various ethnic groups in Zimbabwe, wellness is derived from the cultural understanding of the role of family, community, and the spiritual world in human welfare. According to Murambidzi (2016) and Muridzo *et al.*, (2017), in Zimbabwe, across various regions and ethnic groups, diseases are considered by various cultures to have physical, mental, social, spiritual and supernatural causes. Cures extend beyond physical symptoms to address social and spiritual aspects too (Mandizadza 2016, Muridzo *et al.*, 2017). Most rural communities have a traditional healer. Some hospital clinicians also do not see a conflict between science and traditional practices; therefore, they suggest that patients visit traditional healers if they so wish (Machinga 2012, Mandizadza 2016, Kajawu & Chingarande 2017, Moshabela *et al.*, 2017).

Often, alternatives in health care systems are held to represent various systems of medical practice and ideology, each deriving from a separate historical and philosophical basis and providing a different mode or theory of treatment for the individuals who use them (Singer *et al.*, 2011). Pregnancy and childbirth are also pluralistic health care issues in that expectant mothers choose which medical system best suits their beliefs systems and they act accordingly. It is therefore important to develop a clear understanding and consistent usage within the discipline of the terms medical system, medical pluralism, and health care alternatives in reproductive health (maternal health) (Batisai 2016, Togarasei 2017). In addition, the practice of medical pluralism is universal, with the incorporation of alternative or complementary therapy, which may include homeopathy, herbals, natural healing and holistic therapy. Singer *et al.*, (2011: 1) states that:

Throughout this century and even before, there has been a general assumption even a conviction that folk and popular systems of health beliefs and practices would inevitably decline in modern and industrialised societies. Yet this has not been the case.

In non-Western societies such as Africa, including Zimbabwe, the use of traditional medicine and some of the above practices are incorporated with methods to include indigenous and religious healing rituals. These methods of healing are commonly used in rural communities in Zimbabwe (Chinyoka & Mushoriwa 2018). Pregnancy and childbirth have been entrusted in the hands of different health care systems that are available in the Zimbabwean indigenous societies and care-seekers choose what best suits their belief systems and ideologies (Mathole *et al.*, 2004, Choguya 2015, Musoni 2017, Togarasei 2018). Community and family members play a crucial role in socialising community members on which medical system to use, according to what is best accepted in their culture (Mathole *et al.*, 2006: 50). In this regard, expectant mothers are also influenced on which medical system to use throughout their pregnancy and during delivery. As a result, the use of hospital and maternal health care services in any rural community in Zimbabwe is influenced by the socio-cultural factors and the beliefs of the care-seekers (Mathole *et al.*, 2004: 938). Some of the socio-cultural belief widely recognised in literature (Mathole *et al.*, 2004, Hlatshwayo 2017, Togarasei 2018) include the practice which is done any time between the second and third trimester of a primigravidae who is married so that her (experienced) mother/aunts can guide her accordingly in the perinatal phases – including recognition of early signs of labour onslaught and what to do¹⁶ (Hlatshwayo 2017). There is also the practise to ensure that there would be ease of NVD and decreased risk of C-section or infant suffocation during delivery¹⁷ (Hlatshwayo 2017) and then there is the practice meant to delay the progression of labour¹⁸ when a woman has suddenly gone into labour and the delivery centre is far away. The above mentioned factors support scholarly evidence that maternal health in rural communities has been entrusted in the hands of various health care systems and care seekers (expectant mothers) choose those that suit them best.

In addition to the above-mentioned factors, an examination of the various typologies of plural medical systems particularly stresses the concept of a dominative medical system, which points

¹⁶ *Kusungira (masungiro).*

¹⁷ *Kuvhura masuwo (mushonga wemasuwo).*

¹⁸ *kusunga dombo.*

to the fact that medical systems do not exist in a vacuum but, rather, reflect the class, racial, ethnic, and gender relations and inequalities of the wider society as has been alluded to earlier (Mandizadza 2016, Kajawu & Chingarande 2017, Singer *et al.*, 2019: 234). In a dominative medical system, several different healing traditions coexist in the same society, but one tends to be more closely aligned with the dominant social groups in that society and to be the dominant healing tradition as well. Indigenous or tribal societies exhibit a diversity of healing beliefs and practices as well as an array of different kinds of healers, but these tend to be rather loosely organised and often reflect idiosyncratic patterns resulting in part from the fact that healers commonly are secretive about their medical knowledge (Singer *et al.*, 2019: 234).

Health care in Zimbabwe has been characterised as pluralistic because of the existence of both traditional and biomedical systems and faith healing (Mutambirwa 1989, Dahlin, 2002; Hansson, 2016 & Gukurume 2018). Although medical systems co-exist, the concept of dominative medical systems is also evident in the various medical systems in Zimbabwe. According to Mathole *et al.*, (2004), inasmuch as more than 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 (MoHCC 2016: 48). Many more people have been forced to seek traditional health care because of various factors such as cultural beliefs and ideologies, high hospital fees, and shortage of essential drugs, among other issues (Chimhete 2002, Mukumbura 2000, Ncube 2003). Recently in Zimbabwe, the crisis in the formal health care system has forced hospital professionals, including medical doctors to accept and even encourage people to use traditional care (Ncube 2003).

The TBAs are recognised by the government (Chavhunduka 1994, Mathole *et al.*, 2006, ZINATHA 2015, Chidzambwa 2018 & Mapuweyi *et al.*, 2018) and are part of the Zimbabwe Traditional Healers Association (ZINATHA), the members of which cover a wide range of traditional healers, herbalists, spirit mediums, diviners, prophets, herbalists, and midwives. A study in Zimbabwe by (ZINATHA 2015: 33) indicated that 92% of TBAs also provide herbs and practice other forms of traditional care. Their midwifery roles ranged from taking care of pregnancy and childbirth, treating infertility, and playing an advisory role in family matters (ZINATHA 2015 & Mapuweyi *et al.*, 2018). In other studies, it was revealed that expectant mothers not only in rural communities rely on traditional herbs to care for pregnancy and prepare

for a smooth childbirth process with fewer complications (Mukumbura 2000 & Mapuweyi *et al.*, 2018). ZINATHA (2015) indicated that maternal and child health care in Zimbabwe was provided by traditional, modern scientific, as well as church medicine. In Zimbabwe, the formal biomedical and traditional health care systems seem to be dominative in terms of provision of maternal health care services to community members than other medical systems such as the church (Mathole *et al.*, 2004: 939, Togarasei 2018).

2.18 The Role of Traditional Healers in the Maternal Health in Zimbabwe

The Shona people, the *Manyika* included, are generally spiritually oriented in all they do, including the process of birthing (Beach 1980, Ranger 1984, Bourdillion 1987). Ranger (1984) agrees with Beach (1980) and Bourdillion (1987) that the *Manyika* culture is originally centred on religious rituals and most Manyika people still adhere to their traditional religion that centres on the worship of their *Musikavanhu* (High God and their ancestral spirits), although other members of this culture converted to Christianity during the colonial era up to date. The *Manyika* people's spiritual rituals guide their day-to-day life. Traditional healers¹⁹ are regarded as the spiritual mediums (Chavhunduka 1986: 50, Hund 2003: 161, ZINATHA 2015). Hund (2003: 161) also describes traditional healers as so called "witch doctors" which, according to Hund (2003: 13), is not exact. The term "witch", however, has several meanings Chavunduka, (1986) & Hund (2003: 136) such as a bad person who is envious of others; or a person who goes his own way despite objections of other people, a trouble maker who commits antisocial acts, a deviant. Chavunduka (2003) argues that witchcraft does exist and is not a myth as western missionaries believe. Mutwa (2003) further highlights that traditional healers are also diviners who conduct diagnoses of illness, and further claims that traditional healers play the same role as psychiatrists and priests of various religions and have the ability to foresee future events. Mutwa (2003) further impresses that these people who are called traditional healers have a tremendous store of knowledge which is what the *Manyika* society has used during childbirth. Mutwa (1996) and Hund (2003: 167) refer to a traditional healer as the "guardian of his people and his culture", thus, whatever the Zimbabwean *Manyika* society does, and they consult traditional healers for guidance.

¹⁹ *N'angas*.

Traditional medicine is also still popular due to active traditional healers or medicine men (Yakan 1999: 556). In southern Africa, the term *n'anga* is used to mean traditional healer as has been alluded to. Geschiere (2008) & Hund (2003: 12) writes that the traditional healer is a kind of “super witch” who can heal people who have been bewitched or cursed with misfortune, and offers them protection against witchcraft. It is generally believed that the supernatural powers of witches in Zimbabwe are at the heart of almost everything that brings sorrow, pain, shame, death, illness, insanity, impotence, barrenness, unemployment, and failure in exams, among other things (Mathema 2009: 4). Considering the spirituality surrounding pregnancy and childbirth, and the traditional healer’s role in this, traditional healers were included in this research. Chavhunduka and Last (1986: 259) argue that “Traditional healers have for long been treated like trees on savannah farms, not formally cultivated, yet valued and used, particularly by women and children in African indigenous societies”.

Traditional healers have been referred to as witch-doctors, diviners, medicine men, herbalists and sorcerers by members in the society (Batisai 2016 and Mawoza *et al.*, 2019). In an urban area in Zimbabwe, biomedicine is politically, the seemingly legitimate and mostly acceptable form of health care service, though, the herbalists and diviners continue to practice publicly, they also remain visible in the media (radio, TV and print) remains ever visible: adverts in newspapers, spiritual discussions on both television and various radio stations in Zimbabwe. In rural areas, though not aired on different media platforms, traditional healers are widely recognised in communities and practise publicly (Mburu 1992, ZINATHA 2016, Batisai 2016, Mawoza *et al.*, 2019). Over the years, urban populations that visit traditional healers have increased as some openly seek their care while others secretly do so (Rugwiji 2019). In rural areas, traditional medicine seems to be more popular than in urban areas, as the skill of being a traditional healer is transferred from one person to the other in the same clan (Chavunduka & Last, 1986, Batisai 2016, Kajawu & Chingarande 2016). Ataudo (2015: 1345) describes African traditional medicine as the totality of all knowledge and practices, whether explicable or not, used in diagnosing, preventative or eliminating a physical, mental or social equilibrium and which rely exclusively on past experience and observations handed down from generation to generation, verbally or in writing.

Traditional medicine and indigenous knowledge are treated with importance among the *Manyika* people who have continued to maintain the basic features of their tradition. In my experience of the *Manyika* people, men have the most influence in the family, including any decision taken for birthing, for example, consent to deliver in a public health institution. Nyati (2004: 6), Mathole *et al.*, (2006: 20) and Johnson *et al.*, (2007: 171) observe that among the *Manyika*, people mostly concentrated in the Manicaland Province, normal birth and home births conducted by professional midwives, traditional healers and TBAs and relatives are highly supported.

Mathole *et al.*, (2006) and Choguya (2015) share the same view that 60-80% of deliveries in rural areas in developing countries are assisted by TBAs. In general, rural Zimbabwe has entrusted the field of maternal health to traditional healers who usually perform traditional/home birth attendance methods (Mathole *et al.*, 2006, Choguya 2015). Jaravaza (2013: 1) argues that notwithstanding health care systems co-existing, contraceptives and child birth are biased towards traditional indigenous systems, traditional healers are usually consulted for any health problem occurring among expectant mothers until after delivery and have knowledge on medicines used in managing pregnancy and childbirth. Expectant mothers are educated on pregnancy-related taboos, how to handle infants after birth, and traditional healers are known to have some knowledge of risk signs during pregnancy (Mathole *et al.*, 2004; Jaravaza 2013: 1, Choguya 2015: 5). Given the bias that rural communities have towards traditional birth attendances, it is important to explore the perceptions and experiences of expectant mothers in biomedical health care facilities and what influences their choices in use or none-use of the facilities.

2.19 Training of Traditional Healers as Birth Attendants in Zimbabwe

Traditional birth attendants (TBAs) are also known as traditional, community, or lay midwives (Amzat & Razum 2014). A majority of TBAs are old mothers who have had multiple births and there are a number of men as well. They are primarily responsible for pregnancy related issues including childbirth and child care. The WHO (1992) defines a TBA as a person who assists the mother at childbirth and initially acquires her/his skills by delivering babies by herself/himself and/or by working with other birth attendants. Some of the TBAs also have knowledge of herbs. They attend to pregnant women in cases of pregnancy-related danger signs and take care of the new born. Izugbara and Ukwayi (2003) observed that apart from delivery, TBAs also provide

additional services such as abortion, child sex selection, family planning, and cures for infertility, STDs, serial miscarriage, and vaginal bleeding (Umeora & Egwuatu 2010). TBAs have filled some of the gaps in maternal care. Some of these maternal services are complicated at times, this is the reason it has been considered essential that the TBAs are trained to use basic best practices in maternal care and know when to refer some maternal-related complications to the biomedical services. With the recognition of their roles in maternal health, some TBAs have undergone training through the modern health care sector to upgrade his/her skills (WHO 1992, Izugbara & Ukwayi 2003, Mathole *et al.*, 2006, & Umeora & Egwuatu 2010).

Training of TBAs has been considered an important strategy for improving infant and maternal health care, especially in rural communities in Zimbabwe (Mathole *et al.*, 2004: 66). The WHO took the initiative to promote TBA training in Zimbabwe since the 1970s (Leedam 1985, Mbizvo 2000 & Mathole *et al.*, 2004). The aim of the training was to make home deliveries cleaner and safer. The MoHCC (2016) also facilitated the integration of the two health systems (traditional and biomedical) which, according to Mawoza *et al.*, (2019) is essential for preserving the best elements of each for the benefit of the mothers and children. In Zimbabwe, apart from being taught the essentials of general hygiene and maternal and child health care, the TBAs are trained to recognise and to refer high-risk women and those likely to have complications to the hospital (MoHCC 2016). However, over the years, the MoHCC in Zimbabwe has been speaking against home births although there are no specific policies towards that which have been stipulated by the Government of Zimbabwe (GoZ) under the MoHCC.

The training is nonetheless based on the international generalised guidelines and consists of a 15-day training course (WHO 1991, Mathole *et al.*, 2006, Choguya 2015 & Kanengoni *et al.*, 2019). The training programmes and manuals were jointly prepared by WHO Harare office and the MoHCC. The training is done by nurses (with 2 or 3 years of nurse training) and midwives (with nurse training plus 1-year midwifery course) at their respective health centres (WHO 1991, Mathole *et al.*, 2006, Choguya 2015, Kanengoni *et al.*, 2019). They used lectures, role plays, drama, and songs in their teaching. Continuous supervision and monitoring of the TBAs are supposed to be done through home visits, meetings at the clinics, and quarterly reports that are produced by TBAs on what they have been doing. It is estimated that about 15,000 TBAs have

been trained in the entire country since the programme was launched in 1983 (Mathole *et al.*, 2006, Kanengoni *et al.*, 2019).

The training, however, has been criticised for being complicated and inappropriate for elderly and at times illiterate women, due to its reliance on western, urban models of training and for using culturally inappropriate teaching methods (Goldman & Gleib 2003). The Zimbabwean rural communities are mostly populated by illiterate elderly people who did not have a chance to acquire modern education as they were participants in the Zimbabwe war of liberation (UNDP 2014: 200). These elderly people believe they have a calling and, of course, have indigenous knowledge on herbs and traditional medicine but not in terms of how to read and write. This has posed a challenge for their training sessions and furthermore, on the performance of duties during home deliveries, according to the WHO standards of delivery (Mathole *et al.*, 2006). Other critics such as Dodzo and Mhloyi (2017), Mugadza (2018) and Vondo (2019) have argued that the training entails merely biomedical knowledge and practice. Vondo (2019), for example, argues that the training programme is simply a replica of biomedical knowledge and practices; hence, the TBAs are generally not necessary in communities.

Nunu *et al.*, (2019), further argue that the biomedical perspective has limited the role of traditional midwives, as the previously used skills and practices for which they are popular have been discouraged. The studies of Nunu *et al.*, (2019) in Mberengwa district in Zimbabwe as well as other studies by Haley *et al.*, (2017), Kenneth & Marvellous (2018) and Mambanga (2019) have added to the international debates on suitable approaches to reduce maternal mortality in poor countries through the use of the TBAs. The emphasis on biomedicine in the training of TBAs is being challenged, and understanding the local knowledge and practices is considered central for incorporating the TBAs into evidence-based care (Haley *et al.*, 2017, Kenneth & Marvellous 2018, Mambanga 2019 & Nunu *et al.*, 2019).

From the above argument, one can observe that rural communities have traditional birth systems which are readily available options for delivery. Societies highly regard this maternal health care system due to cultural beliefs and ideologies. Studies conducted by various social science scholars in the field of maternal health in Zimbabwe have reached a conclusion that it is unclear in Zimbabwean rural communities how TBAs handle emergencies and complications

during delivery (Mathole 2013, Maguranyaga 2011, Njovana 2014, Kenneth & Marvellous 2018, Mambanga 2019, Nunu *et al.*, 2019). In addition, considering the long distances between houses of expectant mothers and the hospitals as compared to that of the community available TBAs, one has to consider if it is easy to ferry an expectant mother with a complicated delivery to the hospital from the house delivery point to avoid death (intra-partum transfers). Furthermore, since some believe that being a traditional healer is a calling, they do not find the need to go for training and they perform home deliveries without training, hence, the chances of effectively handling emergencies are slim. In cases such as failure to handle emergencies, the TBA blames the expectant mother for not being in regular standing with the ancestors or doing something wrong during delivery that angers the ancestors (Kenneth & Marvellous 2018). On the same note, since the deliveries are home deliveries done in the private sphere, it is also problematic to monitor if the delivery standards are sufficiently safe and hygienic to meet the WHO standards set in 1970 (Mambanga 2019, Nunu *et al.*, 2019).

2.20 Faith Healing

The interface between religion and biomedical health delivery system continues to be a popular theme of religious development. Zimbabwe is constitutionally and predominantly a Christian country with a population of over 2, 9 million subscribing to Christianity (Togarasei 2019: 19). The last few decades saw a massive growth of the Pentecostal charismatic movement and an ultra-conservative apostolic crusade. The previously dominant African traditional religion characterised by ancestral worship, gradually waned as it was regarded by many as backward, obsolete and sinful (Chitando 2016, Togarasei 2016). Apostolicism is founded on native resistance to foreign divinities preached by the early missionaries (Chitando 2016 and Togarasei 2016). It is therefore, characterised by a mixture of Christian and African traditional tenets. There are many Apostolic groupings in Zimbabwe, but, the two that command sizable following are the Johanne Marange and Johanne Masowe groupings, named after the founders (Machingura 2019: 210). These two leaders were both from eastern Zimbabwe (Manicaland Province) and both had deep religious experiences in the early 1930s (Ranger, 1980, Rosette, 1997, Togarasei 2016). As a result, both started preaching repentance and baptism among African peoples (Mukonyora, 1998, Togarasei 2016), having followers in Zimbabwe, throughout the southern, central and eastern parts.

Schiller and Levin (1988) & Kanengoni *et al.*, (2019) noted that there is a religious factor in health care utilisation. Studies have consistently maintained that in Zimbabwe, religion is associated with health care utilisation and improved health outcomes (Gyimah *et al.*, 2006, Hebert *et al.*, 2007, Chiswick & Mirtcheva 2010). Religion is a prevalent social institution that shapes individual and community health behaviour through its influence on lifestyles, worldviews and motivations (Benjamins 2005, Maguranyanga 2011, Njovana 2014). However, different religious groups have different views on health care and health issues. For instance, Maguranyanga (2011) found that, among the ultra-conservative Apostolic groups in Zimbabwe, religious teachings, doctrine and regulations stressed faith healing and total adherence to church beliefs and practices that sometimes hinder modern healthcare seeking. The Jehovah's Witnesses encourage members not to accept transfusion of whole blood; red blood cells, white blood cells, platelets, and plasma, this is based on the belief on a Biblical passage which prohibits blood transfusion (Loma Linda University, 2014). The group, however, does not object to the use of medical alternatives to blood transfusion.

Several other Christian groups, particularly, the contemporary Pentecostal groups, have liberal health related teachings and doctrines (Gukurume 2018). However, most of them are of the view that seeking spiritual counsel and faith healing should precede use of medication. This is linked to the belief that health problems are caused by the influence of bad diet, natural phenomena, and wrath of God as a punishment for sin, demon possession, lifestyle and malicious spiritual manipulations by enemies (Olanisebe 2002, Ikorok 2003, Gukurume 2018). Moslems also believe in the spiritual causes of health problems and often distinguish between illness that may be treated medically and those that may be related to the will of God (Padela & Curlin 2012). Spiritualising health in the process of determining when to seek medical help or when to apply formal medicine shapes the utilisation of health care by adherents of different religions. Religion abets culture in the formation of beliefs, attitudes and practices. Some traditional practices have been found to be associated with maternal risk (Popal 2004, Dodzo 2011). Both religion and culture affect the utilisation of maternal and new-born health services from a motivational and supply perspective (Gymial 2004, Foun *et al.*, 2009, Mathole *et al.*, 2006, Choguya 2015). Nunu *et al.*, (2019) note that religion influences attitudes and a wide range of behaviours in reproductive health, HIV prevention and health care utilisation.

2.21 The Power of the Holy Spirit in Faith Healing

Maguranyanga (2011) states that the Johanne Marange Apostolic sect, like similar groups, regards itself as a Holy Spirit-led type church. This is one of the bases for its religious beliefs and practices. Musevenzi (2017: 187) points out that the belief in the Holy Spirit is a key for the church in the sense that it works to nurture and restore good health and quality of life, particularly of those who are faithful and observe the religious tenets, teachings and regulations of the church. He further notes that the Holy Spirit is regarded as the source of spiritual revelation, prophecy, healing and protection and that without it, there is no church. The Holy Spirit serves as the divine force that guides the church, and equips prophets and some church members with special healing powers. Musevenzi (2017) notes that evidence also shows that the belief in the Holy Spirit is seen to ensure strict adherence to religious teachings and practices and compliance with all normative values of the group. Imposition of penalties on those who violate church regulations and the belief system is common practice. The beliefs, teachings and practices also tend to reinforce faith in faith healing and strict adherence to the church doctrine.

The concomitant discouragement of seeking help and medication from secular biomedical health services means that a significant proportion of the Apostolic group membership suffer or die from conditions that can be easily addressed by medical interventions (Maguranyanga 2011: 16, Musevenzi 2017: 200). According to Maguranyanga (2011: 16), 40% of women in the Apostolic sects die from sexually transmitted infections (STIs) due to polygamy and non-health seeking behaviours in this Apostolic sect. In his study, it is shown that infant care is weak as church doctrines discourage immunisation among the infants. Between 1998 and 2009, a large population of children from 0-5 years died due to the spread of measles in the Apostolic groups and it was in 2015, due to government interventions, that the group agreed to immunise children at infancy against the eight killer diseases (ZDHS 2015: 333, WHO 2016, MoHCC 2017: 80). Maternal mortality is still high in these sects due to the spiritual nature of birth attendance that regard complications during birth as works of evil spirits and demons that need to be exorcised (Maguranyanga 2011: 300, Musevenzi 2017).

It is against the group's dogma to seek medical help from modern medical services and practitioners. The related practice derives from the group's belief that illness and diseases have spiritual and religious undertones and that these are the primary cause(s) of illness and sickness.

Chakawa *et al.*, (2010) and Musevenzi (2017) add to this argument by pointing out that the church believes that its spiritual interventions have a spiritual competitive edge over secular, modern healthcare services. Thus, there is a strong emphasis on adherence to church beliefs, teachings and doctrine on matters pertaining to religion and health. The susceptibility to, and the severity of diseases, are subject to the Holy Spirit and one's faith. Ultimately, death from sickness is regarded as the will of God.

2.22 Faith Healing and Maternal Health

Birth through the faith healing system is called spiritual birth attendance (SBA) (Maguranyanga 2011, Njovana 2014, Msevenzi 2017). In Zimbabwe, members of different Apostolic sects believe that health, disease and sickness all have spiritual foundations (Gragson *et al.*, 2009, Maguranyanga 2011, Foun *et al.*, 2009, Gymah *et al.*, 2006). In fact, the Shona people believe that ancestral spirits influence the health of the living (Gragson *et al.*, 2009). Most religious people including Christians believe that health is a blessing from God and disease a curse from the devil. Apostolic sect members display maternal practices that are significantly different from most other religious groupings (Maguranyanga 2011). For example, their expectant mothers display a higher propensity to deliver outside the formal health system, without skilled attendance according to (Wei 2012, Musevenzi 2017, Kanengoni *et al.*, 2019). It is also notable that they have a higher propensity to have more than five pregnancies, hence, easily falling within the high-risk segment, and yet without visiting skilled attendance institutions. Indeed, for them, the more children one has borne, the more experience they are considered to have acquired in childbirth, hence, the less-likely they are to utilise even the services of their SBAs (Kenneth & Mavellous 2016, Mawoza *et al.*, 2019). Izugbara (2019) further notes that non-institutional deliveries by unskilled attendants remain common in much of the developing world, notwithstanding decades of modernisation and advances in medical technology. This increases the risk of maternal and neonatal mortality (Gabrysch & Campbell 2009, Duffy *et al.*, 2012).

Approximately two-fifths (38%) of women in Zimbabwe identify themselves as members of the Apostolic denomination (Wei, 2012, ZIMSTAT, 2018: 327). Nyarambi and Mundagowa (2019) found that some of these reject modern medicine and therapeutics, preferring instead to receive services from SBAs. Here they are offered prenatal, intra-partum, postnatal and emergency care in the best way a spiritual health system can afford (OPHID 2019). A claim to offer emergency

obstetric care (EmOC) from a spiritual perspective sounds fatal, and it may indeed be, especially as it is known that EmOC can reduce maternal mortality (Pasha *et al.*, 2019), particularly when deliveries are conducted by skilled birth attendants in controlled and appropriate conditions (WHO 2004). Both of these are absent in spiritual health systems. The proportion of institutional deliveries in Zimbabwe has systematically fallen from 77% in 1999 to 69% in 2007 and 65% in 2012 (OPHID 2012; 224). In a review of EmOC services in sub-Saharan Africa, Montague (2011) found that although highly effective, the uptake of institutional maternal care remains poor even when widely available. This has been known to cause higher maternal mortality (Keber *et al.*, 2007, Lewis *et al.*, 2008, Kanengoni *et al.*, 2019). In Zimbabwe, religion remains one of the commonest barriers to health care utilisation.

In many developing countries, including Zimbabwe, institutional deliveries remain low and are gradually worsening (Montague 2011, Lewis *et al.*, 2018). A number of researchers have demonstrated that Apostolic women have a propensity for non-institutional deliveries (Maguranyanga 2011; OPHID, 2012; Perez *et al.*, 2008 , Odile *et al.*, 2019). Emmanuel (2009) found the rates of maternal mortality among Apostolic church members in the Mutasa and Marondera district much higher than the provincial and national rates. In the United States, Kaunitz (2015) found that religious women who avoided EmOC had 100 times higher mortality than the state-wide rates. This demonstrates that the phenomenon is also common in highly developed states. Hove (2018) also confirmed lower postnatal care attendance among women of the Johanne Marange Apostolic faith in Bocha, Manicaland.

Zimbabwe continues to be one of the strongholds of the African Apostolic Church. Although the exact following of the Apostolic movement in the country has not been determined with certainty, the ZDHS (2015) and the Multiple Indicator Cluster Survey (MICS) (2017: 300) data indicate a rather rapid growth of the group from 20% of the population in 1994 to 21.5% in 1999 to 27% in 2009 to 44% in 2015. CSO & Macro International (2010), Machingura (2011) & ZIMSTAT (2010) argue that this would put the current population following the Apostolic faith at 3.5 million and translates into a 1.4 million increase over the 15-year period. This growth of the Apostolic faith coincided with the development of an HIV/AIDS crisis, a downward spiral of the Zimbabwean economy and the consequent collapse of the health sector, arguably once one of the best in Africa (Kanengoni *et al.*, 2019). Since 2009, the Inclusive Government, with support

from development partners, has been trying to rebuild the health system and increase the coverage of important maternal and child health interventions (GoZ & UN 2010, UNICEF 2018).

Apostolic churches in Zimbabwe have been found to affect adherents' health access and health outcomes in several ways as has been mentioned above. Firstly, the churches provide necessary social support to their members in times of great change or adversity, which can positively support improved physical and mental health (Mpofu *et al.*, 2011). Secondly, their strict doctrine and moral codes on sexual behaviour may offer perceived protection from HIV infection. These have been confirmed in small sample surveys by Gregson *et al.*, (2015) as well as Pearson and Makadzange (2018). Lastly, but most pertinent to the focus on maternal and child health, Apostolic churches emphasise prophet-healing through prayers, holy water and talismans like wooden crosses, red/white strings around the waist/neck, holy stones, and the action of the Holy Spirit. Any use of western and modern medicine is seen as exhibiting a lack of faith in God and is strongly prohibited (Dube 2019). Notwithstanding recent changes in ideology aimed at improving access to health services for members of the Apostolic faith and spearheaded by the Union for the Development of Apostolic Churches in Zimbabwe (UDA-CIZA), traditional beliefs still prevail, especially, among the ultraconservative Marange and Madhidha Apostolic groups (Maguranyanga 2011, Togarasei 2019 , Kanengoni *et al.*, 2019).

The rise and spread of measles outbreaks were allegedly linked to Apostolic gatherings in Zimbabwe Manicaland Province (ZDHS 2005). Notwithstanding nationwide campaigns to ensure that every child in Zimbabwe is immunised, pockets of religious objection exist and these remain of concern (UNICEF 2018). These deleterious impacts on access to health can also be exacerbated by the asymmetric power that the churches bestow to men and husbands which constrains women's decision-making in relation to health. Gregson *et al.*, (2015) found that in the 1990s, children from the Apostolic churches had much higher infant mortality rates. By the 2000s, however, in Honde Valley in Manicaland province, this difference had disappeared. Hove *et al.*, (2018) have documented that mothers belonging to the Apostolic faith are less likely to have used postnatal care services in Manicaland Province. These studies are however, based on small samples in a few confined areas and, thus, their results cannot be extrapolated to other parts of Manicaland province.

There is no doubt that the spiritualisation of illness and disease is the main cause for members of the Johanne Marange Apostolic Church objecting to the use of modern health facilities. These are perceived to be in conflict with the things of the spirit (Maguranyanga 2011 & Musevenzi 2017). When a member accesses modern medical treatment, it is a sign of insufficient faith or trust in God's healing power and intervention. Studies of the church by authors such as Chitando (2007), Musevenzi (2017), Togarasei (2018) and Dube (2019) show that the philosophy of faith healing has disastrous consequences for women and children needing medical assistance, especially, in maternal health. Over the years, and due to the church's teachings and beliefs, church members have sad stories about preventable child deaths and deaths of expectant mothers in communities due to a lack of knowledge of child diseases, especially those which could have been easily prevented by vaccines. Children with diseases are quarantined and treated with special concoctions and parents are forbidden to have sex when the child has an illness such as measles, as it is believed that the child might die.

In such situations, parents have to confess their sin, including adultery, if a sick child is to survive. As a result of the belief system and teachings and due to a high rate of illiteracy, poverty and marginalisation, women are the hardest hit by maternal health care problems, STIs, HIV and AIDS. They are also not equipped to deal with HIV and AIDS, as a result of the level of patriarchy and how sexuality issues are regarded in the Apostolic church. Phiri (2008) rightfully notes that, with the group's anti-modern health methods, women continue to be the victims of polygamy, forced marriages maternal mortality and HIV and AIDS. Women in the Apostolic church have the highest infection rates and, at the same time, carry the heavy burden of providing care for the ill and needy. Phiri's (2015) analysis shows that this resulted in a number of interventions from the MoHCC, Governmental Organisations (GO), NGOs and other stakeholders but with limited success.

2.23 Biomedical Health Care

The biomedical model of health focuses on the physical or biological aspects of disease and illness. This thesis will use a working definition by Annandale (1998: 332) which states that the biomedical model to health ~~is~~ a medical model of care practised by doctors and health professionals and is associated with the diagnosis, cure and treatment of disease". According to the biomedical model, health constitutes the freedom from disease, pain, or defect, making the

normal human ailment ~~–healthy~~”. The model’s focus on the physical processes (for example, pathology, biochemistry and physiology of a disease) does not take into account the role of social factors or individual subjectivity (Crişan & Copoeru 2020: 425). Unlike the bio-psychosocial model, the biomedical model does not consider diagnosis, which affects treatment of the patient, to be the result of a negotiation between doctor and patient. It is considered to be the leading modern way for health care professionals to diagnose and treat a condition in most western countries. Biomedical healthcare systems have been perceived as western ideology of health care in non-western countries (Ferry-Danini 2019, Shaheen *et al.*, 2020).

There has been a persistent, long-term communications gap between medical sociologists and health care policy makers and practitioners. Crişan and Copoeru (2020: 427) state that ~~–medical~~ sociologists working in various primary-health contexts have frequently felt frustration that health-system policy makers and practitioners appear to pay little heed to the importance of understanding the cultural beliefs” and knowledge systems of the peoples they are meant to serve. Policy makers and practitioners have often found it difficult to see how medical sociological descriptions and interpretations of cultural belief systems can be directly and systematically related to specific health care applications (Crişan & Copoeru 2020).

2.24 The Biomedical Health Care System in Zimbabwe in the Post-Independence Era

In Zimbabwe, the use of Biomedical Health care facilities dates back to the pre-independence era. Zimbabwe’s independence saw the ushering in of a Primary Health Care (PHC) approach designed to reduce these many disparities. After a brief post-independence economic boom, much of the population experienced a decline in economic well-being (Farre & Rapley 2017). Post-independence Zimbabwe saw several economic and social reforms relevant to health instituted, although, some have subsequently been eroded since the implementation of an economic structural adjustment programme, and this includes maternal health care services (Nyandoro & Hatti 2019).

Furthermore, scholars such as Buzuzi *et al.*, (2016) and Witter *et al.*, (2019) have agreed that Zimbabwe inherited a colonial biomedical health care system upon independence in 1980. Health services were divided along racial lines in the pre-independence era and there had been profound socio-geographical imbalances in the allocation of physical, financial and human resources in the health sector prior to independence (Sanders, 1993, Konyana 2018, Zeng *et al.*,

2018). For example, Zeng *et al.*, (2018: 60) notes that the average expenditure for the private sector medical aid society that benefited mostly white patients was ZWD\$144 per person per year during 1980-1992, whilst public health care expenditure for predominantly black people was ZWD\$31 per person per year. The amounts are even lower at ZWD\$4 per person for those in rural areas. Witter *et al.*, (2019: 20), also note that 32% of the total government budget for health care during the financial year 1980-1990 was allocated to the Andrew Fleming Hospital in Harare (later renamed the Parirenyatwa Central Hospital) which served the white community.

Following independence, the government made a commitment to the pursuit of equity initiatives in Zimbabwe to address the existing inequalities by investing in biomedical health care services, particularly in rural areas (Mhike 2016, Buzuzi *et al.*, 2016, Witter *et al.*, 2019). Considerable progress was recorded from independence until the late 1990s, as demonstrated by the fact that 616 new rural health centres were constructed and 550 existing ones were upgraded over the three-year transitional period from 1996 to 1999 (Sander 1999: 47, Mkandawire 2020). By 1999, the number of rural health centres and clinics had increased from 247 at the time of independence to 1,062 (Mkandawire 2020). The government viewed biomedical health services as an integral part of development and considered access to biomedical health a human right (Government of Zimbabwe (GoZ), 2018). This understanding guided the post-independence government's health policy, resource allocation decisions and human resource development (Mkandawire 2020).

According to Mhike (2016: 256), in the early 1990s, the government introduced a policy stating that all Zimbabweans earning less than ZWD\$150 per month were entitled to free health services; with about 90% of the population falling below that income threshold in 1990. This implied that the government provided free health care to a large majority of the population, including almost everyone living in rural areas. The government's commitment to primary health care resulted in the improved geographical accessibility of primary care services (Mutopo 2017). During the 1980s and early 1990s, these health centres were adequately staffed with a doctor-to-patient ratio of, on average, 1:6,000 per year within public hospitals (Chikanda 2018: 82). The economic crisis that the country experienced from 1997 resulted in the deterioration of services in the health sector to a doctor-patient ratio of 1:12,000 per year in public hospitals; the dramatic decline in the health budget translated into an increased reliance on user fees, which has had a

significant impact on all service users, the poorest in particular. Chikanda (2018: 86) focuses on user fees and, particularly, their impact on patients who are suffering from chronic diseases.

2.25 Structural Adjustment Period and Healthcare in Zimbabwe

The period of the Economic Structural Adjustment Programme (ESAP) in Zimbabwe saw the decline in use of biomedical health care facilities in Zimbabwe due to the introduction of user fees in healthcare institutions (Mutopo 2017, Mufudza 2018). In 1991, Zimbabwe implemented an Economic Structural Adjustment Programme under the auspices of the World Bank (GoZ 2015). As elsewhere, this package of economic reforms included reduction in social expenditure, currency devaluation and trade liberalisation. In the health sector in Zimbabwe, the collection of user fees was initially enforced in 1992, and during 1993-94 fees were increased (Mufufadza 2018). Concern had already been expressed regarding the impact of cost recovery, particularly user fees, on utilisation of health care services by the World Bank (Mutopo 2017). Subsequent studies during the first two years of ESAP showed a decline in the use of health care facilities in the range of 25-30% (Honogoro & Chandiwana 1994, Mutopo 2017, Mufudza 2018, Douie 2019).

When Zimbabwe became independent in 1980, the government inherited a fragmented health service which was urban-centred and focused on curative services (Gohwa 2017). Post-independence policies were designed to ensure greater equity in access to health services and to strengthen preventive services. This policy led to an expansion in primary care facilities and a rise in health care expenditure, which increased nearly two-fold between 1995 and 1998 (from 4.6% to 8.8%). According to Chirwa *et al.*, (2016), central government expenditure accounted for about 50% of overall health care expenditure. The mission hospitals which accounted for about 3% of expenditure were particularly important in rural areas where church-related hospitals continued to provide most medical care. In urban areas, insurance schemes and personal payment (along with government subsidies) supported the private sector (about 25% of total expenditure). In addition, other bodies such as local authorities (8%), commercial organisations, such as mines, farms, industry (8%), and foreign aid (10%) provided support for health care (Chirwa *et al.*, (2016). The introduction of fees in the health care sector coincided with escalating inflation rates during the early period of ESAP (Muvunzi 2015). Between 1990 and 1992, the official inflation rate nearly tripled, reaching 46.3% per year. The food inflation

rate rose even more steeply, reaching 72.6% per year in 1992. Government salaries in no way kept pace with inflation. For example, nurses received annual increments of 5 to 10%. Devaluation of the Zimbabwe dollar effectively slashed the drug budget and the ability of the government to procure drugs was crippled by inability to clear its debts (Chirwa *et al.*, 2016).

2.26 Maternal Care and the Structural Adjustment Period in Zimbabwe

The ESAP as marked by a decline in the use of maternal health care services in Zimbabwe. The decline of the use of maternal health care services is attributed to economic constraints that were experienced by everyone including women during this period (Mathole *et al.*, 2006). The effects of financial cuts in maternal health spending and the introduction of user-fees showed in Zimbabwe's maternal health-status indicators, which were deteriorating. Life expectancy, which was 45 in 1990, had risen to 64 in 1999, although it dropped down to 60 in 2017 (Chirwa *et al.*, 2016 & Mutopo 2017). Maternal deaths nationally declined until 1989, but increased dramatically by 240% between 1992 and 1994 (Muvunzi 2015: 37). Maternal mortality rates that were recorded in 20 hospitals in Manicaland Province's main obstetric centres doubled during the same period among the resident population, and rose by 40% among the non-resident population referred to the hospitals, a higher-risk group. The causal relationship between these trends can be attributed to the introduction of user-fees in maternal health care facilities and economic challenges that Zimbabwean citizens faced during this period and the burden was worse for rural populations. For example, statistics from Mutare Provincial Hospital showed an increase from 8.8% in 1991 to 13.6% in 1993 in the number of babies born to mothers who had not registered for antenatal care (Muvunzi 2015: 38).

Since the introduction of ESAP in the area of maternal health, there was a reversal of all the good progress made in the decade after independence in terms of improvement in access to maternal health care facilities by every expectant mother who needed it (Muvunzi 2015, Chirwa *et al.*, 2016). In the 1991-94 fiscal years, real per capita expenditure by the MoHCC fell by 18%, and by 12% in 1994-96, and by 1997 it had fallen by 34% from its 1991 level (Chirwa *et al.*, 2016). This drop in expenditure affected the quality and quantity of maternal health services. The health sector remains one area in which women are employed in large numbers due to the employment of female nurses, although males are increasing joining the nursing field (Douie 2019). Due to financial constraints, the number of nurses employed by the MoHCC per thousand

populations dropped by 15% in 1991-92, by 8% in 1993 and by 48% in 1997, hence, there were inadequate staff members in healthcare institution especially in rural areas (Douie 2019: 56).

The recruitment of new staff was difficult in this era, and the poor salaries and working conditions caused by budgetary constraints have been cited as a major cause of a serious “brain drain”, particularly in the health sectors (Chandiwana 2015, Nyandoro 2019, Nhapi 2019). According to Nyandoro (2019: 33), real salaries for the lower grades of civil servants, including doctors and nurses, declined by almost 40% between 1991 and 1994. Budgetary constraints affected the purchase of new and maintenance of old equipment at maternal health facilities, as well as the quantity of supplies. Nyandoro (2019: 35) reports that:

There has been a steady decline in the real value of the revolving drug fund allocated to the government medical stores... There has been a 67% decline in the real value of the drug fund since 1988-89 due to inflation ... In 1992-93; the MoHCC depleted its funds for medical and surgical supplies well before the end of the fiscal year.

Every year there are crises reported in the press, inadequate drugs in the health facilities, as well as inadequate supplies of other essentials (Nhapi 2019, Saunders 2019, Nyandoro 2020). In early 1997, many hospitals were unable to provide food for their patients and a proposal that patients supply their own food was being considered (Saunders 2019: 271). There is no doubt that the above problems affect the efficiency and quality of maternal health care offered in hospitals both in urban and rural areas. Cost recovery measures that were introduced in 1991 at the beginning of ESAP have also had serious effects on the health of the population, particularly for women and children (Nyandoro 2020). The introduction of fees for maternity services, increases in user fees combined with factors arising from budgetary constraints, discussed above, have had alarming and negative effects. In 1994, maternity fees were raised. The deposit to cover delivery charges at all provincial hospitals in Zimbabwe was raised by 257%, from Z\$140 to Z\$500, after an earlier increase in antenatal and maternity fees (Kanji & Jazdowska 1993, Nandoro 2020). This trend of enormous increases in maternal health service fees continued, whilst the non-payment threshold remained constant at Z\$400 (Nyandoro 2020: 37). In 1994, health fees at rural hospitals and health centres rose by 117% and there were even greater fee increases in other health units (GoZ, 1996, Nyandoro 2020). The above mentioned increases and charges are exclusive of drug charges and costs of surgery, anaesthetics, x-rays, prostheses and other

sundries. The majority of Zimbabweans do not belong to private health insurance plans which partially cover medical costs; in general, only those earning high wages can afford to do so (Nyandoro 2020).

Achieving equity in maternal health care is one of the most stressed and notable public health policy concerns shared in almost every country in the world, and it requires that individuals with the same maternal health care needs be granted the same opportunities to access health care (Manyika *et al.*, 2019, Witter 2019, Odetunji *et al.*, 2020). In Zimbabwe, for example, despite efforts to improve access to maternal health care utilisation over the years, inequality in maternal health care remains a public health concern (Choguya 2018, Witter *et al.*, 2019). To date, the GoZ has implemented many policies to improve access to maternal health care, including the Primary Health Care (PHC) of the mid-1980s and the Maternal and Neonatal Health (MNH) Roadmap 2007–2015, launched in 2009, among other policies (MoHCC 2010, Choguya 2018 & Odetuni *et al.*, 2020). As has been highlighted above, Zimbabwe has witnessed one of the worst economic crises in its history that saw the deterioration in the major sectors of the economy, including health, manufacturing and farming (ZIMSTAT 2018, WHO 2019). This caused degradation in the quality of maternal health as a result of the exodus of qualified health professionals to neighbouring countries and abroad, thereby contributing to shortages of health care professional inequalities in the delivery of maternal health care services, especially, in rural communities (WHO 2018, Choguya 2018, Witter *et al.*, 2019). The increase in user fees in health in 1993–2008 is plausibly responsible for the widening gap between the poor and rich in the Zimbabwe (Odetuni *et al.*, 2020). In the rural areas where the poor reside, there have been challenges in accessing health care facilities, leading to an increase in home deliveries, subsequently resulting in increased rates of maternal mortality.

2.27 The Discipline of Sociology of Medicine, Birth Territories and Childbirth

The relationship between the environment of the individual's birth room/space and socio-cultural issues of power, control and the way women experience the childbirth process physiologically and emotionally are issues worth studying in the field of sociology of medicine. Fielder (1996) describes birth territories as both the physical and the social environments of birth. It is pertinent to consider the ways in which the physical location of birth reflects and how it creates social territories, which in turn powerfully affect the physical processes of labour, birth and the

woman's experience of those processes. Oakley (1988), Rothmans (1978), Fielder (1996) and Cheyney (2008) have made vibrant contributions to the field of sociology and medical anthropology by studying birth territories and they further describe the relationship of the birth setting to the emotional-physiological state of expectant mothers and birthing women. In this regard, a birth territory encompasses not only physical space, but also personal relationships, power structures, and access to knowledge (Fielder 1996). Medical sociologists such as Oakley (1988), Rothmans (1978) and Fox (2009) have proposed the continual exploration of the elements in the geography, architecture and metaphysics of birth spaces to which women consciously and unconsciously respond to for these too for part of the childbirth process. Oakley (1988), Rothmans (1978) and Fox (2009) argue that lack of a woman-centred birthing environment, and little control over that environment, are reasons for high rates of obstetric intervention. Labour and birth are whole-being experiences; the autonomic nervous system will shut the whole process down if the woman perceives stress, threat, or danger (Murray 2009).

Oakley (1988) and Cheyney (2008) have made suggestions of the prerequisites of an appropriate birth territory and they state that the best birth territory requires the best attendants. Fielder (1996) further develops this argument by stating that the childbirth process is a reflection of relationships with oneself and with others. These relationships depend on love and spiritual development (a dimension that is rarely considered by obstetrician whose operations are strictly guided by science). Developing preeminent obstetricians and health care workers is an important component in creating conducive birth territories (be it in hospital or births outside hospital facilities). In developing the best birth attendants, Fielder (1996: 96) highlights the importance of seeing open-heartedness people as a requirement and good practitioners; ethical behaviour; self-awareness and a capacity to love. The training environment of all practitioners and obstetricians should encourage the development of nurturing and intimate, through professional, relationships with the expectant mothers; it is that relationship that forms a necessary part of optimal birth territory (Murray 2009). The need to study birth territories in sociology has been stimulated by the fact that over the years, the territory of obstetrics has been largely devoid of patient-relationship considerations and the social factors affecting the physical environment of birth. The field has been committed to concerns about "on-call" hours, clinical rotations, numbers of procedures, and one's place in the departmental hierarchy (Rothmans 1978: 108, Fox 2009). The knowledge used by obstetricians itself is based on pathology and human anatomy – which is

largely “problem-oriented” - a diagnostic/treatment approach that assumes there are pathogens, and goes about finding it. This works well in the rest of medicine, which is really about disease; but colours the teaching approach to the normal, healthy event of childbirth. The recognition of the biases that exist in the field of obstetrics towards science has stimulated a number of feminists in sociology (Oakley 1988, 2017, Rothmans 1988, Fox 2009) to also study birth territories and my study is also motivated by this.

In addition, Cheyney (2008) who also looked at the importance of studying birth territories as part of the comprehensive childbirth process discusses the value of intimacy or connectedness during prenatal, intra, and postpartum care as important in birth territories. In her study, her participants explained why they preferred home to the hospital for delivery. The participants also emphasised a desire for intimacy that they believed was lacking in the hospital. This shows that there are quite a number of social and emotional factors overlooked which form an important component of the birth process. In the study conducted by Cheyney (2008) expectant mothers discussed the desire for intimacy which I also consider pertinent to the experiences of the expectant mothers. It follows that the sense of connection produced in the birthplace (whether between a health care worker and woman, and/or mother, child, family, and friends) is essential to the development of social support networks that help sustain the new family, especially, in the early months of parenting (Cheyney 2008).

2.27.1 Closeness to Birth Territories as Essential for Surrender

A deep desire to create intimacy and a sense of personal connection in the birthplace has been considered an important component of the childbirth process primarily because it creates trust between the mother and the care providers in any given birth territory (Fielder 1996, Cheyney 2008). Trust is in turn, constructed as “essential for a safe and empowering birth” (Cheyney 2008: 262). According to Fielder (1996), expectant mothers and labouring mothers need to establish a relationship of trust and intimacy with their care provider in any given birth territory before labour’s onset so that they would then be better equipped to cope with the pain of labour and the childbirth process in general. Cheyney (2008: 263) states that “feeling safe” during the birth “releases fear” which is believed to make the pain of labour more endurable. Intimacy, trust, feeling safe and the ability to surrender (that is, feeling comfortable) in any given birth territory are viewed as intertwined and essential components of a positive delivery. In addition,

Cheyney (2008: 264) states that “when a birthing mother is confident that someone trustworthy is guarding her and watching out for her and her baby’s well-being,” she can “let down her guard,” “hear her inner voice,” and “fully surrender to birth.” Some birth territories such as hospitals can be too crowded that some birthing mothers feel as they give birth under the watch of “intimate strangers” as noted by (Cheyney 2008: 264). This is caused by the number of care providers who assist the birth process and in some cases the gender/sex of the health care provider. The conduct of the health care providers is crucial in assisting birthing mothers to “surrender” to their respective territories. The sense of safety and the ability to surrender that came with knowing their care providers well is important to consider when studying birth territories. Some women also explicitly connected the decrease in the number of distance-producing interventions and technologies utilised during their deliveries at home with the production of intimacy and their consequent ability to surrender to labour (Cheyney 2008).

2.28 Conclusion

This chapter has considered the existing collected works on maternal health, specifically on maternal health care facilities known as waiting mothers’ shelters, their historical background, their purpose, functions and their contributions to maternal health care in rural communities. In doing so, it has shifted from a global and regional perspective to Southern Africa and, finally, to the Zimbabwean context. In addition, the concept of medical pluralism was defined and explored in detail. Important debates as to how medical pluralism relates to and affects the functions of maternal health care facilities such as waiting mothers’ shelters in rural communities were also analysed.

In this chapter, the crucial issue of long distances between the expectant mothers’ homes and the health care institutions, together with how these distances cause delays in seeking maternal health care services, has been noted. In most of such cases, it was found that expectant mothers do not even seek hospital services for delivery. It has been well-elaborated by the Three-Delays Model how distance has been identified as the major cause for non-institutionalised deliveries in rural communities. Furthermore, in rural communities where distances to maternal health care services are long, coupled with the practise of medical pluralism, expectant mothers find themselves discouraged from seeking maternal health care services from hospitals due to the availability of alternative birth attendance close by, hence they give birth at home. In this section,

I deliberated on the different health care systems that Zimbabweans adhere to that have affected the use of biomedical health care facilities such as waiting mothers' shelters: these are the traditional birth attendance system (TBAs) and spiritual birth (SBA) system associated with faith healing. The literature review emphasises the relevance of the study as it has highlighted and clearly shown how biomedical maternal health care facilities are under risk of not being used by expectant mothers due to long distances, cultural beliefs, among other discussed factors. My study, therefore, deliberates on the experiences of expectant mothers in a biomedical maternal health care facility; that is, awaiting mothers' shelter that is located in a medical pluralistic village where health care facilities are not easily accessible.

CHAPTER THREE

PREGNANCY AND CHILDBIRTH EXPERIENCES: A PARADIGMATIC AND THEORETICAL PERSPECTIVE

3.1 Introduction

This chapter discusses the paradigm and theoretical framework adopted in this study. It helps understand the pregnancy and childbirth experiences of expectant mothers in a waiting mothers' shelter at Bonda Mission Hospital. It begins by examining the contributions of some of the prominent founders of the symbolic interactionism theory. Secondly, it provides an overview of symbolic interactionism as a theory. Thirdly, it presents Mead's approach to symbolic interactionism (Mead 1934). Thereafter, it examines the contribution of Charon (2007), a more recent supporter of symbolic interactionism. This chapter also examines the relationship between symbolic interactionism and qualitative research methodology, before proceeding to unpack the concepts of pregnancy and childbirth an action premised upon the fact that these concepts are central to the study. Furthermore, the study explores the various debates surrounding the adoption and use of these concepts. It traces the conceptualisation of the notion of childbirth and the various meanings attached to it within social science scholarship and society.

The symbolic interactionist theoretical approach has been chosen for the study because of its interpretive approach to social research and the legitimacy it places on the social interaction and meanings that social actors place on interactions in their social environments. It does, therefore, facilitate an understanding of the lived experiences of expectant mothers in their interactions as social actors and the meanings they place on social processes of pregnancy, childbirth, and delivery in waiting mothers' shelters. Using symbolic interactionism (Mead 1934, Blumer 1969, Jacob 1988, Denzin 1992, Charon 2007, Conrad 2015, Redmond 2015, Stryker 2017), the study will show how we can have a context-based understanding of the childbirth experiences of expectant mothers in medical pluralistic rural communities in Zimbabwe.

3.2 The Nexus between Symbolic Interactionism and Qualitative Research Methodology

I chose to carry out this research within the boundaries of the interpretive-constructivist paradigm (Denzin & Lincoln 2005, Haverkamp & Young 2007, Mir & Watson 2000, Morrow, 2007). The interpretive-constructivist paradigm argues that “knowledge or meaning” emerges through “interaction between people” and is therefore, described as co-constructed (Haverkamp & Young 2007: 268, Guillemin & Gillam 2004). Consequently, in an interpretive-constructivist inquiry, the investigator's values are assumed to influence the research process although, for trustworthiness purposes, which I expand in Chapter Four, the researcher is expected to critically examine how her values and beliefs influence the co-construction of that very knowledge. It can therefore, be argued that knowledge is a product of the interaction between the researcher and the participant, and through such a researcher-participant relationship, significant depth can be generated. Interpretive-constructivist scholars do not believe that research should be conducted by value-neutral, impartial, detached “subjects” seeking “to uncover discernible objects or phenomena” (Mir & Watson, 2000: 941). For Mir and Watson (2000: 942) and Hwami *et al.*, 2020 agree that researchers are to be considered as “actors rather than mere information processors or reactors.” Spivey (1995: 314) supports this argument by comparing researchers to “craftsmen” and “toolmakers” contributing to knowledge production (Law 1992: 381). That dynamic relationship between the researcher and the respondents for knowledge creation is central to interpretive-constructivism which my study has adopted.

In light of the argument I raised above, I appreciated that research guided by the interactionist perspective permits the use of specific methods (Denzin 1992). For data collection, symbolic interactionists use methods including participant observation, in-depth interviews, case studies, and letters (Meltzer *et al.*, 1975) and a selection of these was used in this study. As Denzin (1992: 23) states, symbolic interactionists believe in producing narratives that “take the form of small-scale ethnographies, life stories, in-depth interviews, laboratory studies, historical analyses, and textual readings of bits and pieces of popular culture as given in films, novels, and popular music”. Researchers, therefore, ask the question “*how*” in order to understand people’s lived experiences and meanings (Blumer 1969: 257). Drawing on Blumer's (1969) emphasis on the notion of understanding self-examination, Meltzer *et al.*, (1975: 358) highlight that

The use of such observational techniques as life histories, autobiographies, case studies, diaries, letters, interviews (especially of the free, or non-directive, type), and, most importantly, participant observation. Only through intimate association with those who are being studied ... can the investigator enter their inner worlds. His [Blumer's] basic criticism of the experimental, instrumental, and quantitative methodology, in the form of questionnaires, schedules, tests, laboratory procedures, and detached observation from the outside, is that they completely fail to catch the meanings that crucially mediate, and determine how individuals respond to, objects and situations.

Although the data collection methods have been deliberated on in my next chapter, it is important to mention them here since theories underpinning research ought to interact with methods used as noted by (Denzin 1992, Hwami *et al.*, 2020). The technicalities and practicalities of those methods have been discussed.

3.3 Basic Tenets of the Symbolic Interactionist Theory

Symbolic interactionism is an approach that is relevant to the field of sociology (Blumer 1969, Denzin 1969, Charon 2001), particularly, Micro-sociology as asserted by Abraham (2006). Although Herbert Blumer –coined the term symbolic interaction” (Carrothers & Benson 2003: 163), symbolic interactionism originates from earlier works of eminent psychologists, philosophers and sociologists, namely, William Isaac Thomas, John Dewey, Charles Cooley and, more significantly, the work of George Herbert Mead (1934). Mead is the founding father and he laid the foundations of symbolic interactionism (Mead 1934, Blumer 1969, Low 2008). Many other scholars have since adopted the symbolic interactionist approach, including Denzin (1989; 1992), Holstein and Gubrium (2000), Charon (2001), (2007), Lewis and Ritchie (2003), to mention a few. We need symbols to coordinate, connect and have ideas. The importance of symbols to the development of humans both as individuals and collectives is at the heart of symbolic interactionist theory. Symbolic interactionism is essentially about how the presence of symbols is fundamental to the existence of societies, our self-concepts and our minds.

Also, the symbolic interactionist paradigm interprets humans as social beings whose existence is socially constructed and shaped. Symbolic interactionists generally consider humans as acting towards things based on the meaning which the object has for them, unlike animals that act towards each other based on instincts or conditioning. Although meaning remains a product of

social interaction, meaning is generated through the process (Blumer 1969, Jacob 1988, Denzin 1992, Charon 2007). There are three components which define the foundation of the symbolic interactionist theory as recognised by Mead (1984:172), that is, humans act in the direction of things based on meanings the things have for them; The meaning of things arises from social connections that one creates and maintains with others. They are handled and amended through an interpretive process adopted by the individual in interacting with the things s/he comes across (Mead 1934: 172).

From the premises listed above, the significance of the meaning component is apparent and has been acknowledged as the critical component in symbolic interactionist theory (Manis & Meltzer 1972, Jacobs 1988, Denzin 1992). These critical insights show that human beings usually create meanings in particular social settings, huge or minor, face-to-face or virtual and meanings are created in relation to each other as they also perceive each other. The perceptions and opinions are the shared platform for interaction in any given setting (Mead 1964, Dewey 1927, Goffman 1961, Stone 1962, Snow 2001, Plummer 2016). Distinctively, human behaviour and interaction are carried on through the medium of symbols and their meanings (Manis & Meltzer 1972: 6). Plummer (2016: 300) states that “humans are thinking beings and do not merely respond unswervingly to events and circumstances, but give meaning to these”. A person’s activities are then based on the meanings the circumstances have for him/her rather than in direct reaction to the incident or situation. Also, behaviour and human action are grounded on meanings acquired through interaction with one’s self and the general populace (others). Humans are actors who can engage themselves in self-talk. Thus, human action is instigated by interaction amid individuals, as well as by interaction within the individual. The constant active continuing process of thinking, communicating with one’s self when alone and during interaction with others, is important in understanding action (Charon 2007).

3.4 Towards an Understanding of Mead's Symbolic Interactionist Theory

3.4.1 The Ideas of George Hebert Mead

Mead further elaborated that the self is a product of communication, which is the interaction between individuals. However, beyond simple communication, the interpretation of intended meanings which characterise groups is what matters (Meltzer, *et al.*, 1975). According to Mead,

an act is —a stimulus and response based on an inner condition which sensitises the system to the stimulus and quickens the response” (Blumer 1964 as cited in Meltzer, *et al.*, 1975: 32). Mead’s stances departed from mainstream sociology which views society as dependent upon institutions. For Mead (1934: 35):

The most concrete and most fully realised society is not that which is represented in institutions as such, but that which is found in the interplay of social habits and customs, in the readjustment of personal interests that have come into conflict and which take place outside of court, in the change of social attitude that is not dependent upon an act of legislation... Though human attitudes are far older than human institutions and seen to retain identities of structure that make us at home in the heart of every man [or woman] whose story has come down to us from the written and unwritten past, yet, these attitudes take on new forms as they gather new social content.

3.4.2 Important Gestures/Important Symbols/Symbols

The terms *important gestures* (conscious gestures), *important symbols*, and *symbols* were all used by Mead (1934) to reflect the unique capacity of humans to express an idea through a gesture (such as a spoken word) that arouses the same meaning in another person. In contrast to the notions Mead (1934) drew from behaviourism, he integrated principles from a contrasting perspective called pragmatism. Among other things, the pragmatists believe that humans do not just respond to the environment but, instead, are constantly interpreting their environment that is humans give meaning to what they sense. This means that besides responding to gestures, humans can interpret their worlds through symbols. As has been noted before, a symbol is an abstract and arbitrary stimulus to which people place meaning; symbols are interpreted stimuli (Redmond 2015). The notion of abstractness and arbitrariness reflects the fact that in general, the symbol has no direct connection to that which it represents. It is an abstract reference to things, both tangible and intangible (Redmond 2015). According to Hewitt (1976: 27-8), a symbol is arbitrary because its assignment to a given stimulus is done simply at the whim of those who first introduced it. Symbols have meaning "solely by virtue of consensus among those using them," that is —. because a community of symbols users adopts the convention of using given symbols consistently”.

In addition, Mead (1934) notes that symbols are created within a society or culture and those born into that society acquire them. The system of symbols used within a given group of people constitutes a language. Other animals have a language as well but their language consists of a system of signs or gestures. It is important to note that humans know little about the origins of human language, though we do know that no language-less tribe of humans has ever been found. This fact illustrates the universality of symbols as a defining feature of human society (Charon 2007, Redmond 2015). Symbols are probably the single most important quality that gives humans their humanness, separating them from all other animals. Without symbols, no other human creation is possible. Symbols allow humans to remember, reminisce, to evaluate and plan, to coordinate, to communicate abstract thoughts, to think about the future and to consider alternatives and outcomes (Dewey 2008, Redmond, 2015).

Additionally, symbols have been considered to be at the heart of symbolic interactionism by Mead and others scholars who subscribe to this theory (Blumer 1964, Jacob 1992, Charon 2007, Redmond 2015, Plummer 2016). It is for such reason that I placed symbolic interactionism at the centre of the visualisation of the theory presented in this chapter, surrounded by the mind, self, and society. One of the contemporary symbolic interactionist theorists, Charon (2007: 60), wrote:

It is the symbol that translates the world from a physically sensed reality to a reality that can be understood, interpreted, dissected, integrated, and tested. Between reality and what we see and do, stand the symbols. Once we learn symbols, we are in the position of understanding our environment rather than simply responding to it, and once that happens what we come to see and act on is coloured by our symbols.

In this regard, symbols can be considered to be central in the symbolic interactionist theory for they are at the heart of all social interactions in different cultures and societies. Symbols do not exist in isolation; however, they are used by the individuals who constitute the self to interpret social actions.

3.4.3 Self (Symbolic Self, Social Self, and the “I” and “Me”)

Before the theoretical framework of symbolic interactionism, the self was primarily viewed as a freestanding independent entity. Charon (2007) acknowledges that Mead saw the self as an entity that exists within social interactions and, as such, it is both a product of and player in those

interactions. Additionally, one of the critical elements that link self and society are symbols as enacted in those social interactions. Only humans have a sense of self because they have symbols by which they can consider their identity. People's attitudes, values, beliefs are formulated through symbols, constitute part of people's sense of self.

For Mead (1934), the self is used to reflect our ability to see ourselves as objects in the same way that other people see us and attribute symbols and meanings to their perceptions. Our perception of ourselves is symbolically and socially based. For example, a human being can think about other people by adopting other people's perceptions of them. Accordingly, this is a complex process since humans continue to associate with other people who affect their sense of self. The self and the society are systemically linked together, each affecting the other, each changing over time, and each co-dependent upon the other. The attitudes, values, beliefs, among others, of humans as social actors, primarily represent the absorption of those occurring within their social world.

In addition to Mead's (1934) concept of the self, Charles Cooley (1902-64) introduced the phrase "looking-glass self" to reflect his thoughts about the nature of the social self. For Cooley (1964), our "looking-glass self" involves three elements: imagining how we appear to other people, imagining other people's judgment of that appearance and a self-feeling in response to that imagined judgment (for example, pride and embarrassment). Cooley (1964) & (Denzin 1992: 6) have contributed immensely to symbolic interaction and have maintained that the individual and society should be regarded as "opposite sides of the same coin". The self of the person is a reflected appraisal of reactions of others; it is based on self-feeling and the imagined judgments of others" (Denzin 1992: 344).

3.4.3.1 The "I" and the "Me"

Inasmuch as the self is a social process, Mead (1934) also discussed the self in terms of an "I" and a "Me". On one hand, the "I" can be defined as the "initial, spontaneous, unorganised aspect of human experience" (Meltzer 1978: 199). On the other hand, the "Me" is referred to as the "self" as an object or the social self. The "Me" arises in social interaction and is reflected in such concerns as to how we look to other people, and how we compare to others. Mead (1934) considers the "I" to occur first and the "Me" to be the interpreter and evaluator of the "I". For

example, a human being as a social actor can shout in anger (the -I) at a friend and later think to him/herself $\text{-Why did I behave in such a manner (the -Me)?}$ Mead (1934: 174) states that:

The -I of this moment is present in the -Me of the next moment. There again I cannot turn around quickly enough to catch myself. I become a -Me in so far as I remember what I said. ... The -I in memory is there as the spokesman of the self of the second, or minute, or a day ago. As given, it is a -Me , but it is a -Me which was the -I at the earlier time. If you ask, then, where directly in your own experience the "I" comes in, the answer is that it comes in as a historical figure. It is what you were a second ago that is the -I of the -Me . It is another -Me that has to take that role. You cannot get the immediate response of the "I" in the process.

The -I is present whenever human beings as social actors, act, but the moment they begin to consider the act, they are considering something that is in the past; this consideration of their actions represents the -Me .

3.4.4 Society

According to Mead, society should be regarded as the macrocosm of processes involving thoughts, perceptions, and interactions, where individuals and society are regarded as "over 100 lapping units" (Meltzer *et al.*, 1975: 35-46). From the symbolic interactionist perspective, the essence of a society is the interaction and communication of individuals through symbols. As such, "society arises in social interaction; it continues through social interaction; it ends without social interaction" (Charon 2007: 157). Typical qualities associated with being a society include embedded patterns, relationships and roles; diverse people linked together in joint activities over space and time; and people who interact in small social networks that exist and interact with a larger social structure (Stryker & Burke 2000, Hewitt 1976, Stryker 2017).

All these qualities are dependent upon symbolic interaction and symbolic self. "Society, then, is individuals interacting over time: acting with one another in mind, adjusting their actions to one another as they go along, symbolically communicating and interpreting one another's actions" (Charon 2007: 158). For Mead (1934) and Stryker (2017), society was the third part of a visual triangle of symbolic interaction. All of the coordination, communication, and rise of institutions that result in the development of a society are only possible because of symbols. As Charon (2007: 61) asserts:

...symbols create and maintain the societies within which we exist. They are used to socialise us; they make our culture possible; they are the basis for on-going communication and cooperation; and they make possible our ability to pass down knowledge from one generation to the next.

For Mead (1934), societies cannot exist without self. The interaction of selves gives rise to society; however, selves emerge as a result of society. Mead's (1934) conception of society is relevant to waiting mothers' shelters in rural societies. In such societies, the health-care institutions' importance and relevance have been discussed in previous studies while disregarding the importance of humans who are part of those institutions. The central unit of my study is the human experiences and interactions in the maternal health care institutions. The contributions of the founding fathers of symbolic interactionism, although not exhaustively presented in this work, converge towards humans (expectant mothers) and their interaction. The interaction may take place within the individual or between the individual and his/her social group or environment. These contributions constitute a point of departure for the symbolic interactionist perspective, which is examined in the next section.

3.4.5 Generalised Other and Role-Taking

Further from the factors discussed above, it is prudent to acknowledge that Mead (1934) was intrigued by the notion that humans as social actors internalise symbols from their society into their inner self, and create a "generalised other". The "generalised other" is people's conception of the attitudes of their social community. For example, we carry within us a view of people in general, which includes how people, in general, view us. Our sense of self is directly related to our "generalised other" because we experience ourselves from both the standpoint of specific people in our social network and also from the generalised standpoint of the social group as a whole" (Mead 1934: 138). The "generalised other" is part of the self; humans adopt attitudes of the "generalised other" as part of who they are. Scholars such as Berlo (1960) & Stryker (2017) also saw the "generalised other" as a foundation for creating expectations about how people behave and the roles they play. Those expectations and roles are then used to guide people's behaviours.

Additionally, roles represent an intersection between self, society and social interactions. Our ability to create and play roles allows us to successfully adapt and interact with the role someone

else is playing (Redmond 2015, Plummer 2016). A diversity of roles allows us to move from one role to another in a given situation as well as interacting effectively across different situations (Poggi & Sciortino 2011). Mead (1934) observed that our “generalised other” is one way that society extends control over us and impacts our thinking; essentially, these general internalised rules and roles of social influence, and even direct, our thoughts, decisions, and behaviours. Thus, our behaviour, reactions, and interpretations are affected by our “generalised other”. People act according to the values, social protocols, and norms of the “generalised other” to not conflict with the values of the generalised other (Stryker 2017: 274). The ideas of the “generalised other” can be juxtaposed with the habitus concept of Bourdieu (1977) which comprises socially ingrained habits, skills and dispositions. It is the way that individuals perceive the social world around them and react to it. These dispositions are usually shared by people with similar backgrounds. The concept of habitus, also discusses the subjective versus objective dichotomies of social interactions. In this same concept, other related dichotomies such as structure versus agency and freedom versus necessity are also discussed. Just like the “generalized other”, the habitus (social structures) controls peoples activities in everyday social interaction. The society through culture, traditions and belief systems has a way of controlling people’s activities in everyday life. However, the role that the individual play in social interaction remains crucial in Mead’s arguments.

Mead’s (1934) notion of the “generalised other” concerning role-taking solidifies the importance of human actors in social interaction (Mead 1934, Denzin 1992: 4, Blumer 2004, Stryker 2017). With the notion of role-taking, Mead (1934) showed that an individual can take the role of another person by imaginatively placing him/herself in the very position of his/her interlocutors (Mead 1934, Denzin 1992). The role-taking process is a continual process in social interaction that influences individuals' reactions towards interaction with others, and it is vital in trying to understand the acceptance of waiting mothers’ shelters as maternal health facilities in rural communities such as Mawadza village. It can be noted that in the context of Mawadza village, ethnic and religious socialization - collective habitus (church, traditional leaders, traditional healers among others) usually have a contribution in the shaping of women’s perception of biomedical care which is a crucial factor towards the utilization of the waiting mothers’ shelter. Mead further elaborates that the meaning of any social act is not implicit in the act "but is influenced by the response of the other person“ (Meltzer *et al.*, 1975: 333). The establishment of

waiting mothers' shelters as maternal health care facilities by the government is not an act that can be regarded as implicit. It is the response of the community, especially through expectant mothers and other social actors which establishes complete social interaction. The use of waiting mothers' shelters establishes social interaction through role-taking, and this is supported by Mead (1934), who avers that individuals' social conduct "is mediated by the stimulations of others, which lead to responses which again affect these other forms" (Meltzer *et al.*, 1975: 335), that is, it is a continual role-taking process, a process similar to Dewey's (1992) notion of circularity of interaction (Meltzer *et al.*, 1975).

Given that Mead's (1934) symbolic interactionist theory originally focused on the global North, it is necessary to examine how it can be applied and operationalised in the global south specifically in the Zimbabwean context. It is also prudent to acknowledge that African people's experiences, like any society are not rigid and static. Expectedly, experiences are always shifting and changing. These changes and shifts affect all levels of social interactions, from changes in the self to redefined meanings of the experiences such as pregnancy and childbirth to new ways of experiencing the childbirth process, and new ways of understanding societal interpretation and experience of the childbirth process (Better 2014: 17). Msibi (2014) also points out that the issue is not about arguing for the rejection of Western theories, but to learn from what has worked in the West by integrating, questioning, troubling, and even querying its relevance in the African context. I, therefore, subscribe to the view that social theory needs to respond to contextual realities and provide space for issues of childbirth experiences in medical pluralistic communities, which may conform to, modify or challenge the existing conceptualisation. Therefore, in this study, I have adopted a theoretical framework that is reflective and conscious of the social and historical realities that exist in medical pluralistic rural communities in Zimbabwe. The following sections in this chapter will be showing how symbolic interactionism, specifically, the ideas of Mead (1934) can be understood in the context of indigenous medical pluralistic rural societies in Zimbabwe. The nexus between symbolic interactionism and the construction of medical systems, cultural factors, and the childbirth process even in biomedical health care facilities will also be considered.

3.5 Symbolic Interactionism and Medical Systems

As outlined in preceding sections, it is important to concede that medical systems in indigenous societies do not exist in isolation, neither are they purely and only guided by rules and stipulations that govern them; however, the symbolic interaction process is also evident in the operations of these medical systems (Baer 2001: 66). The process of managing illness in indigenous societies involves interaction among human actors as they seek to cure diseases and manage ill-health among them (Pool & Geissler 2005, Alter 2005, Zhang 2007). In their pursuit of a healthy lifestyle, human beings consult are examined and get prescriptions. All these processes do not only happen under prescribed rules but happen among social actors who can understand symbols, and attach meanings to actions and respond to situations based on the meanings they have attached to the situation (Zhang 2007). Pool and Geissler (2005) further point out that the existence of alternative health care in indigenous societies shows that human beings through interaction are aware of the choices available for them and can choose the best health care system that suits their needs according to their perceived realities. Furthermore, in societies where more than one health care system exists (medical pluralistic societies), the symbolic interaction process becomes crucial to draw from in understanding how individuals derive power from social interaction, networks (such as culture and religion) to choose the healthcare system that best responds to their needs (Brodwin 1996, Burman 2019, Fitts *et al.*, 2019, Secombe *et al.*, 2019, George *et al.*, 2020). The symbolic interactionist process is indeed present in the operation of medical systems in societies especially among indigenous groups.

Also, as I explained, regarding the basic tenets of symbolic interactionism as a theory, symbolic interactionism is a theoretical framework that emphasises the cultural and historical aspects of phenomena widely thought to be exclusively natural (Dewey 1992). The emphasis is on how meanings of phenomena do not necessarily inhere in the phenomena themselves but develop through interaction in a social context (Charon 2007). If one views this from another perspective, they would realise that symbolic interactionism examines how individuals and groups contribute to producing perceived social reality and knowledge (Berger & Luckman 1966, Dewey 1992, Blumer 2004). A symbolic interactionist approach to the understanding of the operations in medical systems is rooted in the widely recognised conceptual distinction between disease (the

biological condition) and illness (the social meaning of the condition) (Eisenberg, 1977, Norbeck, Lock 2019, Fitts *et al.*, 2019).

There has not been an absolute consensus on the definitions of health, disease and illness, even though these concepts are central not only in medicine but also in the health social sciences which include medical sociology, health psychology and medical demography (Amzat & Razum 2014). One may wonder why there has not been consensus, notwithstanding the long history of medicine. The concepts are multidimensional, complex, and often elusive. Amzat and Razum (2014) state that disagreements about the meaning of health are common because health is imbued with political, medical, social, economic, and spiritual components hence it is subject to various conceptualisation and interpretations. While all the concepts have their foundations in medicine, a biomedical perspective of health or disease may not be sufficiently comprehensive to understand health and illness (Amzat & Razum 2014). A comprehensive understanding of the concepts of disease health and illness leads to the problematisation of the assumption that diseases are universal and invariant to time or place but also leads to the consideration of the meaning and experience of illness and health as shaped by cultural and social systems of any given society. The social aspect of human health represents the behavioural aspect of human health and should be especially considered when looking at the wellbeing of humans in different societies (Singer *et al.*, 2011). Being a member of society is being in the network of social interaction and being able to fulfill social roles and expectations is very important. The social also incorporates the spiritual dimension. The spiritual aspect could be personal to the individual by connecting to the world of reality and divinity.

Furthermore, Lupton (1997), Baker (1998), Rose (2006) and George *et al.*, (2020) agree that while sociologists have rarely focused on the metaphorical connotations of medical systems, they have examined the impact of cultural meanings embedded in medical systems. In this regard, all medical systems are not the same. This affirms the symbolic interactionism view of the definition of a situation. In one society, different medical or health care depends on the cultural meaning of each health care system to the members of the society (Rose 2006). For example, in different societies some illnesses are generally stigmatised while others are not; some illnesses are highly contested, others are not, some are even considered disabilities, while others are not (Rose 2006). What is important about these distinctions and classifications is that they exist for

social rather than purely biological reasons because social actors define them so (Singer *et al.*, 2011). For example, in biomedical facilities, conditions such as mental health conditions or even pregnancy are treated as purely medical conditions that require medical attention and nothing more, whilst those from the African traditional healers treat the condition as one that requires ancestral intervention as they deem that one can only have mental conditions as a result of the displeasure of the gods (Togarasei 2017). The Spiritual healers/Christian approach and ancestral interventions view such conditions as spiritual, although the way they tackle it is somewhat different. Christians view these as conditions that can only be treated through prayer and exorcism whereas ancestral interventions require the appeasement of the ancestors through spirit mediums for possible solutions prescribed by the ancestors (Chavunduka 1994, Mandizadza 2016, Togarasei 2017).

Singer *et al.*, (2011) further examined the concept of ethnomedicine and conceptions of health, illness, and medical systems in family-level foraging, village-level, pastoral, and chiefdom societies. They examined the phenomenon of medical pluralism in complex societies by examining it in two locales in developing societies, including a village in the Bolivian Andes, Indonesia. They examined various typologies of plural medical systems, particularly, stress the concept of a dominative medical system which points to the fact that medical systems do not exist in a vacuum but rather reflect the class, racial, ethnic, and gender relations and inequalities of the wider society (Singer *et al.*, 2011).

In a dominative medical system, several different healing traditions coexist in the same society, but one tends to be more closely aligned with the dominant social groups in that society and to be the dominant healing tradition as well (Chavunduka 1994, Singer *et al.*, 2011, Kajawu & Chingarande 2016). Indigenous societies exhibit a diversity of healing beliefs and practices as well as an array of different kinds of healers, but these tend to be rather loosely organized and often reflect idiosyncratic patterns resulting in part from the fact that healers commonly are secretive about their medical knowledge. It should be acknowledged that certain indigenous groups manifest the coexistence of a highly elaborate array of medical traditions at the conceptual and the practice level, a pattern called medical pluralism. In other words, the medical system in such societies tends to be made up of various medical sub-systems that coexist in a

social environment that ranges between extensive cooperation and open conflict (Singer *et al.*, 2011, George *et al.*, 2020).

3.6 Medical Knowledge as Socially Constructed

An appreciation of the fact that the symbolic interaction process is evident in the operations of medical systems further leads us to an appreciation that medical knowledge is socially constructed. Over the years, the social construction of health care systems has become a major research area in the subfield of the sociology of medicine and it has made significant contributions to our understanding of the social dimensions of illness, how they are perceived socially and, in turn, managed if not treated. Eliot Freidson (1970) was one of the first few medical sociologists to articulate how medical knowledge is socially constructed. Over the years, social scientists have taken several different paths in the study and prove that medical knowledge is socially constructed and embedded in socio-cultural meanings (Evans 2000, Han 2000, Bensoussan *et al.*, 2004, Sutton 2004). Research has shown that medical knowledge sometimes reflects and reproduces existing forms of social systems, even existing social inequality. Rather than being value-neutral, some medical knowledge, implicitly or explicitly, shores up the interests of those groups in power in societies. Upon close inspection, some medical ideas have been shown to support gender, class, and racial-ethnic inequality in societies (Bensoussan *et al.*, 2004).

The research of medical sociologists in the subfield of science studies also reveals how medical knowledge is conditioned by the social context in which it is developed. Specifically, these scholars explain that what qualifies as biological disease or biomedical evidence is often socially negotiated and interpreted (Joyce 2008, Timmermans 2007). For example, embedded within medical knowledge about pregnancy, premenstrual syndrome (PMS), childbirth, and menopause, one finds clear ideas about women's "proper" (that is, subordinate) place in society as well as moral assumptions about women's sexuality and femininity. In the early twentieth century, expectant mothers were advised against driving an automobile or dancing, on grounds that these activities threatened the health of their unborn child. In the contemporary era, expectant mothers are endlessly warned about the risks of drinking alcohol (Armstrong 2003). In both periods, the medical advice reflects marked cultural anxieties about women's sexual and social freedoms; and, in both periods, when expectant mothers follow the prescribed medical advice, they enact

the dominant cultural ideals of femininity. Medical knowledge about PMS, for example, provides another case worth noting. Precisely because some of the symptoms of PMS (for example, frustration, aggression and anger) defy norms about how women ought to behave; they become *prima facie* evidence of a disorder (Markens 1996, Armstrong 2003). Thus, not only can medical ideas result in the social control of women's behaviour, but they also contribute to our cultural beliefs concerning the existence of unalterable differences between men and women. These beliefs, in turn, can be used to justify gender inequality within intimate relationships, families, institutions and society.

3.7 Cultural Meaning of Childbirth

In my preceding segments (Sections 3.5 and 3.6), I have shown that the symbolic interaction process is evident in medical systems. I have proceeded to show through scholarly evidence how human beings through symbolic interactionism consequently acquire the agency to socially construct what constitutes medical knowledge in various contexts. At this juncture, I focus on the concepts of pregnancy and childbirth as concepts that also exist in juxtaposition with the symbolic interaction process, socially constructed and embedded in the cultural beliefs of any given society. Jordan (1978) and Davis-Floyd (1996) state that birth is a universal process and part of the human female physiology and biology. Nonetheless, medical sociologists (Rothman 1998, Oakley 1999, Annes 2004) have come to understand that birth is seldom simply and purely a biological process, but, it is in every way socially marked and shaped. This fundamentally emanates from the point that humans are social beings who can interact with other social actors and eventually attach meanings to their interactions (Blumer 2004). Hence, symbolic interactionism is evident in the pregnancy and childbirth processes and these processes are always socially and culturally shaped and managed. Studies on childbirth from a socio-cultural context give “legitimacy to the grounded study of human reproduction in sociology” (Ginsburg & Rapp 1991:320, Jordan 1978, Maffi *et al.*, 2019, Kempe 2019, Callister 2020). This is because it explores the various ways in which societal and cultural anticipations affect factors such as the care provided during birth, the relationships of the expectant mothers and care providers in different medical systems and expectant mothers' approaches to the process of childbirth (Callister 2020). It also demonstrates how broader cultural and social norms and recognised understandings of the childbirth process, technology and medical knowledge help to form not

only expectant mothers' awareness of the childbirth process, but also their attitudes towards their bodies, their babies, and their childbirth experiences.

Leininger (1991: 47) defines culture as “learned, shared and conveyed values, beliefs, norms and lifeways of a specific group of people that direct their thinking, decisions and actions in a patterned way”. Culture is among the most important variables that influence a woman's awareness of the childbirth experience (Callister 1995: 237). Jordan (2001: 182) states that “childbirth is an intimate and intricate transaction whose topic is psychological and whose language is cultural. In no known culture in this world is the pivotal life event of childbirth treated with indifference or neglect”. Childbirth has been regarded as the greatest act of humanity (Ayers-Gould 2000). In this viewpoint, becoming a mother changes the meaning of life (Kitzinger 2005). Mecer and Stainton (2018: 29) observe that “the cultural context in which childbirth occurs provides norms that influence the values and interpretations of personal and interpersonal experiences.” According to Callister (1995: 327), studies on culture and childbirth may lead to the following assumptions: within the framework of moral and value systems, cultural groups have specific attitudes towards childbirth and the meaning of the experience, within the framework of ceremonial and ritual systems, cultural groups suggest specific practices associated with childbirth, within the framework of kinship systems, cultural groups prescribe gender-related roles for childbirth, within the framework of knowledge and belief systems, cultural groups influence normative behaviour in childbirth and the pain experience of childbirth.

Admittedly, because expectant mothers are social actors who deduce meanings from their interactions in their social environments, they are normally involved in a decision-making process concerning the mode of delivery, and many factors affect their decisions. These processes are influenced by a person's environment, values, personality, knowledge, and insight, which influence each other interactively. Social science research indicates that one of the main sources of information for selecting the birth territory and the mode of delivery is the account of experiences mothers hear from other women in social gatherings and gabfests (Kennedy *et al.*, 2010, Munkhondya 2019, Saunders 2019, Brandao 2020). These “birth stories” are mostly concerned with unpleasant aspects of childbirth, such as physical pain, psychological pressure at the time of delivery, inappropriate midwifery interventions, and emergencies. These negative aspects are sometimes also emphasised by social media. Considering the negative effects of these

outlooks on women, some opt for popular birthplaces only because it is a depiction of high social class or a “trend” in the society (Kennedy *et al.*, 2010, Munkhondya 2019, Saunders 2019). In general, apart from personal and medical factors, several social and cultural issues are also involved in an expectant mother's tendency towards a certain mode of delivery.

There are many questions regarding the effects of personal, religious, and traditional health beliefs on one's preference for a birth territory and a mode of delivery (Wild *et al.*, 2010). The underlying factor about studying birth territories is that childbirth is a physiological process that is likely to go smoothly in an environment where the birthing mother feels more relaxed, safe, and secure and in control (Cheyney 2008, Nove *et al.*, 2012). These factors need to be addressed in the cultural context of any given society. Few qualitative studies have been conducted to explore the conditions which influence expectant mother's cultural beliefs towards the mode of birth. Latifnejad Roudsari *et al.* (2014) in a focused ethnographic study found that cultural norms and values and social networks are the factors encouraging the choice of birth territory. Also, Zakerihamidi *et al.*, (2014), in a qualitative study, reported that considering childbirth as something sacred based on the participants' religious beliefs affected the participants' decision to choose the environment under which they should give birth or whether they should have a vaginal delivery or caesarean section. There is little knowledge of women's beliefs about different birthplaces and modes of delivery and no extensive studies have been conducted on this subject as a cultural phenomenon.

Also, inasmuch as the childbirth experience is psychological and time-limited, it is much more than a transient physical process. Childbirth is a phenomenon endowed by women with meaning and subjective significance (Coxon *et al.*, 2018). The long-term reminiscences of expectant mothers on the particular detail of a childbirth process and experience demonstrate evidence that childbirth is intensely felt both physically and emotionally. “Socio-cultural beliefs and values provide perspective to the meaning of childbirth for they are within the context of rich sociocultural/spiritual settings that an expectant mother gives birth” (Prosen & Krajns 2019: 26). The expectant mother giving birth constructs her reality as she is allowed to review her perceptions of the childbirth process and experience.

A sociological approach to pregnancy and childbirth centralises the social aspect of these physiological and biological events by understanding the meanings placed on the processes by the expectant mothers and variegated caregivers as social actors. The symbolic interactionist paradigm emphasises the impact of society's values, beliefs, and patterns of behaviour on the way in which they are interpreted and given meaning by people. Pregnancy and childbirth are social events in that they take place within a surrounding economic and social system and are understood within a cultural value system (Muffi *et al.* 2019: 66). Like other social events, such as marriage and death, interpretations, and meanings given by a society are subject to historical change and will also exhibit social class and ethnic variations (Callister 2020). The sociological approach, then, is to stress the nature of power relations in society and how these affect the ways in which pregnancy and childbirth are experienced.

Plummer (2016: 3) states that “meaning on its own is an interactive process because it materialises out of interactions”. Pregnancy and childbirth are connected to a multiplicity of activities each carrying diverse meanings which include but are not restricted to creating intimacy, attaining spirituality, and exercising power (Laumann *et al.* 1994). The symbolic meanings linked to the process of childbirth affect how individuals (especially expectant mothers) think about themselves and how they view their bodies in relation to the cultural setting and ideologies. The self is a process constructed out of encounters and endowed with shifting meaning. Jordan (1977), Rothmans (1978), Oakley (1988) Davis-Floyd (1994), Fielder (1996) and Fox (2009) have argued that childbirth is a biological event that is socially constructed through the meanings people give to it. Moreover, experiences of expectant mothers are centred on the meaning attached to social processes that occur in that particular setting. Symbols are central notions of the symbolic interactionist perspective and these symbols are socially created and used to represent shared meanings among members of societies and/or cultural groups. Consequently, they are used to communicate, are intentional and meaningful. Interaction occurs through the use of symbols (Denzin 1992).

3.7.1 Religious Affiliations as Part of Culture

Although each birth experience by women in different cultures across the world is exceptional, there are some shared meanings as well as culturally specific meanings of the childbirth process. In some cultures, the meaning of childbirth is influenced by one's religious affiliations. Religion

forms part of the people's culture and it also influences not only health-seeking behaviours, but, the choice of birth territory and the birth mode (Singer *et al.*, 2011, Callister 2020). For example, for the Jewish Orthodox culture, "childbirth is viewed as an adult developmental task and they highly value family" (Callister 1995: 328). This is demonstrated by the high significance placed on the umbilical cord as an endless bond present between mother and child. The paradoxical nature of childbirth has presented a bittersweet experience to the women in this particular religious group. For example, it has been noted that Jewish Orthodox women group pointed out that inasmuch as childbirth is a painful process, what a mother gets out of it is something a mother can never get anywhere in the world (Callister, 1995). In this Rockland country's particular culture, childbirth is also associated with a purpose in one's life (Callister 1995). Women interviewed in a study conducted by Callister (1995) on "*The Cultural Meaning of Childbirth*" acknowledged that childbirth gives a better understanding of what is supposed to be done in life; it transforms a woman into someone totally different from what she used to be before the childbirth process. In various other societies, religion plays a crucial role in defining people's identity, bringing people together as a collective group, and shaping people's actions through commonalities in belief systems. Roudsari *et al.*, (2015) also observe how pregnant women's choices of birth territories are affected by their religious beliefs. In the Arike village of Uganda, women chose to give birth at home because their religious beliefs require them to maintain certain values that include genital integrity, maintenance of purity and the desire to imitate the prestigious birthplace as other members of the congregation do (Roudsari *et al.*, 2015).

3.8 Symbolic Interactionism and Childbirth in Biomedical Health Care Facilities

I have operationalised the symbolic interactionist theory by demonstrating its nexus with medical systems, pregnancy, and childbirth process in general. At this juncture, I continue to narrow it down to its applicability in biomedical health care systems which directly refer to my study which looks at the experiences of expectant mothers in biomedical facilities. Admittedly, the symbolic interactionist theory applies to a wide variety of issues in maternal healthcare systems in biomedical facilities such as understanding childbirth and labour procedures in various birth territories as maternity units, exploring social worlds in these facilities, and studying the setting itself (Clarke & Star 2003, Brandao 2020). Individual development and behaviour, expectant

mothers' care situations, interactions between expectant mothers and health care professionals, and wider healthcare practice issues have been additional topics of study that can be studied using the symbolic interactionist approach (Norbeck & Lock 2019, Jones *et al.*, 2019, Fitts *et al.*, 2019, Callister 2020). In addition, applications of the symbolic interactionism perspective within the sociology of childbirth have also focused on topics such as mothers' perceptions on the dichotomy of medicalised versus naturalised childbirth systems and how the dichotomy constructs one's identity (Beel *et al.*, 2006, Deppoliti 2008).

Accordingly, Prosen and Krajnc (2019) observe that the childbirth process was redefined when medicine expanded into obstetrics. It was redefined into medical terms and removed from the socio-emotional context that had been in existence when the birth process was still under the domain of midwives and naturalised. As expectant mothers visit health care institutions for assistance during pregnancy and the childbirth process, the entire process changes its meaning. From its original meaning in society, birth has been redefined as 'delivery' not an activity which expectant mothers engage in but a procedure which health care professionals do and a service that can be provided by the medical field (Coxon *et al.*, 2018). Prosen and Krajnc (2019:26) states that “until pregnancy and childbirth were defined as medical events, midwifery was in no sense an area, branch or interest of medicine as a profession”. A midwife being qualified or not, was not a major issue unless pregnancy started to be treated as a medical concern.

In addition, after a mother stays in a waiting mothers' shelter, moves to the hospital, and delivers successfully, in this scenario, the childbirth process is constructed as a medical event and the baby as a product of the hospital and the waiting mothers' shelter. This is because, in health-care facility births, the doctor/midwife or qualified hospital staff are usually perceived as having delivered the infant; it is the duty of staff to present the infant to the new mother and then teach the mother how to care for herself and the infant or they run a risk of losing lives. In this case, the new mother consequently becomes the receiver rather than the producer of the infant. Due to constant monitoring in these facilities, body agency is highly contested as mothers become less active in the birth of their children, and as more time elapses between the birth and the presentation of the infant to the mother, the infant is then perceived as a product of the maternal health care facility.

Studies have shown a linear kind of relationship between the birthing mothers and the health care professionals in the biomedical health care institutions (Rothmans 1988, Eastwood 2017). As part of postpartum care in biomedical health care facilities, studies have shown the psychological effects on maternal-infant bonding (Beel *et al.*, 2006, Coxon 2019) or the physiological effects on lactation, of the alternative treatment of childbirth. However, they do not consider the implications of constantly monitoring expectant mothers and the effects it has over the mother's body and infant. Amankwa (2005) and Eastwood (2017) who have conducted studies that show the presence of the symbolic interaction process in post-partum care, concur that in various ways, new-borns are processed and, from a symbolic interactionist perspective, this leads to crucial questions such as the perceptions of the mothers over their bodies, the infant as their product or a product of the hospital, clinic or waiting mothers' shelter which made the birth a success. In the whole childbirth process, the self can be appreciated (Mead 1934). Understanding how the birthing mothers understand or perceive their bodies and action shows that although pregnancy and its experiences are unique to every individual, the birthing mothers in biomedical health care facilities view their bodies and interpret their actions not in isolation, but in relation to the nature of their interaction in the facilities, their relationships with health care workers and how they are handled by the health care professionals in the facilities (Eastwood 2017:48). This leads to a better understanding of Mead's acknowledgement that the self is a result of the $-I$ and the $-Me$. The $-I$ reflects the spontaneous behaviours and attitudes that are usually portrayed by expectant mothers during the period of their pregnancies or spontaneous behaviours they portray during the childbirth process (screaming and roaming around the hospital wards due to labour pains). However, the $-Me$, the socialised self that acts in accordance with the norms and values of the society, is the self that follows the orders of the health care professionals in the hospital wards while suppressing the inner feelings. Several scholars such as Foucault (1972), Lupton (2007), Winters *et al.*, (2016), Oh and Choi (2019) as well as Grennan and Swanson (2013) have documented the issues of practice of body agency in health care institutions and they continually agree that the question of the practise of bodily agency in biomedical health care facilities is a contested terrain. From a symbolic interactionist perspective, this shows that the self is a highly didactic component of the $-Me$, which behaves according to the instructions and monitoring of the health care professionals who hold scientific knowledge.

Further to this, Mead (1934) emphasised the idea that a person's sense of self emerges from interaction with others (social interaction/society) and that societies emerge from interactions among people's selves (Blumer 2004, Charon 2007). Hence, the childbirth process in biomedical health care facilities is viewed in relation to civilisation, science, and medical interventions. How expectant and birthing mothers conceptualise their bodies in such environments is influenced by medical science and the practice of health care professionals on the women. This demonstrates the duality of social interpretations derived from interactions (Dewey, 2017) between individuals (pregnant women) and the ideas that govern the biomedical health care facilities in their social spaces. Neither the self nor society can exist without the other; this means that the two complement each other. Using a meaning-centred approach, Rothmans (1978), Amankwaa (2005), Lupton (2007) and Cheyney (2008: 33) further develop the idea that women's sense of self through interaction is suppressed into docile participation during the childbirth process. Cheyney (2008: 265) argues that “when a mother feels herself giving birth to her baby, by her pains, with the help she needs; when she embraces the infant while the umbilical cord still physically connects the new-born to her, then the full authenticity of the baby as a creation of her body is real to her”. In other circumstances in biomedical health care facilities, like in Caesarean section births, a mother can give birth to a baby and is only presented with her baby hours later – somehow entrenching the idea that the baby is a product of the hospital. “Even in birth in which the baby is held up for the mother to see but not touch, and then taken out of her sight for processing, recording and prophylactic treatment, the meaning created by the scenario shows that the demarcation is strong between the mother's birth experience and the existence of the baby” (Cheyney 2008: 266). When the baby is brought to the mother, wiped off, and swaddled in hospital uniform, it is one step further removed from the immediate causal agent of birth.

Furthermore, Jacob (1992) states that human action should not be understood solely and exclusively as a result of the interaction with other individuals, since it also results from the individual interaction that each person makes within themselves. Therefore, symbolic interactionism understands humans as thinking beings who define the environment in which they act. The environment does exist, but what matters is how humans define it. These definitions do not occur occasionally but as a result of the constant social and individual interactions. The environment with which the individual acts and interacts is symbolic. Symbols are produced through interaction and may or may not be altered in the course of the interaction. In hospital

situations, it is important to consider the “active-passive” relationship, which has been present over the years. This is particularly applicable to the in situations of unconscious birthing mothers in an emergency; the health care professionals make all decisions on behalf of the unconscious mother. In the childbirth situation, this relationship is typified by the doctor using forceps or surgery to take the infant out of an unconscious mother. According to a number of feminists in sociology, is important to note is that health care professionals not only have complete control once the mother is unconscious but it is the physician who has the authority, to define the normal and variations from normal in terms of obstetric emergencies as well as the 'state' of the patient (Elvey 2001, Fox 2009, Oakley 2017). Lupton (2006) and Fox (2009) states that the physicians in a hospital birth always hold the power to create an active-passive relationship by having the mother anaesthetised as they deem fit.

Maternal healthcare institutions do not only present the infant to the mother but continue to maintain control of the infant (in cases of complicated births) in the days after birth during postpartum care (Oakley 2017). An infant in a hospital is monitored by the midwives and nursery staff. The mother has access to the infant with the approval of the staff in a hospital. Rothmans (1978: 229) gives the example that a mother is usually wheeled to the door of health care facilities and given their baby to take home. Rothmans (1978: 229) states that:

In more or less subtle forms, the message is that the baby is a product of the hospital in which parents are being entrusted to take home. The baby enters the mother's life not as a continuation of pregnancy and childbirth experience but as a stranger and a product of the wonders of medicine and still requiring medical supervision.

Furthermore, infant supervision after birth is stipulated on schedules timed to meet the institutional rhythm: for example, four-hour feedings and eight-hour shifts. These arrangements are presented to the mother not as arising from institutional needs but as sensible medical management of infant needs (Cheyney 2020). When childbirth was conceptualised as requiring hospitalisation for the mother, one of the results was the necessity of providing care to the infants produced in a hospital. The presence of the nursing staff around newborns has, with time, been interpreted as arising out of the need of infants, thus, legitimating and providing high-status positions for members involved in infant care.

The nature of interaction among social actors in maternal health care facilities can be understood as a result of what is happening in the current situation, as it happens in the current social interaction, in the current thought, and the current definition. The past influences actions mainly because we think about it and apply it to define the current situation. For a better understanding of human action, the symbolic interactionist theory, as has been noted in the above subsections, is based on the following premises: people direct their actions toward “things” because of what they represent for them (Blumer 2004 and Charon 2007). The meaning of such things is a consequence of the social interaction that each one maintains with the other, and these meanings are manipulated and modified as the interactive process between people develops (Charon 2007). In this way, health care professionals and expectant mothers as well as birthing mothers as users, act in relation to care, anchored in what this represents for both. The action-interaction with others allows individuals to signify and re-signify their perspectives regarding care and, thus, progressively, these perspectives lead and assist the decision-making regarding the use or none use of the maternal health care facility.

3.9 Conclusion

This chapter has discussed the theoretical framework that has influenced this study. The chapter has begun by showing the connection between the theory that influenced this study and the research methods I used (although this will be discussed at length in Chapter Four). I have proceeded to discuss the basic tenets of the symbolic interactionist theory and have shown its three basic premises. Following from this, I have discussed the symbolic interactionist theory according to Mead (1934); I have shown how Mead (1934) goes the extra mile to analyse human societies, human action, and group actions, as I have deliberated on his ideas on symbols, gestures, the self, society, the “I” and the “Me” and finally the generalised other and role-taking.

As I proceeded with this chapter, I have shown the nexus between symbolic interactionism and the medical system, and how symbolic interaction is also evident in medical pluralistic societies leading to the social construction of medical knowledge. I have deliberately discussed these subsections to show how symbolic interactionist processes are evident even in medical systems in societies. After placing this foundation, I have shown that pregnancy and childbirth are culturally perceived processes as much as they are biological processes: medical systems are

embedded in the socio-cultural dimension. I have also shown how meanings are created for the birth process in settings that are outside health care facilities.

Lastly, in this chapter, I have shown the connection between symbolic interactionism and childbirth in biomedical facilities. I have zeroed down to symbolic interactionism and childbirth in biomedical facilities where I showed the social processes that occur during the childbirth process in biomedical healthcare facilities as not only biological but also embedded in symbols and social meanings.

Chapter Four reflects on the methodology which situates the current study in an academic context of knowledge creation and the specific methods I used to gather data to create knowledge in this study. It shows the relationship between the theoretical framework, my research design, and how the data gathering strategies I chose are influenced by the theoretical underpinnings of my study. In trying to select a qualitative approach that would suit this study, I first considered the congruency between the paradigmatic framework, the qualitative approach, and the methods and procedures to be used for data collection and analysis. This chapter does not only initiate a solid foundation for my data analysis in my empirical chapters nonetheless also for my methodology as shall be discussed in Chapter Four.

CHAPTER FOUR

METHODOLOGY

4.1 Overview of the Chapter

This chapter discusses the knowledge generation procedure that was used to collect, analyse, and present data in this study. In this section, I introduce the main qualitative approach used and which runs through the entire research process, which is phenomenology; but I specifically decided to focus on one of the most recent phenomenological approaches (Smith *et al.*, 2009, Larkin 2012). The qualitative approach using a phenomenological analysis made it possible to understand the social processes associated with issues of culture, pregnancy, childbirth, and birth territories as perceived in Mawadza village and how expectant mothers experience these social processes. This was assessed from the point of view of the experiences of the expectant mothers themselves.

The second section of this chapter focuses on the data gathering strategies that were used to collect data in this study, and these include content analysis, data abstraction, in-depth interviews, key informant interviews (KIIs), and focus group discussions (FGDs) with community members. Other data collection strategies that were used in the field include observation and informal conversations. An outline of the different types of methods that were used is discussed hereunder and justification is given as to why these methods were selected for this particular study. Ethical considerations are also discussed as well as the methodological challenges that I faced in the field.

4.2 Contentions on Childbirth Research

Inasmuch as I chose to carry out my study in the particular field of maternal health where I was researching the experiences of expectant mothers in a biomedical local birth territory (waiting mothers' shelter), I did not overlook that studies on childbirth are not without their challenges and controversies. Academia has over the course of the last three decades witnessed a veritable explosion in the field of pregnancy and childbirth research (Oakley 1998: 254, Zadoroznyj 1999). The once very limited field dominated primarily by biomedical research has expanded rapidly across a wide range of social sciences. Notwithstanding the field growing, it continues to face challenges.

Studies on childbirth have largely taken a biomedical standpoint where most studies are done by healthcare professionals on the female reproductive system and the birth canal (Zadoroznyj 1999, Davis-Floyd & Sargent 1997, Nilsson & Lundgren 2009, Chadwick & Forster 2014). Women/expectant mothers are usually subjected to scrutiny by scientists and biologists, whose observations are used to further develop biological research on human analogy, anatomy and the childbirth process (Fox 2009: 40). These researches have been viewed as important and necessary in academia due to their informative nature of the female reproductive system and, commonly, how the childbirth process occurs. However, disagreements have arisen on the usefulness of this information without the inclusion of the voices and nuances of the expectant mothers and birthing mothers themselves.

In addition, the inclusion of reproductive (maternal) health care issues such as childbirth in the study of sociology was regarded as non-essential. Most early medical sociological fieldwork was carried out by males, who in general were not interested in childbirth experiences of expectant mothers or were denied access to birthplaces or maternal waiting areas in the various cultures they studied (McClain 1975: 56, Davis-Floyd 1996, Fielder 1996, Heidenburg *et al.*, 2012). This brought limitations to the studies on childbirth experiences of women. The handful of well-known female sociologists of the first half of the 20th century also paid minute or no attention to birth territories and maternal waiting areas as they aimed to understand the processes from a general point of view (Oakley 1980, Elvey 2003, Fox 2009). This omission reflected not only a gender bias in the sociology of medicine but also a general bias toward social and cultural phenomena and away from biology. Ortner and Whitehead (2000) agree with Oakley (1980) and McClain (1992) in advocating for the inclusion of the study of women by women in order to include women in medical sociological texts and to eradicate gender biases. This study was of women by another woman to gather women's in-depth narratives of the childbirth experiences while eradicating any possibility of gender biases (Oakley 1988; 2017).

As part of the controversies encountered in studies on childbirth, there is a track record of scholars in social science scholarship who faced procedural challenges as they conducted studies on childbirth (Slade 2006, Ayers & Joseph 2008, Savage & Castro 2017, Swendsen & Mazure 2020). One of the major weaknesses presented in the researches that I have stated above is the issue of ontological erasure as articulated by Hwami *et al.*, (2020); where the research

respondents are treated as mere sources of data and not active participants of the study. Hwami *et al.*, (2020) state that ontological erasure is a form of violence in research including studies on childbirth. Also, since childbirth is a universal process, researchers tend to be biased towards the presentation of research findings while the overall research masks the voices of other sub-groups of expectant mothers that would have participated in the study. In this regard, the expectant mothers are fundamentally erased from the knowledge generation process, treated only as objects under study and not as active human beings whose presence in a research project can influence the research output in several ways (Slade 2006, Swendsen & Mazure 2020, Hwami *et al.*, 2020). As a researcher, I was highly aware of these controversies that have existed in previous studies as shown by literature and I ensured that I adopted a research design that minimised any possibility of the ontological erasure of my research participants who were also expectant mothers.

Moreover, controversies are also evident in social science scholarship in terms of the ongoing debate between proponents of hospital births and proponents of births outside hospital facilities. On one hand, proponents of hospital births argue that because there is always the possibility of unforeseen complications, women should always give birth in a hospital facility where they are attended by skilled birth attendants and have access to emergency facilities should the need arise (Zadoroznyj 1999, Room *et al.*, 2016, Williams 2020, Reis 2020). For these scholars, childbirth should be managed due to its susceptibility to pathology. However, proponents of births outside hospital facilities also suggest the childbirth process is a process that is natural and part of human physiology and should be treated with normalcy which entails that it does not require any medical supervision (McCourt 1986, Pike *et al.*, 1997, Berry 2005, Kennare *et al.*, 2010, Slutsky 2012, Cheyney & Davis-Floyd 2020). Numerous methodological contentions arise in research on childbirth due to inherent fundamental flaws. A cross-examination of literature shows that proponents of hospital births tend to dismiss the findings from proponents of births outside hospital facilities (Williams 2020, Cheyney & Davis- Floyd 2020). The contradictions in literature have resulted in unresolved disputes on studies on childbirth that further researchers are likely to be trapped in if they do not consider these controversies before they embark on their research. The acknowledgement of the existence of such debates through literature review and content analysis assisted me as a researcher not to fall in this never-ending debate but look at the actual experiences as narrated by the respondents and presenting them as they are.

Procedurally, in social sciences, issues of categorisation are controversial and not clearly articulated by most researchers on childbirth studies. For example, factors such as high-risk and low-risk factors in pregnancy have proven difficult to categorise during fieldwork for most previous researchers (Nove *et al.*, 2014). This is because high or low-risk conditions can change any time during pregnancy as those declared as low-risk can become high-risk at any given time, yet they risk not being categorised accordingly during fieldwork (Nove *et al.*, 2014, Savage & Castro 2017, Swendsen & Mazure 2020). Not being diagnosed appropriately by health care workers, which social scientists depend on for categorisation, may also cause risks of improper categorisations which increase chances of biases in data presented. This risk of improper categorisation due to such technicalities which are highly dependent on the perspectives of qualified health care professionals was considered seriously in my study and minimised by the sampling strategies I employed in this study.

Assuredly, issues of improper categorisation if not carefully considered can pose major methodological challenges during fieldwork in research on childbirth. Nove *et al.*, (2012) narrate how improper categorisation affects results on factors such as inter-partum transfers if they constitute home or hospital especially (those that lead to mortality). Tew (1986) and Nove *et al.*, (2012) agree that there are usual data analysis challenges that are presented to researchers on childbirth when it comes to issues of maternal mortality from intra-partum transfers. In cases where mortality occurs due to intra-partum transfers, it is usually not clarified in most cases, whether it is due to lack of proper care at the process of birth outside the health care facility or due to poor care received upon arrival at the hospital (Nove *et al.*, 2012).

In addition to this argument, the intended place of birth sometimes is usually not accurately recorded and categorised in childbirth studies especially in social sciences (Campbell *et al.*, 1984). In childbirth studies that focused on birth territories, there has been a lack of proper differentiation between the intended birthplaces and place where childbirth occurs (Nove *et al.*, 2014, Savage & Castro 2017, Cheyney & Davis-Floyd 2020). Future researchers are challenged with the task of properly categorising birth that occurs outside healthcare facilities as planned or unplanned to show a clearer picture of the experiences of birthing mothers. Although this may sound straightforward researchers are faced with difficulties recording intended birthplaces not actual birthplace and this has led to errors of omission in most studies. For proponents of hospital

births, there has been a lack of clear articulation of hospital births. The term “hospital birth” covers a wide range of different experiences from midwife-led centres to high technological consultant-led obstetric units (Cheyney & Davis- Floyd 2020). The term hospital/biomedical delivery need to be dealt with, unpacked, and properly categorised by researchers as clearly as possible (Hatern *et al.*, 2008). Issues of categorisation were solved clearly in this study by stating my research question and adhering to my clear and carefully conceived research objectives that avoided any sort of ambiguity. Careful consideration of these aforementioned controversies shaped the way I conducted my fieldwork because I wanted to refrain from falling into the same controversies without generating new knowledge.

4.3 Epistemological and Ontological Claims

All social theory is ontologically formed and methodologically shaped even if these processes remain concealed and scarcely admitted by the researchers (Archer 1995: 57-58). In light of this assertion, my thesis is disposed towards a research methodology which speaks to the ontological arrogates underlying a more phenomenological approach. A researcher’s ontological posture governs the kind of explanations and theories that can be forwarded from within the context of what s/he conceives to exist socially (Schutz 1998). Phenomenological ontology is therefore, established on a stratified perspective of social reality in which both society and people have emergent properties and powers which are irreducible to one another (Agbedahin 2012).

4.3.1 Phenomenology

Phenomenology is a form of qualitative research (Kvale & Brinkmann 2009). Many eminent scholars have contributed to sociology through phenomenological studies (for example, Berger & Luckmann 1966, Schutz 1972, Garfunkel 1967). In the sociology of medicine, scholars such as Rothmans (1978), Oakley (1980; 1983; 1988; 2006; 2016), Toombs (2001), Elvey (2003), Fox (2009) and Carel (2011) among others also contributed through phenomenology. This informed my decision to choose phenomenology as my research methodology because scholars such as Oakley (1980), Elvey (2003) and Fox (2009) used phenomenology to conduct studies on childbirth.

In terms of conceptualisation, Schutz (1972) states that phenomenology studies the phenomenon based on what people experience in their daily life, considering them as elements that act,

interacting and understanding one another within the social world. Schutz (1972: 262) emphasises ways in which actors in the social world construct reality. Social phenomenology aims to understand the social world in terms of inter-subjective meaning (Archer 1995:46). The discipline of the sociology of medicine is also able to draw upon social phenomenology through examining how the health of individuals, larger social formations and the environment are affected by inter-relationships between humans and the social construction of reality (Zaman 2005 & Geest 2003: 73). Ferzacca (2005: 5) emphasises a meaning-centred perspective in unravelling the phenomenological meanings of a plurality of health care and perception in medical pluralistic societies such as my case study area (Mawadza village). Drawing on the meaning-centred perspective, patients along with their families and social networks, place meanings on societal medical systems, hence, social actors are at liberty to select health care systems that satisfy their health demands according to the meanings they place on them. In addition, Chrisman and Kleinman (1983) argue that the co-existence of various medical systems in societies also reflect different meaning-centred perceptions social actors possess of the societal medical systems.

4.3.2 Why Phenomenology?

I decided to carry out this research within the precepts of the phenomenological approach (Schutz 1972, Denzin & Lincoln 2005, Creswell, *et al.*, 2007, Standing 2009). The term “phenomenological approach” is used interchangeably with “qualitative design” (Schutz 1999), and is often considered central to the interpretive-constructivist perspective which strongly influenced my theoretical paradigm (Denzin & Lincoln 1998). In this research, I considered phenomenology as the best approach to be used to gather in-depth information about the childbirth experiences of expectant mothers. I also decided to particularly use interpretive phenomenology as has been propounded by van Manen (1990) as well as Wojnar and Swanson (2007).

Furthermore, cognisant of the existing paradigmatic conflict in the social sciences regarding what constitutes knowledge and how that knowledge is generated, I intentionally employed a qualitative methodology that is influenced by a phenomenological analysis as my current research problem required a naturalistic and interactionist methodology in which I located myself within the prenatal, intra-, and postpartum care experiences, specifically the childbirth

experiences of the expectant mothers in the waiting mothers' shelter. Denzin & Lincoln (2005: 3) submit that:

Qualitative research comprises of the studied use and collection of a variety of empirical materials – case study; personal experience; introspection; life story; interview; artifacts; cultural texts and productions; observational, historical, interactional, and visual texts – that describe routine and problematic moments and meanings in individuals' lives.

Since this study was qualitative and influenced by a phenomenological research design, it, therefore, allowed the foregrounding of subjectivities, meanings, and interpretations attached to the experiences and perceptions of expectant mothers during prenatal, intra- and postpartum care in waiting mothers' shelter at Bonda Mission Hospital. This approach allowed expectant mothers' voices and spaces to be part of the knowledge creation process. Nyanzi (2011: 48) argues that –qualitative models can explore the wider meanings embedded within childbirth to generate more context-specific conceptualisations that disrupt rigid, blueprint definitions”. It enables individuals to self-identify with a body that communicates to them in a routine not executed on them.

Alasuutari (2010:146) notes that the qualitative initiative seeks to capture the truth of social realities thus acknowledging that all knowledge is necessarily situated. Hence, Botha (2011: 314) demonstrates that –epistemological assumptions behind qualitative research methods are generally associated with constructivist meaning-making research approaches and have a typically inductive logic of inquiry”. Given the limited research that has been conducted on childbirth experiences in Zimbabwe, especially, in relation to medical pluralism and birth territories, operationalisation of concepts was to be inductively done rather than imposing narratives on the respondents who took part in my study. Aguinaldo (2012: 767) notes that qualitative research has been used as a key source for prioritising participants' voices, thus it allows participants to assert authority over their lives. This has the potential of eliminating the chances of misinterpreting the childbirth experiences of women as has historically been the case in the medical sciences by treating them as only sources of data and not active research participants (Hwami *et al.*, 2020). In this regard, qualitative research allows one to capture forms of social life hitherto undocumented or under-documented (Aguinaldo 2012: 767). Such an

approach can claim epistemological authority. I appreciate that the approach leads to discoveries of unanticipated findings grounded in participants' lives and the context in which they live (Hill 2009: 334).

4.4 Sampling Strategy

Recruitment of respondents (sampling) is the use of a subset of the population to represent the whole population in a particular study (Khotari, 2004). In this study, participants were recruited through a multi-level sampling procedure of purposive sampling and referral sampling. In purposive sampling, subjects are chosen to be part of the sample with a specific purpose in mind (Khotari 2004). Women's community support groups²⁰ such as the *mukando* group which is a community money club for women were my entry point into the field in identifying strategic respondents in the village. I first approached the chief as a key gatekeeper to inform him about my study and asked for permission to approach the women's groups that are in the village. The *mukando* group was approached to gather more information about the general community set up and general issues relating to women and their activities in the village, including issues to do with how pregnancy and childbirth processes are handled in the village, and identify other potential respondents. I chose the *mukando* group to be the entry point of my study because they provide a platform for women's gatherings; hence, access to them was easier. At the waiting mothers' shelter at Bonda, I sought the gatekeeper's permission from the hospital manager and other staff members such as the sister in charge of the hospital and nurses in the maternity ward. I identified expectant mothers and other strategic professionals such as doctors, nurses and midwives to participate in the study. The hospital staff referred me to the actual respondents who had agreed to participate.

4.5 Sample Size

A sample of 48 participants was used for collecting data in this study. The sample consisted of (15) women some of whom were expectant mothers in the waiting mothers' shelter (11) and others (4) had used the shelter once or twice since 2015. 20 community members constituted participants who were in focus group discussion (FDGs) and (13) members were part of the key

²⁰ A community support group is an organised and voluntary support structure with rules about how the group is organised and run (Kridge 1977).

informant interviews (KII). Participants were drawn mainly from Mawadza village and Bonda Mission Hospital while others were from the district and provincial offices of the Ministry of Health and Child Care of Zimbabwe.

The central unit of analysis for this study was expectant mothers (past and present). In the study, I recruited expectant mothers who were in the shelter and other women in Mawadza village who have used the shelter once or more since 2015. This time frame is significant because it is the period where the government made it a mandate that all hospitals in rural Zimbabwe should have a waiting mothers' shelter through *The Maternal and Neo-Natal Health Road map 2007-2015* policy has been vibrant in refurbishing the existence and functions of the waiting mothers' shelters in rural Zimbabwe (MoHCC 2016: 348, UNPFA 2016: 35), hence, there was a programme to improve awareness on the shelters. Expectant mothers who participated in my study were from different age groups (eighteen to forty-five years of age) and geographical areas regardless of the level of income, ethnicity, and marital status in Mawadza village. The eighteen to forty-five years age group was chosen for this study because, eighteen is the legal age of consent in Zimbabwe and forty-five years is the commonly perceived the age where child bearing should possibly end for most women in the shona culture- women should have finished giving birth to all their children at this age (Mutambara 1985, Maguranyanga 2011).

4.6 Data Collection Strategies

4.6.1 Introduction

According to Burns & Grove (2005: 733), data collection consists of an accurate, systematic gathering of information significant to the study purpose or the specific objectives and questions of the study. The data collection process should be consistent with the research purpose of the study and should be defined according to the characteristics of the environment in which the study will be developed. In this important phase of the study, the researcher must be systematically implementing key tasks such as (a) selecting the subjects under study, in this case, the health facilities that satisfy the sample criteria; (b) consistently collecting data; (c) maintaining research controls to increase the validity of the study, and; (d) solving problems that threaten to put the study at risk.

The choice of the qualitative approach that was selected for the study has been based on the fact that the approach provides the opportunity to document in-depth experiences and perceptions of expectant mothers in waiting mothers' shelters during prenatal, childbirth, and post-natal care. The research employed five data collection techniques which included content analysis, data abstraction, in-depth interviews, key informant interviews, and focus group discussions (FGDs) with community members. The techniques employed complemented each other to collect significant data in order to understand the experiences and perceptions of expectant mothers in waiting mothers' shelters during prenatal, childbirth, and post-natal care. Justification is also provided hereunder as to why I chose to gather data using these data collection strategies.

4.6.2 Primary and Secondary Documents/Content Analysis

My thesis research commenced with a review of secondary and primary literature. The collection and examination of this is a continuous process and it serves several purposes. Firstly, it provides the context in which the current maternal health care issues in rural communities are located; secondly, perusing existing studies helped in identifying the lacunae in current studies on maternal health in rural Zimbabwe broadly and, subsequently, framing the contributions of my thesis; thirdly, it guided in the framing of questions used in conducting my fieldwork; fourthly, some of the literature was used in this study to support the analysis of findings in the thesis and; lastly, the review of literature provided data that, for various reasons, could not be obtained in the field. The review targeted both hard and soft data. Besides academic literature from different university libraries, the main sources of information were a wide range of internet databases with soft data and hard or paper-based data from government departments such as the MoHCC, Mutasa Rural District Council (MRDC), Government Organisations (GOs) as well as NGOs.

The search for internet databases on the internet did not follow strict systematic criteria. Both open access and subscription-based databases were targeted, including Wiley, Google Scholar, ScienceDirect, and Springerlink. Within these databases, relevant journals were purposively targeted and browsed for content. In searching for articles, various search terms such as maternal health, childbirth, medical pluralism, and birth territories were applied broadly at first and then narrowed down to obtain specific studies on Zimbabwe. I obtained relevant information on my case study area, its history and its present state from the MRDC. Content analysis was an on-going process throughout the writing of my thesis. On one hand, the main advantages of

secondary sources/content analysis are that; firstly, they are easier and quicker to obtain than primary data and, secondly, secondary data obtained from official sources are usually high-quality data that have been assessed to reduce inconsistencies. On the other hand, the main disadvantages reside in that sometimes it may cost money to obtain and the researcher usually has to adapt the data to the purpose of the research. In addition, in some situations, there is a lack of systematised information about the process of quality verification of the data (Burns & Grove 2005: 95)

4.6.3 Data Abstraction

Data abstraction refers to the selection of data that is relevant in form of written records for a particular purpose (Kridge 1977). In the study, relevant data was collected from records in the hospital and waiting mothers' shelter. Records were important in that at the beginning of the research I was offered the registers to show the expectant mothers who had checked into the shelter; as the research continued, there were instances where the hospital staff members felt they had to show me some records (hospital inventories) to substantiate their claims in terms of the aid they had received from well-wishers and donors community.

4.6.4 In-depth Interviews

A total of 22 women were in the waiting mothers' shelter during the period I selected my research participants. My study was supposed to have potentially 22 expectant mothers who were in the shelter apart from those who had previously used the shelter. However, the number of women who were in the shelter who participated in my study dropped by 50% from 22 to 11. This was because four out of 22 (36.4%) women were under the age of 18 which was against my stipulated selection criteria. Another group of four out of 22 women (36.4%) were transferred to Mutare Provincial Hospital due to different complications they had developed during the last phases of their pregnancy hence could not participate. Two out of 22 (18.2%) women considered themselves elderly, although, they fell within the age limits of my selection criteria. These expectant mothers were not comfortable sharing their experiences since they were carrying their first pregnancies. One out of 22 (9.1%) was deliberately excluded from the study because she was suffering from mild dementia that was mistakenly treated for demons in the Apostolic sect of Johanne Chishanu. Although she was considered fit to stay with others in the shelter by the

health care professionals, I felt it would raise some ethical challenges, and validating the data from this respondent was going to be difficult for me. As a result, 11 women from the waiting mothers' shelter participated in my study. The other four were those who had previously used the shelter. The four that I selected were those who were available as others had relocated to the city and other villages through marriage.

Consequently, 15 women participated in in-depth interviews because these were the participants who fit in the selection criteria of the study and I was more interested in in-depth experiences and perceptions of expectant mothers before, during, and after delivery in the waiting mothers' shelter. The interview process was guided by an interview guide of open-ended unstructured questions. Since the research design was basically guided by a phenomenological approach, an unstructured organic approach worked well in developing accord with symbolic interactionism (Kuzmanic 2009). In addition, indepth interviews were beneficial in enhancing validity, due to their peculiarity in terms of the relationship between interviewer and interviewee or the way in which during an interview meanings and narratives are constructed through discourse between the participants (Kuzmanic 2009).

In-depth interviews emphasised the importance of individual agency and subjectivity in social life. Hence, as Bryman (2001) suggests, they brought out women's subjective childbirth experiences in the research. In-depth interviews were chosen for this study as they facilitated the provision of in-depth qualitative data. The in-depth interviews were important because they ensured that the evidence collected is solidly grounded in research subjects' perspectives and interpretations without being filtered and shaped by the researcher's pre-established constructs and categories (Seale 2004). In this case, I captured the women's narratives as they are. Reflexivity on my part as the interviewer was also important because it stimulated conversation that produced viewpoints and insights relevant to the study, which were not anticipated before the start of the interviews; in more structured and focused interviews, there was a probability that insights could be lost to the rigid imposition of the 'next' structured question. Despite the flexibility involved in unstructured interviews, this research technique provided for thematic consistency across interviews and, therefore, offered the basis for comparative analysis (May 1997).

4.6.5 Key Informant Interviews

Key informant interviews were also conducted in this study. A key informant is an expert source of information (Marshall 1996: 92). According to Diccico-Bloom and Crabtree (2006), key informants are selected for their knowledge and role in a setting and their willingness and ability to serve as translators, teachers, mentors, and/or commentators for the researcher. They possessed relevant knowledge to the study and were willing to share this knowledge, communicate well; they were unbiased and were able to reflect upon their own biases. If appropriately situated in a social and community context, key informant interviews also render the opportunity to explore multiple positions on community relations pertaining to a given issue (Khatori 2006). Key informants provide an important link to the research subjects (in terms of establishing rapport) and critical information (including important insights) about the community under study (Terre Blanche *et al.*, 2006).

In this regard, I identified a number of key informants with different social backgrounds, institutional locations, and social roles, and I conducted interviews allowing for a free and unhindered flow of ideas. Some key informant interviews were conducted during the early stages of the research process, including during the formulation of the research topic and research problem. In this study, key informants are doctors, nurses, midwives, Provincial Medical Director (PMD) for Manicaland Province MoHCC, District Medical Officer (DMO) Mutasa district MoHCC and traditional healers in Mawadza village. Two representatives were chosen from each category of key informants, but, there were four midwives selected since some went through biomedical midwifery schools and others are traditionally trained midwives. Two representatives provided broader experiences from those on the ground and those involved in supervisory tasks.

4.6.6 Focus Group Discussions (FDGs)

In this research, Focus Group Discussions (FGDs) were carried out to map pertinent social and economic contextual evidence to guide and inform the research process. Twenty community members identified through referrals by community support groups participated in (FGDs). There were two groups of FGDs; one group of ten participants consisted of the expectant mothers' spouses and other male members of the society. Their views are important since

Mawadza village is patriarchal and men play key roles in decision-making in the village. Another group comprised women in the village (including the elderly and those from community support groups). FGDs enabled me to tap a wide variety of opinions and provide many different forms of interaction to gather in-depth data.

In my study, FGDs were useful in capturing detailed information about personal and group feelings, perceptions, and opinions about issues affecting the use or non-use of the waiting mothers' shelter at Bonda Mission Hospital. FGDs are socially oriented tools for collecting data; they allow the collection of data in groups in social settings (Lufebre 1992). In Mawadza, FGDs were conducted in socially accepted settings according to the traditions of the community so as to collect data from the lived realities of the community members. FGDs have been considered a relevant data collection tool for this particular study because group dynamics often bring out aspects of the topic or reveal information about the subject that may not have been anticipated by the researcher or emerged from individual interviews (Lufebre 1992). This means that ideas were generated and shared by community members as they related topical issues to the interviewer. A variety of insights shared by group members were critically essential for the researcher in that variegated views are obtainable at once. Focus Group Discussions may provide immediate ideas on the improvements of certain facilities in the community. In this study, FGDs immediately pointed out issues of serious concern that need to be tackled out for the proper use of the waiting mothers' shelter at Bonda Mission Hospital

4.7 Ethical Considerations

All research implicates ethical issues. As a researcher, I agree with Berg's (2001: 39) contention that "as a social scientist, I have a great extent of ethical obligation to my colleagues, study population and larger society". The Rhodes University Ethical Guidelines first alerted me to the ethical dimensions of my research. Similarly, Birch *et al.*, (2012) argue that ethical questions in the research relationship, the use of data, and the interpretative and analytical processes have all become more significant as the landscape of qualitative research continues to change and researchers face new issues when using new tools to produce knowledge.

In this regard, this study observed the relevant principles and protocols relating to research ethics, including those specifically highlighted in the research guidelines for Rhodes University.

Prior to every interview, each respondent was informed that his/her participation in the study was voluntary and that s/he could withdraw from the study any time s/he wishes to. Consent should be on-going and renegotiated throughout the research process and researchers need to continually reflect on what it is that research participants have consented to (Miller & Bell 2012).

I obtained ethical clearance from the Medical Research Council of Zimbabwe (MRCZ). Thereafter, I got clearance from the MoHCC Manicaland Province. After this, I was also granted permission to carry out my study in Mutasa District by Mutasa Rural District Council, Bonda Mission Hospital, and Mawadza village. All respondents were informed that participation would be for academic purposes. Confidentiality and anonymity of the respondents was assured. Pseudonyms were used to protect the identity of participants. Individual consent was sought from the participants and they were asked to sign consent forms. Given that gender barriers might arise in Focus Group Discussions with male community members of Mawadza village, I employed a male research assistant to assist with handling conversations of spouses of the expectant mothers. In cases of ethical dilemmas, I adopted a contextual, situational, and practice-based approach to ethics suggested by Birch *et al.*, (2012).

4.7.1 Ethical Issues

I was aware that ethical dilemmas are inevitable in all research, but, before I started fieldwork, I was not sure how this was going to play out in practice. These emerged from gatekeepers; I faced challenges in getting gatekeeper's permission from the chief. To counter these ethical dilemmas, I adopted a contextual, situational, and practice-based approach to ethics suggested by Birch *et al.*, (2012), as has been mentioned earlier.

One of the aspects that have intensified my interest to conduct my fieldwork in Mawadza village is the *Madhanga*, where the chief resides and traditional ceremonies are conducted, including childbirth ceremonies. In this regard, I intended to either visit the place or interview the people (as key informants) directly responsible for the activities in *Madhanga* and also those who maintain the place. This was going to help me get information about and access the women community groups in the village. When I briefed these elders about my research and my intentions in May 2018, I was told to bring five dollars that I would use for *kuwombera mambo*

(greeting the chief) and also wear dark clothes only (red clothing is prohibited) in order to get access into *Madhanga*. I agreed to this.

Nevertheless, during my following visit for the gatekeeper's permission, I was told it was no longer possible to do so as the chief had a lot of disputes that he was dealing with. In this dilemma, I alerted myself to Broadhead and Rist's (1976) caution against confrontation with gatekeepers. I, therefore, resorted to coming on a later date when the chief had settled the disputes with other people in the village. The chief could not give me permission in this state for the spirits would be against him doing so.

The way I reached some of my respondents created ethical dilemmas. After getting approval from the chief to conduct my study in Mawadza village, I was helped by the chief's right-hand man to access women's community groups. Following the chief's orders, I had to call upon women's groups to gather at a central point on a Wednesday, whereas the women's groups in the village usually meet *kuchina* (on a Thursday). The agreement was that we meet at a central point so that I could meet group members, engage with them and get the information that I needed about the village set up concerning childbirth issues and, possibly, identify other key respondents. Although this made access easier, it presented ethical problems. My legitimacy as a researcher was severely scrutinised because I had 'summoned' villagers to come for village meetings. As a result, I had to constantly assure the respondents of my position in the community and the fact that only their leaders have the legitimacy to call them for meetings. I also reiterated to them continually of their right to decline to participate in my research process.

4.8 Methodological Challenges

This section discusses the methodological challenges that I faced during fieldwork and how I overcame these challenges so as to obtain in-depth data in the field notwithstanding these challenges.

Before I started my fieldwork, I did not anticipate facing any major challenge or drawback in the field. This is because I did not underestimate the importance of language. As has been noted above, I, the researcher am conversant with *ChiManyika* as I belong to the *Manyika* dialect, and it is the language I speak. I, therefore did not have to grapple with terms and phrases that I did not understand. This helped me get in-depth data because there was no need to repeatedly request

respondents to deconstruct sentences for me during interviews as this would interrupt the flow of the interviews.

Other respondents had certain expectations in their participation in this study. That is, they thought that there were direct benefits associated with participating in the study and therefore, this created power imbalances between me as the researcher and the research respondents. To manage these expectations, I continuously explained my position (university student), the nature of my research (academic research), its purposes (fulfilling the requirements of my degree programme), and their roles in my research. In such a context, one also needed to guard against epistemological fallacy, that is, failure to realise the effects of structural factors when there are such effects (Hwami *et al.*, 2020). Inconsistencies in the information provided by research respondents were noticed in expectation of aid or any material benefits from participation in the study. This was managed by constantly reminding participants of the reasons for this study and the reason for their participation. However, during FGDs with Mawadza village members, I provided refreshments to the participants because it fulfils the *Manyika* basic cultural expectation, *ukama igasva hunozadziswa nekudya* (relations are only consolidated by sharing food) which cements cooperation of participants.

Another methodological challenge that I faced in the field was the unavailability of some research respondents on agreed dates and times due to different reasons. I attenuated this challenge by shifting interviews to later dates and times wherenecessary.

4.9 Limitations and Implications for Future Research

The research is a qualitative study that explored the experiences and perceptions of expectant mothers in waiting mothers' shelters during prenatal, childbirth, and post-natal care. It took a qualitative approach to understand in-depth nuances of the research respondents for a particular case study, Mawadza village in this case. My study provides empirical data only for Mawadza village and does not generalise these findings to other districts and areas in Manicaland Province or elsewhere. This study does not take a quantitative approach, hence, the results from this study cannot be generalised. I, therefore, draw primarily on qualitative rather than quantitative data in presenting empirical chapters. The fact that the study is a qualitative study makes it relevant as it gives a voice to the expectant mothers to narrate their childbirth experiences.

4.10 Conclusion

This chapter has described the methodology that was employed in my study. The first section ensued by showing the controversies that are associated with studies on childbirth as well as the epistemological and ontological orientations of this study. The study takes a phenomenological approach, which is basically aimed at understanding social phenomena from the lived experiences of expectant mothers. The second section of this chapter shows the data collection strategies that were used in my study. Qualitative data collection methods were useful in eliciting rich, in-depth, and detailed experiences of study participants. They allowed for a greater degree of flexibility that was compatible with the subject matter which requires subjectively told stories (experiences) in studying the in-depth childbirth experiences of expectant mothers in waiting mothers' shelters. In this chapter, the different data collection strategies that were used in the field were elaborated and these are in-depth interviews, key informant interviews, FGDs and observation.

Using purposive and referral sampling, I recruited participants who referred me to the respondents, all from whom I still had to seek consent for participating in the study. Thereafter, interviews were conducted accordingly. During the course of my fieldwork, I followed the rules and protocols of the Rhodes University Ethics Committee. I have highlighted the methodological challenges that I faced in the field. It is also important to note that this study looks at Mawadza village only as a case study, and the results cannot be generalised. The chapter closes by chronicling the main fieldwork challenges and how I navigated through these challenges as the principal researcher. The challenges were mainly addressed in a manner that allowed the smooth continuation of the study while getting rich data.

CHAPTER FIVE

UNDERSTANDING PREGNANCY AND CHILDBIRTH EXPERIENCES OF EXPECTANT MOTHERS IN MAWADZA VILLAGE

5.1 Introduction

This is the first of the empirical chapters that identifies and describes how pregnancy and childbirth processes are subjectively constructed and understood in the medical pluralistic village of Mawadza. In this chapter, I attempt to understand the perceptions and experiences of the concept of pregnancy and childbirth process in the waiting mothers' shelter. The next chapter (Chapter Six) builds on this chapter, it explores the particular experiences of expectant mothers in the waiting mothers' shelter at Bonda Mission Hospital and how expectant mothers understand these processes as I go further to determine the level of utilization of the waiting mothers' shelter and factors that influence the choices of the expectant mothers in use or none use of the facility. I start this chapter by profiling some socio-demographics of the respondents who participated in this study, specifically in in-depth interviews and focus group discussions (FGDs).

5.2 Socio-Demographics of the Study Participants

5.2.1 Distribution

Table 5.1 shows the chosen participants for the study. As has been noted in Chapter Four, the central unit of analysis for this study were expectant mothers (past and present). In this study, I recruited expectant mothers who were in the shelter, and other women in Mawadza village who used the shelter since 2015 (as indicated in Chapter Four, particularly Section 4.7). The categorisations were derived according to the identities the participants were comfortable with²¹. In this study, all participants were black Zimbabweans. Among the participants, 73.3% were expectant mothers in the waiting mothers' shelter during the period I conducted the study, while

²¹ The names that are given to the respondents in this study are not their real names but pseudonyms - to protect their identities. I chose to use pseudonyms because it is part of the ethical considerations that I had to take heed of during the course of my fieldwork and presentation of data. By using pseudonyms, I also observed what is termed deductive disclosure or internal confidentiality (Tolich 2004). This occurs when the traits of individuals (in this case expectant mothers) make them easily identifiable in research reports. Given that qualitative research often contains rich descriptions of the study participants' anonymity breaches due to deductive disclosures are common, therefore I had to make use of pseudonyms to protect the identity of my research participants. As such, I did not compromise my study because although it conveys detailed, accurate accounts of the social world, it protects the identity of the research respondents (Sieber 1992).

26.7% comprised of formerly expectant mothers who used the shelter one or more times from the period of 2015.

Remarkably, the ZDHIS (2017: 132) also shows that there was a very low attendance in maternal health care facilities in Mutasa district due to several reasons. This explains that the number of women who used the shelter from 2015 is significantly lower than the number of women who were in the shelter during the study (18% - 22% from 2015-2019).

Table 5.1: Distribution of Participants

CATEGORY	PARTICIPANTS	TOTAL	PERCENTAGE
Expectant Mothers (15)	Present in the WMS	11	73.3%
	Previously used the WMS	4	26.7%
Total%			100%
Practitioners (13)	Doctors	3	23%
	Nurses	2	15.4%
	Midwives from Bonda Hospital	2	15.4%
	Traditional Birth Attendants	2	15.4%
	Traditional healers	2	15.4%
	District Medical Officer (DMO) & Provincial Medical Director (PMD)	2	15.4%
Total %			100%
Community	Male	10	50%

Members (20)	Female	10	50%
Total%			100%

5.2.2 Age Groups

Table 5.2 summarises the age of the participants. In general, most of the participants in the category of the expectant mothers were in their early thirties. This trend has been evident in the records of this particular waiting mothers' shelter and one of the most common reasons is that expectant mothers tend to go and stay in the waiting mothers' shelter during their second pregnancies after at least one complicated home delivery that, in most cases, ends up in the loss of the newly born baby. However, youthful expectant mothers and other older expectant mothers have also stayed in the waiting mothers' shelter at Bonda Mission Hospital. I came across two older (43 years and 44 years) expectant mothers who had stayed there, but, they were not willing to participate in my study. A discussion with one of the staff members at the waiting mothers' shelter about the unwillingness of these two expectant mothers to participate in my study revealed various reasons that included cultural reasons. It is usually harder for older expectant mothers to be flexible enough to follow the midwife's instructions while giving birth, hence, older expectant mothers in this particular setting were not very keen to share their experiences.

Moreover, other older expectant mothers were in the shelter because of the need to protect their first pregnancies after years of failing to conceive. The stigma that these expectant mothers typically face during the period before they finally conceive was also one of the contributing reasons for their unwillingness to share their pregnancy and childbirth experiences. The skewness according to age has significantly impacted on the study in that much of the experiences that are reflected in this thesis will be devoid of the input of older expectant mothers. My study captures the perceptions and experiences of younger mothers to be. This distribution which is skewed towards the younger population, unfortunately, can be incorrectly interpreted to mean that it is the younger expectant mothers who go and stay in a waiting mothers' shelter at the end of their pregnancy as they await labour, thus giving ammunition to those who support home births by arguing that young people are diverging from the natural, non-medicalised birth

systems that have been in this particular community since the pre-colonial era (as noted by Ranger 1980, Mudodo 2001).

The practitioners were also distributed according to their age. The majority of the health care workers who participated in my study are more than the age of 45 years. It was deliberate that this age group forms the majority of my key informants because I needed key informants who were experienced with the trends and issues to do with childbirth specifically the experiences of expectant mothers in the waiting mothers' shelter not only in Mawadza village but in Mutasa district in general. Other key informants were from district and provincial offices. The other group of key informants consisted of those who were in their thirties. This group comprised those who formed junior practitioners who had completed their courses in midwifery, hence, their hands on experiences with the expectant mothers was crucial.

The ages of the community members ranged from 25 to over 45. I deliberately selected this range for I needed perceptions of various age groups in the community expressed in my study to avoid biases of any nature. It should be noted that although the ages vary the participants were divided according to their sex (10 males and 10 females). In this regard, I took note of sex balances as well as capturing the perceptions and experiences of various age groups in my study. The age group range used in my study did not compromise the data I collected because in as much as gerontocracy is important in Mawadza, differentiation due to sex is more important. Men felt free to participate in focus group discussions as long as participants were exclusively men regardless of their ages and the same applied for women.

Table 5.2 Distribution of Participants by Age

CATEGORY	AGE GROUP	NUMBER	PERCENTAGE
Expectant Mothers (15)	18 – 20	2	13.3%
	21 – 26	3	20%
	27 – 29	2	13.3%

	30 – 32	4	26.7%
	33 – 37	4	26.7%
	38 – 44	0	0%
	45+	0	0%
Total%			100%
Practitioners (13)	18 – 20	0	0%
	21 – 26	0	0%
	27 – 29	0	0%
	30 – 32	2	15.4%
	33 – 37	3	23%
	38 – 44	2	15.4%
	45+	6	46.1%
Total%			100%
Community Members (20)	18 – 20	0	0%
	21 – 26	3	15%
	27 – 29	2	10%

	30 – 32	1	5%
	33 – 37	4	20%
	38 – 44	7	35%
	45+	3	15%
Total%			100%

5.2.3 Education

Table 5.3 summarises the distribution by level of education attained by the participants. What is listed is the level that participants were currently at or for which they had already attained a qualification by the time the study was conducted. There was almost an even distribution of participants according to educational attainment, especially among expectant mothers and community members. Other key informants were highly educated with tertiary education, thus interviews could easily flow in vernacular as well as English with some of the key informants. The (DMO) and the (PMD) are medical doctors by profession although they hold administrative positions both at district and provincial level at the MoHCC. Worth noting is that all the participants (expectant mothers/those who had used the shelter since 2015 had managed to attend schooling up to –Ordinary” level, a basic qualification that makes one eligible for employment and further study in Zimbabwe. Other community members had qualifications such as the Zimbabwe Junior Certificate (ZJC), while others were illiterate altogether. Among the illiterate here the traditional healers and a TBA, though with the interviews being conducted in vernacular, no major challenges were encountered. It is also important to note that among community members, the number of literate men who participated in my study was more than that of women, and from informal conversations with the participants I realised that this reflects the situation in the village where literacy levels are generally higher among men than women.

Table 5.3 Distribution of Participant by their Level of Education

CATEGORY	HIGHEST EDUCATION LEVEL	NUMBER	PERCENTAGE
Expectant Mothers (15)	Illiterate	0	0%
	Secondary School – ZJC	0	0%
	Secondary School – O‘ Level	15	100%
	Secondary School – A‘ Level	0	0%
	Tertiary – Non-Degreed	0	0%
	University Education	0	0%
Total%			100%
Practitioners (13)	Illiterate	3	23%
	Secondary School – ZJC	1	7.6 %
	Secondary School – O‘ Level	0	0 %
	Secondary School – A‘ Level	0	0 %
	Tertiary – Non-Degreed	2	15.4%
	University Education	5	34.5%
Total%			100%
Community	Illiterate	7	35%

Members (20)	Secondary School – ZJC	3	15%
	Secondary School – O’ Level	10	50%
	Secondary School – A’ Level	0	%
	Tertiary – Non-Degreed	0	%
	University Education	0	%
Total%			100%

5.2.4 Occupation

Table 5:4 establishes the occupations of the participants at the time of the study. Employment status ranged from unemployment, formal employment to self-employment, although the majority of the participants were unemployed. Amongst those not employed were some housewives, some of whom had just left school and also some who had been retrenched from their work places due to the shrinking economy. Women are mostly unemployed and they have access to properties through marriage. UNDP (2014) has conducted studies in Mawadza village and the same results were established that women were among the less educated. In addition to that they do not own land or livestock which is the most valuable resource in this particular village, they can only do so through marriage.

There are very few female-headed households in this particular community because after one is widowed, they can either go back to their maiden family or they can stay under the wing of their in-laws as they raise the children of the deceased which is basically a process within the *Manyika* culture where a widow is given a husband at least a year after the death of her husband; the widow gets a husband from eligible relatives of the deceased, especially, direct siblings²²). The expectant mothers who participated in this study were largely from low income backgrounds and could not afford the private health care system. Others were from a subsistence farming

²² *Kugarwa nhaka.*

background where they could afford the basics of life, but, could not afford to travel to the provincial capital (Mutare) for private maternal health care services like what other urban expectant mothers do.

Immigrants in this community also have challenges acquiring and owning land. Others still have not acquired land from the government; hence, they work on other people’s plots or in tea estates or plantations. The burden is higher for the immigrant population as they can barely afford even the basic needs. In instances where there is an economic meltdown, as in the period I conducted my study, they would get their monthly remuneration in the form of groceries and maize meal from their employers who were also battling the harsh economic situation. This leaves women in even worse situations and in a very low-income setting. Participants of the study included civil servants (doctors and nurses/midwives were amongst the “elite” of this community), and farmers, although the population of the later is very low.

Table 5.4 Expectant Mothers’ Current Occupation

CATEGORY	HIGHEST EDUCATION LEVEL	NUMBER	PERCENTAGE
Expectant Mothers (15)	Employed full-time	0	0%
	Unemployed	10	66.7%
	Employed part time	2	13.3%
	Self employed	3	20%
Total%			100%
Practitioners (13)	Employed full-time	9	69.2%
	Unemployed	0	0%
	Employed part time	0	0%

	Self employed	4	30.8%
Total%			100%
Community Members (20)	Employed full-time	2	10%
	Unemployed	9	45%
	Employed part time	7	35%
	Self employed	2	10%
Total%			100%

5.3 Understanding Pregnancy and Childbirth in Mawadza Village

The study revealed that pregnancy in Mawadza village is euphemistically referred to by the whole society as *pamuviri*, *kuzvitakura*, *mimba* or *nhumbu*. The childbirth process is referred to as *kusununguka* or *kubara* (which literally means to be relieved) and an expectant mother is also referred as *mbuya mutekede* which is a light-hearted reference of teasing a heavily pregnant woman, regarding her as a mollycoddle of sorts. The use of each term that I have listed above depends on the audience one is talking to. It is thus viewed as more formal and decent to use *kusununguka* instead of *kubara*, hence *kubara* becomes the common word for less formal instances, although the words basically mean the same thing. In other instances, the pregnancy can be referred to as *kumitiswa* which is a derogatory term especially used in reference to “fatherless” pregnancies, or pregnancies acquired outside of wedlock. I have deliberately provided all the terms which are used in this village to refer to pregnancy to show that pregnancy in itself in Mawadza village is perceived not as merely a biological condition but one that is also meaning centred. In this village, the meaning of pregnancy is embedded in cultural values and it is not only the naming that makes it cultural but the ways in which it is cared for until childbirth that shows that in this village; pregnancy is defined beyond its medical nuances as the social and cultural facets are viewed as equally important.

In Mawadza village, the elderly women (who are usually TBAs and SBAs) use various ways to identify pregnancy. They possess important knowledge that is linked to pregnancy and childbirth. In this community, some expectant mothers go to the local clinic only for confirmation that they are pregnant or when complications arise; if not, the elderly women and some men in this community can sufficiently diagnose one as pregnant. One respondent, (Alice who is 67 years old and a TBA) had this to say regarding the issue:

It is not a hard task to identify a pregnant woman, in my experience; I can see that my daughter, neighbour's daughter or any other passer-by is pregnant. You can first identify that by the earlobes turning red, then the skin changes and you can see others act like they are ill from Malaria and you can know that a woman is pregnant. People go to the nurses just to get confirmation, but without the doctors and nurses we can, as elders in the community, tell if someone is pregnant or not (Author's Interview 09/06/2019).

In another interview, an elderly woman-Tilda who is 70 years old and also a TBA said:

It's not hard for me to tell if one is pregnant. I can even tell if my daughters become mischievous and fall pregnant outside wedlock. You can tell by your daughter getting lighter in complexion and earlobes getting lighter. You can even tell that one is pregnant by their sleeping all day (Author's Interview 10/06/2019).

Yet another respondent, Joe a, 72 years of age and a traditional healer affirmed the same position:

The clinics are not necessary since it is very possible to tell that one is pregnant without going to the clinic. Traditionally, pregnancy has been diagnosed by the elderly, so there is no need to go to the clinic as that can be managed well in the society (Author's Interview 09/10/2019).

Biomedical facilities play a secondary role for expectant mothers who choose to go to Bonda Mission Hospital to register for prenatal care. Among the respondents, there was no one who noted that they first discovered that they were pregnant at the clinic or hospital. Most would go to the local clinic to confirm the word of the elders who would have already indicated to the expectant mother that she is pregnant. One respondent, Patience, an expectant mother who was in the shelter, said:

I went to the clinic when I already knew that I was pregnant (Author's Interview 11/06/2019).

Yet another one, Vivian, a mother who has previously used the shelter said:

I only went to the clinic to register my pregnancy for prenatal care after an awareness campaign that was raised by the midwives in our area, otherwise I was told by the traditional healer that I was pregnant and indeed I was (Author's Interview 11/06/2019).

It is noteworthy that the way pregnancy is diagnosed in Mawadza village shows that pregnancy is imbedded in the culture of the people since they claim authority over diagnosis of pregnancy. The dominance that the villagers exhibit over diagnosis and care for pregnancy shows that they are convinced that they hardly need biomedical facilities for diagnosis of pregnancy. This has shown that there is ownership and social construction of knowledge within this society because knowledge on pregnancy and childbirth is socially constructed in relation to the culture of this village which also reflects and reproduces the existing social systems. In Mawadza village, the traditional health care system generally claims dominance over issues to do with pregnancy and childbirth as respondents clearly noted that the clinics are only there for confirmation of already diagnosed pregnancies.

In light of this view, Jiang and Xiang (2017) have stated that in medical pluralistic societies, pregnancy and childbirth processes are handled in a manner that goes beyond reflecting on the differences in the health care systems that are in existence in the society. Instead the handling of pregnancy and childbirth processes also reflects on the claimed independence of each health care system and controversies that arise over issues of struggle towards dominance of each health care system. As a result, the use of a certain health care system in the society will reflect on the care seekers' class, ethnicity, socio-economic status and their level of education. Thus, medical pluralism has proven to be a key factor in the diagnosis of pregnancy in Mawadza village. Vega (2017) takes a neutral stance with regards to the possible controversies that arise in medical pluralistic societies over dominance by celebrating the role of pluralism in the pregnancy and childbirth process. She notes that medical pluralism often provides solutions to different challenges faced by societies in order to handle pregnancy and the childbirth process. Inasmuch as medical pluralism is seemingly the major cause as to why expectant mothers do not go to health care facilities to care for their pregnancies, Vega (2017) notes that medical pluralism

meets the desperate health related needs of people in different geographical, cultural and ethnic contexts. In different geographical locations in Mawadza village and among different ethnical groups, pregnancies continue to be diagnosed without necessarily consulting Bonda Mission Hospital, which is the closest biomedical health care facility.

5.3.1 Ways to Handle Pregnancy in Mawadza Village

In Mawadza community, it is during the early stages of pregnancy that the elderly in this community teach the expectant mothers to handle their pregnancy and other pregnancy related taboos. In Mawadza, some expectant mothers handle their pregnancies up to the point of birth without visiting the nearest clinic or hospital for prenatal care whilst a few minorities do. Different expectant mothers with different beliefs undergo certain processes to avoid miscarriages, known as (stabilising the pregnancy²³). Others just take herbs continually during the early stages of pregnancy to make sure that the foetus is stable and to reduce the chances of a miscarriage. Others go to the prophets of their particular sect and have a prayer vigil for the expectant mother to stabilise their pregnancy. Additionally, in a medical pluralistic society such as Mawadza, pregnancy and birth are everywhere a candidate for consensual shaping and social regulation, the particular pattern depending on local history, medical knowledge and the dominant healthcare system as has been noted by (Wong, 2020).

5.3.2 Significant Episodes on Childbirth in the Context of Mawadza Village

In this village, childbirth is a unique process that is treated with sacredness and as a process that should never be done with any male members present. If any male should be close by, they should only hear the birthing mother crying as the child is delivered not to see the actual process. The squatting position is the most common position one takes when giving birth in this particular community.

5.3.2.1 The Placenta

There are very important elements of birth that were revealed by all the participants in this study. The placenta is very important in the childbirth process. The placenta is called the property of the

²³ *Kutsigisa pamuviri.*

elders²⁴ amongst the *Manyika* of Mawadza village. The placenta makes the childbirth process significant in Mawadza village because it connects the new-born with the ancestors. If the placenta does not come out, it means the birth process is not yet complete, and there have been some cases in this village of expectant mothers who have died from the retention of the placenta. The disposal of the placenta is done by the birth attendants, usually, female practitioners. Burying the placenta symbolically introduces and dedicates the new-born to the ancestors. Burying the placenta in the land also legitimises the child staying in this particular community spiritually. It is perceived that this will appease the ancestors and, in return, the ancestors will protect the child against bad omens, diseases and any negative forces, thus the name *chevakuru* (belonging to the elders/ancestors) was derived from this ritual. Tilda a traditional birth attendant underscored the importance of this ritual, saying:

The placenta is a very important element of childbirth; before one buries the placenta, the ancestors will never know that a child has been born in the family. Your child will be on his/her own. If you bury the placenta, your child will be very obedient and will never give you any problems (Author's Interview, 04/06/2019).

Other members of the community in FDGs also reiterated on the importance of the placenta as Mr Thompson stated that:

The placenta is a very important component of childbirth. It makes us stronger as a people because we know that our children have been accepted by our ancestors.

In agreement Mr Grey another community member stated that:

The placenta is very important to use as male members of the society because it ties our families to our ancestors. It ties our women because the placentas are from their wombs and also our children who were protected by those placentas

5.3.2.2 *The Umbilical Cord*

The umbilical cord is referred to as *rukuvhute* or *guvu remwana* which literally translates to navel/umbilicus or bellybutton. The umbilical cord has been considered very important in this culture. Part of the first and most highly regarded remarks among the women who had home

²⁴ *Chevakuru*.

births and TBAs is that the umbilical cord needs to be cut carefully. Mothers, after giving birth to their children, use various ways to nurse the cord that has been cut. The common way to nurse this cord is by using methylated spirits. This is used until the cord falls down on its own after healing. Other mothers use the cat's dung to put on the umbilical cord until it dries and falls off on its own. The cat's dung is prescribed by the traditional healers and ready for use. The dung will be dried and mixed with a few herbs and put in powder form. This powder is then put on the end of the cord close to the new-born's skin, and this is done continually until the cord has fallen off. This strategy has been practised differently among community members. Some mothers who participated in this study narrated experiences of the cat's dung method of nursing the umbilical cord. Betty, a 25 years old expectant mother who was in the shelter had this to say:

I gave birth to my baby boy before this pregnancy that brought me to Bonda. My son was bouncing and healthy, but, when I started to apply the cat's dung on his umbilical cord, it started to change colour as if it was decaying. I was helped by a woman who is my neighbour, who took me to hospital. My son got a few injections and I was hurt. The nurses shouted at me and I ended up regretting why I had used the cat's dung; from that point up to now, I do not ever want to use any other substance apart from methylated spirit for cord care (Author's Interview 05/06/2019).

The aforementioned important episodes of the childbirth process are defined by the symbolic meanings that they hold in this village. In Mawadza village, pregnancy and childbirth are not just biological conditions but are in every sense socially marked and continually shaped by society, as Davis-Floyd & Cheyney (2020) have noted.

5.4 Medical Pluralism, Pregnancy and Childbirth Processes in Mawadza Village

According to Vega (2017), the value of medical pluralism in the pregnancy and childbirth process should not be distorted or used to disguise and obscure the suffering of the women living in low income settings. How the different methods of attending to and care of pregnancy, childbirth process and the preferences of the expectant mothers to these methods becomes the crucial question of the day. It is through problematising the pluralism in birth practices (traditional, biomedical, and spiritual) that one can understand the experiences that expectant mothers go through and the development of appropriate healthcare across ethnical space and place. It is this very critical factor that drove me as the researcher to firstly explore how

pregnancy is understood in Mawadza village. The narratives of how pregnancy is understood in this village provided a solid foundation to a better understanding of the experiences of expectant mothers at awaiting mothers' shelter at Bonda Mission Hospital which is a biomedical facility that exists in a purely medical pluralistic village.

Furthermore, medical pluralism plays a crucial factor in understanding pregnancy and childbirth in Mawadza village. It is almost impossible to understand pregnancy and childbirth without looking at how these processes are understood using different health care systems that are in existence in this rural community. In Mawadza village, birth processes vary; choice of birth territory and, ultimately, the health care system associated with the birth territory varies – according to the findings of the study, with age, level of education, ethnicity, economic status and religious affiliation. Those who have converted to Christianity, especially, members of the Anglican Church, in this village are more likely to seek biomedical health services from Bonda Mission Hospital and, subsequently, expectant mothers from this religious affiliation also tend to await labour in the waiting mothers' shelter and give birth at the hospital. Religious affiliations have proven to be central to understanding health care systems and health seeking behaviors, as they also influence one's belief systems. In addition, the older one becomes, the more disinclined one feels towards awaiting labour in the waiting mothers' shelter, unless one has had complications in one's previous deliveries. This means that young expectant mothers typically tend to use the facility more than older women.

This study has looked at experiences, perceptions and patterns of usage of biomedical maternal health care facilities and motivations for use across populations by expectant mothers of different economic status and various ethnicity groups among the *Manyika* people of Mawadza, as well as in relation to health beliefs and wider values, and resourcefulness of individuals' social networks. Öhlén *et al.*, (2006) has also demonstrated that decision-making in which the health care system used is influenced by membership of certain social networks. Thus, "becoming a team" with significant others is important in one's choice of health care system. The importance of factors such as religious affiliation in the choice of health care during pregnancy and childbirth shows that the meanings of things around us in the society and of the cultures we practice are affected by the people with whom we interact (Blumer 2004, Charon 2007, Redmond 2015).

The view of choice of health care service for child birth is affected by the people that expectant mothers interact with, which constitute the second crucial premise of symbolic interactionism. The more social interactions one has, the more diversity there is in one's interpretation of things in one's social world and the ideas that one's social group is inclined to accept is likely also to influence their behaviour (Redmond 2015: 14). Such interaction affects one's behaviour, sense of self, relationships and worldview (Mussolf 2003). In some ways, the size of the social network affects the breadth and depth of the meanings one can draw from in interpreting the world (Mussolf 2003). Those who go to the Christian churches are more inclined to use the waiting mothers' shelter to await delivery as has been mentioned in Chapter Two Section 2.3. The symbolic meanings given to the importance of awaiting delivery in the shelter that I have mentioned show the importance of consensus in acceptance of a certain symbol in any given society. It is through interaction and communication that certain symbols become accepted in the society, hence their meanings form the consensus.

An analysis of how pregnancy and childbirth are understood and handled in the context of Mawadza village shows the strength of social interactions and the social meanings associated with these processes to the local people. In this regard, Hewitt (1976: 27-28) postulates that symbols have meaning in any given society –solely by virtue of consensus among those using them,” that is —. because a community of symbols users adopt the convention of using given symbols consistently”. The importance of meaning has been shown to begin with, by the importance placed on pregnancy in the village, where the elders use only gestures and behavioural traits of the new expectant mothers to diagnose pregnancy. For Blumer (2004) and Plummer (2016) this constitutes the first premise of symbolic interactionism. Pregnancy is diagnosed using common meanings that have been well accepted by village members to symbolise pregnancy. The significance of symbols and what they mean and how they constitute consensus among social actors has been well shown by the fact that when one is diagnosed as pregnant by relevant community members, it turns out to be true when cross examined at Bonda Mission Hospital, which is a biomedical facility that bases its conclusions on science.

This does not only show the presence but the significance of symbols and meanings attached to them in social interaction, therefore the importance of symbols and the meanings attached to them by social actors should not be undermined in societies. Trends in Mawadza village have

shown significance over symbolic meaning of the placenta in the childbirth process. For the local people, the childbirth process is incomplete and not so useful if the placenta has not been handled correctly according to their cultural beliefs. The placenta, in this context, becomes more than a product of childbirth that should be disposed, as it is deemed a source of connection between the new-born and the ancestors. This reiterates the fact that symbols are created within a society or culture, and those born into that society acquire them for use and to pass them to the next generation. Blumer (2004) argues that Mead saw symbolic interaction not just as a medium by which societal factors are expressed, but instead as the very basis from which a society emerges and continues to exist. The system of symbols used within a given group of people constitutes their identity (Redmond 2015). The identity of either the expectant mother or the new-born is shaped and defined by the symbolic interaction process that occurs during the period of pregnancy; and this is shaped by the symbolic meanings attached to pregnancy and childbirth process itself. This fact illustrates the universality of symbols as a defining feature of humans in Mawadza and interaction within this society.

In addition, because symbols on pregnancy, childbirth and their shared meanings in this village constitute consensus, it affects how expectant mothers view themselves, which is their symbolic self in the society. The shared meanings on pregnancy and childbirth in the Mawadza village affects how expectant mothers view themselves as pregnant women whose ways to handle pregnancies either converge with the commonly accepted meanings of symbols or as diverging. Mead (1934) saw the self and society as constantly interacting and influencing each other. When considering what interacting with society means, it essentially means interacting with other humans. Society exists and is enacted by its members (Redmond 2015). As such, expectant mothers' interactions with other village members result not only in the acquisition of significant (symbols) related to pregnancy and childbirth, but, also in the acquisition of a self. Each interaction has the potential to modify their sense of self (Blumer 2004, Charon 2007). As they receive positive responses because of a particular behaviour during pregnancy they are highly likely to embrace that quality as part of their self. Similarly, negative responses dismiss a quality or behaviour. Such responses to behaviours affect the sense of self and subsequent behaviours (Blumer 2004). In this regard, expectant mothers' sense of self as pregnant women is affected by the social interactions and their meanings in the village, and this has been one of the major

factors that affect the expectant mothers' use or no-use of the waiting mothers' shelter as a biomedical facility from Mawadza village.

5.5 Pregnancy and Childbirth Experiences in the Waiting Mothers' Shelter at Bonda Mission

In the beginning of this chapter, I showed how pregnancy and child birth is perceived in Mawadza village. This point of departure was very important because it is not complete to seek to understand the experiences of expectant mothers in waiting mothers' shelters without a clear understanding of how pregnancy and childbirth processes are perceived in this society. Medical pluralism defines this village, as I have shown that the birth process receives pluralistic care and it is only a question of preference for the expectant mother (Vega 2017). The community has its own understanding of these processes and homebirths are very popular in these settings. Nevertheless, the experiences are different for women who await delivery in the waiting mothers' shelter. This section is going to show the experiences of expectant mothers who were in the shelter during the course of my study and those who have formerly used the shelter from 2015. Some women, at the end of their pregnancy, await labour in the waiting mothers' shelter at Bonda Mission Hospital. The expectant mothers expressed varied experiences during their stay in the waiting mothers' shelter.

5.5.1 Bonda Mission Waiting Mothers' Shelter

The waiting mothers' shelter is located outside the hospital premises. It comprises two houses that have seven rooms each. Data abstraction and observation showed that in these two structures, only 10 rooms are habitable for the expectant mothers as two rooms in each structure are spared to be a common kitchen and a room for the shelter manager who, in most instances, is a midwife. As part of the amenities of this facility, are a fence and a gate that provides security to the waiting mothers in this facility. The facility contains a cabinet in the common room where medication is stored. Like any other health care facility, there are charts all over the walls written in the local language concerning pregnancy and the childbirth process.

There are no beds in the facility but 20 mattresses where expectant mothers can sleep during their waiting period in the shelter. Resources, mattresses included, are distributed on a first come first served basis in this facility; hence those who start their waiting period later stand a chance

of sleeping on the floor with a plastic cover unless they can bring a mat or mattress from home. The waiting mothers' shelter does not provide food to the expectant mothers in the shelter; they have to bring their own food from home. There is access to tapped water and proper sanitation, including six Blair toilets, in this facility. On the side of the Blair toilets are bathing areas that contain a number of compartments and a washing line where expectant mothers and mothers can hang clothes after laundry. In addition, the waiting mothers' shelter is connected to the electricity line of Zimbabwe Electricity Supply Authority (ZESA), but there was no electricity in the shelter during the period I conducted my study. A staff member who is a midwife, Bella, 36 years of age who works at the facility had the following to say about the electricity situation:

There is usually no electricity in this shelter since Zimbabwe is going through a lot of hardships. It used to be better in the previous years but this year we receive electricity for four hours a day, which is between 1am - 4 am. As a staff member in this shelter, I have to make sure that I find ways to improvise and ensure adequate lighting to avoid unintended harm to the expectant mothers and new mothers in the shelter (Author's Interview 16/06/2019).

An expectant mother Belinda aged 28 was also interviewed on the electricity situation and she had the following to say:

I am from Mawadza village, which is quite a distance from this shelter. What I have realised is we spend the whole day without electricity and it comes in the middle of the night when most of us will be sleeping. When electricity comes that is when we usually wake up to cook our meals for the day and store in a safe place. Those who choose not to wake up will use firewood in the morning, using daylight to prepare their meals. I do not really mind the electricity problems because at home we use candles, so to me everything is basically the same (Author's Interview, 16/06/2019).

The general set-up at the waiting mothers' shelter at Bonda Mission Hospital showed that the expectant mothers who await labour in this facility are well secured in a fenced environment that has all basic resources needed. The fact that the shelter is well resourced and equipped with most basic needs can be considered very beneficial for the expectant mothers because it places the shelter in a better capacity to accommodate more expectant mothers and expands its target groups.

5.5.2 Target Groups of the Waiting Mothers' Shelter at Bonda Mission

Data abstraction showed that the waiting mothers' shelter intends to target all expectant mothers with high-risk pregnancies from the nearby villages. According to the key informants, high-risk pregnancy may include:

- i) Young (teenage) pregnancy in surrounding villages, first pregnancy or old maternal age;
- ii) History of complications in previous pregnancies;
- iii) Pre-existing health conditions, such as high blood pressure, diabetes, and/or HIV;
- iv) Multiples (twins or higher).

The medical professionals have noted that inasmuch as the shelter targets this population, over the years anyone who intends to use the shelter without the prescribed indicators can still use the shelter, more importantly, the expectant mothers who stay far away from Bonda Mission Hospital. In the waiting mothers' shelter, up to 10 expectant mothers can share a single room when they are in their waiting period. Therefore, the shelter can accommodate up to 100 expectant mothers from different villages in its threshold. This is because Bonda Mission Hospital is the central facility that serves quite a number of villages in the locality. In this shelter, expectant mothers are not separated according to any basis other than those who are on prenatal care use one part of the facility and those on post-partum care use another part. However, sometimes with the low numbers in the facility that contains post-partum care cases, compared to the pressure that would be in the facility that contains pre-natal care cases, facility managers and matrons have resolved to put some expectant mothers in the facility that houses post-partum care cases. Basically, women of different age groups, geographical locations, ethical and religious background share rooms in the waiting mothers' shelter.

In terms of staff members, the shelter is run by a shelter manager who is a midwife and available in all the operations of the shelter. According to the matron, the maternity department is very busy because the average deliveries per month are 180. Many patients from other clinics and other surrounding areas are referred to the Bonda Mission Hospital because of the services they offer. Only a few cases are referred to major referral hospitals, in this case, Mutare Provincial

Hospital. The doctors make routine visits to the shelter only when it is necessary, for example when there are emergencies that require attention of the doctor. To relieve the matron/shelter managers (midwives), commonly referred to as *vanambuya* (grannies), are the nurses who are allocated different schedules to assist in the operations of the shelter. One advantage that has been noted by the doctor is that obstetric care offered at the shelter is quite comprehensive since Bonda Mission Hospital has a midwifery school; tutors and students undertaking their studies in midwifery can also be part of the staff members in the shelter, hence, there are more than adequate staff members in the maternity facility so that no one among the expectant mothers goes unattended. This is what doctor Rodney had to say:

The good thing about this mission centre is that it has a midwifery school that houses different professionals in midwifery and visiting gynaecologists who impart valuable knowledge that is used and practised in the waiting mothers' shelter. Bonda Mission has adequate staff members to handle any kind of emergency and complication that can occur during one's waiting period in the shelter and during delivery. I highly encourage expectant mothers to await delivery in the shelter because it is for their own good (Author's Interview 17/06/2019).

The participants' narratives, especially the health care providers show that the waiting mothers' shelter at Bonda Mission Hospital offers an environment which supports comprehensive obstetric care for the expectant mothers and the new mothers (as has been noted previously by Lonkhuijzen *et al.*, 2012). This is evidenced by the availability of adequate skilled staff members which also becomes beneficial for the expectant mothers who await delivery in this facility. The availability of skilled birth attendants has been very crucial in shaping the experiences of the expectant mothers who await delivery in the waiting mothers' shelter.

5.5.3 Services Provided in the Shelter

Data abstraction through records and patients' histories, showed that apart from staff members, the shelter creates a history for everyone in this facility where their health conditions are constantly monitored and relevant medication is administered to the expectant mothers, depending on their conditions. The common tablets noted from the data abstraction included medication for High Blood Pressure (HBP) which was a common condition among the women in the shelter. From the time of my study, 76% of the expectant mothers from Mawadza village had hypertension. Others had other conditions such as HIV infections; hence, keeping track of their

records was vital for the staff in the shelter so as to monitor their condition and habits when taking medication. A common supplement, folic acid, was also administered to every expectant mother for the proper development of their unborn babies. The staff at the shelter reiterated the importance of waiting in the shelter because there is need to have the constant check-ups on one's health when one is expectant to avoid maternal and child mortality in any circumstance. Sandra, a 33 year old expectant mother in the shelter said:

When we are in the shelter we are monitored by the matrons and the nurses to take our medication properly and at stipulated times every day. They explain how the medication will help the baby to grow and then tell us to continue with medication till the baby is born. All the medication we take is recorded on my health history that I will take with to the hospital when I am about to deliver (Author's Interview 11/06/2019).

Patients in the shelter also underscored the need to utilise the facility. Susan a 26 year old expectant mother, who was in the shelter noted:

I am HIV positive and am from Mawadza village, I was diagnosed to be HIV 5 years ago and I have always been using the shelter for all my babies. I like coming here because they monitor my condition closely and I get assistance to take my tablets and this has helped me deliver health babies (Author's Interview 13/06/2019).

Another patient who required medication, Samantha, who is 34 years old explained:

I have High Blood Pressure and this condition worsens when I get pregnant. The doctors have explained to me that it is usually like that when one falls pregnant. Every day ever since I started awaiting delivery they measure my blood pressure (Author's Interview 13/07/2019).

One of the crucial factors about the waiting mothers' shelter that was mentioned by the participants was its ability to provide skilled birth attendants who provided adequate care for the waiting mothers in this village as well as other villages. According to the participants of the study, the shelter has adequate staff members and well-trained personnel that are in a better position to handle any situation from complications to emergencies and save mothers from dying while giving birth. Access to health care facilities is a challenge in parts of Mawadza, and chances of women giving birth at home are high due to lack of knowledge of the waiting mothers' shelter, its functions, significance and several other factors that are discussed at length in Chapter Six. However, for the population that has formerly used the shelter/ was in the shelter

during the period of this study, access to skilled birth attendants is the most crucial benefit that they have experienced awaiting labour at the waiting mothers' shelter at Bonda Mission Hospital.

A key informant noted that the leading direct causes of maternal deaths in Mutasa district are pregnancy-induced hypertension/ eclampsia, postpartum haemorrhage, puerperal sepsis, malaria and obstructed labour. HIV and AIDS-related conditions are the leading indirect cause of deaths and contribute to about 25% of all maternal deaths in Mutasa Rural District (MRD). The successful prevention and treatment of these complications represents the potential to reduce maternal deaths and this will be achieved by awaiting labour in the waiting mothers' shelter by all women in (MRD).

In addition, health care professionals alluded to the fact that there is generally a notable unequal distribution of health care facilities in Mutasa district, specifically maternal health care facilities. Poverty is one of the barriers to accessing health. Mawadza village has been hit the hardest in Mutasa district, with the scarcity challenge as it remains neglected in terms of formal health care structure, specifically, maternal health care structures. Amidst this major challenge, the waiting mothers' shelter has improved the number of hospital deliveries in Mawadza, although they remain fewer as compared to home deliveries, during the time of the study. Hazel, a 36 years old expectant mother said:

It's saving our lives. I have had challenges with my babies not moving in the womb. I have to get induced so that I may have a successful delivery. That is why it is essential for me to come to this waiting shelter towards my delivering date where nurses can monitor my pregnancy (Author's Interview 12/06/2019).

Olga a 26 years old expectant mother who was in the shelter also remarked that:

I really get all the care that I want in this shelter and it has really assisted me to give birth and managing all the complications that were about to arise when I was delivering. I think awaiting labour in the shelter is good because I have an experience of both home delivery and hospital delivery. The hospital delivery is better because it manages my health conditions and complications during birth (Author's Interview 12/06/2019).

Yet another affirmation of the importance of the mothers' waiting shelter was given by Norah a 19 years old expectant mothers who was in the shelter, who added that:

The shelters are saving lives. Some women die while giving birth because they stay far away from hospitals. When you are here, you can easily seek help from nurses and doctors at the hospital. You can quickly be assisted if you face complications (Author's Interview 12/06/2019).

The shelter has been celebrated for saving the lives of different expectant mothers, not only from Mawadza village, by increasing access to more skilled birth attendance. As part of the care that is provided in the waiting mothers' shelter, there are quite a number of activities that are conducted in the shelter as elaborated hereunder. These activities are part of the experiences of expectant mothers in the waiting mothers' shelter that came out from the narratives of the study.

5.5.4 Activities in the Waiting Mothers Shelter at Bonda Mission

5.5.4.1 Pre-natal Care

The waiting mothers' shelter at Bonda Mission Hospital provides an opportunity for expectant mothers to receive health promotion on pregnancy, including information on pre-natal care encompassing the danger signs of pregnancy, labour and childbirth, as well as lessons on new born care. Prenatal care, also known as antenatal care, in the shelter includes the provision of regular check-ups that allow doctors, nurses and midwives to treat and prevent potential health problems throughout the course of the pregnancy and to promote healthy lifestyles that benefit both mother and child. In the shelter, during prenatal care, the expectant mothers are taught about the importance of eating a balanced diet and the importance of taking medication that supports the growth of the baby so as to give birth to healthy babies. Prior to one's waiting period in the shelter, an expectant mother is required to make four visits to the maternity ward at Bonda Mission Hospital for check-ups on the development of the unborn baby, and they then get the final lessons on prenatal care as they await delivery in the waiting mothers' shelter. The importance of prenatal care was noted by the research participants as it has given them vital information to handle pregnancy and to live a healthy lifestyle that benefits the unborn baby.

In addition, the crucial element of prenatal care that has been noted as important is the lessons that expectant mothers go through in preparation for child birth. This includes the positions that women should take when giving birth and how they should possibly go through the childbirth

process. All the lessons given in the shelter with regards to childbirth are informed by science and health sciences that govern human anatomy from medical research. Patience commented that:

This is my first pregnancy and there are a lot of things I didn't know about pregnancy. Nurses teach us about the importance of breast feeding our babies and demonstrate delivering positions, among other things. We are learning a lot from this shelter. It's preparing us for motherhood (Author's Interview 18/06/2019).

Martha, another expectant mother aged 35 said:

I have benefited a lot of knowledge from staying in the shelter as I am now well equipped to give birth. I have received information on how I should handle my pregnancy at this very last stage. Most importantly, they encourage me to have enough rest and lots of fresh air since I am hypertensive, and these are things I probably would not have been practising had I been at home (Author's Interview 19/06/2019).

Expressing similar sentiments, another interviewee, Candice, 37 years of age had the following to say about awaiting delivery in a mothers' shelter:

There are a lot of misconceptions that I had about the childbirth process from the home births that I have had in the past. Thanks to the prenatal care that I have received in this shelter for shaping my care towards my unborn baby, and with all the efforts I have made to follow that guidance of the midwives, I know I will give birth to a healthy baby, although I don't know the sex of my baby yet (Author's Interview 19/06/2019).

Key informants reiterated the importance of prenatal care in the development of unborn babies and the benefit it offers in the prevention of maternal and child mortality during delivery.

Marshal who is a doctor said:

Prenatal care has a number of variegated benefits for both the mother and the unborn child. Firstly, it reduces the risk of pregnancy complications. Secondly, it reduces the foetus's and infant's risk for complications. It helps ensure the medications expectant mothers take are safe. It can also help keep the expectant mother and the foetus safe and healthy. Babies of mothers who do not get prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who get adequate prenatal care in Manicaland Province (Author's Interview 20/06/2019).

5.5.4.2 Prevention of Parent to Child Transmission (PPTCT)

As part of prenatal care offered in the shelter, there has been an important section that has been noted by the participants, particularly those who are living with HIV/AIDS. In the shelter, important lessons are conducted on the importance of prevention of Parent to Child Transmission of HIV. These lessons are offered broadly to every expectant mother but they specifically target those who are living with HIV and from the data abstracted from the records in the shelter, it was revealed that from 2015, all women who are HIV positive and await labour in the shelter have managed to prevent transmitting the HIV virus to their new born babies and this has been a significant achievement for the staff members both at the maternity ward and the waiting mothers' shelter at Bonda Mission Hospital. One key informant, Doctor Rodney said:

One of our greatest achievement as a maternity unit is that we have managed to successfully educate expectant mothers on the use of Nevirapine to decrease the amount of HIV in the body of the expectant mother so that the immune system can work better. This drug lowers the chance of one getting HIV complications (such as new infections, cancer) and improves your quality of life. Nevirapine belongs to a class of drugs known as Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs). In some cases, as doctors, we even give children full Anti-Retroviral Therapy (ART) for up to six weeks to try and improve the chances of preventing HIV transmission from the mother (Author's Interview 20/06/2019).

Susan, an expectant mother living with HIV commented:

I have been living positively and am now pregnant for my second child. I delivered my first baby in the hospital at Bonda and the baby was HIV negative. Now I am here to await labour for the delivery of my second child and I have been going through lessons that will assist me to have more children if I want ... and to prevent transmission (of the virus) to my children at birth. They have been teaching me of a drug called Nevirapine and how it will assist me to give birth to an HIV negative baby (Author's Interview 19/06/2019).

Belinda, a participant who is HIV negative also welcomed the lessons regardless of her HIV status:

I am HIV negative but I now have a lot of information on the possibility of having children if I become HIV positive, and to ensure that I give birth to an HIV negative baby through the process of (transmission)

prevention. I think this information is important because it is not available in the village where I come from because TBAs do not talk about such issues (Author's Interview 20/06/2019).

The expectant mothers in the shelter and the key informants agreed that awaiting labour in the shelter is very significant because it gives expectant mothers the opportunity to know more about HIV/AIDs and how to prevent transmission to the new-borns. This information was noted to be unavailable in the village where TBAs assist in giving birth without knowing one's status; although they practise due caution, they have no way of assisting in the prevention of transmissions. HIV positive expectant mothers have a greater advantage of extra care so that their condition does not affect the health of the new born baby if they go to the shelter. In order to achieve this, expectant mothers who are HIV positive are required to be on the B+ Option²⁵ plan so as to ensure that the safety of the unborn baby is guaranteed.

5.5.4.3 The B+ Option

Expectant mothers who register their pregnancy at the hospital are mandated to get tested for HIV according to the standards of the MoHCC in Zimbabwe. These standards of mandatory testing are also followed by the maternity ward at Bonda Mission Hospital. The expectant mothers who are HIV positive are usually mandated to take medicine immediately and religiously, which was referred to as the B+ Option during the course of my study. The B+ Option was noted by key informants as important as it helps in the Prevention of Parent to Child Transmission (PPTCT). Expectant mothers who are HIV positive are encouraged/in the literal sense mandated to immediately take Anti-Retroviral Treatment early so as to protect the foetus during the time they start prenatal care. When one gets admitted in the waiting mothers' shelter, they are required to continue with their medication so as to protect the foetus. Susan, a research participant who was interviewed explained how she discovered her HIV status:

I discovered that I was HIV positive when I was pregnant because they said it was mandatory that I get tested for HIV. When I was found positive, I was ordered to come back to the hospital with my partner for further tests and map a way forward for the beginning of ARVs. Breaking the news to my partner was not so easy and he did not agree to

²⁵ Option B+ is a prevention of vertical transmission approach for expectant mothers living with HIV in which women are immediately offered treatment for life regardless of their CD4 count.

come with me to the hospital as he needed time to process the news. The phase was hard for me but I had to be brave and go back in order to save the child (Author's Interview 25/06/2019).

In-as-much as the B+ Option has been helpful in PPTCT, in depth interviews conducted with those who have been on the B+ Option showed that there were no adequate counselling services both at the maternity ward and in the shelter for expectant mothers who are mandated to start the B+ Option. In addition, these mothers do not have ample time to complete the phases of going through emotional distress from finding out their status during pregnancy and disclosing the news to their partners. The unborn babies becomes too central in the B+ Option programme that the expectant mothers, as the bearers of the unborn babies, are least cared for in that crucial phase of life. Data abstraction showed that expectant mothers who join the B+ Option end up losing their pregnancies due to emotional distress. Expectant mothers have limited time to process and accept their HIV status and to think about protecting their unborn babies through taking medication. For those with partners, it was also a difficult process to break the news to the husband and, possibly, convince the partner to start ART. Expectant mothers who are HIV positive face challenges in the shelter due to stigmatisation from other expectant mothers, it is difficult for one to keep their status confidential whilst they are on the B+ Option in the waiting mothers' shelter because the health care providers call them publicly to check if they have taken their medication among other checks given to HIV positive expectant mothers. The treatment and stigma that is faced by expectant mothers who are on the B+ Option has been an influencing factor to the non-use of the waiting mothers' shelter, which is deliberated at length in the next chapter (Chapter Six).

5.5.4.4 Physical Exercises

Other activities that are done in the shelter include physical exercises that are done twice a day. The physical exercises that they usually do are mild aerobics that are commonly referred to as *madanzi* (dance moves) by the expectant mothers. Through observation, I realised that these women get into groups and they start singing different songs as they dance along (doing aerobics). This is done with instructors who are usually the midwives, who choose the kind of activities that are suitable for expectant mothers that are almost due for delivery. Moderate physical exercises improve the posture of expectant mothers. Among the benefits that were noted by key informants on aerobic and physical exercise are that it promotes muscle tone, strength and

endurance during the labour process for the expectant mothers. It also helps them sleep better in the evening. It was also noted that regular activity also helps keep expectant mothers fit during pregnancy, improves their ability to cope with labour. Sandra, an expectant mother said:

We wake up in the morning and start doing exercises. They are usually painful and not easy at first but when you deliver you will be used to the exercise. Everyone goes for exercises and the midwives do not want people to joke or not take the exercises seriously. We sing songs so as to make the processes exciting and thereafter we go back to our rooms to rest (Author's Interview 20/06/2019).

Olga, another expectant mother remarked that:

Aerobics are fun but can be tiresome. I sometimes get very tired before we even finish our exercises. The midwives told me that I have to do these exercises because I have High Blood Pressure, so in that way I will manage it so that it does not affect my baby. They also told me that if I do not exercise I run the risk of giving birth through C-section, so I really want to exercise as much as I can (Author's Interview 20/06/2019).

Bridget, a key informant and a senior midwife at the facility explained the importance of physical exercises for expectant mothers:

Physical exercises are an important part of prenatal care in this facility; I have to mention the benefits that I have noted in my 20 years of experience in the field of maternal health. It reduces the risk of pregnancy complications; expectant mothers who exercise are less likely to develop gestational diabetes and less likely to have unplanned caesarean sections than those who do exercise. Expectant mothers who exercise for a minimum of three times a week gain less weight during pregnancy and are less likely to have macrosomic babies (or babies weighing more than about 3.5kgs at birth). Having a heavier baby, in turn, can lead to complications for both mother and baby during delivery. The more expectant mothers increase their pregnancy fitness generally, the faster they will recover physically after childbirth, the more fit they will be after delivery. Exercise during pregnancy reduces depression, releasing endorphins that help improve mood while diminishing stress and anxiety. Blood pressure occasionally does go up during pregnancy, but if it's too much it can be a warning sign of preeclampsia. Staying active — simply walking regularly — has been found to keep blood pressure from rising. The growing baby puts extra pressure on the lower half of the expectant mother, resulting in lower back pain and an achy pelvis. Exercising, however, results in less lower-back and pelvic pain during late pregnancy. Many expectant mothers

report having a harder time falling asleep, those who exercise consistently (as long as it's not near bedtime, which can be too energising) say the quality of their sleep is better and that they wake up feeling more rested. Finally, an active body encourages active bowels (Author's Interview 20/06/2019).

The benefits of physical exercise have been stated at large in this waiting mothers' shelter and expectant mothers who await labour in this facility have also appreciated the benefits as they have experienced them during and after delivery. Apart from the vast benefits from prenatal care that women from Mawadza who await delivery in the shelter gain, there are a number of variegated lessons on post-partum care that are offered to new mothers in the shelter before they are discharged to go home.

5.5.4.5 Preparation for Childbirth (Labour) in the Waiting Mothers' Shelter

One of the greatest functions of waiting mothers' shelters the world over is its significant role in helping expectant mothers to prepare for the childbirth process (preparation for labour). As a crucial part of pre-natal care, expectant mothers undertake various lessons to prepare for, handle and control the labour process, which does not take place in the hospital but in the nearby maternity ward at Bonda Mission Hospital.

The first step in teaching expectant mothers about childbirth is to make them understand what labour and child birth are and the signs that indicate that one is in labour. In this regard, labour is defined in full and the signs that show that one is in labour described. Women being encouraged to approach the midwives or any staff in the shelter as soon as they experience any sort of abnormality. Expectant mothers are taught about terms such as macrosomia²⁶, epidural²⁷, premature birth, C-section, among others, so that by the time the expectant mothers go in to labour, they will be having more and adequate information about the birth options that they might take and, this has been helpful in reducing panic in these mothers. Classes on preparation for labour are conducted by midwives in the shelter who are the birthing health professionals with experience and they specialise in various labour-coping techniques and preparation for

²⁶ The term —macrosomia” is used to describe a new-born baby who's significantly larger than the average weight. A baby diagnosed with macrosomia has a birth weight of more than 4 kgs, regardless of his or her gestational age (Kanyenze 2004).

²⁷ An epidural is medication that is used especially in childbirth to produce loss of sensation below the waist (Muliso 2017).

normal delivery. The classes they offer to expectant mothers offer well-planned basic information about childbirth for expectant mothers. These lessons and classes are conducted in the local *Manyika* language so as to ensure that everyone understands. Where English has to be used, the terms are repeated time and again to ensure better understanding of these important lessons.

The training offered in the shelter as part of pre-natal care does not just involve lectures, but, also includes demonstrations of the childbirth process using mannequins as well as real stories from other mothers who have previously used the shelter, to help expectant mothers understand the final stage of their pregnancies and the childbirth process with a better perspective. Pregnancy material including charts, pictures and notes that explain various concepts such as positions preferred during childbirth, breathing patterns as well as techniques to focus on contractions are also provided in the waiting mothers' shelter. As part of the lessons on birthing positions, the expectant mothers are given training on how to open legs in a circular motion as this helps women better adopt any position required of her during the birth process and this is also done during the period that the women do physical exercises in the shelter. Betty, one expectant mother commended these lessons:

The lessons that we get in the shelter as we prepare for childbirth, for me, are very understandable. I only have five O' Level subjects but I managed to understand all the lectures I have received from the midwives in the shelter. Sometimes they even use dolls to demonstrate how one should position herself on the bed and how they should comply with the nurses' assistance during the childbirth process. The midwife who conducted today's class has reminded us that sometimes they beat people during labour, it is for a good cause that the delivering mother does not relax during labour so as to save the baby. I am grateful for such lessons for without them I don't know if I was going to be able to go through the labour process (Author's Interview 30/06/2019).

Hazel, another expectant mother added her voice to endorse the lessons received at the shelter:

For me, learning about preparation for childbirth has been very important because it is my first time to give birth and I do not have any idea of how the process will be like. I was so scared because I have always heard that the childbirth process is painful and all I have been anticipating is pain, but now I think I will get into the labour room with adequate knowledge (Author's Interview 30/06/2019).

Most mothers give birth in the recumbent position because that is the one that is preferred by the doctors and midwives as it poses little risk of complications. So, the expectant mothers are taught to lie flat on their backs as soon as they start feeling the baby coming. However, the midwives teach them other positions for pain management when labour commences, since epidural at Bonda Mission is not a drug that is administered to every woman to reduce pain, but only to women with special medical conditions that include a weak pelvis.

5.5.4.6 Labour Pain Management Strategies

The expectant mothers learn several effective techniques to manage pain during childbirth because epidural is not given to those without special medical conditions that qualify them for the drug. The procedure for administering an epidural was explained by one of the key informants, Doctor Ben (46 years old) as follows:

To perform an epidural, an anaesthetist places a needle into the space surrounding the spinal cord, then inserts a small tube through the needle. The needle is removed and the tube, called a catheter, is taped in place. The catheter is then used to infuse a measured dose of medicine at regular intervals or via constant infusion. The medicine blocks the nerves that feed the lower body and the result, when performed correctly, is pain relief. Epidurals results in a more relaxed birth experience, allowing the mother to rest between contractions and not be completely exhausted when labour is over (Author's Interview 02/07/2019).

Doctor Rodney also added that:

Apart from it not being generally safe to use epidural on the expectant mothers, it is also particularly not safe to use epidural if the expectant mother has abnormal blood coagulation, certain neurologic conditions like spinal aneurysm, systemic or local skin infections, certain cardiac conditions, and low blood volume (people with heavy bleeding or who are in shock). These complications are not easily detectable in hospital settings like here at Bonda Mission where there is no sufficient technology to conduct tests on expectant mothers prior to childbirth. So, to avoid complications that may arise with the use of epidural, we have resorted to not using the drug and encouraging expectant mothers to employ different ways of coping with labour pains that are not supported by the use of epidural. I think this decision is actually practised by other provinces as well in this country. Epidural is for the white people, here birthing mothers have to either cope with the birth pain or find ways to make the pain less, and of which they learn about those ways in the shelter (Author's Interview 02/08/2019).

In order to manage pain, the expectant mothers are taught about the different positions that they can assume once labour starts to make the process less painful. The key informants divided the labour process into two stages, that is, the passive stage of labour (where the expectant mother feels she is in labour and has pain but the baby is not yet on its way) and the active stage of labour (where the baby will be coming out). With the active stage of labour, the mother has no control over pain as she will be under close monitoring and instructions of birth attendants (midwives, nurses and doctors). However, the passive stage is manageable since the expectant mothers are taught to find a comfortable position that they can lie or sit on for pain management. At the start of each contraction, expectant mothers are encouraged to take a deep breath and sigh out. As parts of the labour management strategy, expectant mothers are allowed to cry out or shout if it helps them feel better. In between contractions, expectant mothers are encouraged to try to relax their bodies and let their shoulders drop. Expectant mothers in the post-partum section and those who have previously used the shelter, during the period of my study, felt that these strategies are not very effective in reducing labour pains.

Common narratives came from the expectant mothers and they all reiterated on recounting their experience with labour pains which they feel that the strategies taught in the shelter do not really help but are an illusion that just assists one not to be scared of labour. In all cases, the mothers echoed the sentiment that labour was the most painful process any human being can ever go through and this is the reason why mothers should be respected in the world. Samantha, one mother said:

Labour pain will not be eased by anything or any position on earth. It is some sort of pain that can never be explained. To me, I think the lessons on pain management are just to make us prepared for the birth process, but nothing will stop labour from being painful (Author's Interview 02/08/2019).

Commenting on the same issue, Norah, another mother in the shelter said,

The lessons we get on labour pain have been helpful to me as they assist mothers to prepare mentally for the birth process, but in actual fact lessons on pain management are not effective because I experienced extreme pain the time I was going through labour (Author's Interview 02/08/2019).

5.5.4.7 Post-Partum Care

The main purpose of providing optimal postnatal care in the waiting mothers' shelter has been to avert both maternal and neonatal death as well as long-term complications. Knowing that mothers and new-borns in surrounding villages are dying, it has been deemed important to provide post-partum care in the shelter in order to identify the high impact interventions that address all the major causes of death during the postnatal period for women not only in Mutasa district but in the Manicaland Province and the nation at large. In Mawadza village, some expectant mothers give birth at home with a TBA. Some women give birth at Bonda Mission Hospital and following childbirth they spend the next 48 hours there. For women who have given birth at Bonda Mission Hospital, Bella, a key informant noted that they should not be discharged before 48 hours after birth:

Regardless of the place of birth, it is important that someone accompanies the woman and new-born for the first 48 hours after birth to respond to any changes in her or her baby's condition. Many complications can occur in the first 48 hours and one of the most feared conditions is post-delivery haemorrhage. Following childbirth at home, it is important that the mother and baby receive a postnatal examination as early as possible, preferably within 48 hours of birth. If the birth was at a facility, mother and baby should receive a postnatal examination before discharge, and this is done at the waiting mothers' shelter (Author's Interview 24/06/2019).

There are plenty of lessons that are delivered to the new mothers in the waiting mothers' shelter as part of post-partum care within the 48-hour period after delivery and even further. The new mothers are taught on the importance of having someone nearby for the first two weeks of their stay at home after giving birth, especially, for mothers who have given birth for the first time. The new mothers are also taught the importance and recommended timing of postnatal visits to the hospital. Also, at this time, the midwives and the new mothers discuss the timing of subsequent visits and the immunisation schedule for their new-borns. The key informant Eunice, 45 years old stated that:

The Ministry of Health and Child Care recommends that the mother and baby be visited at home by a trained health worker, preferably within the first week after birth. However, our hospital does not have adequate staff members to carry out those visits; hence the mothers come to the facility at Bonda Mission for these scheduled visits. These visits early in the

postnatal period are important for the mother and the new-born. It is also an important opportunity to ensure the establishment of breastfeeding and address any difficulties with attachment and positioning (Author's Interview 24/06/2019).

As part of post-partum care lessons in the shelter, the new mothers are taught the importance of the new mother eating more and healthier foods. This is discussed in the context of local practices and taboos of *vaManyika* to ensure women have access to good nutrition. The new mothers are also taught that they should also drink plenty of clean, safe water. The importance of rest and sleep and the need to avoid hard physical labour is also among the lessons they get on post-partum care. Discussions are also carried out in the shelter with new mothers on normal postpartum bleeding and Lochia²⁸; the midwives and the women discuss how much blood loss they can expect, and how long it might continue for. When bleeding is more than normal, they should seek care urgently because, in Mutasa district, this is one of the most feared reasons for post-delivery mortalities. Discussed also are the danger signs for the mother and new-born and the importance of seeking help quickly.

Personal hygiene is also emphasised in the context of local practices of the *Manyika* people and their environment. The midwives and the new mothers discuss the type of pads they should use, their ways of disposal and care of episiotomy in the context of home conditions which are not potentially harmful to these new mothers. Hand washing is deemed particularly important to prevent infections and ensure safety for both the mothers and their new-borns. According to the midwives, it is also important not to insert anything into the vagina and use herbs of any sort to care for the baby or the mother and this includes tying one's stomach with herbs. The midwives talk to the new mothers about when they can resume sexual relations and the importance of condom use to prevent STI and HIV transmission, most importantly, sexual intercourse being avoided until the perineal wound heals. Sexual and reproductive health issues are also discussed, emphasising the importance of birth spacing and counsel on the use of a family planning method to avoid unwanted pregnancies.

²⁸ Lochia is the vaginal discharge after giving birth, containing blood, mucus, and uterine tissue. Lochia discharge typically continues for four to six weeks after childbirth, a time known as the postpartum period or puerperium (Geyon 2004:33).

The midwives and the new mothers also discuss infant feeding and breast care and the importance of only taking prescribed medicines when breastfeeding. They also reiterate the importance of not consuming herbs of different sorts in order to ensure that they will not harm the new-borns. Discussed in the waiting mothers' shelter is the importance of the home environment for promoting the health of the baby and recovery of the mother, such as the need for warmth, good ventilation and hygiene for both mother and new-born. Doctors stated that in Mawadza, where malaria infections are high due to its proximity with Mozambique, the midwives and the new mothers discuss the importance of mother and baby sleeping under an insecticide-treated bed-net so as to avoid the risk of Malaria infections. The facility manager at Bonda Mission Hospital has ensured that holistic post-partum care is offered to all new mothers who await labour in this shelter. One new mother Rosemary, 32 years old, commented:

I have benefitted a lot of information on post-partum care when I was in the shelter; they taught me how to breastfeed my new-born baby. Breastfeeding is not easy and I do not know how I was going to do it without the assistance of the midwives. They also taught me on proper umbilical cord care, which is to use methylated spirit on it till it falls off. After I was taught about breast feeding, I was also told that I had to come to the hospital for post-natal care (*kusikero*) so that I can get my baby checked up for weight gain and immunised against the eight killer diseases that they taught me about (Author's Interview 30/06/2019).

Pamela, another new mother (30 years) that I interviewed said:

I have just delivered my baby boy and the midwives have been constantly checking my level of bleeding and if my baby is breathing well because my baby is 1,8 kg, so they said I will have to stay here for at least a week as they monitor the breathing and sucking patterns of the baby. I have also received lessons on how to clean my baby without exposing him to the cold in this winter. I have been told to use my elbow to check if the water is warm enough for the baby, and I clean him without wasting time so as to not expose him to the cold. I am also learning how to care for the umbilical cord using methylated spirit until the umbilical cord falls off (Author's Interview 30/06/2019).

Reiterating the benefits that the lessons on post-partum care have, Vivian, another expectant mother described how:

I gave birth last year and I stayed in the waiting mothers' shelter to await delivery, and I also stayed for two days for post-partum care. For me, the

midwives were particular with the clothes that I used to put on my baby and they discouraged all the woollen clothes I had in favour of softer clothes that were good for the baby's skin. I was also taught the importance of umbilical cord care, and this helped me as I was scared to hold my child with the umbilical cord on (Author's Interview 30/06/2019).

The mothers who received care in the shelter after delivery noted the benefits of using the shelter as it did not only provide care during prenatal care and delivery, but post-partum care was comprehensively provided for and this was very beneficial to the mothers.

5.5.4.8 Perineum Wounds Care

One of the crucial parts of post-partum care in the waiting mothers' shelter noted by the participants was perineum wounds²⁹ care. For most mothers involved in this study, the child birth process resulted in the tearing or cutting of the perineum by the doctors to allow a smoother passage of the baby. Mothers are fearful of the cutting or tearing of the perineum, hence the need to open up the birth canal through *kuvuranzira* practise (well explained in Chapter Seven) to avoid tearing or being cut. Mothers narrated that after leaving the hospital they go to the shelter and are given their initial practical lesson on how to care for the perineal wounds until they heal.

To care for the perineum, the new mothers revealed that they are instructed by the midwives to put three teaspoons of course salt on damp cotton wool and put it directly on the wounds for at least 30 minutes to an hour after bathing. The mothers shared that this process was very painful because the salt dissolves into the wounds with a lot of discomfort and pain. Health care professionals noted that it is not harmful in any way to treat wounds with a moderate amount of salt. A moderate amount is important in maintain the right PH balance for the vaginal area. Mothers are instructed with strong emphasis to repeat the process at home every day until the wounds heal because failure to do so has resulted in major medical problems for the mothers (as noted by the health care professionals). Betty narrated on her experience in caring for perineum wounds when she stated that:

The lessons on caring for the perineum wounds were so helpful for me the period I left the shelter. I could not walk or use the toilet properly

²⁹ Wounds that result from the area between the vagina and back passage tearing or being cut by the doctor or midwife during childbirth (episiotomy). The doctor or midwife repairs the tear/cut by using stitches which usually take a month and a half to heal if cared for properly (Frohlich 2015, O'Kelly 2017).

during the first days of delivery but as I continually used salt on cotton wool, my stitches started falling off bit by bit till all fell off. I also got help from my mother who kept on monitoring if I was doing it every day (Author's Interview 29/06/2019).

Marry also added that:

The perineal wounds are too painful. It is that which makes childbirth very complicated because new mothers cannot use the toilet well soon after delivery. I had troubles urinating because the urine would get to the wounds and cause a lot of discomfort. If I think of what I went through as a mother on my first pregnancy I would not be comfortable to see anyone biting or harassing my child (Author's interview 29/06/2019).

In contrary to this, Vivian narrated that:

I was going to think that childbirth is an easy process, had I not experienced problems with my perineum wounds. I literally walked myself to the hospital when I started labour, the midwives were even shocked with how strong I was. I immediately gave birth upon arrival at the hospital. I think I delayed going to the hospital because I was expecting the labour pains to be worse than what I was experiencing. My tragedy started when I finished giving birth and the midwife put some stitches on me without any pain killer (*chiwewe*). I could feel the needle piecing my flesh and I cried. The midwife ignored me and my stitches got up to 17. I could not walk back to the shelter. I only used salt once when I was in the shelter but stopped when I got home due to the excruciating pain I was in. After about two weeks the stitches began tearing off and opening the perineum again, it was smelly and producing pus, I panicked...I was re-admitted in the hospital and the doctor put the stitches again and I received medication to kill infection. I spent a month in hospital being monitored by the midwives as I used salt till I healed properly. I don't think I want to have another child again because of what I went through, if I do, I will take heed of the midwives' instructions and use salt till I heal (Author's Interview 25/06/2019).

Midwives also gave their comments regarding perineal wound care in the waiting mothers' shelter. Bella stated that:

It is very important that mothers care for the perineum wounds as soon as they leave the shelter. We give them a practical lesson how they do it, although most of them do not cooperate due to post-delivery pains. Salt is not harmful to the new mothers if it's used moderately, too much salt can be hazardous to the mothers. We have had several cases of mothers who did not properly care for their wounds when they went home and they

came back. Some of them had splits up to the anus which is not good. I really appeal to family members of new mothers to assist them by monitoring if they are using salt so as to avoid complications (Author's Interview 30/06/2019).

Another key informant Joe had a different view altogether and he had this to say:

Cutting or tearing of the perineum is because people do not want to follow tradition and take heed of what we teach them. Long ago we never heard cases like these. This is because expectant mothers nowadays do not follow the practice of opening up the birth canal (*kuvhuranzira*). Opening of the birth canal (*kuvhura nzira*) is very important because the baby will just pass without one tearing or being cut. It is important for families and spouses of expectant mothers to support them as they go through the process of opening of the birth canal (*kuvhura nzira*) so as to avoid nursing any wounds for a month or so after the childbirth process (Author's Interview 01/07/2019).

The narratives that came from the experiences of the mothers show that care for the wounds is a phase of post-partum care that is considered important in the shelter. The key informant reiterated on the importance of support from family and spouses during the period that the mothers care for the wounds. This led to an appreciation that post-partum care is a process that does not exist in isolation; nevertheless, the involvement of family in post-partum care is of paramount importance.

5.5.4.9 Family Involvement in Post-Partum Care

From the narratives that I gathered from the study, it is deemed ideal for the family of the new mother to be involved in taking the lessons on post-partum care in the shelter, but the efforts have not yielded much result. This is so because spouses of the new mothers can only spare time to collect them from the shelter and not to come and attend lessons on post-partum care as they are perceived to be feminine. The importance of such information to other village members has been to disseminate information of post-partum care so that other family members will be in a position to care for mothers when they need care since Bonda Mission Hospital is far away from Mawadza village, and to notice early danger signs in the post delivery period so that they may ferry the mother to the hospital quickly. Personal care needs such as bathing, eating, and sleeping were the most common needs mentioned, and mothers also placed cleaning and cooking in the same category of importance. Fulfilling these basic needs was essential for women to feel that

they were more capable of dealing with the physical and emotional stressors inherent to the postpartum period. Mary (31 years), a mother shared her experience:

My second birth was a Caesarean birth, and I was in more pain this time than I was the last time. Besides that, the breastfeeding was harder for me as well. My breasts had just engorged so badly and so much like... it was just that bad! At this point, I needed someone to help me with work and cleaning myself and the baby, but my husband could not do much because he was occupied with work so that he could feed the family (Author's Interview 28/06/2019).

Every woman has unique circumstances that affect them one way or the other, after giving birth. Susan described her situation as follows:

As an HIV positive woman, I guess I felt stressed because I am HIV positive and I didn't have the help from the father of my child as much as I expected I to get. I am an orphan and my mother is late; trust me, I would have gone to my parents for help. So, I cried a lot. I felt like I didn't want to be bothered with the baby even though I knew he had to eat; I knew he had to be washed; I knew he had to be changed. So, I knew I had to do it, like I felt I was being forced to do it because I had no one to assist me with that process (Author's Interview 28/06/2019).

Expressing her desire for her husband to contribute with help whenever needed and frustrated by his reluctance to do so, Martha bitterly complained:

The one person I resent is their father because I'm like, you see what I have to do and I shouldn't have to tell you what to do. That should come automatically. I shouldn't have to be like, okay the baby's clothes need to be washed and things like that. Those things as a parent, you share those responsibilities. My husband refuses to assist me with all those chores because he says his relatives will think he was given a love portion! (Author's Interview 28/06/2019).

Mothers who were not in the waiting mothers' shelter spoke about emotional support as being able to talk to someone about what they were going through, especially after having a baby; receiving words of encouragement and pampering from loved ones, and they did not have this kind of support as their husbands were occupied with work-related commitment in order to feed the families. Partners were continually identified as the primary resource for emotional support that was needed by the mothers, but, some mothers also sought aunts, grandmothers and other mothers from the village to talk about their feelings and post-delivery experiences.

I am appealing to the men in the surrounding villages to support their spouses in their post-delivery period because most mothers go through post-delivery stresses that are not handled due to lack of support from spouses and the society at large. We have made efforts such as not discharging mothers if their husbands do not come to collect them. This was a way to involve men in the post-delivery experience of their wives, but this has not yielded much results. Men generally do not get involved and the main reason is work commitments, which consume most of their time (Author's Interview 29/06/2019).

Counselling was mentioned as a trustworthy source for emotional support, especially among mothers, by the key informants, but, the greatest challenge is that spouses do not attend any post-partum lessons in the waiting mother's shelter. In addition, mothers identified the use of prayer as a way of coping with feelings in the absence of people they could talk to. One woman said that prayer "was like medicine" and another said that she would "only talk to the Man above" since she did not feel her partner would understand how she felt.

5.5.5 Income Generating Skills in the Waiting Mothers' Shelter

As part of the benefits that were noted by the women who have previously used the Bonda Mission Hospital waiting mothers' shelter, is the knowledge they have gained on income generating skills during their stay in the shelter. In the waiting mothers' shelter, women take time to get lessons from different professionals from Bonda Mission High School on skills that they can develop in order to generate income and not be dependent on their husbands. The common activities that expectant mothers are taught include; sewing, cooking and knitting. When they get information about these skills it will be up to the mothers to pursue these income generating projects in their different villages. Mothers from Mawadza join the community groups who are divided into different categories that suit the passions of different women. Vivian described her experience with baking:

I developed an interest in baking bread when I was at the waiting mothers' shelter waiting for labour. I was taught by some teachers who came from the mission centre that I can start baking bread for sale and make a living from it. After my delivery, I then went to the *Mukando* community group for women that did baking lessons and I got the skill. Now, due to economic challenges and lack of capital, I can no longer produce much for resale but I have the skill and I can work for big companies like Bakers Inn or Lobels Bread in the city, baking bread (Author's Interview 01/07/2019).

Betty, another expectant mother, narrated how she developed an interest for projects as she said:

I realised that I can do a project and be self-sufficient when I was at the waiting mothers' shelter. I had problems at my house with my husband as he kept on accusing me of misusing his money and being too dependent for his liking. After the motivation at the shelter, I realised that I can start knitting jerseys that I can sell, and I have been doing that since I left that shelter. I thank the shelter management for helping me develop my skill as I am now a better woman in the community (Author's Interview 01/08/2019).

The experiences of the expectant/new mothers in the waiting mothers' shelter show that the application of meanings to the things social actors encounter involves an interpretive process whereby humans communicate with their selves (Blumer 2004: 33). Underlying this premise is the realisation that human beings develop a self which can be an object of humans and their own thoughts; expectant mothers/new mothers are able to talk to themselves as humans who are social actors while they are in the shelter because they possess a symbolic language. This ability to talk to their selves comes into play when making sense of their environment in the waiting mothers' shelter and evaluating the kind of treatment they receive in the shelter as well as the relevance of the lessons they receive in this facility. Blumer (2004: 38) asserts that humans' interaction with things involves an interpretive process that includes conversations that they have with themselves as they sort out what is meant. Meanings are not cut and dry, however, as different meanings are often attributed to a single situation and the social actor has to determine which meaning best fits the given situation. Similarly, working out which meaning applies to the things that human encounter is part of this interpretive process. As part of the interpretive process, Blumer (2004: 67) sees two steps to this process; the first involves human beings as social actors pointing out to themselves the thing that has meaning. While walking in into the waiting mothers' shelter, expectant mothers see and engage in a lot of activities (prenatal, childbirth preparation and post-partum), and seeing this as well as engaging in these activities leads the expectant mothers to recognise and notice the activities in depth and the symbolic meanings they have. As they look at these activities which form part of their experience, they try to check if they have had similar experiences previously. This is the first step in the interpretive process.

In the second step, humans (expectant mothers) select, rearrange, discard, modify and transform meanings relevant to the situation and their own dispositions, directions, goals, attitudes, etc. (Charon 2007:83). In this regard, the interpretivist nature of symbolic interaction of meanings attached to activities is under constant modification in accordance with the situation. For example, due to cultural expectation, expectant mothers are socialised to handle pregnancy quite differently from the shelter's approach. Expectant mothers, therefore, through an interpretive process, modify actions in accordance to how they are expected to behave in the shelter. Blumer (2004: 40) contends that this interpretive process leads to developing a line of action, a plan of what to do or how to respond. That leads to conformity, even non-conformity with the stipulations of the shelter can be influenced by the interpretive process of expectant mother's conversation with oneself and this ultimately affect their behaviour and response to situation. Once the people have socially acquired meanings and the ability to think symbolically, their lives are filled with an interpretive process where they are constantly "talking" to themselves as they manage their lives. In addition, interpretivism has been shown by the way expectant mothers interpret lessons on preparation for labour and the pain management process. This shows that expectant/new mothers do not merely read meanings from the surface, but, they engage in conversations with selves and evaluate the effectiveness of these lessons, and this has brought the conclusion that most of the participants echoed, that lessons on labour management might be offered but they do not assist significantly to relieve pain.

Notwithstanding the fact that, inasmuch as it is prudent to acknowledge that expectant mothers have the ability to converse with selves using interpretivism and deduce meanings of their world and later on redirect their behaviour to how they interpret the world around them, it should be noted that the interpretive nature of expectant mothers' ability to converse with oneself and inform their behaviour is highly undermined in the waiting mothers shelter because it is a biomedical institution which bases decisions on science rather than how the individual expectant mothers experience the scientific activities and how they affect their interpretation of reality. In the shelter, scientific expiations override any other form of thinking and this pacifies the ability of expectant mothers to talk to themselves and give meanings to their surroundings and influence their action.

5.5.6 Bio-Medicalisation of Pregnancy and Childbirth in the Waiting Mothers' Shelter

The narratives that I have shown above show that the waiting mothers' shelter at Bonda Mission Hospital, as a biomedical maternal facility, handles pregnancy differently from how it is perceived culturally and handled generally in Mawadza village. The biomedical model of pregnancy and childbirth management involves the conventional approach to medicine as predominantly practiced in Western societies that base diagnosis and explanation of illness as a malfunction of the body's biological mechanisms (Conrad 2014, Wong 2020). As such, in the waiting mothers' shelter, pregnancy is treated largely as a medical condition that attracts monitoring from the responsible health care professionals in this facility. The biomedical approach to handling pregnancy and childbirth in the shelter is based on the assumption that each disease or ailment has a specific cause that physically affects the human body in a uniform and predictable way, meaning that universal 'cures' for people are possible (Amzut & Ruzum 2014: 210). This perspective is the same perspective that is used to care for pregnancy in the waiting mothers' shelter at Bonda Mission Hospital. That is, pregnancy is a universal process that should be treated from a universal diagnostic way, as result, it is well managed. It involves a mechanical view of the body as a machine made up of interrelated parts, such as the skeletal and circulatory systems (Gabe *et al.*, 2010: 44). Medical research, training, and practice increasingly focused on attempts to treat pregnancy from a purely medical angle and, thus, move away from the perspective of social medicine and its focus on the social origins of disease (Zakeyo 2016, Hlatshwayo 2017). As such, the waiting mothers' shelter diverges from the culturally and socially perceived approaches to pregnancy that are popular in this medical pluralist village as it handles pregnancy from a purely medical approach.

Considering that Mawadza village is a medically pluralistic village where there is pluralistic care available for expectant mothers to choose from the waiting mothers' shelter claims dominance of the biomedical health care system and little is recognised about the local culture of *vaManyika* in Mawadza village and more importantly, the ethnical diversity that the village houses. In this regard, this approach has invited scholarly attention (Powles 1973, Floyd 1983, Cheyney 2020, Wong 2020) as they note that while the biomedical model of handling pregnancy and the childbirth process has represented a significant advance in understanding pregnancy, it underestimates the complexity of pregnancy and the childbirth process, particularly, by

neglecting medical pluralism, cultural, social and psychological factors that also affect pregnancy and the childbirth process. The idea of specific aetiology, in fact, does not only apply to a limited range of stages of pregnancies but to all.

The narratives I have provided in the first section of this chapter showed how pregnancy and childbirth is understood in Mawadza village and they have indicated clearly that pregnancy and childbirth processes are more complex than how they are portrayed by biomedical facilities such as the waiting mothers' shelter because they are imbedded in the culture of the local people. The biomedical approach to pregnancy reiterates the implications of pregnancy and childbirth as being likely to involve multiple factors such as physical condition, nutrition and stress, which affect an individual's susceptibility to illness, as has been noted by (Dubois 2018). This approach is underpinned by mind-body dualism and a focus on monitoring the health-related conditions that are associated with pregnancy and this can lead to the objectification of patients who are the expectant/new mothers in the pre and post-delivery periods, respectively. Since pregnancy is only viewed in physical terms in the waiting mothers' shelter, as something that can be objectively observed, treating 'it' takes primacy over all other considerations and expectant mothers become objectified as 'pregnant bodies' or 'cases', rather than treated as unique individuals with particular needs that also relate to the way they were socialised in accordance to their cultural beliefs, norms and values (Vega 2017: 23). This form of analysis often underpins claims of health care professionals' linear relationship with expectant mothers. This situation is also related to what scholars such as Fritjov Capra (2019) call 'medical scientism'; that is, a reverence for scientific methods of measurement and observation as the most superior form of knowledge about understanding and treating patients - including expectant mothers. Therefore, expectant /new mothers in the post-delivery period's thoughts, feelings and subjective experiences of pregnancy and childbirth are considered 'unscientific' and are mostly dismissed.

In addition, pregnancy and childbirth in the waiting mothers' shelter have been reduced to purely biological and pathological factors. The development of medical science in maternal health care institutions has led to an increasing focus on smaller and smaller features of human biology for the cause and management of pregnancy from organs to cells to molecules and mostly genes (Wong 2020). By reducing its focus on pregnancy and childbirth to the biological, cellular, molecular, and genetic levels, medicine and its facilities (such as the waiting mothers' shelter)

has ignored or downplayed the social and psychological aspects of pregnancy and childbirth. The experience of pregnancy and childbirth in waiting mothers' shelters is treated as if it occurs in a social vacuum. Not only does this marginalise the importance of social support networks, but it also ignores the role played by social factors such as poverty, poor relationship with spouses, and discrimination according to one's HIV status in affecting an expectant mother's physical and mental health during pregnancy.

Furthermore, biomedical maternal health care facilities such as the shelter at Bonda Mission Hospital can be criticised for adopting a purely medical stance towards managing pregnancy and childbirth and its tendency towards victim-blaming, which is basically the process whereby social inequality is explained in terms of individuals being solely responsible for what happens to them in relation to the choices they make and their assumed psychological, cultural, and/or biological inferiority by locating the cause and cure of disease as solely within the individual (Ryan 2020). Wong (2020: 150) states that "instead of asking why an illness occurs and trying to remove the conditions that lead to it, medical researchers try to understand the biological mechanisms through which the disease operates so that they can then interfere with them". In this regard, the expectant mother's body becomes the focus of intervention, and maintaining a healthy body when one is pregnant becomes primarily viewed as an individual responsibility. A pre-occupation with treating the individual has the potential to legitimate a victim-blaming approach to pregnancy, either in the form of genetic fatalism (your poor health is the result of poor genetics) or as an outcome of poor lifestyle choice factors, which basically refer to the decisions expectant mothers make that are likely to impact on their health, such as those relating to diet, exercise, smoking, practice of safe sex and non-usage of herbs when one is pregnant. The term implies that people are solely responsible for choosing and changing their lifestyle. By ignoring the social context of pregnancy and childbirth and locating primary responsibility within the individual, there is little acknowledgment of social responsibility; that is, the need to ensure healthy living environments in the shelter for expectant mothers.

5.6 The Socio-Cultural Approach to Pregnancy and Childbirth Management

The social-cultural approach to pregnancy and childbirth has been discussed by a number of scholars over the years and it has been revealed that a consideration of a socio-cultural approach to the management of pregnancy and childbirth does not necessarily antagonise the biomedical

approach, but it complements the areas that the biological approach cannot address thereby offering a holistic approach to maternal health (Jordan 1973, Rothmans 1978, Oakely 1988; 2017, Fielder 1996, Davis-Floyd 1996; 2020, Cheyney 2008; 2020, Wong 2020). The socio-cultural approach to pregnancy and child birth refers to approaches that focus on the socio-cultural determinants of pregnancy and child birth (Gillespie & Gerhardt 2005, Broom 2014). It focuses on social determinants of pregnancy and childbirth management such as social organisation of health care, construction of pregnancy and childbirth by local people, culture, ethnicity, and indigenous knowledge systems. The socio-cultural approach acknowledges that pregnancy is a socially constructed experience in all societies. Sutherland (2019: 7) notes that “If literature is considered, one would acknowledge that there is no known society where pregnancy and birth are heeded by the people involved in its doing as merely physiological function”. On the contrary, it is everywhere socially marked and shaped (Jordan 1983: 1; Gimlin & De Vries 2012; Wong 2020).

This approach directs attention to the management of pregnancy through community participation and social reforms that address living conditions of the expectant mothers, and it entails incorporating some of the indigenous practises on birth that identify the expectant mothers as *Manyika* expectant mothers/new mothers in the waiting mothers’ shelter. In addition, it also entails the involvement of TBAs and SBAs in the activities conducted in the waiting mothers’ shelter, and offers training to these birth attendants in order to offer holistic care that both addresses the medical, and socio-cultural requirements of pregnancy and childbirth processes for the women in Mawadza village where health is pluralist.

Broom (2014: 52) states that “the social model pregnancy and childbirth management locates expectant mothers and new mothers in social contexts, conceptualises the physical environment as socially organised, and understands ill-health among expectant mothers as a process of interaction between people and their environments”. Therefore, the socio-cultural model is not intended as a replacement for the biomedical model as I have noted earlier, but rather coexists alongside it. The socio-cultural model assumes that pregnancy and childbirth is a social responsibility by examining the socio-cultural determinants of expectant mothers’ health status and their health-related behaviour.

5.7 Conclusion

This chapter began with the presentation of socio-demographic information about the participants in Mawadza village. This has been motivated by the need to show the nature of socio-economic status of the research participants. I moved further to explain in detail how pregnancy and childbirth processes are understood in this particular society. I concluded that in Mawadza village, medical pluralism plays a crucial role in the understanding of pregnancy and childbirth; hence the processes have different meanings in this society depending on the health care system one is using.

I proceeded to show the experiences of expectant mothers in the waiting mothers' shelter at Bonda Mission Hospital. In this facility, pregnancy is handled from a purely biomedical perspective, that is, pregnancy is treated like a medical condition that requires assistance and monitoring from medical professionals. I have shown the experiences of expectant mothers during prenatal care and the preparation of childbirth in the shelter, including how expectant mothers with special conditions such as high blood pressure and HIV/ AIDS are treated and taken care of as they await labour in the waiting mothers' shelter. The importance of PPCT has also been shown as emphasis was placed on the B+ Option. I rounded up the chapter by providing an analysis of the biomedical model of health in relation to pregnancy and its limitations in practice. As a further point of analysis, I have deliberated on the Social Model of Health and how adopting this in conjunction is potentially holistic in providing maternal health care in indigenous communities such as Mawadza village.

CHAPTER SIX

DETERMINANTS OF UTILISATION OF THE WAITING MOTHERS' SHELTERS AND FACTORS INFLUENCING ASSOCIATED CHOICES

6.1 Introduction

This chapter builds on Chapter Five which focused on understanding pregnancy and childbirth experiences of expectant mothers in Mawadza village. In this chapter, I look at the level of utilisation of the waiting mothers' shelter and factors that influence use or none use of this maternal health facility at Bonda Mission Hospital by the expectant mothers from Mawadza village. In order to fully understand the experiences of expectant mothers in this facility, it is of great importance to determine whether or not the facility is being used and to know the factors that influence the choices of the intended users to use or not to use the facility. Literature has shown that the central reason for the non-use of maternal health care facilities is that they are too far from the houses of the expectant mothers. Apart from medical pluralism being one of the critical factors and long distances between expectant mothers' houses and health care facilities, the chapter brings to fore cultural as well as social factors that influence the level of utilisation of the waiting mothers' shelter by the expectant mothers and, indeed, whether or not to use the facility. Other factors that also came out as pertinent in the study include the structural, religious and economic factors, as deliberated in detail in the following paragraphs.

6.2 The Need to Access Skilled Birth Attendants

The need to access skilled birth attendants has been constantly improving the level of utilisation of the waiting mothers' shelter by expectant mothers in Mawadza village. The need to use the waiting mothers' shelter varied with the different medical conditions of the expectant mothers, birth experiences and complications among other factors. A significant population of the expectant mothers interviewed agreed that they needed the shelter because they were safe in the hands of health care workers who would constantly monitor their pregnancy with expertise, and they would give birth in the nearby Bonda Mission Hospital with the assistance of state registered, trained midwives and a doctor. The following are sentiments from some of the interviewed expectant mothers. Belinda stated that:

I always want to await labour in the shelter because it gives me access to nurses and doctors whenever I need them. Right now, the country is going through strikes but we have midwives in the shelter who sleep with us when they are on duty and they constantly teach us on how to do the correct thing with our pregnancies. I think that is very important to me as a mother (Author's Interview 10/07/2019).

In agreement with Belinda on the need to be attended by skilled birth attendants, Susan stated that:

As I have noted, I am a HIV positive expectant mother and my condition requires me to give birth at a hospital so that I can save my new-born child from getting infected. I, therefore, need qualified health care workers to assist me during delivery; so, for me, waiting for delivery in the shelter is important (Author's Interview 10/07/2019).

Furthermore, Hazel acknowledged the need to give birth under the supervision of skilled birth attendants by articulating that:

I have hypertension, and the condition worsens every time I get pregnant. This gives me the reason to await labour here at the shelter because I am dependent on the health care workers for my own safety and the safety of my new born baby (Author's Interview 12/07/2019).

Norah also commented on her need for skilled birth attendants and stated that:

As a new mother, it is important that I use the shelter because I really have no idea how I can even start handling the labour process. I get to learn a lot and I also get a lot of knowledge that I did not get in full from the TBAs in the village (Author's Interview 12/07/2019).

Post-partum care received in the shelter has also increased the level of utilisation of the waiting mothers' shelter, according to the data abstracted and the key informant interviews conducted. The recorded statistics showed that the number of women using the shelter increased by 16.2% from January – June 2019, which has been a very significant increase for the hospital, although the figures still need to rise as noted by the key informants. Post-delivery haemorrhage, which usually results in the death of new mothers in the surrounding villages, has been a common problem cited by key informants. The fear of this condition has driven mothers to use the shelter for proper assessment before they are discharged out of the facility. Doctor Rodney had this to say:

98% of the mothers who use the shelter do not suffer from post-delivery haemorrhage, and the last recorded case in this hospital was handled well with proper medication to stop the new mother's profuse bleeding. Other conditions that have been common are Yellow fever and Jaundice among new born babies. This requires extra check-ups and care and when mothers experience this, they realise the need to await labour in the shelter in order to receive comprehensive post-partum care (Author's Interview 15/07/2019).

Narratives presented by the participants show that there is a growing dependency on the waiting mothers' shelter among facility users from Mawadza village due to the services offered and this has been supported by some of the by-laws in the community that support the use of the mothers' shelter. The existence of these by-laws has also facilitated the increased level of utilisation of the waiting mothers' shelter.

6.3 Criminalisation of Home Births

The community, through by-laws, has criminalised homebirths³⁰. Chiefs and village heads penalise mothers who give birth at home. All participants acknowledged that in Mawadza village, when one gives birth at home she pays the sum of a goat for a baby girl and two goats for a baby boy so that the chief can write a letter to the hospital acknowledging that there is a new-born baby in his village book. This letter serves as a notice to the hospital so that the baby can be examined, put on an immunisation plan and, later on, be eligible for registration in the registry department for issuance of a birth certificate. Participants noted that without the letter from the chief, one cannot register one's new-born baby; hence, the baby will not have a birth certificate or national identity or any other documentation. Home-birth in Mawadza village falls in the same category as other unaccepted behaviours that attract sanctioning. Behaviour that can be sanctioned through a traditional court system include civil disputes, leaving one's cattle astray to graze in other people's fields, and working in one's field on a day that has been declared sacred and set aside for rest (*kurima musu wechisi*) among other issues. The penalty (*kuripiswa*) that people receive for violating any by-law ranges from cows to goats or chickens, depending on the magnitude of the offence. Giving birth at home in all in Mawadza attracts a penalty; hence one may say home births have been criminalised. Chief Mutasa commented on the issue of criminalisation of home births and noted that:

³⁰ Conducting a birth process at home has its consequences from the Ministry of Health and Child Care. The Maternal and Neonate Care Policy of 2015 encourages women to give birth at the hospital.

We try our level best to penalise families who allow expectant mothers to give birth at home. I usually have meetings with the hospital staff or any visiting NGO in this area to discuss any health-related issues that concern the people. Issues of maternal health have been on constant discussion as there is need to reduce maternal mortality in Mawadza village. Some people have since stopped giving birth at home in fear of penalties or being summoned to by place every time. As a Village Head, I can say that this has reduced the number of women giving birth at home but a lot still needs to be done. Others are still giving birth at home and this behaviour is unacceptable according to the stipulated by-laws of this village (Author's Interview 28/07/2019).

Doctor Ben further remarked of the same issue as he noted that:

The MoHCC does not really encourage home births, especially in this Zimbabwean context, and mostly in our rural communities. By-laws then act as a social control mechanism to support the use of formal maternal health care facilities by rural women so as to reduce maternal and infant mortality, especially during or soon after delivery. These by-laws have been useful in encouraging a certain population of expectant mothers to attend prenatal care at the hospital and come to the waiting mothers' shelter to await delivery (Author's Interview 29/07/2019).

In FGDs, participants noted that one of the challenges that arise with giving birth at home is that one is required to pay the midwife after birth. Usually, people pay a fee of chickens up to goats, depending on how complicated the birth was and also, in cases of twins, the payment is usually in the form of goats. Payment to the midwife is usually a problem for most people since they do not have livestock in abundance. Families are presented with a double burden of paying TBAs and penalties to the chief. This has encouraged mothers to go and await labour in the waiting mothers' shelter for them to be eligible to give birth at Bonda Mission Hospital. Although the by-laws of the village have lessened the number of women giving birth at home by increasing the number of expectant mothers in the waiting mothers' shelter, TBAs and traditional leaders expressed a divergent view from the one that was expressed by the community leaders and other health care workers. They noted that criminalising home births was not a noble idea because it portrayed an image that TBAs and traditional healers are illegal people in the community who are not supposed to assist in the birth process. Through data abstraction, certificates of freelance TBAs who were trained by missionaries in the pre-independence era to assist in the delivery of babies were shown. Other traditional healers showed their certificates from ZINATHA that legitimises their practice in this village. However, none of the SBAs showed any form of

documentation that qualified them to be experts in the activities that they performed. They emphasised, however, that theirs was more of a calling than anything else.

A traditional midwife, Tilda, complained about how she feels their serves are deemed criminal in the village and stated that:

I get confused when I hear that home births are criminal. This is because I was trained in the Smith regime by the white man to assist deliveries in communities. I was given a bicycle to patrol in the community to check the welfare of expectant mothers and I have a certificate to prove this. I think our services are needed in the village; they are not criminal (Author's Interview 29/07/2019).

Joe, a traditional healer also expressed his views on how their services have been considered illegal by stating that:

I am not an illegal operator in this village; I help women to care for their pregnancies with herbs that are well known to be of assistance during pregnancy. I help women in the childbirth process and also to dispose placentas in a culturally acceptable way. Most mothers who come from the hospitals bring their children to me for important treatments to make babies strong and treat their umbilicus. I do not see then how my activities with expectant mothers or new mothers become illegal (Author's Interview 30/07/2019).

Another traditional midwife, Alice, further articulated on how important her services are to the villagers as she stated that:

I don't have a certificate to prove my worth in the lives of expectant mothers in this village, but I have been called to assist expectant mothers deliver their babies without problems. I can even tell in the spiritual realm that this expectant mother needs prayer to fight evil spirits for her to deliver well. When I conduct the deliveries, I use latex gloves, razor blades and all the equipment necessary, and I don't think my activities are criminal; they are of importance to this village (Author's Interview 30/07/2019).

The conflict surrounding the criminalisation of home births shows that in medical pluralistic societies, different health care systems do not only co-exist but sometimes antagonise and contest (Singer *et al.*, 2011). Ideally, medical pluralism entails that different healthcare systems co-exist in societies with the full acknowledgement of each other; however, contestations arise in these

societies where one system may discredit the operations of the other. For example, the traditional health system practitioners are of the view that indigenous society members are drifting away from their culture by not following some of the traditional ways of caring for pregnancy in preparation of childbirth (opening of the birth canal). Traditional healers have shown concerns but on the contrary, the biomedical approach country-wide usually has the support of legal systems and stakeholders who draft policies in the country to stop any practice that is deemed unsafe by natural sciences. This has shown clearly what Singer *et al.*, (2011) have postulated that medical pluralism does not exist in a vacuum; however issues of dominance are continually evident as health care systems contest for recognition.

By criminalising home births, the self as postulated by Mead (1934) has been in some sense undermined. Charon (2007: 77) acknowledges that Mead saw the self as an entity that exists within social interactions and, as such, it is both a product of and player in those interactions; meaning that social interactions are very crucial in producing expectant mothers in Mawadza village. In addition, one of the critical elements that link self and society are symbols as enacted in those social interactions. Only humans have a sense of self because they have symbols by which they can consider what constitutes their identity. People's attitudes, values and beliefs which are formulated through symbols, constitute part of our sense of self. Home births and natural traditional ways to care for pregnancy and prepare for childbirth are processes that hold important symbolic meanings in Mawadza village forming their values and beliefs. These processes during pregnancy are so crucial that they form the identity of expectant mothers in this village. Nevertheless, the biomedical approach to health that has the support of other social structures, such as the legislature, undermines the self that has been built as a result of a consensus of symbols, values and beliefs on childbirth as it criminalises home births, an activity highly valued in the society due to its symbolic meaning among other factors.

Further from the factors discussed above, Mead (1934) discusses the notion that human beings as social actors internalise symbols from their society into their inner self and create a "generalised other". The "generalised other" is people's conception of the attitudes of their social community. For example, humans carry within them a view of people in general, which includes how people in general view them. The generalised other plays a role in Mawadza village of reminding expectant mothers to await labour in the shelter, in an effort to avoid criminalised home births.

Our sense of self is directly related to our “generalised other” because we experience ourselves from both the standpoint of specific people in our social network and also from “the generalised standpoint of the social group as a whole” (Mead 1934: 138). Thus nurses and midwives among other people become important as the generalised other in influencing the behaviour of expectant mothers from Mawadza village. The “generalised other” is part of our self; we adopt attitudes of the “generalised other” as part of who we are. Scholars such as Berlo (1960) and Stryker (2017) also saw the “generalised other” as a foundation for creating expectations about how people behave and the roles they play. Those expectations and roles are then used to guide our own behaviours. In this regard, expectant mothers, due to the role of the generalised other, internalise the expectations of the health care workers to await labour in the shelter and give birth in a hospital facility so as to avoid home births that are perceived criminal.

Further on this point, FDGs revealed that, inasmuch as the criminalisation of homebirths has frightened expectant mothers from Mawadza village into awaiting labour in the shelter, there are other factors that were expressed by participants that still deter expectant mothers from using the facility as much as they are supposed to. Participants noted other variegated factors that affect women’s use or none use of the shelter as a maternal health facility.

6.4 Factors Influencing Expectant Mothers’ Use or Non-use of the Waiting Mothers’ Shelter

6.4.1 Deterences at the Community Level

6.4.1.1 Lack of Adequate Knowledge about the Waiting Mothers’ Shelter

The participants noted that lack of proper in-depth knowledge about the waiting mothers’ shelter is one of the reasons why some women choose not to await labour in the waiting mothers’ shelter. The lack of knowledge is gendered as all men who participated in the study stated that they do not have adequate knowledge about the shelter, its operations, its usefulness, and the benefits of using the shelter and how they are involved as fathers in the prenatal and post-partum stages at the shelter. Only the chiefs and headmen and other male health workers displayed adequate knowledge about the waiting mothers’ shelter as an essential maternal health care facility in the community. A community member, Mr Floyd, articulated on his lack of adequate knowledge about the shelter when he stated that:

I thought that waiting mothers' shelters are facilities that are specifically designed for women and men were not really supposed to interfere with the issues that are discussed there. As we would grow up, ladies would also go to private meetings with grandmothers and aunts, where they were taught issues to do with women. As men, we never used to interfere and our fathers always reminded us that women should be allowed their private gatherings, of which I thought the waiting mothers' shelter facilitated women's private gatherings (Author's Interview 18/07/2019).

Another community member, Mr Josephs, similarly expressed his lack of adequate knowledge about the waiting mothers' shelter when he noted that:

I really have no idea what happens in the waiting mothers' shelter; I have never really got to understand what happens there, so much so that I see no point of my wife going there. If it is all about pregnancy, there are always aunts in our village who can do everything for them. Maybe if they tell us more about the shelter, we may better understand (Author's Interview 18/07/2019).

Yet another community member, Mr Thompson, further elaborated on how men are generally not adequately knowledgeable about the purpose of the waiting mother' shelter. He stated that:

In my life as a man in this village, I have never seen a man being called for a meeting for waiting mothers' shelters. We have, thus, developed a mentality that it is only for women and has to do with women affairs and nothing to do with us. We wish to have deeper knowledge about these facilities. If they want us to be part of the activities or allow our wives to go there, I think we also need to be part of their awareness meetings. (Author's Interview 18/07/2019).

Ten of the total expectant mothers that participated in the study, who were in the shelter, also indicated that they do not get adequate information about the shelter before they went to the shelter. They got to know of the benefits of awaiting labour at the shelter through their experience in the shelter. However, others noted that they knew about the shelter before they awaited labour, thus, they made the choice to await labour in the shelter. All women who participated in this study, particularly through FGDs, expectant mothers in the waiting mothers shelter and those who formerly used the shelter and the female key informants noted an important aspect that the lack of knowledge that is displayed by men about the waiting mothers' shelter significantly hinders expectant mothers from using the shelter since men hold the ultimate decision-making power in family and community matters in this patriarchal community.

Lack of knowledge about the shelter revealed by some of the participants demonstrates the fact that medical knowledge is socially constructed and perceived and it is gendered as well. What constitutes medical knowledge is constructed by the people of any given society as has been noted by Singer *et al.*, (2011) as well as Amzat and Razum (2014). In Mawadza village, what constitutes medical knowledge related to pregnancy and childbirth is embedded in the cultural and traditional health systems of this village, hence, there is not strong recognition of the shelter as a health care system that can offer comprehensive maternal health care services to the village members. The villagers, especially men, who are not very involved in the childbirth process tend to view the waiting mothers' shelter as a foreign facility to the culture of the local people, hence, they do not make efforts to equip themselves with knowledge about this biomedical facility that is located in an area which practises medical pluralism. The lack of knowledge displayed by men reiterates that what constitutes medical knowledge which is well accepted and recognised by the local people in societies is constructed and shaped by those local people through the symbols and meanings given to it by the indigenous people (Singer *et al.*, 2011).

This leads to an appreciation of the second and the third premise of the symbolic interactionist theory (Mead 1934, Blumer 1969; 2004, Charon 2007, Conrad 2012, Redmond 2015). The second premise entails that the meanings people hold in life are affected by the people they interact with. The nature of social interaction and the social networks one is involved in determine the perceived meanings one possesses over certain things (Blumer 2004, Charon 2007). It is through social interaction that members of the Mawadza village define the birth territories surrounding them. As such, the waiting mothers' shelter as biomedical birth territory is not so popular with village members due to the readily available knowledge about birth territories and the childbirth process in the village. Lack of knowledge about the shelter is gendered-men display lack of knowledge about the shelter than women in the village. This is also aligned to the nature of interaction men are involved in in this village and their social networks which affect the meanings of their social world with regards to the childbirth process and birth territories. Men in Mawadza village leave issues to do with childbirth in the custody of women, especially elderly women in the village. Therefore the nature of the social network in this patriarchal village does not fully equip with enough knowledge of the waiting mothers shelter unless more awareness campaigns are raised in this village.

According to Blumer (2004), the third premise of the symbolic interactionist theory entails that the meanings in our social world are subject to change over space and time. Men are continually (although the progress is small) getting involved in issues to do with childbirth and it can be predicted that with a continual dissemination of information about the waiting mothers' shelter, men are likely to gain more knowledge about the shelter than what they currently know. The involvement of men in the childbirth process, especially, at the hospital has changed from what was traditionally known with a few men, especially, the Anglicans getting more and more involved in support of their wives, although this is to a lesser extent. This shows that social interaction does not occur in a static environment; however meanings are dynamic and subject to change over space and time (Redmond 2015: 16). The lack of knowledge about the waiting mothers' shelter that men displayed during interviews affects women's use of this facility, since, they lack the decision making power in this patriarchal community.

6.4.1.2 Women's Lack of Decision-Making Power to Use the Shelter

Expectant mothers noted that one of the major reasons that affect their use of the shelter is that they lack the power to decide on their own whether or not to use the shelter. The female participants agreed that they depend on their husbands' authority to use the shelter. For those who do not have husbands, a male member of the family's authority is needed before going to the shelter. All the expectant mothers agreed that they were there with the full knowledge and consent of their husbands and male family members. With the lack of knowledge that has been displayed by men over the significance of the shelter on the childbirth process, expectant mothers who participated in this study believe that most women would love to await labour in the shelter but they are not allowed by their husbands. There are three participants who noted that they awaited labour in the shelter for their first pregnancies only but were not allowed by their husbands to do the same for the second time and some for the third time even. Vivian narrated how she could not await labour in the waiting mothers' shelter after her first pregnancy by stating that:

I really wanted to await labour in the shelter for all my children because I saw the benefits of being in the shelter when I had my first child. However, my husband saw no need of waiting for the second time because he believed I had gained experience from my first pregnancy.

My husband argued that even those who go for masungiro³¹ do that once and not every time they get pregnant (Author's Interview 05/08/2019).

Patience further expressed her views on how she could not continue using the shelter to await pregnancy when she stated that:

My husband did not want me to keep on going to the shelter after my first pregnancy. He kept on explaining to me that there was no need to spend resources using the shelter every time I fall pregnant as it was going to be difficult for him to fund for that (Author's Interview 05/08/2019).

Expectant mothers noted that their husbands sometimes preferred to pay fines to the chiefs due to the abundance of livestock than to purchase the required commodities needed in the shelter. Key informants, who work directly with the expectant mothers in the shelter, noted that most women come to the shelter with their husbands' authority because they do not have the decision-making power to come to the shelter without the husband's consent. Husbands usually face challenges in taking care of the families when their wives are away. Bridget, a midwife at the shelter, remarked on women's lack of decision making power to use the waiting mothers' shelter as she expressed that:

It is our wish to include men in the activities of the waiting mothers' shelter. This is because they hold the decision to release expectant mothers to come and await delivery in the shelter. It is so unfortunate that women are not empowered in these communities to make decisions on their own about issues that concern their health. They need their husbands to tell them the health care system they should follow and this is usually affected by their husbands' ability to care for the family on their own while the women are away (Author's interview 06/08/2019).

6.4.1.3 Family Expectations

Apart from the lack of power to make decisions to use the shelter, expectant mothers also highlighted that they have family commitments that require their on-going presence at their homesteads. In this village, all female participants agreed that women (mothers) are the most important figures in a family set up. They are responsible for a number of tasks such as household chores and child rearing, apart from child bearing. The mother plays such a big role in running a family in Mawadza village, that her absence from the home makes a notable

³¹ *Masungiro* is a practice where a newly-married wife goes back to give her parents' home towards delivery during her first pregnancy, so that her mother may guide her through the involved processes.

difference. The fathers usually do not want to let go of their wives to go to the shelter for they do not want to be burdened by household chores and child rearing duties. In this village, most village members prefer that the expectant mother's pregnancy be monitored at home. Expectant mothers noted that most village members, including some men and TBAs, believe that it is normal for an expectant mother to do household duties when she is up to eight months pregnant. For this reason, families opt for home births than having their wives await labour in a waiting mothers' shelter where they cannot care for their families. An expectant mother, Susan, expressed how she desired to be with her family when she noted that:

It is because of my condition as an HIV positive woman that I have to await labour in this shelter, but my heart will be at home where I left my other children and I doubt that my husband will be able to bath and dress them well before they go to school. I also left my cattle and my garden where I grow vegetables; I hope they are well taken care of (Author's Interview 02/08/2019).

In addition, another expectant mother, Martha narrated her family commitments when she articulated that:

I have so many commitments at home that require my attention as a mother. I have other young children who still need my care. I ended up taking them to my mother for proper care when I am away. I also have a field that is not being tilled at the moment because the people who assist me cannot come when I am not there. Coming to the shelter disrupts the normal way of life but there is no option because we need to save the babies' lives and our lives too (Author's Interview 02/08/2019).

Other expectant mothers in the shelter noted that they did not have much commitment at home since it was their first time to be in the shelter, but their husbands also felt that the women should be closer to family. This was articulated by Norah as she articulated that:

It is my first time to be in the shelter after I had spent a month at my parents' place. My husband noted that I should consider coming back home as he is failing to live by himself for such a long period (Author's Interviews 02/08/2019).

All expectant mothers in the waiting mothers' shelter at Bonda Mission Hospital highlighted that they spend most of their time undisturbed and learning about prenatal and post-natal care. It is only in the morning during meal times and physical exercises when expectant mothers get busy

with tasks in the shelter as they spend most of the time relaxed, which is against what is perceived normal for pregnancy in this village. In Mawadza village, it is generally expected that a pregnant woman must be strong enough to handle every chore presented to her; women in general are not encouraged to be idle. According to village members, pregnancy, does not hinder anyone from conducting household chores. Therefore, the whole idea of using the waiting mothers' shelter is deemed unnecessary for most of the village members. A key informant and a traditional midwife, Alice, expressed why she thinks awaiting labour in the shelter is not necessary as she asserted that:

I do not see the reason why an expectant mother should be away from family to spend time being idle in the shelter. Being pregnant does not hinder anyone from performing normal household chores like any other day. This is what makes one strong in preparation for the birth process. In addition, I am not in support of the idea of leaving husbands alone for too long because they cannot care for themselves and the children properly (Author's Interview 10/08/2019).

Expectant mothers also echoed that, as they navigate the challenges of getting approval from husbands and also attempt to balance awaiting labour at the shelter with their family responsibilities while they are away, they also face challenges reaching the waiting mothers' shelter and hospital. There are long distances between the houses of the expectant mothers and the waiting mothers' shelter, and poor transport and road network system further compounds the situation.

6.4.1.4 Long Distances to the Shelter and Lack of Effective Transportation System

Furthermore, among the reasons women do not use the waiting mothers' shelter up to the level it is supposed to be used, are the long distances that exist between the expectant mothers' homes and Bonda Mission Hospital, lack of proper transportation to the health care facility and a poor road network. The waiting mothers' shelter has not been properly utilised for the past years due to the issue of distance. Expectant mothers have to travel a long distance in order to register their pregnancies at the hospital, and hence to be eligible to await labour in this waiting mothers' shelter two weeks before delivery. The issue of long distance and lack of transport to the hospital has been mentioned by participants as a major hindrance in the utilisation of formal maternal health care structures and this has resulted in home births. Participants indicated that they use

donkeys, bicycles and motor bikes as transport to the hospital for prenatal care before they are due for their waiting period in the shelter. This has posed challenges to them because, with the state of the road network, it is difficult to use a bicycle till one reaches the hospital. Hiring a car or a motor bike is expensive, and so it is usually for those who are rich. The hospital has only one ambulance that is used for emergencies in the hospital. The ambulance services are funded but, due to economic challenges, the ambulance is usually without fuel, hence, cannot be used to fetch expectant mothers who need its services. Participants also noted the challenge that is posed by the presence of Matidei River, which makes it difficult to use the shorter route to the hospital. Key informants noted that there is evidence of delay in reaching health care facilities for expectant mothers in labour, hence there is a need for improvement in transport availability through the provision of adequate and functional ambulances so as to bridge the distances between the expectant mothers' homes and health care facilities, thereby ensuring that expectant mothers give birth under the supervision of skilled birth attendants. An expectant mother, Pamela, complained about the logistical challenges she faced to reach the hospital when she asserted that:

Coming to the hospital is very hard, especially with the nature of our roads. There are so many potholes in the roads that using a donkey and scotch cart is difficult; you will reach the hospital with a backache. Most of us cannot afford hiring vehicles to the hospital and even the motor bikes are so expensive. The honest truth is that coming to the hospital is a great sacrifice and risk to the baby because the roads and transport are so discouraging (Author's Interview 12/07/2019).

Another expectant mother, Candice, further elaborated on transport related challenges faced by expectant mothers to reach the hospital by stating that:

There are a few ambulances and they don't come where we live. It's too remote. It's long a distance for us to go to the nearest point where we can get transport. That can be challenging when one is closer to giving birth and needs to go to the waiting mothers' shelter. A woman needs to be near a hospital during that time because only a professional can help you deliver the baby safely, but transport is our main impediment (Author's Interview 13/07/2019).

Yet another expectant mother, Betty, also narrated the challenges she encountered to reach the hospital by stating that:

I was given a bicycle to use by my husband, but, it's not efficient because I have to cross Matidei River before I reach the hospital using the short cut. If I use the proper road, I will arrive at the hospital late because it's so long and there are a lot of potholes to navigate as I ride my bicycle (Author's Interview 13/07/2019).

Belinda, another expectant mother, further reiterated on these concerns by expressing that:

I used a motor bike for prenatal care before I came to await labour in this shelter. The motorbikes are expensive and my husband had to sacrifice a lot of money to pay the drivers to take me here. Their ambulance is not reliable because every time it's always out of service. Using the short cut is hard because there is a river so we had to use the longer route (Author's Interview 13/07/2019).

Other key informants indicated that transport (scotch-carts, motorbikes and bicycles) is available in the Mawadza village, but, not typically arranged in advance for the expectant mothers, and therefore perceived as unavailable. Key informant interviews with chiefs and village heads further raised the issue of limited advance planning for delivery of the expectant mothers in this village and suggested the solution of strengthening individual and community planning efforts to ferry expectant mothers to the waiting mothers' shelter. Doctor Ben commented on the transport related challenges expectant mothers face and the possible ways to cope with these challenges when he said that:

The problem is that transport is not readily available in the village to ferry the expectant mothers to the waiting mothers' shelter when they are due for their waiting period. I do not think it's wise to keep on complaining about lack of transport but we should encourage families with expectant mothers to prepare for transport well in advance and also to encourage community members with cars and motor bikes to assist whenever there is an emergency need for transport, either to the waiting mothers' shelter or to the hospital in general (Author's Interview 19/07/2019).

In addition, all the men who participated in the FGDs highlighted that transport is a problem when one requires taking his wife to the waiting mothers' shelter. It was noted that lack of an available functioning ambulance has caused so many inconveniences as most men are turned down after requesting for one, hence forcing them to then make an alternative –usually resulting in delays or getting an option such as scotch-carts, which they usually do not want to use. A

community member, Mr Thompson, narrated the transport related challenges men encounter in order to ferry their wives to the waiting mothers' shelter when he stated that:

The main challenge that we face when we want to send our wives to the waiting mothers' shelter is that there is no available ambulance at the hospital. When our wives go for antenatal care prior to their waiting period, they are usually told to budget for ambulance fee – which we budget well in advance, but when it's time to use the ambulance it is always out of order (Author's Interview 22/07/2019).

As expectant mothers grapple with challenges of accessing the waiting mothers' shelter, they also highlighted that they are faced with challenges of securing the required consumables to use during their waiting period in the waiting mothers' shelter.

6.5 Deterrences at the Individual Level

6.5.1 Lack of Adequate Facility Requirements

Facility requirements are also amongst the factors that deter women in Mawadza village from awaiting delivery in the waiting mothers' shelter. At Bonda Mission Hospital, the requirements to await labour in the shelter include having registered one's pregnancy at the hospital. For one to register her pregnancy, she was required to pay a sum of RTGS\$30 at the time the study was conducted. The expectant mothers also have to attend pre-natal care sessions at the maternity unit at the hospital prior to their waiting period in the waiting mothers' shelter. When the expectant mother is due to go to the shelter, she is required to bring provisions such as a note book, firewood, food, pots, blankets, buckets, toiletries, including detergents to clean the toilets, latex gloves, cotton wool, candles, razor blades, shaving cream, and presentable clothing – preferably nightwear. These provisions are usually required to be utilised by the expectant mothers during their stay in the shelter. The expectant mothers prepare meals of their choice in this facility, as long as they have the food. A balanced diet is highly recommended in this facility and, for those who cannot bring *chimukuyu* (dried meat) or *bakayawo* (dried fish) as a source of protein, vegetables mixed with peanut butter are usually a recommended substitute to eat with sadza (the main source of carbohydrates). All expectant mothers stated that they are encouraged to cook in groups as they interact with one another. In cases where a group of expectant mothers does not have firewood, members of the family are encouraged to bring from home. The stipulated time table for meals amounts to three meals a day (breakfast, lunch and supper).

However, this time table is no longer strictly adhered to due to economic hardship. The expectant mothers have at least two meals of their choice in a day, as groups. Failure to provide the necessary required provisions hinders most expectant mothers from using the waiting mothers' shelter. Mrs. Anderson, the head of a community based fundraising group called *Mukando*, narrated the group's efforts to assist expectant mothers when she stated that:

We have tried to assist women in this village by providing for them some of the basic consumables that they cannot purchase on their own. The idea behind this initiative is to ensure that all who wish to await labour do so without the impediment of lack of resources. However, the level at which we assist expectant mothers from the village has decreased due to the economic challenges that most are suffering due to our ailing economy (Author's Interview 23/08/2019).

The challenges of providing one's own consumables while awaiting labour in a waiting mothers' shelter are common in Mawadza village. Complications of pregnancy and childbirth can pose serious risks to the health of expectant mothers, especially in resource-poor rural settings. These result in some not being able to meet the required standards, so they resort to non-use of the facilities. Intervention from governments and other stake holders to assist with provisions such as food and sanitary wear is vital so as to encourage those without access to these to also use the waiting mothers' shelters.

Apart from the required food stuffs that should be brought by the expectant mothers to the shelter, these mothers are also allowed visits every day of the week from 13.00 hours to 14.00 hours. It is during these visits that waiting mothers get extra food stuff and other provisions, depending on the family's income level. It was revealed in the study that there were cases where the midwife usually gets some of the food stuffs or other provisions from the expectant mothers so that they have a better stay in this shelter. It was revealed that the expectant mothers are usually treated differently, depending on the provisions one brings to the shelter and also how popular one is in this village. Rosemary, one of the expectant mothers commented on the issue of unequal treatment in the shelter when she stated that:

I went to await labour in a waiting mothers' shelter because my first homebirth gave me complications. I went to the waiting mothers' shelter without a lot of provisions and food stuff; my husband did not have much money to buy a lot. The midwives never used to treat me with good care

and they never used to talk me. When I was in labour, I called them and they never responded; they acted as if they did not hear me...I was rushed to the hospital when the baby was already on its way out. If one does not have money to please the midwives, it is very hard to await labour in the waiting mothers' shelter (Author's Interview 10/08/2019).

Vivian also pointed out that there is preferential treatment in the shelter when she articulated that:

I had a hard time under the care of the midwives. I will never go back to the waiting mothers' shelter to await labour again. When I went there to await labour, I was very young. I was afraid to cross paths with the midwives, so every time I received a visitor, I would share the food (biscuits or home cooked meals) with them so that I could have a better stay. Well, to pay a goat fine to the chief after giving birth at home is better than being under the care of the midwives at the shelter. The midwives will treat you bad and they prefer to deal with expectant mothers who are generally not too clever or the quiet ones. Ah! Awaiting labour at that waiting mothers' shelter requires one to be strong (Author's Interview 12/08/2019).

In response to this, Bridget a midwife at the waiting mothers' shelter stated that:

We do not abuse expectant mothers and the new mothers in this shelter. People have to note that we stern but not in a bad way! We need to make sure that mothers go home with babies than to leave them not taking heed to important instructions that serve their lives and that of their babies. I have never taken any bribe from anyone in this shelter, I believe I am not only on this job because I am qualified but to me this is a calling that I do with my passion and all my effort that some expectant mothers/new mothers think I am overzealous or cruel (Author's Interview 21/08/2019).

Another staff member at the shelter, Bella, added that:

Some of our patients think that we work in antagonism with doctors and we do not apply the ethics of our jobs when we deal with them. Dealing with pregnant women is not easy. Many of them come from different backgrounds with different beliefs that we need to control into acceptable standards of the MoHCC in a space of only two weeks that most of them spend as they await labour in the shelter. Applying these standards is not some form of cruelty but is to ultimately save lives of the mothers and their babies. We are answerable to the MoHCC in any case if fatality and it may result in use losing our jobs if the fatality is not explained

adequately. For this reason we do all we can even it means being stern, to the mothers to save lives (Author's Interview 21/08/2019).

The expectant mothers and the hospital staff members, especially the midwives, with whom they interact more often, showed an antagonistic relationship, although this is passive due to the expectant mothers' lack of capacity and perhaps lack of knowledge to formally complain. From the narratives of the two parties, I gathered that some of the challenges that strain the relationships of the expectant mothers and the midwives are due to differences in beliefs held by the expectant mothers and the health care workers. Bonda Mission Hospital is a biomedical facility that operates under stipulated regulations which are guided by science; however the expectant mothers from different belief systems and economic backgrounds take time to conform to the demands of these regulations.

The symbolic interactionist process that is associated with the relationship that is exhibited by the expectant/new mother and the hospital staff members show that women's sense of self is active as they await labour in that they have the ability to communicate with their selves and process the actions of the healthcare workers before they classify those actions in to good or bad treatment. Humans are in constant social interactions and derive meanings from every form and nature of social interaction (Charon 2007: 82). This leads to further stresses as indicated by Davis-Floyd (1994), Fielder (1996) and Callister (2020) who state that birth places and the activities that surround them are not only a resemblance of complicated machinery and bio-technical equipment in in a hospital room filled with pregnant women; but are influenced by socio-cultural processes, with economic processes included. The economic factors are some of the major stresses that deter expectant mothers/new mothers from using the waiting mothers' shelter at Bonda Mission Hospital as shall be discussed hereunder

6.5.2 Economic Challenges

Zimbabwe is burdened by major economic challenges and the government is not in the capacity to provide adequately for facilities like beds, blankets and detergents to clean the blankets, hence facility users have to make alternatives and provide themselves with the necessary requirements in order to stay in the waiting mothers' shelter. The expectant mothers are expected to bring their own latex gloves because public hospitals all over the country (Bonda Mission Hospital included) are facing challenges and there is no equipment to use, hence care seekers (expectant

mothers) indicated that they buy their own sets of gloves for use during the birth process. Bridget remarked on how economic challenges have affected the operations at the shelter by stating that:

The current economic challenges have affected the operations at this hospital. The hospital is no longer well-resourced with basic things like latex gloves and we require the patients to bring their own. I know it is hard for them but sometimes they make arrangements on their own to share a box of gloves so that they can share the costs. It has been an issue under discussion in parliament, whether or not women should provide for themselves with necessary medical equipment if maternal health services are for free. However, discussions are still going on and we will have to know their outcome because operating under such conditions is very problematic (Author's Interview 30/08/2019).

It was further revealed in the study that some expectant mothers share a box of the gloves; up to four expectant mothers can share the box. All expectant mothers indicated that candles are also used in the shelter as there are power supply problems throughout their stay. In addition, during labour, one goes with a candle for lighting purposes because the hospital does not have constant electricity supply from the Zimbabwe Electricity Supply Authority (ZESA). Generator services are usually an option but not very sustainable in the current situation in Zimbabwe where fuel supplies are very limited. The burden of lighting is usually pushed to the care seekers who, in this case, are the expectant mothers. The expectant mothers who await labour in the waiting mothers' shelter bear the burden of providing everything that is needed for one to give birth: the gloves, cotton wool, and razor blade for cutting the infant's umbilical cord, detergents for cleaning the facility and candles for lighting purposes. Mary expressed concerns on how she had to provide most utilities that were needed to sustain her stay in the shelter and assist the childbirth process as she indicated that:

We provide everything on our own when we come here to await labour. It has not been easy since we are burdened by the economic challenges that are affecting everyone in the village. Things are now expensive; giving birth is actually now expensive and, if things continue like this, I don't think I will be able to await labour in the shelter again due to incapacitation (Author's Interview 22/08/2019).

All expectant mothers stated that the hospital does not have adequate funds to hire a permanent cleaner to provide sanitation services; hence the expectant mothers will have to perform these duties on their own. At Bonda Mission Hospital, expectant mothers take turns to clean the

facilities they use. They take turns to clean the Blair toilets using the detergents that they bring from home. In pairs, every morning, the expectant mothers clean up the toilets and common bathing area. They also fetch water from the hospital reservoir to fill the drums. This is the water used during the day since the hospital does not supply water throughout the day due to electricity problems. The warden of the facility, who is a midwife, is also required to check if the facility is clean. It is due to economic hardships faced by the government that the hospital cannot hire cleaners for this facility. In this same hospital in the paediatric (0-5 years) ward, mothers who bring minor patients also do the cleaning of the wards and every facility they use, including toilets. Samantha narrated how women in the waiting mothers' shelter take the responsibility of cleaning the facility as she articulated that:

We clean the toilets on our own because the health-care workers tell us that the hospital cannot afford to hire cleaning staff for the shelter. I think it also helps us not to be idle always since we spend the day not doing anything. I see no problem with cleaning the toilets and the surroundings because, after all, we are the occupants (Author's Interview 17/08/2019).

Norah further expressed her concern in relation to the idea of cleaning toilets in the waiting mother' shelter by stating that:

I really do not like the idea of cleaning the toilets on our own because the midwives sometimes choose people randomly to go and re-clean if the toilets are messed up. It is not fair because they choose people they do not like and people who are generally quiet, in most cases (Author's Interview 17/08/2019).

Sandra further stated her views, by pointing out some of the disputes that arise in the shelter, when women take turns to clean the facility when she said that:

I wish the shelter would have a cleaner so as to end cleaning disputes in the shelter. People quarrel a lot when it comes to cleaning and re-cleaning the toilets. Well, I suggest that women could form a group to hire a cleaner and then pay the cleaner even with groceries, if possible (Author's Interview 17/08/2019).

Participants further highlighted that the economic challenges that the country is facing have pushed the healthcare professionals to take industrial action. The doctors in the country have been striking for close to six months (January - June 2019) at all public hospitals, including mission hospitals. At mission hospitals, the strike is covert because data abstraction showed that

doctors log on for duty in the log book every day. However, they just disappear soon after logging on; hence wards remain understaffed with qualified doctors. One of the major reasons cited by key informants, apart from poor salaries, is the government's failure to provide equipment for use in hospitals. Doctor Rodney expressed his concern by stating that:

The challenges we face in running the waiting mothers' shelter and the maternity ward is lack of adequate equipment for use, which includes proper lighting in the hospital's maternity ward. Imagine, the hospital can no longer provide gloves. The delays and disturbances in the birth process can result in complications that may lead to death of either the mother or the new born – or, in some cases, babies might be born with deformities. Without proper lighting and equipment, chances of this happening are very high. The absence of adequate doctors due to the strike in this facility leaves expectant mothers vulnerable; especially in cases of emergency, for example where a C-Section has to be conducted. The vulnerability of these women leaves the midwives/nurses on duty with no option but to refer cases to Mutare Provincial Hospital (MPH), sometimes unnecessarily so. All the emergencies are combined in one ambulance and then ferried to Mutare (the provincial capital) because there is only one ambulance at Bonda Mission Hospital and the hospital is also facing challenges to secure enough fuel to ferry all emergencies to the provincial hospital as they occur. Transporting emergencies to MPH is basically referring emergencies to another hospital that is also understaffed, where chances of receiving care in time is slim, and this has also put women at risk of not receiving care on time to avoid death of either the mother or new-borns (if not both) during delivery. Even if you read in the newspapers, the Manica Post of 11 October 2019 reveals that there were 13 cases of deaths of the referral cases at MPH due to delayed care, I think at provincial level hospitals should be well equipped with satisfied staff members and equipment for better operations (Author's Interview 30/08/2019).

The narratives from the participants show that economic issues play a pivotal role in defining the pregnancy and childbirth experiences of women in medical pluralistic societies. One's economic status determines the kind of care one uses and even access to the waiting mothers shelter. As shown above, some of the expectant mothers fail to await labour in the shelter due to economic issues such as failure to procure enough provisions to sustain them during their waiting period in the waiting mothers' shelter. This shows that this biomedical facility's stipulations categorises the women according to classes of those with provisions and those without the provision which ultimately affect their access to the facility. Furthermore, for those with the provisions who qualify to wait labour in the shelter, a closer analysis shows that differences are also noted as

those with more provisions supposedly receiving better care and treatment than others who have basic provisions only. Others go to the shelter with provisions that they will have acquired through donations from community members and their community support groups and money clubs (*mukando*). From a symbolic interactionist perspective all these processes affect the expectant/ new mothers' sense of selves and ultimately affect their identity. An appreciation of Cooley's (1969) looking glass self is prudent in this scenario - we view ourselves in relation to how others around us view us. The expectant mothers in the shelter tend to view themselves according to how others view them in relation to the material possessions they have and the amount of resources they have to sustain their stay in the waiting mothers' shelter. Those with not much provision are likely to assume a subordinate personality throughout their stay in the shelter.

Biomedical facilities have a long history of categorising people due to economic statuses since the colonial era. This has also been noted by Zvobgo (1982) who stated that categorisations were documented in the colonial era as urban hospitals were created for the whites while mission hospitals were created for the rural populaces. Even in urban areas local clinics were used by the working class where facilities were not compared to those that were used by the white population. Zimbabwe has adopted the Rhodesian primary health care system from the pre-independence era that categorised care seekers into different classes and each access services that are within their financial limits and economic class (Dodzo & Mhloyi 2017). This has also been one of the major deterrence of the utilisation of the waiting mothers' shelter by the expectant mothers.

Furthermore, a closer analysis of the narratives from the participants shows that it will be an enormous error to view issues to do with pregnancy and childbirth in biomedical facilities from a one dimensional view and conclude that these processes are merely surrounded by medical personnel, medication, complicated medical technology as well as hospital beds (as have been noted by Rothmans 1988). Childbirth processes in these facilities are imbedded in socio-cultural factors of which economic factors are not an exception. Economic factors have affected the overall operations at the shelter from the attitude of the health care workers and the ultimate utilisation of the facility. All these factors, as they interconnect, are also interpreted within the realms of the symbolic interactionist theory. Every form of interaction that humans are involved

in is imbedded in the meanings of those things. Economic factors heavily affect the interactions at the waiting mothers' shelter as they seem to be the anchor of every sort of interaction. The economic challenge faced by the nation at large has also affected the nature of interaction at the shelter and the ultimate utilisation of the facility.

6.6 Deterences at Institutional Level

6.6.1 The Relationship between Expectant Mothers and Health Care Workers in the Shelter

Overall, participants from Mawadza village highlighted many reasons influencing their decision to either use or not use the waiting mothers' shelter to await delivery. When asked to identify some of the factors that worked as barriers, participants spoke about their relationship with health care professionals. 60% of the participants (expectant mothers and health workers) listed the patient-provider relationship as a reason why women delay/or do not await delivery in the shelter. Expectant mothers indicated that health workers often mistreat or demean them during their antenatal visits and their stay in the waiting mothers' shelter. Additionally, health workers agreed that expectant mothers often do not receive the care they deserve due to staff shortages owing to the current economic hardships.

While none of the TBAs and traditional healers interviewed listed the relationship between expectant mothers and health care providers as the reason why expectant mothers do not await delivery in the waiting mothers' shelter, it had been a barrier for most expectant mothers and a reason why they felt their peers currently delay to seek care. The expectant mothers and health-care provider relationship was categorised into several themes: mistreatment at the shelter was mentioned by all of the expectant mothers; time spent waiting for service was mentioned by 13 expectant mothers; the clinic appointment system, cultural beliefs of clinic personnel regarding when to present for care, and overall treatment or attitude of the healthcare providers towards the expectant mothers were also among other factors that were mentioned by the participants.

6.6.2 Mistreatment at the Waiting Mothers' Shelter

Negative attitudes and mistreatment by health workers at the waiting mothers' shelter was the most reported theme in this section. Participants shared those health care providers, especially the midwives, frequently shouted at them. They noted that while it was easier to tolerate the shouting and mistreatment at the waiting mothers' shelter, the conditions in the shelter were

unbearable, especially, in winter, when there are inadequate mattresses and blankets for the expectant mothers to keep warm. Expectant mothers/new mothers noted that they were often in much pain and dependent on the health care provider for their own and their new-born baby's lives. This was an area that participants longed to see improve, as Betty noted:

The treatment we get in this shelter is harsh at times. The midwives usually shout at us and they do not care how we feel after they shout at us. What I would like to see in this shelter is that, when an expectant mother comes into the shelter, she should be treated with respect and dignity like any other human being. They should treat us like their daughters, not to shout at and beat us ... So, I would love to see the midwives welcoming and treating us well (Author's Interview 16/07/2019).

Expectant mothers stressed that their mistreatment by the health care providers amounted to what they believed was a misuse of their authority. This abuse took the form of the tone of voice used in conversation or snide remarks made to expectant mothers regarding their pregnancies. Expectant mothers stated that they felt helpless in these situations as they rely on these professionals for care. Furthermore, since most of the expectant/new mothers were of a lower socio-economic status, they feared speaking up or were unsure what to say in those situations. Sandra indicated that:

Sometimes the midwives just shout at people for no reason. Sometimes they shout at us and sometimes when you are asking them a question on something that you don't know, they think you are so stupid, and you don't deserve to ask them such questions...I am even afraid to ask questions because I do not want to be embarrassed in front of other expectant mothers in the shelter (Author's Interview 18/07/2019).

Olga also supported the views expressed by Sandra as she stated that:

Sometimes you can meet a very wicked nurse and midwife, especially the female ones who can slap you, and they can curse at you, and they will tell you I wasn't there when you were getting pregnant, don't put this on me'. That time you will be struggling with labour pains and if they want to fix you, they will make you walk to the maternity ward from the shelter. However, if they like you, they will ferry you on a wheel chair to the maternity ward (Author's Interview 18/07/2019).

The midwife health care workers responded to the claims by the women (expectant mothers/women who had used the shelter). Bella stated that:

We do not mistreat women in this shelter and we have no reason to do so. Our main aim is to assist women to deliver healthy babies. In doing this some women do not cooperate and tougher ways to make them take heed to beneficial instructions are taken (Author's Interview 28/07/2019).

Doctor Ben took a neutral stance as he stated that:

We are not involved in the day to day activities at the shelter so as doctors, I don't think we are in the rightful space and capacity to confirm that there is mistreatment of the women or to dismiss their claims. However from a professional point of view, I do suggest that anyone who feels mistreated should report to the authorities. It is very unethical to beat up a patient in any circumstance hence I do not support that if it is happening. Women also have a tendency of not working together well if they are put into groups, so it is highly likely that conflicts arise in that shelter, but I strongly suggest that people should stick to professionalism (Author's Interview 30/07/2019).

As I have noted in the preceding sections of this chapter, high-quality maternity care includes not only clinical components, but also ensuring positive care experiences for women in the waiting mothers' shelter. All women deserve dignified, respectful health care throughout pregnancy and childbirth as well as freedom from violence and any form of discrimination (WHO 2019: 1). Evidence from the narratives of the women, although, dismissed by the midwives, shows that women are being mistreated during childbirth in the waiting mothers' shelter. Identified chiefly is physical and verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and the midwives at the waiting mothers' shelter and, health system conditions and constraints as primary manifestations experienced by women during childbirth in health facilities. This leads to an appreciation of Cooley's (1969) input to the symbolic interactionist theory, the looking glass self. As I have noted in Chapter Three (Section 3.4.3), for Cooley (1964), our 'looking-glass self' involves three elements: imagining how we appear to other people, imagining other people's judgment of that appearance, and a self-feeling in response to that imagined judgment (for example pride and embarrassment). Mistreatment in the waiting mothers' shelter affects the identity of the expectant mothers because they tend to view themselves and their bodies in relation to the judgement of the midwives who are usually in the position of power and authority. Constant mistreatment leads to low self-esteem and perhaps another reason for the non-use of the shelter.

6.6.3 Health-Care Provider Attitude

Health care workers admitted that it was often difficult to maintain positive attitudes throughout the day due to staff shortages, with the current economic hardships being faced in Zimbabwe. Nurses and doctors have embarked on industrial action and the staff-members at Bonda Mission Hospital are not allowed to strike since it is a mission station. Bonda Mission Hospital has the responsibility of providing primary, secondary and tertiary care. The health care professionals noted that the patient load is often greatest at these facilities than at the primary and secondary level. In addition to staff shortages, health workers confirmed that expectant mothers were mistreated or shouted at when they presented late for care or when they do not follow simple instructions that do not need to be repeated. Bella discusses how sometimes the mistreatment of the expectant mothers in the shelter may be due to the burden and stress of the job in the scenario below.

I think much of it is the personal attitude; it could also be related to the long shift we are taking these days. It was better in the past when we were never short-staffed. However, at the moment, we are not short-staffed in theory but in practice people show up for work for a few hours and then disappear because nurses and doctors are on strike nation-wide. You may find that one doctor could be having one shift that he is doing; he has one shift and another shift and another shift, and they are tired. (Furthermore), you are telling this expectant mother (what is wrong), and she is not understanding you, and the expectant mother is doing something else and then you yell on top of your voice (Author's interview 19/07/2019).

Attitudes are as a result of the interpretation of the world around us (Charon 2007). Further understanding on how institutional structures and processes affect the experiences of expectant mothers in biomedical health care facilities is required in order to provide better woman-centred approach to maternal health care. It is prudent to acknowledge that structural dimensions influence mistreatment in maternal health care facilities during childbirth due to historical biases, power inequalities, normalization of poor treatment and communication barriers between the expectant mothers and the health care providers. It is important for policy makers to look at factors such as gender and social inequalities, and judgements about women's sexuality, to ensure that any interventions adequately account for societal context (WHO 2019). Preventing mistreatment in maternal health care facilities during childbirth is a crucial move that should be

engaged by the MoHCC and this can be achieved through inclusive and equitable processes that engage both expectant mothers and healthcare providers. I suggest that strategies including redesigning waiting mothers' shelters to allow for privacy and labour companionship. The health care providers, especially the midwives, should be taught stress-coping mechanisms so that they better handle the patients even in cases where they are also stressed as care providers. Other factors including ensuring that healthcare providers are empowered and supported through supervisory structures; that workloads are manageable; and that remuneration is adequate can also be harnessed with other strategies to ensure that expectant mothers are not mistreated in the waiting mothers' shelter. The mistreatment of the women in the waiting mothers' shelter motivated me to probe further and explore how the women feel with the increasing involvement of men in hospital birth.

6.6.4 Increasing Involvement of Men in the Hospitalised Birth Process

When expectant mothers await labour in a waiting mothers' shelter, they are transferred to the hospital to deliver in a health care institution. In the hospitals, there is the presence of male midwives and male doctors. The birth process has traditionally been handled by women (female midwives) both in hospital deliveries and home births. However, over the years, there have been a considerable number of men joining the field of gynaecology, obstetrics and generally being trained to be midwives at Bonda Mission Hospital. Data abstractions showed that 26% of the midwifery students at Bonda Mission School of Midwifery are male, and they are deployed to different health care institutions within the province after completion of their studies. The increase in number of men joining this field has also gone along with the fluidity of most gender roles in contemporary societies. In maternal health, specifically, in Zimbabwe, this has been influenced by the growing medicalisation of the birth process and the need for more skilled birth attendants, hence men end up joining, if not dominating the sphere. Expectant mothers are monitored by a male doctor in the maternity ward at Bonda Mission Hospital. This is viewed with mixed feelings by the expectant mothers who await pregnancy in the waiting mothers' shelter. All expectant mothers interviewed expressed discomfort with male midwives assisting them in the shelter and male doctors assisting them in the birth process. Norah stated that:

I really am not comfortable with male midwives in the shelter; they make me so shy, and it's against our culture to expose our bodies to males –

regardless of the help that they could be offering. The males are even rude because they keep on telling us to be professional because they would be at work and not there for jokes (Author's Interview 10/08/2019).

Olga further stressed that:

I really had a hard time giving birth on my first delivery because I was attended to by a male doctor. He kept on putting his hand inside my birth canal. I was in too much pain to be shy but to me it is not acceptable. The shelter and the maternity ward should be occupied by females because as females we better understand these processes than men... I am sure having men in the maternity ward is one other reason why our husbands do not recommend that we go to the shelter to await delivery (Author's Interview 12/08/2019).

In addition, key informants noted that male doctors at Bonda Mission Hospital are also the professionals who decide whether or not an expectant mother is having complications, whether or not a woman needs to be induced for early delivery and whether or not a woman needs to have a caesarean section. From the point of view of the medical personnel, these are decisions that doctors cannot come to without a thorough assessment of the patient, which is a process that the expectant mothers are very uncomfortable with. Most expectant mothers showed discomfort with the arrangement of being assisted by male midwives on preparation for the birth process or when giving birth. For the expectant mothers, this was not only a question of them being uncomfortable but it is a taboo to have another man touch a married woman's private parts. For the expectant mothers, the birth process is something that should be done by female doctors or midwives and Bonda Mission Hospital has only male doctors. Doctor Marshal had this to say:

Women show displeasure with us as the male health care providers. Sometimes they even get into labour and do not say it out to us because they are uncomfortable to be checked by us as males... We are professionals like any other person and the passion to see mothers deliver healthy babies is what drives us to do our job (Author's Interview 13/08/2019).

Only two of the expectant mothers expressed lack of concern over male health care providers in the maternity units. In fact, the two expectant mothers preferred male to female health care providers. For these expectant mothers, they will continue to use the shelter if they are assisted by male health care providers. Martha said:

I actually prefer to be assisted by male health care providers in the shelter and at the hospital because they are gentler than the female ones. I was assisted by a male doctor during delivery and he never shouted at me. I started being shouted at by nurses after the doctor had left the room after my delivery... Women will never click well with other women; I, for one, prefer to be assisted by a man (Author's Interview 15/08/2019).

Candice further said that:

I actually want to be handled by a man during delivery because men are not rude and they do not beat you up. They assist you to push the baby quietly. I have also realised that nurses do not shout at you if the doctor is there, but if the doctor leaves they start scolding you and giving you instructions that are hard to comply with since you will be in pain after giving birth (Author's Interview 15/08/2019).

The increasing involvement of men in hospitalised birth is an area of major concern from the narratives of a significant population of the participants. A closer analysis shows that the concerns of the women arise from their cultural beliefs and the respects of the women's reproductive system and genitals more specifically in this village. The norm has been that girls keep their virginity till marriage. Only allowed to see/have accesses to their genitals are the people who they are married to, not with any other person. The dismantling of this tradition results in women not being comfortable giving birth in the hospital and resort to the perceived dignified home birth that is surrounded by women. Expectant mothers who have no problems with associating with men on issues to do with their genitals for medical reasons are viewed by others in their communities as lost sheep, who have adopted the traditional ways of legitimating cultural identity and belonging. The changing of traditions has occurred for various reasons, such as through formal education. Men and women have been compelled to leave their homes to go to schools set up by the government and missionaries where they were instructed through formal education and they received religious instructions from Christian missionaries (Kanogo 2005). This has led to processes of social differentiation and fragmentation of the individual's sense of identity and belonging (Kanogo 2005). It is clear that the changes brought about by globalization substantially affect the principles of cultural identity formation and belonging.

6.6.5 Waiting for Service

Expectant/new mothers complained that they have often waited unnecessarily long for service because the workers worked slowly, took an extended lunch or were conversing among

themselves. This usually happened when expectant mothers were checking in to the waiting mothers' shelter and when new mothers were checking out of the shelter. The waiting mothers' shelter as a facility opens at 07.30hrs. However, expectant mothers would arrive at 0700hrs and often wait two or more hours before receiving simple services such as checking vitals, after which they would have to re-join the queue and wait to see the midwife or the doctor before they are checked into the shelter. Expectant mothers believe the delays were unwarranted, and that health workers did not respect their time. The spouses of some expectant mothers who had escorted them became impatient due to the delays caused by the health care workers. Pamela described how:

I came to the waiting mothers' shelter early the day I was supposed to check into the shelter, but the nurses attended to us late and, as a result, my husband had to leave me to check in alone because he had to go back to work. I heard that doctors are few; you have to stand on the line for quite a long time waiting for the doctor to come and do a proper check up on you before you are checked into the shelter (Author's Interview 20/07/2019).

In addition, Samantha shared how:

The service is so poor that it requires one to have patience and wait long on the queue. On the day I was supposed to be discharged, my baby and I had to be examined by the nurses first. It took them 3 hours just to attend to 2 mothers who were supposed to be discharged. They kept on going for tea breaks and lunch breaks that I ended up going home late with my new-born baby (Author's Interview 20/07/2019).

Health workers agreed that women often endured long waiting times before being seen they, however, attributed the long waiting periods to staff shortages. Almost every health worker interviewed stated that the increased number of patients per day and a limited number of staff members made it difficult to attend to patients timeously. Bella said:

Well, it depends on how many providers are there; the nation-wide strike has disturbed a lot in the hospital at large. We are not allowed to strike at Bonda Mission, but people are just briefly reporting for duty and they go back home after logging in their names. If I am by myself, they are here for hours, but if we have a few people helping they are probably here for 3 hours. It gets complicated if we want anything like a urine dipstick or labs the women have to go to different departments in the hospital to get this basic test before they are then cleared to go to the shelter. We do all

these vital checks for expectant mothers before they check in to avoid complications and also vital checks for new mothers so as to check on both so as to avoid post-delivery complications that usually result in death (Author's interview 21/07/2019).

The period that women take before they receive any sort of care is crucial, especially during delivery and during post-partum care. A closer look at the delay in the services provided to the women leads to an appreciation of the suggestions made by WHO (2019), that women, especially in rural communities, should receive timely care during childbirth so as to avoid unnecessary complications.

6.6.6 Appointment Booking Dates

All interviewees stated that an appointment booking date was a barrier to receiving timely care and to be eligible to use the waiting mothers' shelter. Expectant mothers need to book an appointment before a provider could see them prior to their waiting period in the waiting mothers' shelter. Expectant mothers schedule an appointment on dates they are allocated by the health care providers and return on the given date. Participants reported that expectant mothers often show up for services only to be given an appointment that is weeks away. It is difficult for the expectant mothers to follow the appointment dates due to the long distances they have to travel in order to get to the hospital, hence they end up not showing up for appointments and, eventually, not awaiting labour in the waiting mothers' shelter. Doctor Ben stated that:

Most women come at around four, five months and... It depends on when they book and how far along they are at the time of booking. Because they are booking about twenty-five patients in each initial visit, so if you are coming already late and... the visits are full then, possibly, you will be seen quite late or given another date. Thus, from the hospital's side, we can contribute, I think, some harm. From the patients, as well, there are some who want to come and start antenatal care early by choice, so we cannot work with people's choices but standards (Author's Interview 23/07/2019).

Hazel further stated that:

Booking dates present a problem to us as expectant mothers because it requires so much patience and commitment to get an appointment and get the care you need on your appointed date. Sometimes when there are too many patients, the dates can be shifted. I wanted to start at two months (October), but the nurses told me that I have to come in November (three

months). So, because of this, I came here and at the reception they told me that I needed to book an appointment, so they told me to come back in December (four months) (Author's Interview 23/07/2019).

Participants highlighted that personal hygiene is also one of the important aspects in the waiting mothers' shelter which has defined relations between the health care providers and the expectant mothers.

6.6.7 Personal Hygiene

Personal hygiene was highlighted by all expectant mothers as of importance in this facility, as soon as an expectant mother moves into the shelter. The expectant/new mothers are taught about personal hygiene and personal care. The health care workers conduct lessons on personal hygiene related to childbirth, post-partum care and ensure the expectant/new mothers adhere to the facility standards of cleanliness and personal care, which include having short nails, proper care of one's hair and the importance of bathing at least twice a day. The midwives also ensure the expectant mothers are clean shaven, both in armpits and genital areas, in preparation for the birth process. According to the midwives, this is done so that any time the expectant mother goes into labour they will be ready for birth and the genitals will be clean for a hygienic birth process and just in case one gets examined by a male doctor. This is the reason why the expectant mothers are required to bring razor blades and shaving cream to the waiting mothers' shelter. Susan stated that:

I think the lessons on personal hygiene are important because they teach us what is important, what to do in preparation of labour, and you can utilise these lessons even at home when you are out of the shelter. Some people think that the lessons are not important but I think these lessons are good for us as women (Author's Interview 12/08/2019).

It was noted that, upon arrival in the shelter, expectant mothers are not treated on a one-on-one basis with some degree of privacy, but, if one is not shaven they are called as a group to shave their genitals before they spend their first night in this facility. Several participants recounted how they were called to go and shave, with the nurses using vulgar language. Six of the interviewed expectant mothers came without the shaving creams or razor blades and they faced challenges being checked in to the shelter. Others were given new razor blades by friends who were in the shelter so that they are not sent back home. For those who fail to secure the blades,

the midwives will have no option but to send them back home to get enough provisions. Patience expressed that:

Lessons on personal grooming are good but I feel that the health care workers should be gentle with us, especially after delivery. I just delivered a baby yesterday and they expected me to clean myself and the baby instantly. I am still weak and I need a bit of support till I can do it on my own (Author's Interview 23/08/2019).

Sandra further noted that:

The grooming on personal hygiene is done in a very bad way. The healthcare workers, especially women, speak a lot of vulgar language and words that are not decent, especially to those who do not come well shaven. Most women are usually embarrassed in front of all mothers as they are told to shave and then inspected thereafter. This treatment makes me think twice about coming to the shelter the next time I get pregnant (Author's Interview 14/08/2019).

Mary also said that:

I really have no problems with the lessons or grooming that we get in the shelter but I have a problem with the way this is done. In the shelter, this is done in a dehumanising way. We are told to do the right thing in front of other women and it is embarrassing. There are no one-on-one lessons on personal hygiene, considering that we are adults who deserve a bit of privacy (Author's Interview 13/08/2019).

A larger population of the expectant mothers noted that they are not prepared to continue using the shelter if there is no improvement in the way the expectant mothers are taught about personal hygiene. Sentiments shared by all the expectant mothers on how they are treated in the shelter with regard to personal hygiene leads us to the following theme, which is the lack of privacy in the waiting mothers' shelter which is elaborated below.

6.6.8 Lack of Privacy in the Shelter

Privacy has been mentioned as one of the inhibiting factors to the expectant mothers using the waiting mothers' shelter. All expectant mothers noted that there is lack of privacy in the shelter as they are put randomly in rooms without categorisation according to age. Older expectant mothers felt uncomfortable sharing rooms with younger expectant mothers as it is culturally not

acceptable. All participants noted the challenge posed by male health care workers on duty in the shelter with regards to privacy. Belinda had this to say:

I really do not think I will use the shelter again because there is no privacy at all. We dress up in front of young kids and it makes me very uncomfortable. I wish they could categorise us according to different ages and put people of close age ranges in the same room. The midwives also do not do one-on-one sessions with us; when they want something they just shout when everyone is hearing and it's like we are in prison (Author's Interview 01/09/2019).

Betty further specified that:

Privacy is our biggest problem in the shelter. There are no proper curtains to screen the areas we sleep in, so when there are males it's hard to change after bathing and we usually change when they go out. We have raised the issue with the female midwives and they said that they will look into the matter but they keep on telling us that the male midwives are just midwives like them and we need to get used to them (Author's Interview 02/09/2019).

In the post-partum care section, expectant mothers also expressed concern over lack of privacy during the post-delivery bleeding period and this made the new mothers uncomfortable using the shelter in the future, unless this was corrected or additional rooms were constructed. Hazel stated that:

The main challenge I faced yesterday after giving birth was that I could not have a private place to change my cotton wool because I was still bleeding. I had to change my cotton wool in the presence of other mothers who were lactating. It's confusing, actually, because everyone will be doing their own thing just after labour and delivering their babies. Others have told me the trick of going to the toilet to change but the truth is I did not have the strength to go to the toilet (Author's Interview 02/09/2019).

The health care professionals noted that the issue of privacy can only be solved by extending the shelter into more rooms that are habitable or to limit the numbers of women who await labour. Limiting the number of women was not an option they could consider because they want as much women as possible to know about the shelter and use it. Bridget had this to say:

Privacy is a problem in the shelter, yes we admit, but the expectant/new mothers should just understand and bear with us. After all, they would all

be women in the same condition just as there would be different women in different stages of labour in our maternity ward. No one really checks who is doing what. We plead with the mothers to bear with us (Author's Interview 04/09/2019).

In spite of privacy being a point of concern in the waiting mothers' shelter, one of the factors that were highlighted by the participants as a reason for their use of the facility was Christianity as their religious affiliation. Nevertheless, others who belonged to other forms of religion showed different opinions and perceptions over their stay in the shelter and this affected their future choices in using the shelter. The different views shared by the expectant mothers and other participants are shown here under.

6.7 Religious Factors

6.7.1 Christianity as a Doctrine

In Mawadza village, one's religious affiliation has a direct impact on one's use of the waiting mothers' shelter. In this village, for the expectant mothers who have converted to Christianity, it is not acceptable to give birth under the supervision of a traditional healer as it is against most Christian doctrines, hence, they are mandated to await labour in a waiting mothers' shelter and give birth in a hospital facility. My study revealed that religious affiliations have an impact on the use or non-use of the facility by the expectant mothers in Mawadza village. Expectant mothers whose families have converted to Christianity are more likely to use the waiting mothers' shelter than those who are not Christians. The Christian doctrine has also affected how operations at the hospital are run. Samantha stated that:

I use the shelter in all my pregnancies because I go to the Anglican Church; it is against my fundamental beliefs as a Christian to go to a traditional healer for assistance on how to manage my pregnancy. I always come to the shelter and this is my second pregnancy, and if I fall pregnant again, I will come to this shelter to await delivery because the benefit is mine at the end of the day (Author's Interview 20/08/2019).

Belinda added that:

At church we are always encouraged to await labour in the shelter. This is mainly to support our health care facilities as Anglicans... So, we basically like using this facility because it is our facility and we feel at home (Author's Interview 20/08/2019).

The study also revealed that health care services at Bonda Mission Hospital are offered mainly for evangelical purposes. In the waiting mothers' shelter, every morning prayers are said, and the chaplain at Bonda Mission School visits the hospital, including the shelter, to say a prayer and share words from the Bible with the expectant mothers and the staff members in this facility. This is done with the intention of spreading the gospel through the provision of health care to communities just as it was done by early missionaries in Rhodesia. The influence of Christianity as a religion on the daily activities at the waiting mothers' shelter has discouraged non-Christian expectant mothers from using this facility. Pamela stated that:

In the morning, we start our day with prayer meetings because that is what we believe in. There are different coordinators from the surrounding villages who come to the shelter to conduct prayer meetings and daily devotions. On good days, we have the chaplain to bless us with the word of God. Women who go to the Anglican Church usually await labour here and they have been very supportive to the operations of the shelter. They take leading roles in prayer sessions. However, the shelter does not discriminate one due to their religious affiliations; everyone is welcome (Author's Interview 27/08/2019).

The idea of the mothers' shelter being affiliated to Christianity and involving its doctrines in the daily operations of the waiting mothers' shelter does not resonate well with other expectant mothers, especially those of different religious backgrounds such as the *Vapostori* (apostolic sects).

6.7.2 Expectant Mothers from the Apostolic Sects

As has been noted in my previous chapter, Mawadza village is a medically pluralistic village that has more than one health care system that co-exist. The study revealed that the use of health care systems is also influenced by religious affiliations. In Mawadza village, different health care systems have proved to be influenced by different religious backgrounds, and these do not only coexist but sometimes antagonise one another. In the waiting mothers' shelter at Bonda Mission Hospital where Christianity is the dominant religion that influences the daily activities and operations, expectant mothers who are affiliates of different religious systems apart from pure Christianity are not well accommodated in this facility. This is due to conflict of religious interests. Two of the mothers who had previously used the shelter revealed how expectant mothers from *vapostori* (apostolic sects) find difficulties using the facility. In the waiting

mothers' shelter, substances such as *dombo remuteuro* (stone talismans) are not allowed. Stone talismans are used by the members of the Johanne Marange Apostolic sect. These stones form part of their beliefs and are a common form of protection in this sect. The Johanne Marange Apostolic sect is a mixture of Christianity and African Traditional Religion (Ranger, 1980). According to Ranger (1980), this sect rose as a result of certain Africans' failure to fully adopt and adjust to Christianity, hence they adapted to both. Mothers from the apostolic sects showed that they do not decide to go to the shelter to access skilled birth attendants but go there after being either invited or convinced by someone to go to the shelter. A mother, Vivian articulated that:

I am from the Johanne Marange apostolic sect and I used to await labour in this shelter last year. I came to a decision to use the shelter because of my condition that is called by the doctors Jaundice. So, consultation with the care providers at church was proving not so helpful till I was visited by one of the midwives to talk to me about staying at the shelter for the better monitoring of my baby... In the shelter I was uncomfortable with a number of things which will make me never to use the shelter again. After all, I now know that with jaundice you only need to sit in the sun for long with the baby so I will never go to the shelter. They discourage the way we are used to praying in the morning, in favour of the Anglican way. The midwives do not allow beads around the waist and they will tell you to cut it off immediately. In summary, you are not a proper human being if you are not Anglican in the shelter, so I better go back to the care providers at my sect next time I need assistance (Author's Interview 01/09/2019).

A mother, Rosemary, added that:

My experience in the shelter was not so fascinating since I was invited by a midwife to come and await labour at one of the campaigns they made in Mawadza village. I felt like a stranger because most of the activities speak to those who have an Anglican background. Sometimes when they pray in the morning it's like they are praying for you to convert and it did not go well with me. I was told to throw away my stone talismans and they were important for me. I do not think I will use the shelter again (Author's Interview 02/09/2019).

It was revealed in the study that for the *vapostori* members of the Johanne Marange Apostolic sect in this village, pregnancy is first identified in the spiritual realm by the prophets in the congregation. Pregnancy is protected not by herbs like most society members do but by *miteuro*

yesimbiso (stone talismans for the stability of the pregnancy), which are believed to protect the pregnancy from evil spirits that might cause miscarriages and even stillbirths. It is against the beliefs of the sect that expectant mothers in the sect take supplement tablets such as folic acid during prenatal care. These tablets are believed to lead to giving birth to babies that are overweight. Pregnancy should be cared for by prayer and a possible protection against spirits of destruction. As a result of these beliefs, some expectant mothers who are forced by circumstances such as complications in previous deliveries get tablets as part of prenatal care and do not take the medicine as prescribed by the health professionals. Vivian, a mother, further noted that:

The usual way of handling pregnancy in our apostolic sect is to make sure that our pregnancies have been stabilised and also there are various ways we use to make sure that the foetus grows healthy till we get to delivery. The way pregnancy is cared for in preparation for delivery (at the shelter) is different from how we do it as Vapostori. The way it's done in the shelter is different from what we are used to in the sect, and really getting used to the methods they use in the shelter takes time but it's doable. If I were to choose between coming back to the shelter and going to my sect, I would choose my sect because I am used to the operations and doctrines there (Author's Interview 03/09/2019).

In addition to differences between general Christianity and apostolic sects, consulted women indicated that cultural beliefs are also among the reasons that affect their use or non-use of the waiting mothers' shelter.

The doctrines of Christianity have historically demonised the activities of traditional healers, especially in indigenous communities, generally (Koenin 2012), and this has also been observed at the waiting mothers' shelter in Bonda Mission Hospital. Koenig (2012: 1) further argues that "religion, medicine, and healthcare have been related in one way or another in all population groups since the beginning of recorded history". It is only in the contemporary world that the systems of healing have been separated, and this separation has occurred largely in highly developed nations of the global north; in many developing countries, there is little or no such separation (Koeinig 2012, Gazimbi & Magadi 2019). Religion, Christianity in particular, medicine and health care continue to show a strong relationship in developing countries as the first hospitals in Africa were built by religious organisations and staffed by religious orders (Gazimbi & Magadi 2019). This has been noted at Bonda Mission Hospital which is a health

care facility built by the missionaries affiliated to the Anglican church, hence the operations are inclined to the doctrines of the Anglican church. The extent to which the operations of the shelter are inclined towards the doctrines of the Anglican Church forms the identity of this shelter. The traditional ways of handling illnesses remain unaccepted in mission health care facilities (Green *et al.*, 2005, Koenig 2012, Kambezi 2019), and this has also been shown in the shelter. The religious hospital staff has discouraged traditional ways of handling any illness or disease, especially in the hospital set up. In agreement with Koenig (2012) is Goden (2019), who specifically alludes that maternal health care issues in rural indigenous societies are inseparable from religious affiliations because religion forms part of the people's culture.

In addition, religion which has been identified by a number of scholars such as Stevenson (1998) and Beyers (2017) as an integral part of culture can affect individuals' behaviours as it has proven to do so in the case of the expectant mothers in Mawadza. Religious beliefs and practices have influenced the entire community. Religious practices shape, and are shaped by, the culture around the people in the community. In Mawadza village, converting to Christianity, especially being a member of the Anglican Church, has proved to have an influence on one's beliefs and behaviour; expectant mothers get motivated to await delivery in a waiting mothers' shelter because of their belief system as Anglicans.

Furthermore, when looking at religion, a study of culture is inevitable. Mulder (1985: 35) indicates that looking at religion implies that one gets to appreciate an expression of human culture. Religion is, thus, expressed and clothed in cultural guise (Beyers 2017). The reciprocal interaction between culture and religion must be recognised: religion is determined by culture, but, religion also influences culture. The fate of religion and culture is, thus, interwoven. In Mawadza village, religions have affected cultural belief systems in two ways that have been reflected by the findings. Firstly, there is the opposite relation between culture and religion - with religion being in opposition to culture (religion as anti-culture). This has been shown by some of the cultural activities or symbols such as strings of beads around the waist (commonly referred to as waist beads) being criticized in the waiting mothers' shelter due to the Christian belief system that govern the operations of the shelter. Secondly, sometimes religion becomes part of the culture as shown by the fact that other expectant mothers from other religious affiliations agree to go to the shelter following campaigns by members of the Anglican Church to go to the shelter.

This shows the unifying function of religion in the society, thus becoming part of a people's culture. To support this analysis, Figl (2003: 36) argues that "whatever the relation between culture and religion is, either as absorbed or in opposition, culture and religion still remain inseparable". In the end, the intertwined relationship between religion and culture cannot be denied or ignored (Figl 2003: 37).

How religious beliefs and affiliations affect the choice of the expectant mothers to use or not use the waiting mothers shelter makes us better understand structural symbolic interactionism and the role of the "significant other" as propounded by Mead (1934). In Mawadza village, adherence to Christ who is the "significant other" influences the choice of expectant mothers in using the waiting mothers' shelter. Mead was interested in the notion that as humans internalise symbols from the society into the self, they create a "significant other". The "significant other," according to Charon (2007) and Redmond (2015), includes people in various positions of authority such as parents, siblings, and other adult authorities. Woelfell & Haller (2018) further describe the "significant other" as persons who, by word or example, can convey substantial information to an individual and this information can be used by the individual to define themselves and their experiences. Human beings tend to categorise themselves into groups of desirable achievements based on societal expectations of good or bad; and it is the "significant other" who conveys messages or living examples to younger members of the society so as to achieve desired behaviour in social interaction. Christian expectant mothers are motivated to await labour in the shelter as part of their perceived mandate as believers to support their institutions. Notwithstanding the controversies that arise over religious affiliations in the particular facility, expectant mothers who are Christians and members of the Anglican Church engage in activities such as worship and daily prayer sessions while in the shelter as part of their perceived mandate as Christians who are following the living example of Christ as the "significant other".

In addition, parents and family members also play a crucial role in influencing the use or none use of the waiting mothers' shelter by the expectant mothers. Through socialisation, young children, from a tender age, are socialised into the norms and values of the society, including religious affiliations from their parents as "significant others". This has been evident by the mere fact that expectant mothers whose parents are Anglicans have in-laws who are Anglican and,

ultimately, receive support to go to the waiting mothers' shelter to await delivery. These close family members become also the *significant other* who influence the behaviours of the expectant mothers and influence their choices to use the facilities. In contrast, expectant mothers who are not of the Anglican denomination are also socialised into the beliefs of their religious affiliations such as the *"Vapostori"* expectant mothers of the apostolic sects. This was noted by lack of support from close family as their *significant other* to use the shelter, and those who do, do so after campaigns by midwives to come to the shelter and they usually feel out of place in the shelter since the activities, such as way of prayer, are different from what they have been socialised in by their *significant others*. Significant others remain relevant as individuals who have an important influence or play a formative role in shaping the behaviour of another (Redmond 2015). Such responses, in terms of the behaviour of the expectant mothers, affect their sense of self and subsequent behaviours (Blumer 2004, Mussof 2013, Stryker 2017)

6.7.3 Cultural Beliefs

Health workers and expectant mothers agreed that cultural beliefs are one of the major reasons that affect women's use of the shelter. Women expressed different views on how cultural beliefs affect their choices to use the shelter. It was common for women to delay seeking prenatal care prior to their waiting period in the shelter because of the cultural belief that a pregnancy should be disclosed only after it is visible. A midwife at the hospital, Bella, stated that:

Yes, it happens in some cases that a woman will report at eight weeks then they (health workers) will say there is nothing when the woman is really pregnant. But what we were supposed to do is that when a woman reports and we have examined her, and we feel there is no pregnancy, I think we have to do a pregnancy test by urine to confirm that she is pregnant (or not). Because sometimes there is nothing simply because the fundus is just small, and we cannot palpate it, but in real sense that woman is pregnant. We have to confirm with the pregnancy test. Turning away these women when they feel pregnant will make them never come back again. It will also make them seek alternatives in the village and, ultimately, not use the shelter or formal maternal health care structures to deliver (Author's Interview 03/09/2019).

Martha, an expectant mother, further highlighted that:

Yes, it's true that people do say not to tell anyone, but as for me, personally, once I know that I have conceived, I will tell my husband and

then my relatives. They also say you shouldn't come to antenatal until you are about five months because something has to be visible (Author's Interview 03/09/2019).

The cultural beliefs related to pregnancy in Mawadza village reiterate Mead's postulations that we carry within us a view of people in general, which includes how people in general view us. That is, our sense of self is directly related to our generalised other because we experience ourselves from both the standpoint of specific people in our social network but also from ~~the~~ generalised standpoint of the social group as a whole" (Mead 1934: 138, Blumer 2004: 20). The generalised other constitutes part of our self, we adopt attitudes of the generalised other as part of who we are. The generalised other refers to all other people in our lives. Our behaviour in society is influenced by the generalised other and the social groups we are affiliated to. In this case, one's choice of a birth space is influenced by one's cultural beliefs, and one's waiting period in the waiting mothers' shelter is shaped and influenced by one's cultural beliefs. The attitude of the generalised other shapes one's behaviours. Alexander (2019) notes that the generalised other is a foundation for creating expectations about how people behave and the roles they play. In other words, the way the expectant mothers behave in choosing to (or not to) await labour in the waiting mothers' shelter is largely influenced by others in their networks and the groups they associate with in the village. Chamaz *et al.*, (2019) further develops Mead's analysis and suggests that expectations and roles prescribed by society are then used to guide our own behaviours. For example, in the shelter, expectant mothers who are not Anglican try to fit in to prayers sessions and Bible studies because of their imagination of what others in the shelter expect them to do. In this regard, roles represent an intersection among self, society, and social interactions.

The ability shown by the expectant mothers in the shelter to create and play roles allows us to successfully adapt to and interact with the role someone else is playing. In Mawadza village, the choices of the expectant mothers are usually influenced by the social networks they are involved with. Each interaction has the potential to modify people's sense of self (Stryker 2017). As one receives positive responses because of a particular quality or behaviour, one might embrace that quality as part of the self. Similarly, negative responses might cause one to dismiss a quality or behaviour. Mussof (2013) notes that a diversity of roles allows us to move from one role to another in a given situation as well as interacting effectively across different situations. Mussof

(2013) further observes that our generalised other is one way that society extends control over us and impacts our thinking; essentially, these general internalised rules and roles of society influence, and even direct, our thoughts, decisions, and behaviours. Thus, our behaviour, reactions, and interpretations are affected by our generalised other (Poggi & Sciortino 2011).

6.8 Conclusion

This chapter built on ideas in Chapter Five, which concentrated on understanding pregnancy and childbirth experiences of expectant mothers in Mawadza village. This chapter established the level of utilisation of the waiting mothers' shelter. I have further developed this chapter into discussing the factors that influence use or none use of this maternal health facility at Bonda Mission Hospital by the expectant mothers from Mawadza village. The respondents have shown that the waiting mothers' shelter is being utilised for two main reasons; that is the need to access skilled birth attendance and bylaws that support the criminalisation of home births in this village. This process has encouraged women to await labour in the waiting mothers' shelter so that they can give birth in the hospital where there are skilled birth attendants.

However, some of the factors that influence the use or none use of the facility by expectant mothers, apart from long distances to and from maternal health care facilities in respect to their homes, and medical pluralism, include religious factors, economic hardships and cultural issues, among others. A detailed analysis on these factors that has been done in this chapter, has also led to an appreciation of the structural symbolic interactionist theory and its relevance in the context of Mawadza village. Social institutions such as religion have an influence in the development of the self through social interaction. Religious factors are part of the contributing factors why women from apostolic sects do not await labour in the waiting mothers' shelter. Symbolic interactionism, in general, has also showed relevance in the sense that the society is as a product of interaction of selves who accept symbolic meanings to make them the norm. This has been shown in this chapter by non-compliance to the increasing involvement of men in the hospitalised birth process.

CHAPTER SEVEN

UNDERSTANDING DISCOURSES OF BODILY AGENCY AND TRADITIONAL BIRTH PRACTICES IN THE WAITING MOTHERS' SHELTER

7.1 Introduction

This chapter further elaborates the experiences of expectant mothers in the waiting mothers' shelter, particularly focusing on bringing to fore the extent to which expectant mothers exercise their bodily agency and traditional birth practices as they await labour in the waiting mothers' shelter. This chapter is an expansion of Chapters Five and Six, as I have already outlined the experiences of expectant mothers through a detailed analysis of how pregnancy and childbirth is understood in Mawadza village. I have gone further to show the level of utilisation of the waiting mothers' shelter and the factors that influence the use or non-use of the facility. In this chapter, I deliberate on the experiences of expectant mothers in relation to bodily agency and use of traditional birth practices in the waiting mothers' shelter. I start by outlining the common understanding and perception(s) of expectant mothers' bodies when they are pregnant and how this affects their identity as social beings in this indigenous society. I then proceed to outline common indigenous knowledge systems and traditional practices of caring for pregnancy and how these are perceived by medical professionals. Furthermore, I deliberate on the relationship that exists between health care professionals and expectant mothers in the waiting mothers' shelter, with regards to bodily agency, considering that there are various traditional practises relating to pregnancy and childbirth that expectant mothers in this society are socialised into in Mawadza village.

7.2 Pregnant Bodies in Mawadza Village

In order to fully understand the experiences of expectant mothers in the waiting mothers' shelter, I realised that it was vital to also understand pregnancy not from how society views it but from the nuanced views of the expectant mothers themselves. Expectant mothers revealed that being pregnant comes with changes, apart from obvious physical changes that commonly result in the stomach bulging, cravings, nausea and fatigue, among others. For the expectant mothers, pregnancy comes with emotional changes and may be described in the form of the honour that it brings to the expectant mother in the community. Pregnancy also means an extra responsibility

to care for someone (the foetus that they will be carrying). The expectant mothers stated that pregnancy shows signs of fertility, femininity and the signs of pregnancy when one is happily married bring honour, pride and joy. For the expectant mothers in Mawadza village, pregnancy symbolises a high level of femininity as one is viewed as able to add new members to the husband's family. Barrenness is a shame to womanhood in this village, inasmuch as it is a shame to manhood. Therefore, pregnancy in this village is highly regarded and taken care of. Consequently, when women fall pregnant, they feel important because they carry a symbol of life and continuation for the society. More importantly they undergo certain rituals to show off their femininities, especially during periods when signs of pregnancy begin to show. An expectant mother, Norah, stated that:

My husband was happy when I fell pregnant; he was fascinated by the fact that, finally, I was pregnant and I would finally give him children. He was even more excited by the fact that I could give him a male child. The fact that my husband was thrilled with my pregnancy shows that men love children and it is the pride of every woman to be pregnant (Author's Interview 27/10/2019).

Another expectant mother, Olga, in concurrence, said:

I think falling pregnant gives you a better position in the society. Getting married and not falling pregnant poses so many challenges for one in the society. Even after falling pregnant, you can discover that the body changes and one becomes beautiful, especially when one is carrying a baby girl (Author's Interview 29/10/2019).

Yet another expectant mother, Rosemary, similarly highlighted that:

Falling pregnant is very important for me and it strengthens the marriage bond because the man will be happy that his clan will be growing bigger. When I discovered that I was pregnant, my husband would hold my stomach even before it began bulging, every day he brought me all the things I wanted. The treatment I got from my husband after getting pregnant made me feel special and I realised that for the marriage to work, a woman has to fall pregnant (Author's Interview 22/10/2019).

A common theme among the respondents who were pregnant for the first time was that pregnancy, indeed, alters the body, and most expectant mothers showed displeasure with how the stomach bulges during pregnancy, showing the whole community that one has had sexual intercourse and conceived. For most women in this village who fall pregnant for the first time,

accepting changes to their bodies proved difficult as they are usually nervous about experiencing pregnancy for the first time. The same feeling of being uncomfortable is experienced by women who fall pregnant outside marriage, which is commonly referred to as *kumitiswa* as noted in Chapter Five (Section 5.3). In fact, it was revealed that when pregnancy begins to show for these expectant mothers, one begins to feel ashamed and even shies away from facing parents, neighbours and the community at large.

Hazel revealed that:

When I fell pregnant, I was very shy to face the community, I was newly and happily married but the thought that my parents knew I was already having sexual intercourse made me very shy. It was very hard for me to walk around when my pregnancy began to show its signs but my aunt then reminded me that falling pregnant is a blessing that I needed not to shy away from (Author's Interview 23/10/2019).

Martha also stated that:

I failed to go to a church camp meeting when I realised that I was pregnant for the first time. My case was different in that I fell pregnant when I was staying with my parents and I later eloped to my boyfriend who is now my husband when I was two months pregnant. I did not want my stomach to show and I was constantly controlling myself not to spit frequently for I did not want my parents or anyone to notice that I was pregnant (Author's Interview 23/10/2019).

Candice also stated that:

Being pregnant sometimes is not so exciting as people see it to be, it only serves to strengthen one's marriage. When I fell pregnant for the third time, I started growing pimples on my face and I was clueless on how they would disappear. The pimples disappeared after I had given birth, when my baby was four months old. For me, being ugly when I am pregnant does not give me a good feeling (Author's Interview 23/10/2019).

Apart from the emotional and psychological meanings that pregnancy has for the expectant mothers, there are other issues that were common in their narratives. Drawing from the narratives of the study, most expectant mothers noted that most of the things that happen when one is pregnant are involuntary; hence, actions of pregnant women should not be taken seriously. While pregnant, for example, some expectant mothers develop a strong dislike of certain people, and

can only begin to associate with the people again after childbirth. Apart from that, it was also noted that some behaviours during pregnancy could also be spontaneous and unique to every individual, hence cannot be described using one umbrella explanation.

Understanding the views of the expectant mothers on their bodies and actions shows us that, although, pregnancy and its experiences are unique to every individual, the expectant mothers in Mawadza village view their bodies and interpret their actions not in isolation, but in relation to how the society views pregnancy. This leads to a better understanding of Mead's (1934) acknowledgement that the *-self* is a result of the *-I* and the *-Me*. On the one hand, *-The -I* is the initial, spontaneous, unorganised aspect of human experience", (Meltzer 2017: 19). It reflects the spontaneous behaviours and attitudes that are usually portrayed by expectant mothers during the period of their pregnancies. This entails cutting one's hair impulsively, or cleaning one's body regularly, as has been noted by the respondents. On the other hand, the *-Me* is understood to be the *-self* as object or the social self (Conrad 2012: 66). The *-Me* arises in social interaction and is reflected in such concerns as how we look to other people, and how we compare to others (Conrad 2012: 67). In other words, the *-Me* is the socialised self that acts in accordance with the norms and values of the society. Furthermore, Mead (1934) considers the *-I* as occurring first and the *-Me* as the interpreter and evaluator of the *-I*. After all, despite the feelings of dislike of one's pregnancy and the mixed feelings one has when one falls pregnant for the first time in Mawadza village, almost all expectant mothers who participated in my study indicated that they eventually feel proud of being pregnant because of the importance pregnancy has been given in Mawadza village. The *-Me* in this vein serves as a mirror through which the self-perception of the individual, the *-I*, is reflected upon, in conversation with the societal expectations and dictates.

In addition, there is the *-I* where one behaves spontaneously (the *-I*) and later think to self, why did I behave in such a manner (the *-Me*)?; that is, there is the part that is nervous about being pregnant and scared to face community members among expectant mothers in Mawadza, but after the realisation of the joy and pride associated with pregnancy by society members (through rituals and ceremonies), one begins to also handle pregnancy with confidence and pride. Mead states that the *-I* of this moment is present in the *-Me* of the next moment (Redmond 2015). The *-I* in memory is there as the spokesperson of the *-self* of a second, or minute, or

day ago. As given, it is a –Me”, but it is a –Me” which was the –I” at the earlier time (Mead, 1934, Conrad 2012 & Redmond 2015). If one asks, then, where directly in one’s own experience the –I” comes in, the answer is that it comes in as a historical figure. It is what one was a second ago that is the –I” of the –Me”. Something that is in the past, this consideration of one’s own actions represents the –Me” (Conrad 2012, Redmond 2015).

The presence of the I’ in any form of social interaction is vital to the understanding that human experiences and unprompted constructions of reality are important (Conrad 2012, Redmond 2015). Furthermore, an understanding of the conceptualisation of women’s bodies when they are pregnant in Mawadza village is prudent for it provides a better understanding of the relationship between individuals and societies; between a self and others and how others shape how one views the self. As simple as it might seem, a profound insight shared by Mead (1934) was that a person’s sense of self emerges from interaction with others (social interaction/society) and that societies emerge from interactions among people’s selves. Hence, pregnancy is viewed in relation to societal expectations in this particular village. How pregnant women view themselves is influenced by societal perceptions on pregnancy which, in part, is also influenced by how these women carry themselves in society. This demonstrates the duality of social interpretations derived from interactions between individuals (expectant mothers) and the society. Neither the self nor society can exist without the other; this means that the two complement each other (Conrad 2012, Redmond 2015).

Meanwhile, the vast acknowledgement of pregnancy as a symbol of pride and joy in Mawadza village is heavily influenced by societal views of pregnancy. In this regard, the expectant mothers assume a certain role in the society as bearers of new members. Stryker (2017: 82), in his work on roles, treats social roles as emerging from a reciprocal influence of networks or patterns of relationships in interactions as they are shaped by various levels of social structures. That is, the role of expectant mothers in Mawadza as bearers of the new members of the society is influenced by the society and the networks that they are involved in, which regard pregnancy as highly significant. Stryker (2017: 82) defines roles as expectations which are attached to –social” positions or symbolic categories –that” serve to prompt behaviour‘ (Stryker 2017: 83). According to Stryker (2017: 84), expectations of roles vary across situations and within the context of cultural or social change. In taking the attitudes of others in a situation, an individual

uses ‘symbolic cues’ built from prior experiences and normative expectations of status from social positions to assess potential lines of action. In this way, roles as they are attached to positions may be analysed as predictors of future behaviour for individuals in various social categories. Pregnancy in Mawadza village comes up as a role that should be taken seriously because it is considered important for one to be pregnant. The role of ‘being pregnant’ is very important in Mawadza as it has been associated with the indigenous knowledge system of this village. The relationship between pregnancy and indigenous knowledge systems has an effect on how expectant mothers view their bodies as pregnant bodies and this, in turn, affects their experiences in the waiting mothers’ shelter, as shall be explicated in the following sections.

7.3 Indigenous Knowledge Systems on Pregnancy and Childbirth in Mawadza Village

In Mawadza village, pregnancy and childbirth processes are highly associated with the indigenous knowledge system of this culture³². Indigenous knowledge on pregnancy and childbirth in Mawadza village is produced and managed through beliefs and practices that inform this particular period. These beliefs and practices are unique to the *Manyika* culture and are mostly drawn from the expertise of the elderly, and are passed from generation to generation. Most of these beliefs and practices are accompanied by rituals for protection, purification, or as a rite of passage. The generated knowledge arising from the beliefs and practices informing pregnancy and childbirth in Mawadza village is dynamic as it is continually influenced by internal creative experimentation as well as contact with external systems. The management of pregnancy and childbirth is an important component of primary and family health care and is a special domain of women in Mawadza village. In this regard, women as mothers, grandmothers, wives, sisters or daughters often represent the first line of family health care inclusive of indigenous modes of managing pregnancy and childbirth. Respondents who are considered custodians of the culture in this village agreed that pregnancy and childbirth processes can never be separated from the pregnant bodies in the society and this affects how expectant mothers view their bodies. Alice asserted that:

³² Generally, indigenous knowledge systems can be conceptualised as the common-sense ideas and cultural knowledge of local peoples concerning the everyday realities of living (Graca 2015, Mapara 2017). They encompass the cultural traditions, values, beliefs systems, and world views that, in any indigenous society, are imparted to the younger generation by community elders.

We cannot talk about pregnancy and childbirth without talking about our indigenous knowledge systems in the *Manyika* culture that help people conceive and handle pregnancies well up to childbirth. I started assisting people through the birth process a long time ago and I realised that there is a strong connection between our culture, herbs and a successful birth process. I know there are some members of the Anglican Church who are congregants at Bonda Mission who no longer believe in our indigenous knowledge system but the truth of the matter is that childbirth processes are linked to indigenous knowledge systems (Author's Interview 20/10/2019).

Tilda added that:

We should always observe that one cannot give birth well without observing our tradition and indigenous knowledge systems associated with the village. The reason most expectant mothers give birth through the C-section or experience vaginal raptures during the birth process is due to the fact that they ignore the herbs associated with a smoother birth process. That is the very duty of midwives in the community; to assist expectant mothers to do what is required, but these days most people do not seek the knowledge (Author's Interview 20/10/2019).

Indigenous knowledge in pregnancy and childbirth in Mawadza village is demonstrated by the way that the period of pregnancy and childbirth is marked by a number of beliefs and practices complemented by rituals that ensure the safety of both mother and child. Certain rites and rituals are observed and carried out during this period. Senior women in Mawadza village are usually tasked with the duty of nurturing the pregnancy and childbirth process of the younger expectant mother placed under their care and guidance. Joe highlighted that:

The rites and rituals accompanying this period commence during the third month of pregnancy and are concluded after birth when the child develops his/her first teeth (Author's Interview 22/10/2019).

Concurring, Tilda echoed that:

These ceremonies and rituals should be conducted so as to protect the foetus and introduce the foetus to the ancestors. This helps protect the pregnancy and, above all, this is our culture (Author's Interview 22/10/2019).

Alice supports the other two respondents by stating that:

Ever since I was a young woman, I have been socialised into appreciating that issues to do with sexuality, pregnancy and childbirth are highly associated with our indigenous knowledge system as the *Manyika* people. It makes us different... It does not add any value for an expectant mother to give birth to a baby without using the correct herbs required to handle pregnancy and aid the childbirth process. I appeal to all our children awaiting labour in the waiting mothers' shelter to go there after they have been treated with the essential herbs to assist the childbirth process. These herbs include elephant's dung, most importantly, burnt pumpkin leaves and even maize meal, among others (Author's Interview 29/10/2019).

Furthermore, in Mawadza village, a new-born is regarded as fully human and recognisable by the ancestors after developing first teeth. Below, I outline the sequential beliefs and practices informing the period of pregnancy through to childbirth in Mawadza village: *mataguta muriwo* (a process whereby there is the formal announcement of pregnancy within the husband's family so that the foetus is accepted by the paternal ancestors), *masungiro* (the process of informing the in-laws (wife's family) of the pregnancy so that the foetus is accepted by the maternal ancestors) then, finally, the childbirth process.

7.3.1 Mataguta Muriwo

Taguta muriwo literally means 'we have been fed with enough relish and we are full'. A respondent explained that the *muriwo* (relish) refers here to what the husband supplies, that is, his sperm, and when the woman says *taguta muriwo* it means that she has been 'fed' with the sperm and she has finally conceived. The *taguta muriwo* is one of the ceremonies conducted in Mawadza village. The ritual is performed with the ultimate intention to introduce the foetus to the paternal ancestors, as I have indicated above. Traditionally, in Mawadza village, pregnancy for any expectant mother who is married was formally announced through the *taguta muriwo* ritual, and this still remains the way for a husband to formally announce of his wife's pregnancy to his family and the family elders. After a woman misses her menstruation period, common signs that lead to pregnancy develop, and these are noticed by the elderly in this village – including TBAs and SBAs, as I have alluded to in Chapter Five, Section 5.3. When she misses her menstruation period for four months, the woman is obliged to confide to the elderly member of her husband's family (usually female member), who then facilitates the *taguta muriwo* ritual. In other words, the daughter-in-law announces the *mataguta muriwo* to her in-laws through the

elderly women. The expectant mother approaches the elderly women (in this case a sister to the husband) with a small amount of money, maize meal, a hen, a reed woven basket and a white cloth. Since pregnancy is a result of sexual intercourse, which is considered a taboo subject for those that are not in unions considered legitimate in the society, the community members in Mawadza village make use of euphemisms to relay or discuss such issues. Hence, *mataguta muriwo* is considered a subtle way of announcing the results of one's lovemaking to the family. In other families in Mawadza village, the person who presides over the formal announcement of *mataguta muriwo* is the one whom the expectant mother and her delegation first approached during the *kuwe zano* ritual, which is a ritual that is done to acquaint the daughter-in-law with her in-laws' family traditions. After the *mataguta muriwo* ritual, the foetus will have been introduced to the ancestors as well as his/her paternal family.

After all the important people in the family are made aware of the new development of pregnancy, all the daughters-in law of the family, guided by the eldest aunt, take the basket of maize-meal, the small token of money and the hen, present them to their mother-in-law whilst lying face down before her and the eldest announced *taguta muriwo*. Thereafter the mother-in-law informs her husband and his brothers and this signals the end of the announcement. Nowadays, there is a new dimension to the *taguta muriwo* ritual, whereby other families now accept the token for the announcement in the form of money. It is important to note that the announcement of the *taguta muriwo* is never made without an accompanying token, and that prostrating is a sign of humility and respect for the elders and the ancestors. As part of the *taguta muriwo* ceremony, the family members of the husband to the expectant mother contribute to the brewing of traditional beer, which is used to inform the ancestors of the pregnancy and to invoke them to be protective of the pregnancy. The process of brewing beer begins with all family members contributing the grain (millet or sorghum) used to brew the beer and other requirements for the ceremony as a way of showing their gratitude that the family is being multiplied and growing. Traditional beer is an important symbol that accompanies most of the rituals in Mawadza village. Beer in this village symbolises quite a number of elements such as friendship, communion, oneness and acceptability, and is an accompaniment for indigenous ceremonies, festivals and covenant-making rituals.

Expectant mothers who have gone through these ceremonies have noted that these ceremonies make them view their pregnancies differently, that is, when the family of the husband and their own family accept and celebrate the pregnancy, it brings acceptance to the expectant mother and approval from the ancestors thereby bringing a sense of pride and joy to the expectant mothers for the pregnancy that has been legitimised. Mary stated that:

When an expectant mother goes for the *-taguta muriwo*” ceremony, that is when she starts feeling like a real woman; the changes on her body as a pregnant woman become more acceptable to her and the society. When I eloped to my boyfriend’s place who is now my husband, firstly and foremost, he denied paternity of the pregnancy as he indicated that he was not yet ready and he did not want to embarrass his parents. When I called for the *-taguta muriwo*” ceremony, his family responded positively and this brought relief to me. It even changed the way I viewed my body as I was no longer shy and nervous of the experience. I went to the waiting mothers’ shelter to await labour after I had done the *-taguta muriwo*” ceremony (Author’s Interview 28/10/2019).

Another respondent, Patience, also narrated her experience and said:

I was a bit naïve when it comes to pregnancy, all I remember is I continually felt nauseated and unwilling to talk to people. My aunt was the one who sent a word to encourage me to announce the *_taguta muriwo*’. When I announced the *_taguta muriwo*’, I noted a difference in treatment from my in-laws. I became a bit more relaxed towards my in-laws because they accepted me and did not deny paternity of the child. What also made me happy was the fact that my in-laws escorted me to the waiting mothers’ shelter when I was due for delivery. My aunt was happy because of what was done by my in-laws, because it showed that they viewed me as a real woman (Author’s Interview 28/10/2019).

Relating her different circumstances, Candice stated that:

The *“taguta muriwo”*; ceremony was never done for me since I fell pregnant without being married and my boyfriend was from town where I used to work. After falling pregnant and not being able to sustain myself in the city, I came back home but I was shy and I also realised I had shamed my parents. The *“taguta muriwo”* ceremony is done for those who get married properly, not for people like me. People always remind me that it does not matter that the *“taguta muriwo”* ceremony was not done for me, but I would have loved to introduce my son to his ancestors like any other child in the Manyika culture (Author’s Interview 29/10/2019).

Drawing from these narratives, it is clear that the *taguta muriwo* ceremony plays an important role in helping expectant mothers to conceptualise their bodies during pregnancy. For some, after the performance of the ceremony, there is a feeling of joy, acceptance and pride, and for others non-performance of the ceremony brings shame and a non-acceptance of their pregnancies. This, in turn, heavily influences how pregnant mothers view their bodies and handle pregnancy till childbirth. I have already shown how expectant mothers in Mawadza village have their own unique experiences which could be unprompted during pregnancy and cannot really be universalised. Nevertheless, they also view their bodies and pregnancies in relation to how pregnancy is perceived in the village, and this has been prudent in enhancing the understanding of the concept of the I and the Me in this particular context. It has solidified the important view of the symbolic interactionist perspective that individuals influence society and society (though beliefs, norms and values) also affects individual behaviour as social interaction occurs.

The *taguta muriwo* ceremony and how it affects the way expectant mothers perceive their bodies when pregnant, coupled with the ability to exercise their bodily agency, also leads to an enhanced understanding of Cooley's (1964) idea of the looking-glass self. For Cooley (1964) and Redmond (2015: 34), "our looking-glass self involves three elements: imagining how we appear to other people, imagining other people's judgment of that appearance, and a self-worth in response to that imagined judgment", (for example pride, embarrassment). In other words, human beings always behave in relation to how other social actors view them. For a sense of self-worth to be achieved by the expectant mothers in Mawadza village, they do not view their pregnant body in isolation, but they imagine how they appear to other people in the community. This relates to other people's perceptions about their pregnancy, as well as legitimacy issues of the pregnancy and acceptance of the pregnancy by the community members in general. This resonates well with Stryker's (2017) views of socialisation as the process through which individuals learn normative expectations for actions as they relate to role relationships. By building up from the person to the situation within the larger social networks of interaction, Stryker (2017: 32) shows the mutuality of the individual and society. In every situation, individuals identify themselves and others in the context of social structure. Individuals then instinctively apply what they perceive to be others' identifications of them that, over time, become internalised expectations for behaviour as part of the self. These internalised expectations, when accepted and enacted by individuals in various roles, become identities.

As part of the society, the father of the unborn child and the paternal relatives play a crucial role in how the expectant mother views her body as a pregnant woman and this, in turn, affects her identity. The *taguta muriwo* ceremony entails formal acceptance of paternity of the child and the support from the paternal in-laws that they acknowledge paternity of this unborn child. In this view, one observes that pregnant bodies are viewed in relation to societal belief, ceremonies and rituals in this culture that bring a sense of acceptance. A further analysis in this case reveals that the father and paternal family of the unborn child plays the role of the significant other to the expectant mother in relation to the acceptance of the their pregnant body. Indications have shown that no matter how other society members may accept one's pregnancy, if the paternal family does not accept the pregnancy through the *taguta muriwo*, the expectant mother tends to feel unwanted and unaccepted both by family and ancestors, hence a feeling of embarrassment and shame towards one's body. The conceptualisation of women's bodies as pregnant is vital because it provides a background for contrasting with how they are treated in the waiting mothers' shelter at Bonda Mission Hospital, which also affects how they, in turn, view and understand their pregnant bodies. The next ceremony that I will deliberate on is the *Masungiro* ceremony.

7.3.2 *Masungiro*

Masungiro is a ritual that is undertaken in Mawadza village in preparation for childbirth. This ritual is conducted during the first pregnancy of every woman³³. The expectant mother goes with a male messenger and aunts from the family of the expectant mother's husband as escorts³⁴. This ritual entails that the messengers contribute a goat, chickens, maize meal, and a pair of white cloth to use for rituals during the process of *kusungirwa*. This is to appease the maternal ancestors because the elderly cannot assist in preparation of the childbirth process without appeasing the ancestors first. The *masungiro* ritual is done by the elderly women from the expectant mother's family side when the woman is six to seven months pregnant. They teach the expectant mother about processes that occur to indicate that the baby is due, as well as how to breastfeed and care for the infant.

Alice reported that:

³³ This ritual is a process whereby the expectant mother goes back to her family to learn on how to prepare for childbirth and to care for the infant.

³⁴ *Munyayi, madzitete, madzimbuya.*

The masungiro ritual is important because it is the period when the expectant mother can get herbs and remedies to open up the birth canal in preparation for the childbirth process. There is no other person who is eligible to give an expectant mother herbs and remedies for the first time except for their biological mother or any person with a biological relationship with the expectant mother. Other remedies and herbs from strangers can then follow, but the herb should be from a person with a biological attachment. This is so because the ancestors bless children through their parents. Most expectant mothers are giving birth through the caesarean section because they are not given the herbs to open up the birth canal. Some of the expectant mothers would have fallen pregnant out of the wedlock, hence there will be no masungiro ritual for them, and the herbs they get from strangers cannot work since there would not have been a form of blessing through the parents from the ancestors and this is sad (Author's Interview, 26/10/2019).

Tilda also explained that:

The expectant mother should have her first baby at her parents' place. The *masungiro* ritual is very important and useful as it helps the expectant mother to have a smoother birth process because the ancestors would have been introduced to the womb and they know that their child is pregnant. The ritual will enable the ancestors to open the womb even in the future so that their child will continually have children. Evil spirits and bad omens can possibly hinder progress and good luck in people's lives, so masungiro will help by driving away any possible spirit that may arise to deter good luck and progress in the life of the expectant mother (Author's Interview, 27/10/2019).

Reiterating on the importance of the *masungiro* ceremony, yet another key informant Joe stated that:

The masungiro process is very important in our society and culture, it is mainly due to financial constraints that most people do not practise the ritual nowadays but it is very important. The ritual helps to prevent backaches associated with their child engaging in premarital sexual activities or extra marital sexual activities without their knowledge or parental blessing (it is a common African belief that if a parent suffers from a sudden backache it could be a sign that their children have engaged in premarital sexual intercourse). When an expectant mother comes home for the masungiro ritual, there is a slot by the door step in the form of a door mat that the parents have to jump. This very cloth is then tied around the waist of the expectant mother and this helps prevent the backaches. Most parents are suffering from backaches because they do not do this ritual, hence their children are not considered by the

ancestors to be sexually active and eligible for childbearing (Author's Interview, 28/10/2019).

Ideally, throughout this process, the expectant mother is expected to be at her family's home up until she gives birth, which gives her ample time to heal from the process and nurse the perineum wounds before she can go back to her husband. The woman can deliver either in the hospital or at home (at her parents' place). After childbirth, the mother can spend up to two months at her family as she experiences the new process of motherhood with guidance from the elderly women in the family on how to care for the infant and breastfeed. According to tradition, for the second pregnancy up to the stage a woman reaches menopause, she does not need to go back to her family for the *masungiro* ritual because the womb will have been already introduced to the maternal ancestors and there is no need to re-introduce the womb to the ancestors.

Joe stated that:

There are some parents who have tended to be greedy over the years, and they usually make things hard for their in-laws by demanding the *masungiro* ritual to be done every time their daughter falls pregnant. Tradition states that an expectant mother should go for *masungiro* ritual once in her life time; this means that if she has been married and she separates with the first husband for her second marriage there is absolutely no need for the ritual (Author's, interview, 29/10/2019).

Other families, due to Christianity, no longer adhere to the details of this ritual and in some cases; some do not even follow this ritual that has been followed in tradition. Mrs Green, a village member and a member of a community money club noted that:

The *masungiro* ritual is there to basically bother our children, in this day and age who follows that? (Author's Interview 29/10/2019).

Another respondent, Mrs White, who is also a villager and a member of a community money club, also noted that:

The *masungiro* tradition is so obsolete, it was practised long ago and should not really apply nowadays (Author's Interview 29/10/2019).

For some expectant mothers, it is not necessary to spend a long period of time at their family's place. Therefore, most of them customarily go and perform the ritual and then go back home with their husband; to them what remains of great significance is to introduce the womb to the

maternal ancestors to avoid backaches and to get the blessing from one's parents for a smoother birth process. Some expectant mothers these days even go back to stay with their husbands because, apart from the need to be adjacent to family, they have other family commitments that they have to take care of that they cannot leave for a lengthy period of time. Respondents noted that the expectant mothers may sometimes learn about how to take care of pregnancy and prepare for the childbirth process through baby showers and baby welcomes.

The *masungiro* ritual has shown the importance of family in one's pregnancy and it is through family and its blessings that one is prepared for and ushered into the next stage of motherhood after pregnancy. Drawing from the narratives of the expectant respondents, I realised that some families still adhere to this ritual in detail and some no longer do but, for those who do not, they still introduce their wombs to the ancestors and seek the blessings of the ancestors through family. Family remains an important element in one's view of their pregnancy or motherhood stage. In the *taguta muriwo*, the paternal in-laws proved important in the acceptance of the pregnancy and a general acceptance of one's body as a pregnant woman. After one has done so, her family becomes important through the *masungiro* in blessing her womb and preparing her for childbirth even if she decides to give birth in a hospital facility. More importantly, the two families work together to support the pregnancy till the child is born. It is undisputed, then, that family is significant in the understanding of one's pregnancy and how they view their body during that period. In understanding the role of the family, one can appreciate the role that the significant other plays in handling the pregnancies of expectant mothers and preparation for childbirth and motherhood. The significant others who are the family members and the paternal in-laws, play a crucial role in shaping the nature of associations and interactions of the expectant mother with the wider society that is the generalised other. How expectant mothers interact with other community members, including medical professionals at the hospitals and waiting mothers' shelter is as a result of how she is handled by the significant other (family and in-laws), which leads to a conceptualisation of her body as a pregnant woman which in turn, creates her identity. Notwithstanding that pregnancy is a unique process experienced uniquely by every woman, it is prudent to acknowledge that the significant others have an impact on the development of pregnancy in this village and the creation of the identities of the expectant mothers.

7.3.3 *Kuvhura Masuwo-Nzira (Opening the Birth Canal)*

Kuvhura nzira (opening up the birth canal) is a process that is common among the *Manyika* people where they prepare for the childbirth process³⁵. In this process, the expectant mothers in the village usually drink a mixture of water and elephant dung³⁶ a month before they are due for delivery. Some expectant mothers in the village acknowledge the use of some sand from a mole hill³⁷ (the sand from a mole hill if consumed by expectant mothers is metaphorically perceived to facilitate contractions and expansions during childbirth. In some instances a mixture of maize meal and water, while others use herbs. It is perceived by the Traditional Birth Attendants (TBAs) that as the expectant mothers take up this mixture, they widen up the birth canal for a smoother childbirth process with fewer complications that include the perineum tearing or being cut by a doctor. As one takes this mixture, the vaginal canal continually expands and, as a result, when an expectant mother gets into labour the childbirth process will be swift. The process entails that women take the mixture of water and elephant dung together with inserting one's fist in the vaginal canal so as to expand it in preparation of the childbirth process. One should insert their fist into an ant hill³⁸ first before they insert it into their vaginal canal. According to the respondents, in the *Manyika* culture, an ant hill is a significant place where one generally places a wish and it comes to pass. In this regard, an expectant mother goes an anthill to insert her fist as a sign that when she inserts her fist into her vaginal canal it will indeed expand. After inserting one's fist into an anthill, expectant mothers, for a month before labour, drink a mixture of elephant dung and insert their fist in their vaginal canal until the day they give birth.

Tilda, a key informant noted that:

It is very possible that women with a small foot size usually are the ones who have a smaller birth canal, so I usually encourage women with a smaller foot to open up their birth canal for a longer time than those whose feet are slightly bigger in size...In my experience as a traditional birth attendant, I have realised that the smaller one's foot is, the smaller the expansions during birth, so they need more time to open up the birth canal before delivery (Author's Interview, 22/10/2019).

³⁵ *Kuvhura nzira* is a process that has been practised by the indigenous Shona people, of which the *Manyika* are a subgroup. This process is a metaphor which symbolises the diameter of an elephant's birth canal which the human birth canal is believed to imitate if one takes the prescribed mixture.

³⁶ *Ndove yenzou*.

³⁷ *Ivhu renhuta*.

³⁸ *Pachuru*.

Alice, another key informant further highlighted that:

The womb is also supposed to be widened before one gets into labour so that the labour process is smoother. When one is not pregnant, the womb is usually as big as an avocado, and when one conceives it grows with mucus surrounding it to protect the baby from infections. When the pregnancy gets due, the baby will be around three kilograms in weight, but as the pregnancy grows, the opening of the womb does not grow hence it needs to be widened to allow smooth passage for the baby during child birth (Author's Interview, 22/10/2019).

However, in contrast to these views, the health care professionals at Bonda Mission Hospital saw no need for this process before childbirth as Doctor Ben expressed that:

My dear, people should not bother about using different strategies to open up the birth canal. Human beings were created in a wonderful way. If you get a chance to know about human anatomy you will realise that all that is not necessary. White people, black Americans give birth without opening the birth canal. Even the Chinese also give birth without complications although they are considered to have a generally smaller pelvic girdle. Without getting into deeper science, one just has to know that we are created in such a manner that the pelvis naturally accommodates the baby during childbirth. Pain during birth is a law of God (Author's Interview, 22/10/2019).

Bella, a midwife, also weighed in against the *kuvhura masuwo* practice by pointing out that the following:

I grew up in this region and the practise of opening up the birth canal is a very common one in the *Manyika* culture. However, let me point out clearly that, from a midwifery point of view, the practise is dangerous. At no point should an expectant mother insert her fist in the vaginal/birth canal. At no point as well should an expectant mother allow anyone who is not a qualified doctor or nurse to insert their fist in the birth canal. This is so because one might insert their fist to a point where it might perforate the placenta and cause complications that may cost the life of either the mother or the new-born. Imagine inserting a fist for two months every day, definitely it disturbs the baby...Its also unhygienic and causes so many infections in the birth canal that may affect the foetus (Author's, Interview 22/10/2019).

Mavis, another health care worker who oversees issues to do with maternal health at provincial level in Manicaland opined that:

The greatest challenge that the MoHCC is facing in Zimbabwe today is the presence of alternative health care, especially in rural areas. Even in urban areas, especially in Mutare, expectant mothers are increasingly using herbs to care for pregnancies, including opening the birth canal. The common methods that have been widely reported are the use of herbs, the use of elephant dung – which has reached a point of being sold by traditional healers and herbalists, and insertion of the fist in the birth canal in preparation for childbirth. The by-laws of the MoHCC are against these practices as they are posing a major threat to the use of health care facilities and it also discourages women from attending prenatal care, which is also a crucial part of maternal health (Author's Interview, 23/10/2019).

The process of opening up the birth canal has been considered a very important practise that most expectant mothers perform when they prepare for pregnancy. As has been noted earlier in my analysis, the term ‘symbolic interaction’ discusses, the atypical and distinctive character of interaction as it takes place between human beings as has been noted in the case of interaction that occurs among family members through childbirth rituals in Mawadza village. The peculiarity of this social interaction consists of the fact that human beings interpret or ‘define’ each other's actions instead of merely reacting to each other's actions. In the rituals conducted in Mawadza, action is not merely responded to, but symbolic meanings derived from action are interpreted and responded to. For example, the act of announcing the *taguta muriwo* by the expectant mother solicits a response from her in-laws and the response creates meaning regarding how the expectant mothers conceptualise their pregnant bodies. This, ultimately, creates some form of identity. In addition, ‘response’ in social interaction is not in direct response to the actions of one another but, instead, is based on the meaning which they attach to such actions (Blumer 2004: 82). Thus, human interaction in every culture is mediated by the use of symbols, by interpretation, or by ascertaining the meaning of one another's actions (Conrad 2012, Redmond 2015). In the *masungiro* ritual, the expectant mother's actions of going back to her family solicit a response based on the meaning attached to the tradition by her family members. In fact, it is not this visit that basically stimulates such a response of *masungiro* but the symbolic meaning attached to pregnancy in Mawadza village that pushes family members to regard such rituals as important and, in the process, give a response. The view that human interaction in every culture is facilitated by the use of symbols, by interpretation, or by ascertaining the meaning of one another's actions is equivalent to inserting a process of interpretation between stimulus and response in the case of human behaviour. The simple

recognition that human beings interpret each other's actions as the means of acting toward one another has permeated the thought and writings of many scholars of human conduct and of human group life (Blumer 2004, Conrad 2015).

Symbolic interactionist theory entails a lot more than simply communicating through symbols. Inherent in a symbolic interaction are two important notions: that is to consider, interpret, and adapt to other people's acts, and to acknowledge that symbolic interactions in the society connect and reflect the society in which social actors (humans) are acting (Blumer 2004, Conrad 2012). Blumer (2004) further argues that Mead (1934) saw symbolic interaction not just as a medium by which societal factors are expressed but, instead, as the very basis from which a society emerges. Another way of thinking about this is to consider the expectant mothers' own interactions relative to their own culture in Mawadza. Culture, norms and values affect their activities whilst they are pregnant, hence they engage in certain rituals in order to fulfil cultural expectations. Culture and society exist only within symbolic interactions, it is these symbolic interactions that define and keep societies intact (Muller 2018). Besides being the basis for the development of society, symbolic interactions are the basis for the emergence of our mind and sense of self (Redmond 2015: 38). An appreciation of these ceremonies has provided the foundation for how pregnant bodies are generally perceived and handled in society. The basis that has been laid in this initial part of the chapter solidifies that understanding of issues of bodily agency in the waiting mothers' shelter as practised by expectant mothers.

7.4 Traditional Birth Practices in the Waiting Mothers' Shelter

The sections above have detailed some of the most significant beliefs, ceremonies, rituals and practices that are usually conducted in Mawadza village to care for pregnancy and prepare for the childbirth process. These processes are practised as part of the culture that defines the *Manyika* people of Mawadza village. It has been shown that these ceremonies affect how women view their bodies as pregnant women and, in turn, shape their identities. However, inasmuch as these practises are of significance in defining the *Manyika* people, they are not practised in the waiting mothers' shelter at Bonda Mission Hospital. Once an expectant mother has started awaiting labour at the waiting mothers' shelter, she has to adhere to the rules of the shelter; meaning that her pregnant body is under the supervision of the medical professionals at the

shelter as she has to act according to the guidance that she receives from the medical care professionals whose operations are guided by science.

7.5 *Kuvhura Nzira* (Opening the Birth Canal) in the Waiting Mothers' Shelter

Substances such as elephant dung and herbs are not allowed in the waiting mothers' shelter. The doctors acknowledged that the herbs can be used as important medicine to cure certain conditions, but they work according to the regulations of the MoHCC which stipulates that the herbs should undergo laboratory testing and they should be regulated into dosages that are not harmful for consumption, as approved by the Medicines Control Authority of Zimbabwe (MCAZ).

The practice of inserting one's fist in the vaginal canal is highly forbidden in the waiting mothers' shelter; the midwives and doctors are the only professionals who are allowed to insert their hands in the vaginal canal of the expectant mother for the purposes of monitoring the labour process, expansion and contractions. The medical professionals noted that they do this only when it is necessary, either in checking the progress of the baby or in assisting in the childbirth process so that the baby comes out and is not suffocated in the birth canal. The practice of inserting one's fist was noted to be dangerous for the stability of the baby and causing premature labour, according to the healthcare professionals. The healthcare professionals noted high risks of vaginal infections that could result from one inserting their unclean fist. The bodies of pregnant women/expectant mothers are highly regulated in the waiting mothers' shelter. Once one starts awaiting labour, she has to adhere to the activities, rules and regulations that are stipulated by the health care professionals in the shelter. The healthcare professional added by noting that, inasmuch as it is antagonistic to the cultural beliefs of the locals, the process of *kuvhura nzira* should be stopped as it is still possible for one to undergo the process and yet give birth through caesarean section all the same, because there are several factors that the healthcare professionals consider before they decide whether one has a normal vaginal delivery (NVD) or childbirth through the caesarean section.

Patience emphasised that:

The midwives do not want to see or even have an idea of someone using herbs to open up the birth canal in the waiting mothers' shelter. Last

week someone was evicted from the shelter after she was found in possession of herbs and she said she wanted to use the herbs to open up her birth canal. The truth is I might want to open up the birth canal to avoid giving birth through C-section but I am scared of being evicted by the midwives (Author's Interview, 28/10/2019).

Vivian also stated that:

When one first gets into the shelter, we are usually told that all traditional practises should be left at home, so I left home when my birth canal was already in good size to allow the baby a swift passage, and it did not take me long to deliver. My advice is that, if one wants to open up the birth canal, they should do it at home before they start awaiting labour in the waiting mothers' shelter (Author's Interview, 28/10/2019).

Mary weighed in also and said:

I realised that it's not useful to go back and await labour at the waiting mothers' shelter because the midwives do not allow us to use herbs to open up the birth canal. My aunt had already packed the herbs for me and they ordered me to throw them away. Luckily, I was not evicted. As I was at the shelter, I used to insert my hand to open up the birth canal. I used to do that in the evening while others were sleeping (Author's Interview, 28/10/2019).

However other expectant mothers held different views from the ones narrated above. A further probe revealed that expectant mothers who were against the opening of the birth canal through herbs were members of the Anglican Church.

Norah highlighted that:

I have never liked the idea of opening the birth canal that is usually taught about in our village. I do not like that at all, because for one, the lessons are hard to follow, and also it is very painful to insert a fist – especially during the first days. In the shelter, the midwives do not like the idea of inserting one's fist, and I am very much in support of that. Maybe those who continue to do it do so in the middle of the night when people will be sleeping, but it's highly unacceptable...In addition, it is not acceptable at church to take some of the herbs that are taken by some expectant mothers to open the birth canal (Author's interview 15/10/2019).

Another expectant mother, Susan said:

I was told by the nurses that my condition does not allow me to play around with the unborn baby because I am HIV positive. Taking any substances such as elephants dung will weaken my immune system and as of now I want to maintain my CD4 count at a level that will not make me prone to more diseases. I try my best to follow the advice of the nurses and the midwives in order to protect myself therefore , herbs and elephants dung are a no go area for me (Author's Interview 16/10/2019).

From this perspective, it needs to be noted that one of the key features in Mead's (1934) in symbolic interactionist analysis is that humans have a –self". This notion of the –self" involves both external social interactions and (integrally) internal feelings of oneself. This idea should not be cast aside as obscure or glossed over as something that is obvious and, hence not worthy of attention. In considering that the humans has a –self", Mead (1934) had in mind, most importantly, the fact that the human being can be the object of his or her own actions. Humans can act toward themselves as they might act toward others. It is important to note instances in which humans get angry with themselves, reject themselves, take pride in themselves, argue with themselves, try to strengthen their own courage, set goals for themselves, make compromises with themselves, and plan what they are going to do (Charon 2007: 87). That humans act towards themselves in these and countless other ways is a matter of easy empirical observation. Recognising that humans can act toward themselves is no mystical conjuration (Charon 2007: 88). To note that individuals have a self is instrumental in understanding how expectant mothers understand their bodily agency, how they understand their bodies and how they interact with others in relation to how they understand their bodies.

Drawing from the narratives of the expectant mothers, it was revealed that when an expectant mother is admitted to the shelter –whether Primigravidae³⁹ or Multigravidae⁴⁰, she has to follow the regulations of the shelter. She ceases to rely on her own experiences to go against the regulations and instructions of the midwives; however, expectant mothers are required to learn from the midwives and nurses every day. It is at the hospital, during the childbirth process that the Multigravadaes are expected to show experience in the process without much support that could be required by Primigravidaes. In the shelter, the prime requirement is personal hygiene

³⁹ *Primigravidae* refers to a woman who is pregnant for the first time (Geily, 2013). (Check Chapter Two, Section 2.12).

⁴⁰ *Multigravidae* refers to a woman or a female who is or who has been pregnant for the second time (Geily, 2013). Check Chapter Two, Section 2.12.

(as noted in Chapter Six Section 6.4.7.6). This is controversial for some women as shaving the genital area could be against their partners' desires, but expectant mothers do not have a choice on how they want their genitals to look when they go for labour. Upon a cross-examination with the midwives, it was acknowledged that pubic hairs do not in any way harm the baby or cause diseases, but, it is for hygienic purposes and for one to be presentable to the doctors.

Bella, a hospital staff member and midwife, indicated that:

It is impossible that the doctor examines a woman with genitals that are not clean. Pubic hairs should not be allowed to grow and they hinder a smooth birth process. It is very unhygienic to be seeing long hairs on the genitals during the birth process. These hairs also are the ones that keep all the sweat and sometimes you see the hairs changing colour to a light brown colour and that is totally unacceptable not only for the doctors to see but also for one's personal grooming (Author's Interview 26/10/2019).

Bridget, a hospital staff member and midwife, stated that:

We don't only encourage mothers to shave when they are in the shelter; women should develop the habit of shaving every time so as to keep the genitals clean because failure to do so, one will develop infections. Do you know that Candidiasis can be as a result of keeping pubic hairs? This is because the vagina will be subjected to uneven PH Balance and an environment that supports the growth of fungi, and this leads to infections such as *Candida*⁴¹ and, most commonly, Thrush. The sad reality is that when most of the women check into the shelter, they will be suffering from these when we test their urine (Author's Interview 26/10/2019).

7.6 Personal Hygiene and the Politics of Adornments in the Waiting Mothers' Shelter

Most expectant mothers noted that by shaving pubic hairs they would be altering what is usual on their bodies to appear presentable to the doctors/nurses and midwives. Notwithstanding practising their body agency by making a choice to go to the waiting mothers' shelter to await labour because they think it is best for the protection of their own health and that of the new-born babies, expectant mothers are basically treated as though they were naïve beings with no

⁴¹ Candidiasis is an infection caused by a yeast (a type of fungus) called *Candida*. *Candida* normally lives inside the body (in places such as the mouth, throat, gut, and vagina) and on skin without causing any problems. Sometimes *Candida* can multiply and cause an infection if the environment inside the vagina changes in a way that encourages its growth. Candidiasis in the vagina is commonly called a "vaginal yeast infection." Other names for this infection are "vaginal candidiasis," "ulvovaginal candidiasis," or "candidal vaginitis" (Meyer 2018: 2).

knowledge of the birth process and this leads to the questioning of the importance of the self as postulated by Mead (1934). Mead (1934), Blumer (2004) and Conrad (2015) regard the ability of humans to act toward him/her as the central mechanism with which the human being faces and deals with his world. This mechanism enables the human being to make an indication to him or herself of things in his/her other surroundings and, thus, to guide his or her actions by what she or he notes. Anything of which a human being is conscious of is something which she or he is indicating to him or herself. This also applies to processes of pregnancy such as morning sicknesses, cravings and bulging stomach, among others. Furthermore, Mead (1934) notes that the conscious life of a person from the time that she or he awakens until she or he falls asleep is a continual flow of self-indications, notations of the things with which she or he deals and takes into account. This is the mechanism that is involved in interpreting the actions of others. To interpret the actions of another is to point out to oneself that the action has this or that meaning or character.

Apart from personal hygiene as a major issue that affects how expectant mothers are forced to go beyond their normal bodily standards to suit the standards of the waiting mothers' shelter, it was noted that adorning one's body with ornaments⁴² (both traditional and religious) is highly condemned in this health care facility. There are some village members who have been married to other cultures in Zimbabwe that practice adorning one's body with ornaments. Rosemary and Sandra, for instance, are two of the women in Mawadza village who once used the waiting mothers' shelter at Bonda Mission Hospital who noted that they are married to men from the *Tshangane* tribe of Chiredzi – where women are required to wear a string made of beads around their waists (commonly referred to as waist beads) as a symbol that one has received sex education from the elderly women and they are ready for good performance during sexual intercourse in their marriages. The strings made of beads (waist beads) are a lifetime ornament that should be worn every time and at no time be removed. In this particular culture, ornaments define a woman's sexuality, but when they went to the waiting mothers' shelter they were commanded to remove the ornaments from the waist firstly for hygiene purposes, secondly, for the medical perspective that the beads in the waist do not expand as the stomach bulges, hence it would tightly tie the stomach and, possibly, harm the unborn baby.

⁴² Chuma.

Rosemary remarked that:

I was told to cut the beads that were in my waist because the nurses were afraid that the beads would harm the baby. I told them that the beads are usually in my waist and not on the stomach, but they did not understand. They said I could only place them back on my body after childbirth (Author's Interview 20/10/2019).

Sandra lamented as she revealed her ordeal:

I was heartbroken when the midwives cut my beads because they could not accept that in the waiting mothers' shelter. I had received those beads from my in-laws when I got married; the midwives were not in a position to accept that I give birth while wearing my beads (Author's Interview 25/10/2019).

On the same note, expectant mothers from the apostolic sects also face challenges that other expectant mothers are concerned with. The same ornament that is worn by some women is also worn by women from the apostolic sects for spiritual reasons. In this case, ornaments are not in the form of beads but a string that is simply tied on the waist or wrist of any woman. Parents or guardians usually protect their children, no matter how old, against attack from evil spirits through these strings. As in the case of bead ornaments, the strings are not accepted in the waiting mothers' shelter for the same reasons that it will possibly hurt the foetus.

Betty narrated her experience:

As for me, it was my first time to go to the waiting mothers' shelter. I had my beads on my waist, hands and legs, but when I got to the shelter, they told me to remove the beads. They said I should remove the beads because they were linked to evil spirits. I was offended because the beads are a symbol of prayer at our church" (Author's Interview 25/10/2019).

However, expectant mothers who are devotees in the Anglican Church were also opposed to the idea of beads and ornaments on any part of the body. Belinda stated that:

We just grew up knowing that beads are associated with evil and witchcraft. Even at church, we are always discouraged to wear beads because they attract evil spirits with them. We have heard stories of women who were given beads by traditional healers and some of them later on turned into snakes. I for one will never wear beads no matter what. Even if people think that I am not good in bed I do not mind. After

all I do not need to prove to the world that I am good in bed but to my husband, of which he is content (Author's Interview 22/10/2019).

An expectant mother in the shelter, Samantha also opined that:

I cannot really tell the difference between beads and the jewellery that we wear for personal adornment, but I don't think wearing beads on the waist for a lifetime is a good idea. To me, anything you are given to wear for a lifetime is initiation to some form of a cult. I associate beads with evil, and even at church, we are told the same. I support the midwives for the idea of not allowing such demonic things in the shelter. This is because demons have a way of spreading (Author's Interview, 23/10/2019).

Hazel, showed indifference towards this issue. She said:

I really see no reason to monitor what is on one's body. We all have our bodies and we do what we want with our bodies. In this day and age, people are using skin lightening creams and they are doing what they want with their bodies. Others are piercing their bodies and those who want to wear beads should be allowed to do so if it is well with them. I see people judging each other in the shelter because of beads. I think people should just mind their business with their bodies, but the problem is the midwives are one-sided; they do not like the idea of beads (Author's Interview 22/10/2019).

Bella, one of the midwives at the waiting mothers' shelter emphasised that beads are not accepted in the shelter:

We are aware of the fact that there are various belief systems in our societies, but, in the shelter we need to have standards that apply to everyone. We are also mandated to practise high levels of impartiality, so, allowing others to wear beads while we discourage others to bring jewellery such as wrist bands and the like will not be fair. Beads also do not expand as the stomach bulges, hence are not good for the development of the unborn baby. Expectant mothers think that we do this from a point of cruelty but it is for their benefit (Author's Interview, 22/10/2019).

Doctor Marshal, in support, stated that:

Beads and ornaments are part of the people's culture, but I do not support the idea that they remain in the waist during, especially towards, childbirth. From my experience, the beads sometimes affect the varicose veins due to the growth of the unborn (Author's Interview 22/10/2019).

According to Mead (1934) and Blumer (2004), the ability of an individual to make indications to self is of paramount importance. The importance lies along two lines, firstly, to indicate something is to disengage it from its setting, to hold it apart, to give it a meaning or, in Mead's (1934) terms, to make it into an object (Redmond 2015: 22). An object, that is to say, anything that an individual indicates to him or herself is different from a stimulus; instead of having an intrinsic character that acts on the individual and which can be identified apart from the individual, its character or meaning is conferred on it by the individual (Plummer 2016: 44). The object is a product of the individual's disposition to act instead of being an antecedent stimulus which evokes the act. Instead of the individual being surrounded by an environment of pre-existing objects which play upon them and call forth their behaviour, the proper picture is that humans construct their objects on the basis of their on-going activity (Plummer 2016: 45). In any of the individual's countless acts, whether minor, like dressing him/herself, or major, like organising him/herself for a professional career, the individual is designating different objects to him/herself, giving them meaning, judging their suitability to his/her action, and making decisions on the basis of the judgment. This is what is meant by interpretation or acting on the basis of symbols. This shows that the self is a major component of the symbolic interaction process (Plummer 2016).

In the waiting mothers' shelter, the self is suppressed to the regulations of the facility, hence, the actions of the self in the symbolic interaction process are altered. According to Blumer (2004), the second important implication is the fact that the humans make indications to him/herself, that is, the human action is constructed or built up as influenced by the interaction instead of being a mere spontaneous release of action. Whatever action humans engage in, the individual proceeds by pointing out to him/herself the divergent things which have to be taken into account in the course of his/her action (Plummer 2016: 47). Human beings have to note what they want to do and how they want to do it; they have to point out to themselves the various conditions which may be instrumental to their action and those which may obstruct their action; humans have to take account of the demands, the expectations, the prohibitions, and the threats as they may arise in the situation in which they are acting. The individual's actions are built up step by step through a process of such self-indication. The human individual pieces together and guides their action by taking account of different things and interpreting their significance for their prospective action (Plummer 2016: 49).

In addition to this, other modifications on the body have been condemned by medical professionals and cultural practices for the adornment of the genitals have also been condemned in the waiting mothers' shelter and in the hospital maternity units. In the Manyika culture, a woman should adorn her genitals to define her sexuality. This is done through elongation of a portion of the genitals' labia minora⁴³ so that this works as a foreplay and sexual pleasure enhancement feature, affectionately referred to as *zvidhori* (toy for the husband to play with during foreplay and sexual intercourse). A girl is supposed to wake up before the sun rises, wipe her hands in the dew on the grass and start pulling the labia minora till it reaches the desired size. With the passage of time and cultural diversity due to migration and assimilation of other ethnical groups in the *Manyika* culture, herbs have been added to the process. The young girls are supposed to smoke certain herbs, and as they get choked by the smoke and sneeze, the labia minora is said to elongate on its own. Others in this village indicated the use of burnt bat wings that are mixed with petroleum jelly to assist in the easier elongation of this part of the genitals.

A key informant, Tilda explained that:

The elongation of the labia minora has been a common practise among the *Manyika* people as a whole. It is a common practise that defines the people and makes them unique from all other tribes in Zimbabwe. I have monitored a lot of young girls and taught them how this is done, and in my experience, they use a powdered burnt bat wings that has been put in petroleum jelly. This helps speed up the process of elongation and gives desired results. This practise has proved to be very important for us and saved the marriages of so many of our daughters in this village (Author's interview, 23/10/2019).

Another key informant added that:

The elongation of the labia minora is part of our culture that I do not understand why nurses and doctors think that it is an act of madness to do so, but it defines the kind of people we are... Our elders gave us knowledge that these should be aided by smoking herbs while in the process of elongation as this will speed up the process" (Author's Interview, 23/10/2019).

Medical professionals show concern with such practices because some of the sizes that the labia reach can affect the childbirth process. The longer the labia minora, the more it interferes with

⁴³The part that forms the smaller inner fold of the vulva on a female's genital (Benjamins 2019).

the passage of the baby out of the vaginal canal. This interference causes unnecessary delays and challenges for the medical professionals who assist in the childbirth process. The delays and challenges come with trying to protect the genital's adornments and also trying to make sure the baby passes out of the birth canal in time so as to avoid complications. It gets more unnecessarily complicated in the event of rapture where the medical professionals have to take into consideration the adornments as they put back the ruptured section to shape. Bridget states that:

Cultural practices continue to become a threat to institutionalised maternal health care services. The elongation of the labia minora, as much as it may be a common cultural practise, has its own shortcomings. In my experience as a midwife, I have realised that, it is common for the perineum to tear to some extent during childbirth. Tears can also occur inside the vagina or other parts of the vulva, including the labia minora. Up to 9 in every 10 first-time mothers who have a vaginal birth will experience some sort of tear, graze or episiotomy. Hence, longer labia minora will cause more complications and pain to the mother when it tears (Author's Interview 29/10/2019).

Doctor Marshal added that:

The labia minora are generally pink due to the presence of numerous blood vessels in that particular area. These blood vessels swell when stimulated, such as during sex, and this general appearance of a woman's labia minora will often change as she progresses through pregnancy and as she nears childbirth. As pregnancy progresses, blood flow to the labia minora increases, and hormonal changes occur. These changes begin as early as one month into pregnancy and cause the labia minora to turn slightly blue in colour. In addition to this colour change, the labia minora will swell and generally increase in size. Although this swelling is usually mild, it can be more prominent in some expectant mothers, especially those who are pregnant for the first time. Swelling of the labia can also increase after prolonged pushing during childbirth and this swelling is not good for the healing process of the new mothers... If the situation is like this for mothers with a normal size of the labia minora, what more of those who elongate them up to the size of your finger? This certainly invites complication during and after childbirth (Author's Interview 30/10/2019).

Doctor Rodney provided an example:

We had a case in 2015 where, after childbirth, the new mother came out with a horizontal tear to her labia minora. At this point, it was completely lacerated into two separate halves. We tried to have one stitch put in

after birth, that didn't hold, and at a follow up appointment we placed another stitch, which also didn't hold, until we had to refer the patient to Mutare Provincial Hospital (MPH). Usually, when the labia minora tears into two, a process called labiaplasty⁴⁴ has to be done to get it back to normal. Those kinds of processes are done in private institutions only in the capital city in Harare or outside the country, and our rural women cannot afford them. Labiaplasty is like plastic surgery and none of our rural populations can afford this. I urge the others not to elongate their genitals. They should leave them as they are to avoid such lifetime complications after childbirth (Author's Interview 29/10/2019).

For this reason, women are generally discouraged from letting their young girls undergo this process as it has negative effects in the long run. Nevertheless, this is a major antagonising perspective with the cultural beliefs in this society. That is, women who have elongated labia minora stated that they face some body shaming from the medical professionals in the shelter, especially the midwives.

Olga states that:

I just grew up with the knowledge that I was supposed to elongate parts of my genitals as it was said to help me in my marriage. I only got to know the use of elongating the genitals after marriage because I got married a virgin. However, when I went to the waiting mothers' shelter to await labour, I was body shamed by the midwives who asked me why I had elongated my genitals. I was so embarrassed but I just kept quiet (Author's Interview 20/10/2019).

Vivian also added that:

I was body shamed by the midwives when I was giving birth, they took turns to come and see how my genitals looked like, I was so embarrassed because even some people who were not working in the maternity ward came to check on my genitals as I was in the process of labour. After I had delivered, as I was receiving post-partum care one of the nurses then asked me why I had genitals that were like that, that is when it became evident that I was a topic of discussion the previous night I was in labour (Author's Interview, 21/10/2019).

In contrast to this, Martha noted that:

⁴⁴ Plastic surgery performed to alter the appearance of the labia, typically the labia minora, or to construct labia (Sandburg 2018: 4).

I have never received any body shaming of any sort. I, for one, have elongated genitals. Maybe I will be shamed by the nurses when I get into labour, but as of now in the shelter, nobody examines or looks at my genitals in a negative way. So, maybe it varies with individuals or with the mood of the midwives because I have heard others complaining that they get body shamed when they are here, but I am still to see that (Author's Interview 22/10/2019).

Candice added by saying that:

Maybe it also varies with one's age. I am one of the oldest expectant mothers in this shelter, but I do not get body shamed. In every situation, the midwives have treated me with respect together with other elderly mothers who are in this shelter. Usually, people who get body shamed are those who do not comply with the midwives instructions, and they end up shaming them as a way to scare and make them comply with instructions (Author's Interview 26/10/2019).

Genitals are highly regarded in Mawadza village in that they are the sources of life⁴⁵ for the society so anything that has to do with the genitals of a woman should be treated with respect. Genitals should be treated as a private organ that carries the pride of every woman. The importance of the genitals is such that the man has to pay a bride price (*roora*) in form of cows for him to formally access the genitals. Apart from building relations with the in-laws, narratives from the study show that, the fact that men pay bride price gives pride to the women, and it reminds them of the importance of their genitals, which is not the same treatment that they receive in the waiting mothers' shelter.

The medical professionals in the maternal health facilities regardless of their acknowledged critical role in the society to assist in the important event of childbirth, have been criticised by community members, especially, those who have used the waiting mothers shelter, for not respecting the genitals as a private organ that carries the pride of every woman. In the shelter, when one goes into labour, she can be asked to open her legs for the midwives to check the stage at which she is in labour in the presence of others. Failure to do so swiftly carries the risk of being shouted at for not responding swiftly to orders. Midwives have over the years been reported to be harsh and use harsh sexually offensive language in the waiting mothers' shelter.

Mary recounted that:

⁴⁵ Genitals are also referred to as *sikarudzi*, literally meaning 'source/creator of generations.'

When the waters broke, I knew that labour had already started. However, I needed an ambulance to ferry me to the hospital since I was in pain and could not walk. The midwife told me to open my legs in order to check the progress of the labour process, I could not instantly do that due to pain and she hit me with a slap on my thigh and I heard her saying it's easy for you to open legs for a man for sexual intercourse but hard for you to open your legs for me to assist you give birth (Author's Interview 25/10/2019).

Patience also stated that:

Sometimes the treatment from the midwives is too harsh to bear. I got a slap the day before yesterday after I failed to pull up my sleeves so that she checks my BP. If they tell you to remove your clothes, you should do so immediately because if you fail to do it in time, they will definitely beat you up... I did not feel good after being beaten up, but I had to let it go (Author's Interview 26/10/2019).

In dissimilarity to these experiences, Hazel narrated that

I have never been beaten by the midwives because when they tell me to do something I do it immediately. I think the trick to survive in the shelter is to follow instructions and act like a fool who simply follows instruction. If you take time to respond to instructions, they will beat you up. I have seen others being beaten, but it has never happened to me (Author's Interview 27/10/2019).

Bella, a midwife, had this to say:

I have never beaten anyone in the shelter. I do not do that; I only assist women to push the baby sometimes; I get harsh on them to push the baby so that the baby is not suffocated in the birth canal. I think anyone would thank me for such an action because no one wants to go home with a dead baby. Sometimes I am harsh in the labour ward only to save lives... I cannot smile at a mother who does not push the baby and gamble with their baby's life, I become cheeky and harsh but when we meet later on in the streets, all the mothers say will be 'thank you' (Author's Interview, 27/10/2019).

There have been concerns over the harsh treatment in the waiting mothers' shelter that has resulted in physical abuse of the expectant mothers. Although expectant mothers are usually tolerated by society when they have mood swings or cravings or any other pregnancy related actions, the midwives give a constant reminder that there is no one to tolerate that ~~because~~

husbands are at home”. The narratives of the study also showed that expectant mothers are beaten for non-compliance once labour starts.

Samantha recalled that:

I got into labour in the afternoon and I realised by the waters breaking. I told the midwife who was on duty and she told me she needed to see the stage of labour which I was now in. When she realised that the baby was not close and I could walk on my own to the maternity ward that is close by, she ordered me to clean up the discharge from the waters that had broken before I could go for labour (Author’s Interview 20/10/2019).

When it comes to activities that take place in the shelter, expectant mothers do a series of physical exercises to keep fit and provide enough oxygen for the baby. The healthcare professionals explained that most physical exercises done in the shelter are for the benefit of the foetus and preparation for the childbirth process. The expectant mothers have no choice to go or not go for these physical exercises as it is compulsory. During the practise sessions, expectant mothers are expected to do the exercise up to the standard and expectation required by the supervising midwife. If one does not do up to standard, the expectant mother risks being embarrassed as she can be reprimanded for this. The activities done in the shelter show that the expectant mothers do not have total control over their bodies because they expected to act according to the regulations of the facility. It has also been shown that the emotional being of the expectant mothers is not also considered in this maternal health facility. This is shown by the fact that expectant mothers who do not behave according to the required standard of the shelter are not reprimanded privately but sanctioned and reprimanded in the presence of fellow expectant mothers.

Bridget a midwife, explained:

Some expectant mothers do not comply and they actually show a negative attitude when you tell them to start doing the exercises. The truth of the matter is that the activities we do are a benefit to the expectant mothers, not us. However, it gets to a point where it is disturbing to realise that someone is showing you a negative attitude when you tell them to do something that benefits them and their baby. Managing the shelter is not easy. We meet different personalities such that sometimes we need to be stern with the mothers in order to get things done. If we leave them not to do this, the shelter will be closed by

the MoHCC for not following proper standards of prenatal and post-partum care and we may end up losing our jobs. We are also accountable for any still birth or any mortality during delivery or 6 weeks after delivery. We do our work with due diligence, although dealing with different personalities with different cultural beliefs is not a stroll in the park (Author's Interview, 27/10/2019).

The narratives from the respondents show that women are not ignorant of the changes occurring in reproductive politics or simply submissive recipients of orders and instructions from medical professionals (see Zadoroznyj 1999). The women who are not fully obedient to doctors' orders and those who assert their agency over their childbirth experience by trying to shape them are generally viewed as non-compliant and stand the risk of being sanctioned through embarrassment. Apart from being embarrassed as a way to ensure conformity, expectant mothers or new mothers who do not follow the orders of health care workers are pacified into believing that if they do not follow instructions they expose their unborn or new-borns babies to a lot of health-related risks. Although the activities conducted in the waiting mothers' shelter are considered beneficial for the expectant mothers, it is important to acknowledge that the level to which they exercise their bodily agency in this facility is limited.

7.7 Post-Partum Care in the Waiting Mothers' Shelter

After giving birth, a mother goes back to the waiting mothers' shelter so that she can learn how to care for the new infant for two days before she is discharged. One of the initial lessons that the mother learns after giving birth is to care for the vaginal canal so that it does not develop infections. So, the mothers are to wash their genitals with saline water. However, women in the study revealed that healthcare professionals (midwives and nurses) do not teach this with patience and gentleness.

Mary noted that:

As I was coming from labour, I was told by the midwives to hold my baby on my own, yet I was in so much pain. I held the baby and I walked to the shelter so that I could sleep. When I got there, I was not given space to sleep as I was immediately told to wash my baby (Author's Interview 22/10/2019).

Olga added that:

After giving birth, I wanted to sleep a bit since I had spent more than 24 hours in labour and I was so tired. The midwives could not allow me to rest as they came to teach us how to clean our babies. I was scared to hold the baby and clean it, but they kept on reminding me that they were not up to jokes but on a serious mission, hence I had to hold the baby on my own and clean the baby without wasting time. I started having proper rest and proper guidance on how to clean the baby when I went back home to my mother (Author's Interview 26/10/2019)

After giving birth, one would be in pain and needing gentle care and assistance to nurse her wounds. It was revealed that the midwives order the mothers to walk swiftly and to be strong when they come from the maternity ward. Mothers wash their own genitals with salt water, with little assistance. They are only instructed on what to do, taking instructions carefully regardless of the fact that they will be in pain. Their post labour pain is given little attention by the midwives, whose main aim is to teach them how to care for their bodies. Some mothers, due to pain, long to rest before they can get assistance on how to care for the body, but the midwives always say if one takes too long without being active again and learning to care for the genitals, they might develop problems in the long run. Mothers are also taught to clean their babies. Although some may still be in pain due to labour, they are still expected to hold their babies and clean them according to the instructions of the midwives. One interviewee said:

When I gave birth, I was in pain and I just wanted to sleep after the process. I could not sleep and properly rest due to the midwives who kept on nagging me with instructions. I was told to wash my body and the baby. They told me if I don't, I would develop infections that they would not give priority to when and if I were to come back to the hospital... I will never go back to give birth at Bonda Mission again, the midwives are rude (Author's Interview 24/10/2019).

In addition, soon after birth in the Mawadza village, mothers are expected to tie their stomach with stems from sweet-potato plants. The stems are used to tie the stomach and put it back to shape (as corsets do) so as to avoid the stomach bulging too much. As the stem dries, it is believed that the stomach will also shrink, so the stem has to be left in place until the mother's stomach completely shrinks. This is not allowed in the waiting mothers' shelter. According to the health care professional, it's not hygienic for one to tie the stomach with plant stems until they shrink, and this also does not apply to those who give birth through the caesarean section. As such, mothers who spend time in post-partum care in the shelter are not allowed to tie their

stomachs after giving birth, no matter how important this is considered in the community. In this regard, a woman, after giving birth, has restricted control over her body in the waiting mothers' shelter. She cannot decide on how to care for the stomach in a manner that she pleases and that, ultimately, makes her feel well about her body after giving birth. A concerned waiting mother Belinda said:

The midwives do not want us to tie our stomachs soon after childbirth.... The midwives are rude and nagging. If I don't tie my stomach, it will continue to grow big and cause me backaches in the long run, but they do not care about all that Bonda is the worst facility ever for me (Author's Interview 24/10/2019).

Betty, however, shared a different view by stating that:

I did not receive any form of harsh treatment from the midwives and the nurses who assisted me from the period I was giving birth up to the period I was discharged from post-partum care in the shelter. I have heard people complaining a lot, maybe I was lucky to find nice people on duty the time I was giving birth. The nurses would actually laugh with me and encourage me to exercise so as to flatten my stomach since it had grown too big. They told me not to use the sweet potato leaves like others would do and I am grateful for this advice (Author's Interview 30/10/2019).

Martha also noted that:

The midwives are not so bad after all. Before I came to the shelter and during prenatal care, I used to be so scared of them and stayed away from them as much as I could because I was scared of being shouted at. However, during the time I was in labour, both sister Bella and Sister Bridget would come and check if I was not so much in pain. They told me to sit down and rest every time they felt I was too tired due to labour. To me, those women were kind. When I went to the post-partum section, they helped me clean my baby and they reminded me on the importance of exercise in order to keep my body in shape and flatten my stomach (Author's Interview, 30/10/2019).

In addition, Bridget had this to say:

New mothers should try as much as possible to care for their bodies and exercise to take them back to shape, including flattening their stomachs. Tying the stomach with leaves and herbs still remain myths to me. The only possible way to keep bodies in shape is by exercising. I am quite

sure that most women will manage this because they get involved in a lot of manual work in the fields back in Mawadza Village, hence its good exercise for them (Author's Interview 30/10/2019).

The narratives of the respondents lead to an appreciation of the fact that from prenatal, intra-to post-partum experiences, women are not in full control of their bodies, however their bodies are controlled by with a number of individuals. From pregnancy the expectant mother shares her body with the unborn baby, health care professionals, family, in-laws, SBAs and TBAs among others. In the waiting mothers shelter the extent to which bodies are shared with health care workers is unborn babies/new-borns is quite pronounced. As such, many feminists in the field of sociology of medicine and anthropology, Davis-Floyd (1994), Rothmans (1993) as well as Oakley (1980; 1988; 2017) have criticised biomedical facilities for controlling women's bodies during the birth process. Oakley (2017) notes that medicalisation of the childbirth process is viewed as alienating many women, separating them from their bodies and making them passive recipients of medical care. Most mothers in the waiting mothers' shelter comply to certain actions not because it is how they feel but because they want to serve their babies through the instructions of health care workers, hence, mothers are viewed as constantly sharing their bodies.

Although other respondents acknowledged the benefits of the post-partum care in the waiting mothers' shelter, it is prudent to note that control over women's bodies affect their experiences in transition to motherhood. The care that these women have experienced in the shelter has influenced some to revise their beliefs and perceptions about pregnancy and the childbirth process. Expectant mothers and new mothers in the shelter fail to use some of the traditional ways to care for their bodies as part of prenatal, intra and post-partum care regardless of the fact that the hospital is located in medical pluralistic setting. This resonates well with the ideas of Rothmans (1993) and Davis-Floyd (2020) who state that in biomedical facilities women lose the autonomy of their bodies and transfer control in to the hands of health care workers.

Another crucial factor that has been noted by medical sociologist is that soon after childbirth mothers are expected to return to their usual bodies as soon as possible (Oakley 1980, Elvey 2003, Fox 2009). Mothers are expected to swiftly manage their responsibilities such as bathing the baby and themselves, nursing perineum wounds and breastfeeding among other duties. This is done with little or no consideration of the aching body of the new mothers that needs time to

heal. Mothers are expected to abruptly dissociate themselves with the childbirth process by being swamped with responsibilities to care for the new-borns and fulfil social roles such as breastfeeding at the expense of their bodily needs (Upton & Han 2003, Wall 2001, Shaw 2004, Avishai 2007). Control of women's bodies in the waiting mothers' shelter remains evident even in other post-partum activities such as breast feeding.

7.8 Breastfeeding in the Waiting Mothers' Shelter

The mothers are also taught how to breastfeed in the waiting mothers' shelter. Breastfeeding is a challenge for most mothers, especially those who are giving birth for the first time. For most mothers, breastfeeding is actually uncomfortable at first as the milk might take too long to come. In the waiting mothers shelter the, lactating mother will have no choice than to continue trying to breastfeed the baby regardless of the fact that the milk might not be coming out and the process is painful. As one will be learning to breastfeed, the nipples can develop sores from the sucking of the baby. In the waiting mothers' shelter, mothers are not given space to nurse these wounds. However, if it is time to breastfeed, they have to comply. One affected mother said Mary:

At first, breast feeding is a challenge for most of us as mothers. The milk takes long to come out and the nurses do not understand. They usually order us to keep the breast on the baby till the milk comes out and this is painful. However, when you have a baby in your hands, you sacrifice just to keep on breastfeeding till the baby is fed (Author's Interview 26/10/2019).

Rosemary added that:

At the post-partum care section, I was told to breastfeed my baby, without removing the breast. It was very sore to breastfeed for the first time and the nurses told me that they were going to beat me if ever I removed the breast from the baby's mouth. I continued to breastfeed even though I was in pain (Author's Interview 23/10/2019).

Candice, however, narrated that:

My labour process went with no major trouble from the midwives. I was in pain but I just tried to do what they told me to do. Breastfeeding was not so easy at first but I continued for the sake of my baby. I never really got challenges, honestly speaking, and it seems the older you are, the more respect you get in the shelter (Author's Interview 25/10/2019).

Bella added by noting that:

Breastfeeding the baby is one of the key initial steps to post-partum care, according to my experience. Breastfeeding for the first time soon after birth is not easy due to hormonal imbalances in the body and, as hormones try to balance, mothers are usually subjected to excruciating pain during the first few days of breastfeeding, but breastfeeding has to be... We are pretty much aware of the pain they go through during the first few days of breast feeding, remember we are also mothers and we have gone through the same processes. Mothers have to try their level best to breastfeed the babies in order to start providing nutrition to the baby and to create a bond due to hormonal sensation between mother and child. All we do is in the spirit of ensuring the best care for the baby once the baby is born, not to unnecessarily fix mothers in the waiting mothers' shelter. I would rather be unpopular for telling mothers to do the right thing than to be popular for doting them whilst infant mortality due to malnutrition remains high (Author's Interview 30/10/2019).

Drawing from the narratives of the study, it was revealed that concerning breastfeeding, a mother has to do all she can to make sure that she provides for her child. After one develops the skill to bath the baby and breastfeed it, she will be discharged from the shelter and sent back home. Mothers who stay in the shelter are not allowed to leave the shelter on their own without a family member who comes to take them. Therefore, with a representative from home, a mother is then discharged from this maternal health facility.

The narratives of the study indicate that the health care professionals in the waiting mothers' shelter are not sensitive to different cultural beliefs and practises pertaining to pregnancy and childbirth, although they disagreed with the views that were expressed by the expectant mothers. Cultural competence on the part of biomedical health professionals is a necessity in order to promote holistic health care systems, especially in indigenous African communities where the majority of people exercise both indigenous and contemporary health seeking behaviours (Hlatshwayo 2017). Pregnancy and childbirth are processes that are heavily informed by the cultural beliefs of any given society. These cultural beliefs are in the form of certain rituals meant to protect the mother and her pregnancy as well as the use of herbal medicines and practices for cervical dilation, muscle relaxation and body toning to enable an easy birth as noted in previous chapters. As such, some of the cultural beliefs and practices are castigated by biomedical professionals. Cultural competence, therefore, calls for cultural awareness and

cultural sensitivity to the beliefs and practices of patients. According to Kanengoni et al., (2019), cultural awareness, is appreciating external signs of diversity which are displayed through one's physical appearance and mode of dressing. For example, a pregnant woman may have a charm tied around her waist to protect her pregnancy (Hlatswayo 2017, Kanegoni *et al.*, 2019). Biomedical professionals are encouraged to exercise cultural sensitivity when dealing with expectant mothers from various cultural and ethnic backgrounds.

Cultural sensitivity has more to do with good personal attitude on the part of the biomedical health professional avoiding language that might be offensive to one's ethnic or cultural background. In a study on cross-cultural evaluation of maternal competence in a society with diverse cultures, authors have raised the concern that there is a critical need for the training of nursing staff in cultural competence in order to avoid misconstruing the traditional beliefs of clients (Mulisa 2001, Makange 2004, Mathole *et al.*, 2006, Moyana 2016, Wong 2020). These same sentiments are raised by Kwagala (2010), who argues that the professional training of biomedical healthcare staff should incorporate cultural competence, sensitivity and professional ethics. In her study, Kwagala (2010) notes that women were not comfortable with utilising public health facilities due to limited cultural competence from the medical staff. This cultural incompetence hindered effective communication between the health service provider and the expectant mothers. In order to bridge this gap, Kwagala (2010) and Moyana (2016) agree to accommodate cultural practices that are beneficial to the health and well-being of the expectant mothers seeking attention from health professionals.

7.9 Conclusion

In this chapter, I initially deliberated on pregnant bodies in Mawadza village. I have tried to bring to fore how pregnant women in this village view their bodies and develop a sense of identity. I have discovered that women view their bodies in relation to others in the society such as family members and other community members. Moreover, as part of the defining factor to the pregnancies of the expectant mothers, the community is involved in beliefs, ceremonies and rituals to care for pregnancies as part of the indigenous knowledge systems in this village. The three ceremonies that I have discussed in detail are the *taguta miriwo*, *masungiro* and *kuvhura nzira/masuwo*. The study revealed that these ceremonies and practises are important in helping women conceptualise their bodies and, in turn, develop a sense of identity as pregnant women. I

have also shown the importance of family in the conceptualisation of pregnancy and, ultimately, how women view their bodies.

The foundation of understanding the ceremonies and practises conducted in this village have been very useful in understanding women's experience in the shelter concerning their bodily agency. The study has revealed that expectant mothers exercise body agency but not on their terms all times. This has been shown by the experiences of some who are not allowed to practise the common tradition of *kuvhura nzira* as part of their traditional ways to prepare for childbirth. Professionals at the shelter show total intolerance to the act. In the worst cases, some have been evicted for bringing herbs that aid the opening of the birth canal (*kuvhura nzira*). In addition, I have shown how adornments are viewed as problematic and a possible interference with one's pregnancy that can possibly harm the baby. In all these experiences, expectant mothers showed concerns relating to how they are controlled over acts like tying their stomach after childbirth, and expectant mothers are concerned about this.

I conclude that the biomedical approach to health and the traditional approach that is related to the indigenous Mawadza people's culture are mutually exclusive approaches to health. It is prudent to note that some aspects of the local people's culture related to management of pregnancy and child birth can be allowed into the shelter if proven not harmful/pathological to the women. Engaging in workshops between the hospital staff (biomedical approach) and traditional healers (traditional health system) could be highly beneficial in trying to develop a policy that accommodates the two as long as it safe for the women. This is important because it ensures the provision of a holistic approach to maternal health care provision in Mawadza village.

CHAPTER EIGHT

COMMUNITY MEMBERS' PARTICIPATION IN SUPPORTING THE OPERATION OF THE WAITING MOTHERS' SHELTER

8.1 Introduction

This chapter discusses the involvement of the community members of Mawadza village in the operation of the waiting mothers' shelter at Bonda Mission Hospital. During the course of my field work, I managed to get nuances and narratives from community members related to their views and involvement in operations of the waiting mothers' shelter. In my previous chapters, particularly Chapters Six and Seven, I showed that not all women in Mawadza village benefit from staying at the waiting mothers' shelter. In fact, some actually still prefer utilising their homes for awaiting labour due to a number of reasons that include preference for embracing medical pluralism, child care and family commitments, lack of understanding of the importance of the waiting mothers' shelter, lack of practice of body agency in the shelter and cost of food and utilities during the expectant mothers' stay in this facility, among other factors. Looking at all the factors mentioned above, understanding the level of community involvement in the operations of the waiting mothers' shelter is critical since it can inform strategies that may be employed to increase women's use of this facility and to sustain the activities conducted thereat.

Before I discuss further and consider the narratives from my respondents about community participation in support of the operation of the waiting mothers' shelter, it is necessary to unpack the term "participation" for a clearer contextual understanding of this term. The definition of the word, "participation" can be broad⁴⁶. There are different degrees of participation that communities can offer to any project in their community. Kyokan (2016) notes that merely informing or consulting the community is not real community participation. However, real participation means that power of decision making is delegated to the community and the community controls issues concerning a certain community project. In their participation, communities should also be in a position to make the best solutions which fit to local circumstances as understood by the locals. From this point of view, it should be acknowledged

⁴⁶ Participation refers to the action or state of actively taking part in something; this includes association with others in a relationship (as a partnership) or an enterprise usually on a formal basis with specified rights and obligations (Meheyer 2010: 366).

that participation is far more than consulting or informing community members, but about control and decision making as I elaborate in this chapter.

8.2 Community Leaders' Involvement in the Operations of the Waiting Mothers' Shelter

As noted in Chapter Six (Section 6.3), the MoHCC has put in place some bylaws to discourage home births that occur especially in rural areas, and Mawadza village is not an exception. In Mawadza village, the traditional leaders are supposed to ensure that this is observed too. In doing so, every family that has an expectant mother who gives birth at home is supposed to pay a fine of a goat to the chief's traditional courts⁴⁷. In trying to enforce bylaws that criminalise home births, the community leaders advocate for the use of hospital facilities at Bonda Mission Hospital for childbirth. As part of processes and procedures to give birth at the hospital, expectant mothers have to await labour in the shelter before they are transferred to the maternity wards. Chief Zulu noted that:

It is not allowed for expectant mothers to give birth at home; it is a criminal offense. There are some people who came from Mutare MoHCC and the Mutare Municipality, together with the professionals at Bonda Mission, to teach us that it is now a criminal offense to give birth at home that is punishable by a fine of a goat because most women were dying while giving birth at home. Expectant mothers should go await labour at the waiting mothers' shelter and then give birth in the maternity ward at Bonda Mission. Failure to do so, the family to which the new-born has been born is fined a goat so that I can be able to write a letter to the hospital to confirm the birth. The hospital also writes another letter that will assist the new-born's parents to get a birth certificate for the baby. It is sad that people do not heed the call to await labour at the shelter because giving birth at the hospital helps avoid deaths and makes it easy for the baby to acquire a birth certificate (Author's Interview 05/10/2019).

The community leaders noted that, apart from the punitive measure that they take to stop home births and encourage expectant mothers to go to the waiting mothers' shelter, they also do awareness meetings in the village to remind people on the importance of hospital deliveries, considering how times have changed. An adviser to the chief, Mr Munyoro, added that:

We always try our best to raise awareness in the community through meetings with women, to encourage them to use the waiting mothers'

⁴⁷ *Dare.*

shelter. We usually get letters from the hospital management to conduct these meetings and that has been our mandate ever since the hospital engaged us. However, I feel that a lot has to be done for people to follow and understand this because not so many people use the shelter. We usually fine people some goats when they have a home delivery in order to assist them to get a birth certificate, but I feel like people no longer feel the burden of paying the goats since the home births are not decreasing significantly despite our efforts (Author's Interview 06/10/2019).

Drawing from the narratives of the community leadership, I observed that the fact that home births have been "criminalised" has not stopped home births from taking place in Mawadza village. Some families in this village still uphold the idea of home birth, for this reason the waiting mothers' shelter runs a risk of not being used to capacity. This consequently works against the district, provincial and national goals towards the reduction of child mortality rates. Community leaders also feel that door-to-door monitoring in the village should be put in place to ensure that expectant mothers go to the shelter to be assisted by skilled birth attendants.

8.3 Mukando

Women in this Mawadza community form groups called *mukando*⁴⁸ that they use to put money aside on a monthly basis, and this money is shared equally among group members. I managed to include some members of *mukando* in my FGDs and I conducted follow up interviews, in which they explained how their groups function in this community and how they assist in the operations of the waiting mothers' shelter. The women get into a group of twenty-four women and put themselves into pairs which pick a particular month of the year. All twenty-four women each put aside a sum of 50 rtgs (the currency that was used in Zimbabwe at the time I conducted my field work) every month and a particular pair is mandated to take all that money and start a business of their choice or buy house furniture and then return the money in the following month with 20% interest. The interests that are charged to the members of the *mukando* group are then used to assist on various activities that involve women in the community, and the women have supported the waiting mothers' shelter. The *mukando* groups have been assisting with the operations of the waiting mothers' shelter since 2010, particularly targeting women who are in need.

⁴⁸ *Mukando* groups can be also be conceptualised as community support groups where in a support group, members provide each other with various types of assistance, usually non-professional, material and nonmaterial, for a particular shared, usually burdensome, characteristic (Moyana 2006:56).

In a FDG, a Mrs. Williams indicated that:

The women in the *mukando* group have been assisting expectant mothers who do not have enough essentials to go to the shelter. The money was used to procure cooking oil, bath-soap, candles and other basic commodities one might need to stay in the shelter (Author's Interview 06/10/2019).

In the same FGD, Mrs. Brown added that:

The money from the *mukando* group helped a lot of expectant mothers in this village. At some point in time, we even bought detergents to clean the toilets because the toilets were no longer safe to use. Had it not been for the mukando groups, many would not have made it to the shelter (Author's Interview 08/10/2019).

Miss White reiterated that:

The women in the *mukando* group have done some good work to support the waiting mothers' shelter (Author's Interview 08/10/2019).

All the women who participated in the FGD agreed that the *mukando* group has been useful in supporting the operations at the waiting mothers' shelter. When all these sentiments were shared in the FGD, I probed further to understand how members (especially senior members of this *mukando* group) went through the process of assisting expectant mothers in the village with essentials to use when they are in the waiting mothers' shelter. Mrs Anderson, the head of the *Mukando* group had this to say:

We started our group in 2010 when Zimbabwe was still using the US Dollar as its trading currency. The group comprised of teachers from surrounding mission schools and other women in the community who wanted to form businesses. We have helped in a lot of activities in this village, especially those that include women. We have helped during funerals, especially when a woman loses a husband, and we have also assisted in sending the children to local schools. When we realised things are not well at the shelter, we also decided to intervene. I have so many receipts of the things we purchased to assist expectant mothers to qualify for their stay in the waiting mothers' shelter (Author's Interview 10/10/2019).

Stella, a member of the mukando group, added that:

Life is getting tough these days and it was better when we were still using the US dollar because money still had a better value. 50 rts will not purchase much because of inflation. Most members are pulling off the group. The mukando group is now a burden to us as we can no longer keep up with monthly subscriptions. Ever since 2019 started, we haven't done much to assist expectant mothers who await labour in the shelter. There are actually about six expectant mothers who failed to await labour in the shelter because of lack of essentials, and we also failed to assist. We agreed with fellow group members that we give our donations directly to the expectant mothers because there have been rumours of midwives using donations for personal use at their homes. With the way life is getting tough in Zimbabwe, the midwives are definitely taking advantage of the situation. This year we have only managed to assist expectant mothers with maize meal; as for cooking oil and washing soap, we don't know what they will do because it has turned out to be too expensive (Author's Interview 10/10/2019).

Mrs Green, the deputy leader of the *mukando* group, in a follow up interview after the FGD also said:

What did not go down well with me was the fact that we once donated a few blankets in 2016 for winter but as a group we heard that some of the blankets were taken by the midwives to their own houses. Even the 5 litre containers of Jik (disinfectant) that were purchased by the group to assist in the cleaning of toilets was also rechanneled for personal use by the midwives at the shelter. This is not good because life is tough in Zimbabwe. From that point up to today, if we have hand-outs to give away we give directly to the expectant mother before they go to the shelter, not to make donations to the shelter (Author's Interview 08/10/2019)

An interview with Bella over the issues of misuse of donations in the shelter revealed this:

We receive donations from the mukando groups of Mawadza village and other surrounding villages. These are not the only well-wishers who assist us; we also receive assistance from the Anglican Church, Government Organisations (GOs) sometimes, and even NGOs. All the aid we receive is supposed to be recorded down and then shared to the intended beneficiaries only when there is need. We are not allowed to take aid for our own personal use and neither are we allowed to take aid and just use it without acknowledging that there is aid on paper and the correct quantities...We do not misuse aid and we also do not use aid for personal gains (Author's Interview, 12/10/2019).

Bridget added that:

All the aid that we have received from any group or civic organisation has been put to good use. As the general overseers of this shelter, we put all the donations to good use. Sometimes expectant mothers from different communities might not understand the logistical challenges we go through in running a shelter with little resources available... We keep tablets in here and other valuable utilities that assist the expectant mothers, and we just let the beneficiaries use them. Other things such as detergents are misused by the expectant mothers themselves and it's quite some work for us to control them not to misuse these things (Author's Interview 12/10/2019).

In addition, data abstraction from the records I was offered by Bella showed that there are available records in the shelter, of which a duplicate is kept at the hospital maternity wards for accountability purposes. The records showed all donations made from the year 2018, the quantities, what was used and what still remains. Other records from the previous years were missing during the period I conducted fieldwork, but, Bella promised to provide them as soon as her paperwork is in order. The duplicates at the hospital maternity ward had also gone missing during the period in which I conducted fieldwork.

The *mukando* group has been largely vibrant in assisting expectant mothers financially and even with material needs required for them to qualify for their stay in the waiting mothers' shelter. This group has also been active in cleaning of this facility on certain occasions. The *mukando* group has done a clean-up campaign at the shelter on two occasions since 2014. On these two occasions, the senior members of the group acquired permission from the hospital superintendent to visit the shelter and conduct a massive clean-up. These clean ups are part of community service by these women, that they felt very proud to conduct for their community. Community service in form of clean ups have also attracted the efforts of male members of this village. These clean ups are important in assisting the expectant mothers who are heavily pregnant and who do not get any assistance from cleaners since the hospital cannot afford to employ any.

8.4 Men's Involvement in the Operations of the Waiting Mothers' Shelter

The findings from the study showed that male members have not done much to assist in the operations at the waiting mothers' shelter. This is due to little understanding of the shelter and the activities that are conducted in this facility. From the data gathered in FGDs, women appeared more dominant in strategies and activities that assist in the operation of the waiting

mothers' shelter. A few men who have knowledge and understanding of the waiting mothers' shelter have assisted on a yearly basis at the shelter through a programme called chief's work party⁴⁹. The chief's work party is a programme which forms part of community service conducted by every member of the community. The programme is done for a day and it is led by the chief in the village. The chief either invites people to work on his house and field or he chooses a field of a community member so that people can go and work there for a day. Chief's work party is accompanied by food and alcohol as community members will be working. As part of the chief's work party programme, the men in Mawadza village have assisted in fetching of firewood at the shelter. The men who would be available in the village on the day of chief's work party have assisted in fetching firewood to work as a cushion for expectant mothers. The firewood, if it lasts up to winter, is also used to make a fire in the facility for warmth since the winters are generally cold in Manicaland.

Mr. Josephs noted that:

As men, we feel so challenged by the women who made an initiative to raise money and assist expectant mothers with utilities. We have other projects as men, like burial projects where we assist with funeral arrangements, but it had never crossed our minds to assist the women. Now that the women have showed us their efforts, we have realised the need to assist them to keep the shelter running) (Author's Interview 16/10/2019).

Mr. Floyd also added that:

As men we assist the shelter during the *zunde ramambo*⁵⁰. We thank the chief who brought the initiative of fetching firewood for the expectant mothers. The firewood also assists in winter, because the mothers make a fire to keep them warm (Author's Interview 16/10/2019).

Mr. Thompson also voiced his thoughts, indicating that:

I think we should help the women, with all the work that they have done, to assist the operations at the waiting mothers' shelter. As men, we will call for a meeting so as to see how we can assist the women with this

⁴⁹ *Zunde ramambo*.

⁵⁰ The chief's work party, where village members gather and do community services to please the chief Nyambuya (2011: 2).

good project that we did not take seriously (Author's Interview 16/10/2019).

The narratives that came from the male members of the community show that community involvement in the operations of the waiting mothers' shelter is highly gendered. Women take the leading role while a few men take a passive role. This revelation led me as the researcher to probe further into how men have possibly assisted in the operations of the shelter through other ways, apart from financial and community services. A dominant theme that came out from the respondents was the issue of emotional support.

8.5 Emotional Support

All the male members who participated in the FGD shared similar sentiments as those stated above. They also highlighted that, although not assisting financially, some of them (who have a better understanding of the shelter) have assisted by supporting their women who are expectant mothers to go through their waiting period in the shelter. Three of the men (Mr. Leninton, Mr. Grey, and Mr. Faraday) in the FGD highlighted that the emotional support that they each offer their partners has assisted greatly to encourage the women to stay at the shelter. Men in the FGD noted that some women are reluctant to go to the shelter for the fear of leaving their families unattended and, most importantly, they would be seeking the husband's approval. It is after the man approves that an expectant mother may go to the shelter, and then the woman freely goes to the shelter.

The challenge that the other seven men who shared a slightly different view highlighted is that there is not enough awareness on the functions of the shelter in them, hence they do not feel as part of the facility and, most importantly, they do not feel as if their input as men is important.

Mr Joseph explained that:

I feel like the issue concerning the operations at the waiting mothers' shelter largely concerns women. When they conduct their meetings, we are always under the impression that they would be discussing issues that concern women only. It can be likened to a stage where my daughter begins to develop breasts. I cannot personally talk to my daughter but wait for the aunts, who are other women, to talk to her (Author's Interview 17/10/2019).

Mr. Jones also queried that:

The issues concerning the operations at the waiting mothers' shelter can never be properly understood by us as men. My question is, when the midwives and the nurses come to the community to conduct meetings, why do they not include us so that we make financial contributions with full knowledge? (Author's Interview 17/10/2019).

Mr. Thompson furthered the query and said:

I wish they could include us in their meetings because we have little knowledge about the shelter. Honestly, it's hard for me to be involved in a meeting that only speaks directly to women and in a meeting where I am not invited. In the *Manyika* culture, we believe in educating someone in order to empower them. So, we do not feel empowered as men on issues to do with the shelter (Author's Interview 17/10/2019).

The healthcare professionals at the waiting mothers' shelter also reiterated the limited support that they receive from men in all the surrounding villages, including Mawadza, although they acknowledged the chief's work party function as also one of their strengths. The staff members at the hospital expressed their views on the involvement of men in the operation of the waiting mothers' shelter.

Doctor Marshal said:

We appreciate the help we get from men when they conduct the zunde ramambo. Their contributions are very helpful as it makes it easier for the mothers to cook and warm water without going to fetch firewood, or bringing their own. In winter, the overseers at the shelter use the same firewood to make fires so as to keep the mothers warm. I, however, appeal for an improvement in support from men by bringing their wives for prenatal care to the hospital. We are raising campaigns in villages, reminding men that a couple falls pregnant, not only the woman. Once a woman has been diagnosed pregnant, both the mother and father to the unborn baby should visit the hospital together for prenatal care. We hear sad cases of expectant mothers who test HIV positive during pregnancy and when they tell their partners to visit the hospital for counselling and a plan to start ART, the husbands do not comply. Some women are escorted by their family members to check into the shelter when their husbands are busy drinking in the local beer halls. We have made it a mandate that a new mother does not get discharged from post-partum care unless they are picked up by a spouse but we had to loosen up the rules to any relative when we realised men are not cooperating. More

education should be given to men; much more is needed from them in terms of supporting their spouses in the waiting mothers' shelter (Author's Interview 19/10/2019).

Doctor Ben added:

Fathers also need to create bonds with their children as much as the mothers do. It is due to the public nature of the maternity ward at this hospital that we do not accept men in the labour ward, but I see no problem that a man waits outside the labour room for his wife to deliver and be one of the first people to welcome his child on earth, put him on his chest for bonding as paediatricians and psychologists always encourage. It's sad that women go through all the labour process alone. Most men in the surrounding villages are shy to come to the maternity wards, more specifically the shelter. Sometimes those who visit do not take time in the shelter because they do not want to appear as if they were given love portions by their wives. As much as I am a doctor, I am also a man, some cases of the so-called married women are pathetic, and they bear all the burden of childbirth alone with little or no support from their husbands. Even for immunisation I have never seen couples coming with their children, I only see mothers. Men need help on this one, their support is really lacking in the shelter (Author's Interview 19/10/2019).

Doctor Rodney jokingly expressed his views by stating that:

The men in these villages are very stubborn; all they know is to impregnate women and then run away from responsibility. The situation is better in urban areas because men now attend bachelors' parties where they are taught about family care and responsibility. In rural areas, a lot still needs to be done because once a man can make a woman pregnant, provide shelter and food; they feel they have done it all - of which it is not the case. Expectant mothers need emotional care and support too (Author's Interview 19/10/2019).

Bridget also added by saying:

I feel that the job that has been done by the women in the *mukando* group should be supported by men. It feels so sad that women fund-raise money through difficult ways to support other fellow women with utilities when their husbands are alive, and some of them drink alcohol every time they get paid, leaving nothing for their families. Community leadership in Mawadza should appeal to the men to contribute financially also towards the running of this shelter (Author's Interview 20/10/2019).

The narratives from the community members further highlighted the fact that community involvement in the operations of the waiting mothers' shelter is gendered, as women take the major role. Apart from looking at the contributions of men and women separately in the operations of the shelter, I also looked at other pertinent groups such as the community Faith-Based groups and the TBAs and Traditional Healers.

8.6 Faith-Based Community Initiatives

8.6.1 Anglican Church Faith-Based Community Group (FBCG)

In this section, I discuss the contribution of the Anglican Church Faith Based Community Group (FBCB) in the operations of the waiting mothers' shelter. The FBCG has both a direct and indirect impact on the operations that are conducted at the waiting mothers' shelter. This is so because it is involved in the day-to-day operations of the shelter, and it also tries to reach out to community members which has a bearing on the operations of the shelter. In Mawadza village, there is a group of men and women from the Anglican Church who work as evangelists in the village and assist in church related business. The group has also been involved in the operations of the waiting mothers' shelter.

The most crucial contribution that the members of the group highlighted was that they conduct prayer sessions at the hospital administration as well as at the waiting mothers' shelter. The group takes turns on a monthly basis with groups from other villages such as Sanyatwe and Saburi to go and administer prayers with the staff members and the expectant mothers in this facility. The prayer sessions are vital for the well-functioning of the shelter, according to the Christian participants, as *“the Lord is the foundation of everything”*. In addition, conducting prayer sessions have served evangelical purposes as well as educating the expectant mothers about the Anglican Church doctrines so that they may convert to the Anglican Church when they are ready.

Mr. Lenninton indicated that:

We go as a church-based community group to the shelter to conduct prayer sessions because without God as the solid foundation, the staff members will not do much. Once every month, we go to the shelter and conduct preaching sessions and prayer. Those who want extra prayer

sessions are usually visited after they give birth and leave the shelter (Author's Interview 16/10/2019).

Mr. Grey also noted that:

We usually assist expectant mothers through prayer because our doctrine compels us to do so. There are quite a few people who converted into our church through their experience in the waiting mothers' shelter (Author's Interview 16/10/2019).

Apart from prayer sessions, the FBCG is also involved in the administrative operations of the shelter. This is so because these groups conduct elections at church level to nominate the senior staff members at the waiting mothers' shelter. The church is involved in choosing senior members at the shelter because the church contributes to a fraction of their salaries and they provide accommodation close to the hospital. The senior midwives at the shelter have other benefits such as free education for their children at Bonda Mission School. As part of the credentials, apart from a qualification in midwifery, one has to be a strong member of the Anglican Church with a good reputation in the community and with the capability to uphold the doctrine even when delivering their duties. The FBCG works as church representatives in choosing members of their choice among the qualified medical personnel at the hospital. Nevertheless, there has been a lot of church politics that has hindered these elections from properly taking place till the provincial offices of the MoHCC has had to intervene. In addition, there seems to be some disparity between this practice and the reportedly bad behaviour of at least some of the midwife staff at the shelter.

Mr. Jones illuminated this point:

After every five years, we conduct elections to choose senior staffs at the shelter. We do this for evangelical purposes. However, these days church politics has disturbed the smooth running of the election process. As you know, the Anglican Church has split into two groups, and each group wants to interfere with the running of the shelter – even the hospital at large. The last dispute was resolved by the MoHCC, which resolved that the current senior staff members at the shelter should stay. Sometimes the midwives bribe fellow church members to vote for them. Church politics is so real here, just that we cannot go public about it for fear of tarnishing the church image (Author's Interview, 17/10/2019).

Bella advised that:

The Church has been very supportive in the operations of the shelter and we appreciate it. The Church provides an anchor from which we derive both spiritual support and guidance in the word of the Lord Christ Jesus our saviour. If funds become available, we continue to appeal for more utilities at the shelter because we are operating with very low a resource base, which makes it too hard for us (Author's Interview, 21/10/2019).

The church has been vibrant in participation and in the operations of the waiting mothers' shelter. Although the narratives have shown that the involvement of the church in the operations of the shelter is not without its own problems; it is prudent to note that religion and health care systems in medical pluralistic societies cannot be separated (Singer *et al.*, 2011). Green *et al.*, (2005; 2012) also noted that religion and health can not be separated especially in developing countries. The influence of religion in biomedical health care facilities is evident in mission hospitals as has been revealed by the level of involvement of the Anglican Church in the operation of the waiting mothers' shelter. According to Ranger (1980), in mission hospitals such as Bonda Mission Hospital, the church is heavily involved since mission hospitals are church-based institutions since the time they were established in Zimbabwe in 1930. This has left other members of the society who do not subscribe to Christianity feeling alienated from the waiting mothers' shelter as a maternal health care facility that should be available to serve community members regardless of religious affiliations.

8.6.2 Traditional Healers (TH) and Traditional Birth Attendants (TBAs)

The traditional healers and the traditional birth attendants, as part of the Mawadza village, openly dissociated themselves from the operations of the waiting mothers' shelter in the interviews I conducted with them. This is because they felt that the staff members at the hospital, and specifically at the shelter, do not positively recognise their activities. All the participants I interviewed expressed that, given the chance, they would be very keen to work together with hospital staff members, but their activities are strongly criticised. Through data abstraction, the traditional healers and the traditional birth attendants showed me certificates from ZINATHA and others from the MoHCW 1985 training programmes. The fact that these individuals feel as qualified as the nurses and doctors makes them bitter as to why their contributions towards childbirth are demonised by the hospital staff members.

Alice said that:

I am a trained midwife that was trained by the Ministry of Health and Child Welfare before it changed its name. My friends whom I was trained together with joined hospitals and became midwives, although most have retired and died. I, however, chose to operate from home using the indigenous knowledge systems and I have, all of a sudden, become a half-baked midwife because those who did not were chosen to work from hospitals and I, being illiterate, could not operate in a hospital. I worked so hard in Mawadza in the pre independence era, and I was given a bicycle by the white people to help women deliver. The community knows that I am a good birth attendant and I do not leave our culture behind in all that needs to be done during the childbirth process... I do not support the shelter and their operations because they also do not consider us useful (Author's Interview 17/10/2019).

Tilda added by saying:

Our services are slowly becoming unrecognised by the healthcare workers at Bonda Mission Hospital. I do not think they even need our input for the proper functioning of the waiting mothers' shelter. They always make campaigns against us, which is not good. When one is advertising their product, they should never do so by de-campaigning another product because it's not good. In my experience, I have assisted hundreds of women to deliver and nothing will ever go wrong in my hands because I am experienced. The good thing about our village members is they know that we are good. Those who come to us are penalised by the chiefs. Of course, numbers have dropped in the past 2 years, but not very significantly (Author's Interview 18/10/2019).

Uncle Joe said:

I have nothing to do with the waiting mothers' shelter, they do not consider us as humans because we are illiterate, but it does not require education to handle pregnancy. It does not also require education to handle an infant, giving proper medicines for a healthy life of the infant. I believe I am still relevant in this community because I have saved the lives of many mothers and their children. Even those who discourage others to come and get help from us come here at night after work and we help them. I am waiting for one day when I will expose those hypocrites (Author's Interview 15/10/2019).

In response to these views, Doctor Ben said:

We are not against the traditional healers and the traditional birth attendants, but remember our sole mandate is to save lives – both of the mother and the new-born babies. I, for one, do not question their experience and expertise because I know they are experts. What we

question is the capacity of the traditional healers and the traditional birth attendants to handle emergencies when they attend to birthing mothers at home. How do they handle such cases as post-delivery haemorrhage? How do they deal with raptures of the vaginal tract during delivery? The truth of the matter is, when a complication arises, the traditional birth attendants are not in a better position to handle the emergencies – and even if they refer the emergency to the hospital, it might be too late due to logistical challenges arising from the long distances and the poor road network system (Author's Interview 23/10/2019).

The differences in practice between the biomedical health care system and the traditional healers have resulted in antagonism in their respective operations and practices and this has affected the operations of the waiting mothers' shelter. As has been noted above by the respondents, the traditional health care system feels alienated from the hospital operations. This has been caused by the high level of criticism received by the traditional health care system from the hospital staff members. The level of contestation between these two dominant health care systems in Mawadza has resulted in other expectant mothers not awaiting labour in the shelter due to the influence of the THs and TBAs.

8.7 Community Involvement and Symbolic Interactionism

The involvement of women in the village in assisting other expectant mothers with groceries so that they qualify for their stay in the waiting mothers' shelter has basically led to a clearer understanding of the first premise of symbolic interactionism: we act toward things based on the meaning that the things have for us (Blumer 2004: 99). We learn symbols that are associated with something and associate particular meanings to those symbols. Those meanings include how we are to act toward the thing, our attitudes toward the thing, and how we might use the thing (Blumer 2004, Conrad 2012). Pregnancy and childbirth processes are symbolic processes that are highly regarded by society in Mawadza, but better understood by fellow women based on same experiences. Shared meanings and experiences of the childbirth process affects how women in the community assist other expectant mothers who are in need.

In addition, the meanings we give things arise out of our social interactions with others in society, and this has been shown by the involvement of men in the operations of the waiting mothers' shelter. It is prudent to conjecture that the meaning for things comes from our social interactions with the members of a given society. The men in this society have little knowledge

and understanding of the shelter because of the nature of social interaction in this community that heavily includes and excludes men. The meanings that these men developed will be highly skewed towards the thought that the waiting mothers' shelter is for women and a responsibility of women only. Social interaction with community members around every human, objects, family, friends, values, beliefs, among others, the meaning for all of them came from social interactions with other people. Once we acquire such meanings, we can then create additional meanings or combinations of meanings through the process of thought, but all thoughts start with meanings learned in our social interaction.

The meanings of things for humans in relation to their cultures are obviously affected by the circles and nature of association. The more diverse one's social interactions, the more diverse one's interpretation of things. Such diversity affects one's behaviour, sense of self, relationships and worldview (Mussolf 2003). In my view, when it comes to Mawadza village, this diversity lacks the involvement of men. This has been shown by the exclusion of men from meetings concerning awareness on the importance of awaiting delivery in the shelter and giving birth in the hospital facility. As a result, they are alienated into passive observers of the operations of the waiting mothers' shelter. In some ways, the size of one's social network affects the breadth and depth of the meanings they can draw from in interpreting the world (Redmond 2015: 24). As much as it is not as popular in the community, as noted in this chapter, families who get involved in home deliveries are fined in an effort to discourage them from being involved in home births. This works as a form of awareness being raised in the community to encourage community members to await delivery in the shelter and, as a result, give birth in the hospital facility and this form of interaction gives a broader perspective of the shelters in the community. Different forms of interaction that are held in the community in support of the shelter assist in shaping the meanings of this very facility to community members.

8.8 Society

In this chapter, a clearer understanding of society is observed as postulated by Mead (1934). From the symbolic interaction perspective, the essence of a society is the interaction and communication of individuals through symbols, as has been seen through the involvement of community members in the operations of the waiting mothers' shelter (Plummer 2016: 50). As such, –Society arises in social interaction; it continues through social interaction; it ends without

social interaction” (Charon 2007: 157). It is prudent to consider what might possibly happen without social interaction in Mawadza village. Without communication that arises from symbolic interaction, there is no society (McCall 2013: 72), meaning that community involvement in the operations of the shelter would be limited, if not non-existent altogether. Typical qualities associated with being a society include embedded patterns, relationships, and roles; diverse people linked together in joint activities over space and time; and people who interact in small social networks that exist and interact with a larger social structure (Stryker & Burke 2000, Hewitt 1976). All of these qualities are dependent upon symbolic interaction and a notion of a symbolic self. –Society, then, is individuals interacting over time, acting with one another in mind, adjusting their acts to one another as they go along, symbolically communicating and interpreting one another’s acts” (Charon 2007: 158). For Mead (1934), symbols create and maintain the societies within which we exist. They are used to socialise us, they make our culture possible, they are the basis for on-going communication and cooperation and our ability to pass down knowledge from one generation to the next they are made possible (Charon 2007: 88).

In addition, for Mead (1934), societies cannot exist without the self. The interaction of selves gives rise to society although the selves emerge as a result of society. This might appear to be a conundrum, but some scholars, such as Stryker and Burke (2000) (structural symbolic interactionists), see society as the dominant force from which our sense of self develops. For structural symbolic interactionists, the focus of study is on the current state of human affairs within societies, and it is into these existing societies that people are born and develop a sense of self. In this view, it is the existence of the shelter that shapes the behaviour of the community members into involvement or non-involvement in the operations of this facility. The focus on society first tends to then lead more to examination of social phenomena and how those phenomena affect individuals. Regardless of the focus, it is prudent to remember that in symbolic interactionism, –society is to be understood in terms of the individuals making it up, and individuals are to be understood in terms of the societies of which they are members” (Meltzer *et al.*, 1975: 31).

8.9 Conclusion

In this chapter, I have analysed the involvement of the community in the operations of the waiting mothers’ shelter. The community has been involved at different levels. Women through

the *mukando* group have made significant contribution to the operation of the shelter. The *mukando* group has assisted with groceries to expectant mothers who wish to go to the shelter so that they qualify for their stay in this facility. They have also made donations such as blankets and detergents to assist the shelter. However, due to financial challenges, the group has faced challenges in raising funds to assist like before.

In addition, the chapter has shown how traditional leaders and people in positions of authority help to enforce people to await delivery and give birth in a hospital. This is done through fines that are paid to the chief in form of goats as an admission of guilt for giving birth at home. In addition, other groups within the society, such as FBCGs, have also contributed towards the operations of the shelter through prayer sessions, although this has caused a few conflicts with other expectant mothers. The group also assists in electing senior members at the shelter; this is done to preserve the evangelical purpose of the shelter and also to ensure that the doctrines of the Anglican Church are well-followed in this institution. However, it was revealed that due to church politics, there have been problems in electing the senior member; hence the MoHCC has intervened to resolve the problems. In light of the findings gathered, it can be noted that men in this community feel alienated in the operations of the waiting mothers' shelter. The programmes available in the village do little to involve men. Men even showed little knowledge about the proper function of the waiting mothers' shelter. However, for those who have assisted, they have fetched firewood on a yearly basis to assist the expectant mothers and they have supported their spouses to use the facilities, although this constitutes just a few men.

CHAPTER NINE

REFLECTIONS, RECOMMENDATIONS AND CONCLUDING REMARKS

9.1 Introduction

I completed my fieldwork in October 2019, and as I left Mawadza, I began reminiscing on my fieldwork experiences, thinking of what would become of my research participants. As I left the field, I longed to come back to this place soon, not only to do research, but to see how the mothers who shared their experiences in the waiting mothers' shelter with me are doing. Many times during my study, I reflected on how this study would impact on the lives of future expectant mothers and mothers in Mawadza village. A considerable number of women who took part in the study viewed their participation as the first opportunity to relate their concerns with regards to their experiences during prenatal, intra-, and postpartum care in relation to their use or non-use of a waiting mothers' shelter in this medical pluralistic village of Mawadza. Consequently, a lot of women throughout the study reflected on what they wanted their future pregnancy and child birth experiences to be like in this facility and at Bonda Mission Hospital. Throughout the study, I constantly reflected on that question and even upon writing this chapter, reflection on this pertinent question still unrelentingly persisted.

In this chapter, I revisit the numerous questions leading to this study as well as those that were developed throughout the unfolding of the thesis. I begin by making a summary of the entire thesis, highlighting the key findings of the study as well as the conclusions that I draw from these findings. After this, I engage in a discussion from the perspective of the symbolic interactionist theory, explicating how the theory enabled me to understand the experiences of expectant mothers during prenatal, intra-, and postpartum care, in relation to their use or non-use of a waiting mothers' shelter within the medical pluralistic village of Mawadza. In doing this, I reflect upon the weaknesses and strengths of the symbolic interactionist theory in helping me to understand and explain the experiences of pregnant women. I then devote my energy and attention to discussing how my thesis makes empirical, theoretical as well as policy contributions. I then move on to identify possible areas for future research, drawing from the findings of the study.

9.2 Summary: Key Findings and Conclusions

The main objective of this study was to understand the perceptions and experiences of expectant mothers in relation to their use and/or non-use of the waiting mothers' shelter at Bonda Mission hospital. The main objective of this study was achieved by asking the following sub-questions:

- What are the expectant mothers' experiences of waiting mothers' shelters before, during and after delivery?
- What are the determinants of utilisation of the waiting mothers' shelters by the Mawadza village community members, and what are the factors that influence women's choices regarding use or non-use this facility?
- To what extent do expectant mothers exercise their bodily agency and traditional birth practices during their waiting period in the waiting mothers' shelters?
- What is the extent of community members' involvement in supporting (or not) the operation of the waiting mothers' shelter at Bonda Mission hospital?

The research problem that is addressed in this thesis is established in the first chapter. Several gaps that exist in literature on experiences of expectant mothers who use and those who do not use waiting mothers' shelters during pre-natal, intra and post-partum care are examined, contributing to the establishment of the significance of the study. This was followed by the research objectives which contributed to the formulation of the research questions. From there, the theoretical framework and the methodology steering the thesis were also articulated in the chapter.

The first objective was addressed in Chapter Five which identified and describes how pregnancy and child birth processes are subjectively understood and constructed in the medical pluralistic village of Mawadza. In this chapter, the perceptions and experiences surrounding the concept of pregnancy and child birth are explored. I first explored the subjective perceptions and constructions of pregnancy and child birth in the village. Here, I explicated the experiences and perceptions of the child birth process, but firstly the socio-demographics of the study participants were explored with a view to justify how these participants were expected to fulfil the research

objectives. The perceptions of child birth in Mawadza village are varied. Although pregnancy is a physiological process, it is held to have certain meanings in society; hence it is socially marked and shaped. As such, local names of pregnancy such as *pamuviri* (lit. on the body) or *kuzvitakura* (lit. carrying oneself) all directly translate to the symbolical meaning of carrying something. Childbirth is also referred to as *kusununguka* or *kubara*, which directly translate to ‘being relieved’. These socially constructed names symbolise that childbirth in African societies represents fulfilment. Related to this, are the roles of TBAs, the study has shown that they hold an important position in society, in which entails helping diagnose pregnancy as well as assist with the childbirth process. These social roles of diagnosing and assisting with child birth, indeed, play an important part in the reproduction of existing social systems within the society, contributing to the sustenance of traditional practices of caring for expectant mothers and childbirth assistance.

The second objective of the study has been addressed in Chapter Six. Here, I explored the multiple conundrums expectant mothers face and factors that influence their choices and decisions concerning the use and non-use of waiting mothers’ shelters. I showed that on one hand the need to be attended by skilled birth attendants, the criminalisation of home births and awareness campaigns conducted in the community have been factors that have encouraged expectant mothers from Mawadza village to use the waiting mothers’ shelter. On the other hand, the chapter shows how the medical pluralistic nature of the community makes expectant mothers rely heavily on traditional healers, TBAs and SBAs. This highlights that the ready availability and easy accessibility of traditional healers, TBAs and SBAs in the village influences women to prefer visiting these first before they visit the local hospital. Expectant mothers are able to get all that they need within the village (like some kind of one-stop maternal shop) and also, the traditional means of giving care to expectant mothers accepts all forms of payments which makes them more (affordable and) preferable. Long distance to waiting mothers’ shelters is one of the main reasons why women prefer to use traditional methods of care and assistance with child birth over the biomedical option, deemed inaccessible by many, especially, in their condition of pregnancy.

Factors that influence the choices of expectant mothers concerning care and assistance with childbirth have also been established in this study. These influences include religious factors,

where Christianity is a major influencing factor leading expectant mothers to await labour in the waiting mothers' shelter and opt for hospital deliveries, and heavily criticize traditional practices. Traditional practices are highly criticized by Christianity and thus expectant mothers who subscribe to Christianity use hospitals for childbirth. The study reveals that the different Christian religious sects impact differently on child care practices. Whilst women from some Christian Apostolic sects support the use of religious paraphernalia such as stone talismans in child birth, some do not use these. The use of paraphernalia such as stones by the different members of Apostolic sects, thus, signifies that some Apostolic religious sects are a mixture of African Traditional Religion and Christianity as has been alluded to by Ranger (1980). In addition, while some women value traditional ways of opening up the birth canal for child birth, such as using elephant dung, hospitals criticize the use of these – hence the some women prefer using traditional practices of childbirth where no one hinders them to do what they believe in. Other factors leading to the none use of facility use include the lack of knowledge about the shelter, facility requirements, economic challenges, lack of privacy in the shelter, relations with the health care provider, the stigma attached to HIV and AIDS and family expectations among others. The biomedical and social models of health were also explored to shed light on the limits of both and their influences on the health seeking behaviours of expectant mothers. The major criticisms levelled against the biomedical approach are its tendency to underestimate social and psychological factors relating to pregnancy and child birth which constituted the bulk of the narratives of my research participants.

Objective three was addressed in Chapter Seven which showed various ways through which expectant mothers exercise their bodily agency and traditional birth practices during their waiting period in the waiting mothers' shelters. I submit that women who use waiting mothers' shelters are not passive bodies but they are active in making decisions either to use or not use the waiting mothers' shelter. With regard to bodily agency, Chapter Seven proceeded to explore the experiences of expectant mothers in the shelter relating to their bodily agency and the complex relationship between them and health care professionals. The thesis demonstrates the utility of cultural competence on the part of medical professionals so that they become sensitive to cultural practices (those that are proven not harmful/pathological) meant to assist expectant mothers during pregnancy, on giving birth and after giving birth. The biomedical professionals who took part in this study demonstrated awareness of cultural ways of caring for pregnancy but are

sceptical on the safety of these ways to care for pregnancy both for the mothers/unborn babies/new-born babies. Expectant mothers in waiting mothers' shelters felt that within the shelter they were not able to demonstrate their agency through the use of traditional birth practices.

In addressing the third objective, I concluded that although medical pluralism and distances between expectant mothers' homes and health care facilities determine the use and/or non-use of waiting mothers' shelters, it is not established that traditional methods of caring for pregnant women during pregnancy, at child birth and after child birth, are a hindrance to the use of biomedical facilities by pregnant women. Traditional practices can be rather, complimentary to biomedical practices and they close the gap that is left by the biomedical institutions. It is within this ambit that I propose that the biomedical fraternity should find ways of harnessing indigenous knowledge and traditional practices that are proved not harmful in caring for pregnant women, before and during childbirth as well as after childbirth.

The fourth objective is addressed in Chapter Eight, where I deliberated on the participation of the community members of Mawadza village in the operations of the Bonda Mission waiting mothers' shelter. In addressing the previous objectives in the previous chapters, I exhibited that not all women in Mawadza village benefit from staying at the waiting mothers' shelter. Instead, a significant size of the population actually utilise their homes because of various reasons such as medical pluralism, child care and family commitments, lack of understanding of the importance of the waiting mothers' shelter, lack of body agency and cost of food and essentials during the expectant mothers' stay in this facility, among other factors. Looking at all the factors mentioned above, understanding the level of community involvement in the operations of the waiting mothers' shelter was of great importance since it raises awareness and provides insights that have the potential to increase women's use of this facility and sustain the activities conducted at the shelter, once applied. The thesis revealed that although the community is involved in the operations of the shelter, women take a larger burden through their community support groups. Men have taken a largely passive role in the support of the shelter, which has only served to exacerbate the women's burden.

9.3 Understanding Maternal Health Care Services in Waiting Mothers' Shelters from a Symbolic Interactionist Perspective

My intention in this thesis was to show how the symbolic interactionist theory can be used to understand pregnancy and childbirth experiences, both within the waiting mothers' shelter at Bonda Mission Hospital and in the context of how pregnancy and childbirth is conceptualised and understood and cared for in the context of Mawadza village away from the waiting mothers' shelter. At this point, it is apparent that understanding pregnancy and childbirth experiences of expectant mothers in Mawadza village using the symbolic interactionist theory is perfectly possible. This is largely due to the fact that the symbolic interactionist theory has allowed me to analyse data using an interpretive approach, where interpretation and legitimacy is placed upon social interactions and meanings that social actors place on interactions in their context, (Blumer 2004, Charon 2007, Redmond 2015). The emphasis that the theory places on the individual (expectant mothers) was very pertinent to my study as it gave the individuals (expectant mothers) command in narrating their experiences and how they place meanings to these experiences in their culture and social worlds (Schutz 1972). The theory that I used was well supported by my research design that used a phenomenological approach.

Accordingly, the thesis was informed by the symbolic interactionist theory, where experiences of expectant mothers lived in their interactions as social actors produced meanings of social processes tied to prenatal, intra-, and postpartum care in the waiting mothers' shelter. This was, specifically, in light of the experiences and the disparities that expectant mothers face when using indigenous knowledge and traditional practices of maternal care within the facility. The thesis brings out the understanding that navigating the terrain of maternal care in a medical pluralistic village is a huge task for expectant mothers as they are faced with the option of utilising traditional practices of maternal care, at the same time taking into consideration the availability of maternal health biomedical facilities with skilled birth attendants. The ability to choose to utilise waiting mothers' shelter demonstrates agency since women are surrounded with various options due to the presence of alternative care in the villages. Indigenous knowledge and traditional maternal care practices are not allowed in the shelter which shows a limited extent to which bodily agency is practised within biomedical fraternities.

9.3.1 An Interactionist Perspective of Pregnancy and Childbirth

The interactionist perspective facilitated an integrated understanding of pregnancy and childbirth, with particular reference to the care that expectant mothers who use or do not use waiting mothers' shelters receive. From an interactionist perspective, there is need to understand pregnancy and childbirth experiences indigenous cultures. This should be followed by an exploration of how expectant mothers navigate pregnancy and childbirth, especially, in rural communities distantly located from institutionalised maternal health care facilities. This section consolidates the interactionist perspective on pregnancy and childbirth, drawing from the findings of this study.

9.3.1.1 Symbolism of Pregnancy and Childbirth

Pregnancy and childbirth in Mawadza village are important occurrences which, from a symbolic interactionist perspective, can be seen as symbols, marking certain important stages in people's lives. Pregnancy in Mawadza village symbolically represents a woman carrying something that is precious, implying that pregnant women need special treatment. The society's view in conceptualising pregnancy and childbirth birth processes affect how expectant mothers view their bodies and form their identities. This could be the reason for different health care systems in this medical pluralistic village attempting to take good care of expectant mothers and the unborn babies, who are important for the regeneration of the society. Pregnancy also carries with it symbols that are used by people within the traditional fraternity in the community to determine important phases of pregnancy. The thesis has uncovered novel ways through which locals, without the use of sophisticated technological machines such as scans but merely relying on gestures and symbols that are conveyed by the expectant mothers, are able to determine important signs of pregnancy or even signs of imminent childbirth.

9.3.1.2 Interpretation of Symbolic Interactions and Health Seeking Behaviours of Expectant Mothers

Symbolic interactions between the different actors within Mawadza village give rise to variegated interpretations of pregnancy and childbirth as well as the care that the expectant mothers should receive. The study demonstrates the usefulness of the symbolic interactionist theory in helping to explicate how the interactions between local people and expectant mothers in Mawadza village influences their image of the self and, ultimately, their health-seeking

behaviours. With regards to interaction, the experience of pregnancy and childbirth both in and out of waiting mothers' shelters carries with it a difference in treatment than previously, when the women were not pregnant. This treatment definitely impacts on the self-image of the women as they come to view themselves as different from other members of society and needing special treatment. This has also an impact on their health-seeking behaviours in biomedical facilities as highlighted in this thesis.

Assuredly, expectant mothers in Mawadza village are accorded special treatment and carry with them a different title as they are regarded as crucial in bringing new lives into the community. The specialised treatment and respect they get from fellow community members affects their identity and creates within the expectant women a sense of trust of the people surrounding them and, definitely, this leads them to trust the traditional maternal care practices and birth attendant methods that the community prescribes for them. However, while institutionalised systems of caring for pregnant women do offer much-needed support for expectant mothers, there are several inhibiting factors. Some of these include the lack of appreciation for indigenous knowledge and traditional practices for maternal health care leading to the criticism of these by the health professionals, thereby creating a rift with the expectant mothers. In addition, the semi-confinement of women in these facilities does not auger well with the women who need emotional, psychological, physical and social support at these times. This is compounded by the issue of long distances to the health care facilities, and the high cost of institutionalised maternal care leads expectant mothers to present late at these facilities or avoid using them altogether.

9.3.1.3 Symbolic Contestations for Authority and Control of Expectant Mothers' Bodies

This thesis is indicative of the unspoken challenge that both the biomedical fraternity and other dispensations dealing with maternal health care pose to each other. These are embodied in different symbols such as the use of traditional and religious paraphernalia in assisting expectant mothers with pregnancy and childbirth as well as biomedical approved medicines and pills to assist women during pregnancy and childbirth. Expectant mothers' bodies, in this sense are seen as sights of contest where both the biomedical and other medical pluralist discourses and practices co-exist, antagonise and sometimes compete for space to determine and/or regulate the pregnancy and childbirth experience. Expectant mothers act as the centre-point of the interactions between biomedicine and other medicines and, as such, expectant mothers have to

make meaning of the different medical discourses that struggle to shape their pregnancy and childbirth experiences as they interact with the proponents of these discourses.

Biomedical professionals and TBAs, SBA as well as traditional healers are engaged in a silent contest to control the discourse on pregnancy and childbirth experiences. This contest involves the use of various strategies to enforce and influence the expectant mothers to pay heed to their advice on ways to care for pregnancy and go through the childbirth process. For the traditional healers and birth attendants, assisting women to give birth in villages and finding ways to ensure women use indigenous knowledge and traditional birth practices even within the biomedical institutions such as waiting mothers' shelters where they are taken care of during maternity. Nevertheless, biomedicine has the support of by-laws that mandate women to deliver at clinics, failure of which they are 'criminalised' and penalised by bylaws. Women have, however, found ways of circumventing this as they deliver at home, and use traditional routes (the "normal" way of registering births – which was introduced by the biomedical system) of getting birth records and certificates for their children. This involves payment of a fine in the form a goat or other items to the chief, who then writes a letter to the registrar confirming the birth so that the newly born babies can go on national birth records. Thus, use or non-use of the shelter does not necessarily have to do with the deficiencies of the shelter but the plural medical facilities in the village, which exist in the form of traditional practices and Christian faith healing practices, and are in continual contestation.

9.4 Establishing the “True Self” and the Quest for Safe Delivery

The symbolic interactionist perspective enabled the analyses of how the interactions between expectant mothers and the plural maternal health providers in Mawadza influence the quest by expectant mothers to establish their identity in a medical pluralist village. Given the on-going socio-economic transformations and the various contestations between different social actors with regards to control of women's pregnancies and childbirth experiences, the responses of the expectant mothers to these are important. Expectant mothers in Mawadza exercise bodily agency through the decisions they make concerning maternal health care. Although clouded by the plethora of healthcare options from the plural maternal health care providers in the forms of biomedicine, faith healing and traditional medicine, expectant mothers do not merely consume these, but make choices on the care they want. It is, however, important to point out that these

choices are informed by the macro-social relations in the community, which determine how the expectant mothers socialise with the different medical providers. In this vein, where biomedical maternal awareness campaigns are carried out, there is an increase in use of waiting mothers' shelters. However, after one's choice of health care system, the issue of bodily agency, therefore, becomes a contested terrain as the expectant mothers are supposed to conform to the demands of the healthcare system that they would have chosen. For example, when one goes to the shelter to await delivery, the expectant mother has to conform to the regulations stipulated in this facility to guide and care for pregnancy in preparation for childbirth.

Macro-social structural factors, such as the provision of detailed information with regards to the benefits of institutionalised care stimulate increased use of the facility by expectant mothers. However, where such information is not provided adequately by the biomedical fraternity, expectant mothers, even their families and spouses (to those who have), rely on readily available information and resources within the village, that are found in repositories such as the traditional healers, SBAs and TBAs. The use and non-use of the medical facility in Mawadza village, thus, depends on the readily available information and resources that expectant mothers use to make choices. Hence, expectant mothers' actions are not solely influenced by their interactions with other actors but by the information they get from biomedical professionals and traditional medical practitioners at the nearby hospital.

9.5 The Otherisation of “Medicine”

In this thesis, findings from Mawadza village indicate that although there is no open contestation between the different plural healthcare system providers, each has a way of encouraging expectant mothers from Mawadza to affiliate with them rather than the others. In this vein, the three prominent healthcare system providers in Mawadza, namely, biomedical practice, traditional practice and faith healing, have ways of promoting use of their medical dispensations over those of others. Whilst in traditional practice expectant mothers are encouraged to use traditional medicines associated with making the birth process easier (such as *kuvhura nzira*) and the birth process lighter, biomedical professionals encourage the use of institutionalised facilities and criticize other practices such as traditional medicine and faith healing.

In this study, biomedical professionals regard institutionalised healthcare facilities such as waiting mothers' shelters as "the only place" where expectant mothers should be taken care of during pregnancy through to childbirth. Therefore, in line with national maternal health policies, nothing to do with traditional medicine or faith healing is entertained within the biomedical fraternity. Thus, expectant mothers are discouraged from taking any medicines and advice other than that from biomedical health professionals in the shelter. Medical practices other than bio-medicine are, thus, ascribed the label; "other" medicines. This has led to the strict imposition of rules relating to the use of other medicines beside bio-medicine during childbirth in biomedical healthcare facilities. This is notwithstanding the fact that some of the medical practices regarded as "other" have, over the years, actually proven to assist expectant mothers to get safely through pregnancy and childbirth. Interestingly, the views of expectant mothers concerning what they regard as the medicine to use during childbirth are variegated as views oscillate between biomedicine, faith healing and traditional medicine. This illustrates the fluidity of expectant mothers' preferences with regards to the maternal care they need during pregnancy and childbirth.

9.6 Thesis Contributions to Knowledge

In this section, I discuss how this thesis contributes theoretically, empirically and at policy levels. The literature review in Chapter Two revealed the theoretical, empirical and methodological gaps that exist in current literature on pregnancy and childbirth experiences. The data analysis sections spanning from Chapters Five to Eight answered the research objectives which sought to address the gaps that exist in current studies. This section provides summaries of the findings, showing how the study gaps were addressed in this study.

9.6.1 Theoretical Contributions: Sociological Analysis of Pregnancy and Childbirth Experiences

Theoretically, this thesis expands the understanding of pregnancy and childbirth by bringing a sociological dimension to the understanding of how expectant mothers experience pregnancy and childbirth within medical pluralistic villages in contemporary rural Zimbabwe. The thesis' theoretical contributions are encompassed and bound in the fact that symbolic interactionism has scarcely been used in sociological analyses of issues to do with women's health, particularly pregnancy and childbirth in Zimbabwe. Whereas in Chapters One to Four, I make the submission

that symbolic interactionism has rarely been applied in issues to do with health care, particularly maternal health care issues (pregnancy and childbirth), this thesis advances the argument that pregnancy and childbirth are phenomena bound by symbols, interaction and subjective interpretations of the interactions within cultures. An important contribution of this thesis is the emphasis that even a biological process such as pregnancy and child birth can only be fully understood within a social context, given the different meanings which are attached to the various aspects of the child birth process by the various actors: mothers to be, mothers, biomedical practitioners and traditional healers as has been previously alluded to by scholars such as Davis- Floyd and Fielder (1996).

Symbolic interactionism, therefore, makes a novel contribution to the inquiries on pregnancy and childbirth since it afforded a comprehensive understanding of pregnancy and childbirth experiences of women in Mawadza showing how both those who use and do not use the waiting mothers shelter navigate the terrain of pregnancy and childbirth within a medical pluralist village, as symbolic actors, demonstrating their agency in navigating the challenges encountered. To that end, symbolic interactionism enabled me to understand how actors, through attaching meanings to their social interactions, are able to exercise agency, not only through subjective interpretations, but also through constructing responses to the challenges faced in their interactions. Where professionals within hospitals and waiting mothers' shelters demonstrated a lack of appreciation of some local cultures and traditions that they deemed harmful for the expectant mothers and their new-borns, the expectant mothers responded by finding ways of using indigenous knowledge and traditional practices to make pregnancy and childbirth more bearable for them.

Furthermore, the thesis expands our understanding of symbolic interactionism to formerly uncharted domains, that is, it includes the dimension that humans are actors interacting with information from the interactions; they derive subjective meanings based on the symbols and meanings that they attach to these interactions as has been alluded to by (Blumer 2004, Charon 2007, Conrad 2012, Redmond 2015). This expansion is crucial as it depicts information as a social actor, where most would regard it as a static component in people's everyday lives. Significantly, people's everyday interaction with information in the form of knowledge does not

leave it static as it is ramified, thereby demonstrating the intricate relationship between actors and knowledge-particularly medical knowledge systems in societies.

9.6.2 Empirical Contributions

This thesis is a qualitative, micro-level empirical study of pregnancy and childbirth experiences of expectant mothers in relation to their use and non-use of the waiting mothers' shelter in a medical pluralist village, in Manicaland, Zimbabwe. The thesis expands on studies conducted by scholars such as Millard (1991), Poovan *et al.*, (1990), Chandramoham 1994, Eckermann (2008) and Lonkhuijzen *et al.*, (2012) among others. On one hand, this thesis highlights how pregnancy and childbirth are experienced by expectant mothers and establishes their reasons for possible continual use of the waiting mothers' shelter. On the other hand, it captures the experiences of expectant mothers and establishes reasons for their non-use of the facility in a medical pluralist village. While some experiences and strategies outlined in the thesis are not necessarily novel, the thesis' contributions are on empirical data which speaks to the experiences of expectant mothers and how they navigate the contests of medical pluralism, using indigenous knowledge and traditional practices in hospital facilities and the waiting mothers' shelters. What is quite novel about the empirical findings of this study is the exploration of medical pluralism in the management of pregnancy and the child birth process and how these processes are interpreted differently by different social actors. Furthermore, the thesis has empirically demonstrated how expectant mothers experience pregnancy and childbirth in a medical pluralist village and how they negotiate the socio-structural conditions obtaining in Mawadza village. Whilst some studies have portrayed experiences of pregnancy and childbirth as universal physiological process (Davis- Floyd & Fielder 1996), this thesis revealed the differentiated experiences and fractured responses exhibited by some expectant mothers in Mawadza village. The study has captured a broader perspective on different experiences from women starting from prenatal, inter-partum and post-partum care in the waiting mothers' shelter. Notwithstanding these experiences of women from a common socio-cultural setting, childbirth experiences were unique to every participant who shared their perceptions experiences.

Significantly, new empirical data on pregnancy, childbirth experiences and medical pluralism in a village situated in a remote area of Zimbabwe that is scarcely researched was provided by this thesis. Empirically comprehensive and new insights into pregnancy and childbirth experiences of

expectant mothers, the challenges they face and how they navigate them are also highlighted in this study. The study, particularly, gathered empirical evidence highlighting that in a medical pluralist village, use and non-use of waiting mothers' shelters is not necessarily determined by what the facility offers or lacks, but by a plethora of factors. These factors include distance, available information on the services provided and the type of service offered, cost of care in the facility as well as the flexibility of women to use practices and other medicines that they think are useful for pregnancy and childbirth whilst they are in the facility.

Most importantly, the study has generated new and empirical knowledge on birth territories and the environments under which women give birth in, in medical pluralist societies. This is an extension of the works of Jordan (1993), Davis-Floyd (1994), Filder (1996) as well as Cheyney (2008; 2020) who are medical anthropologists, who also looked at the importance of studying birth territories and environments under which expectant mothers give birth in. These scholars were motivated by the fact that birth territories are not only physical environments where childbirth takes place, but they are in every way socially constructed and shaped by the culture of the indigenous people. Although I focused on a unique birth territory (waiting mothers' shelter) from the ones that the scholars I mentioned above studied, the experiences narrated by the participants of this study in relation to their use and non-use of the facility reiterated the fact that birth territories are not merely physical spaces where child birth takes place but in every sense socially constructed and shaped hence studying them is necessary (Cheyney 2020). This study therefore becomes one of the few studies in the sociology of medicine to look at birth territories. This has been a field congested with medical anthropologists (Davis-Floyd 1994, Fielder 1996, Cheyney 2008; 2020) who conducted ethnographical studies to study birth territories of different indigenous cultures. My study has shown the possibility of studying birth territories in medical sociology without necessarily using ethnography as my data gathering strategy like the majority of the previous researchers have done.

In this regard, the thesis has also contributed significantly by addressing some of the methodological challenges and errors that have been noted in literature as far as studies on pregnancy and childbirth are concerned especially in the sociology of medicine. The study took strong heed of Oakley (1988) pertinent concerns of the importance of conducting women's pregnancy and childbirth studies by other women so as to control the gender related challenges

associated with studies on pregnancy and childbirth, and also to capture women's voices in the texts of medical sociology. The aspect of the voice of the expectant mothers in research is very pertinent because it does not only provide empirical data but gives women the voice to provide clear insights into their experiences and perceptions.

9.6.3 Contribution to Maternal Healthcare Policy

This thesis has yielded insightful knowledge which could be of practical relevance and importance in the field of maternal health. The findings in this thesis can inform the responses and actions of practitioners with regards to the circumstances faced by expectant mothers during pregnancy and childbirth, especially for the expectant mothers who live in medical pluralist communities. This can enable the practitioners to build the maternal health care systems for better resilience of women during pregnancy and childbirth, given the circumstances that they face. I have illuminated the understanding of pregnancy and childbirth in a medical pluralist village in order to assist practitioners to construct meaningful and better-informed ways of providing maternal healthcare services for women in these circumstances.

At policy level, empirical evidence has been provided by this thesis. This evidence supports novel approaches to maternal healthcare policy and practice in Zimbabwe, premised on the centrality of women's views, experiences and practices. In this thesis, I have highlighted the implications of some of the maternal health care assessments some of which can entrench misguided conceptions of maternal healthcare in medical pluralist societies. These can, in turn lead to misguided maternal health care policies that do not take into consideration the experiences and perceptions of women with regards to pregnancy and childbirth. This thesis, therefore, advocates for more open-minded assessments that are not blind to the concerns of expectant mothers. These assessments should be more inclusive of women's strategies of coping with pregnancy and childbirth.

Whilst dominant dispensations on maternal health suggest that pregnancy and childbirth in Zimbabwe are straightforward, this thesis reveals that pregnancy and childbirth experiences of expectant mothers are intricate. The thesis, thus, shifts the attention of policy makers to the fact that expectant mothers do not only experience pregnancy and childbirth but also contest the disparities they encounter in medical pluralistic settings. Current policy emphasis should be

placed on ensuring the improvement of pregnancy and childbirth experiences of expectant mothers; should factor into consideration the premise that expectant mothers are also constantly responding to socio-cultural factors that influence their experiences during pregnancy and childbirth.

Discussions on maternal healthcare in Zimbabwe have revealed that there is weak appreciation of the comprehensive needs of expectant mothers, since the biomedical professionals' approach to pregnancy and childbirth does not fully take into consideration the social and cultural dimensions of pregnancy and childbirth that expectant mothers encounter. This attitude of medical professionals has led to their disdain of indigenous knowledge and traditional practices of caring for expectant mothers during pregnancy and at childbirth. The thesis has revealed that women and local people are more informed about the comprehensive social, psychological and physical conditions and needs of expectant mothers. They therefore, construct comprehensive ways of ensuring that expectant mothers receive appropriate care, whether they are in waiting mothers' shelters or not. As such, there is a need to recognise local people's understandings and discourses on pregnancy and childbirth. Although my study was small-scale, which makes it inappropriate for me to generalise my findings, I argue that a qualitative enquiry into local people's understanding of pregnancy and childbirth provide rich ways of questioning pregnancy and childbirth experiences. This creates a more complex view of pregnancy and childbirth, than the imagined premises currently obtaining in existing studies (Millard 1991, Poovan *et al.*, 1990, Chandramoham 1994, Eckermann 2008, Lonkhuijzen *et al.*, 2012) and national policy frameworks.

9.7 Possible Areas for Future Research

In this section, I suggest possible areas for future research, based on the findings, knowledge and insights garnered from this study, as well as from existing studies on pregnancy and childbirth (Millard 1991, Davis-Floyd 1994, Fielder 1996, Poovan *et al.*, 1990, Chandramoham 1994, Eckermann 2008, Lonkhuijzen *et al.*, 2012, Cheyney 2008 & 2020). My central argument is that future studies should extend sociological understandings of pregnancy and childbirth. Firstly, I have shown how pregnancy and childbirth are conceptualised in Mawadza, how expectant mothers experience pregnancy and childbirth, and how they respond to challenges in receiving care within a medical pluralistic community. This thesis also revealed the dominant responses of

expectant mothers to their experiences of pregnancy and childbirth, especially with regards to the constraints posed by receiving care during pregnancy and childbirth within a medical facility. I am convinced that repeated inquiries to tap into the experiences of a wider group of expectant mothers who have used, or are using, waiting mothers' shelters, could provide deeper insights into pregnancy and childbirth experiences in medical pluralist villages. In this regard, the symbolic interactionist perspective can deepen the analysis and understanding of pregnancy and childbirth experiences.

Another possible area for further research could be on the relationship between indigenous knowledge and pregnancy and childbirth. Although some of the research participants pointed out use of indigenous knowledge in assisting with expectant mothers during pregnancy and childbirth, they did not reveal the extent to which indigenous knowledge can be harnessed for pregnancy and childbirth within the biomedical fraternity. The indigenous knowledge that locals use in assisting women during pregnancy and childbirth in traditional practices is instrumental in assisting women during maternity. There is need for further exploration of the basis of the contestations of use of indigenous knowledge systems, with a view to provide insights into how the biomedical fraternity can harness indigenous knowledge in construction of care practices for pregnant women. Related to this is the task of reconciling indigenous knowledge and scientific knowledge in maternal health studies. There is need for devoted research to study in depth the impacts or outcomes of indigenous knowledge and traditional practices of caring for pregnant women and assisting them with childbirth. The study has highlighted that use or non-use of the waiting mothers' shelter has both positive and negative impacts for the pregnant women. Although my study is a particular one it nevertheless has shed light on the various issues which are likely to arise in other studies. Thus, it brings to light the sort of issues which should influence both regional and national policy in Zimbabwe and possibly further afield. It is, thus, needful for studies to further interrogate this dimension.

9.8 Concluding Remarks

In conclusion, I highlight that I have illuminated on the pregnancy and childbirth experiences of expectant mothers in Mawadza village. In shedding more light on pregnancy and childbirth experiences of expectant mothers in Mawadza village, I have uncovered the nuanced relationship between different social actors in the practice of interpreting pregnancy and childbirth as well as

giving care to women during pregnancy and at childbirth. The principal agents that I focused on in this study are the maternal health care providers (be they those affiliated to the local traditions or those aligned to the biomedical tradition). The significant finding in this thesis is that even a biological process such as pregnancy and child birth can only be fully understood within a social context, given the different meanings which are attached to the various aspects of the child birth process by the various actors: mothers to be, mothers, biomedical practitioners, traditional healers etc. In addition, in a medical pluralistic village, the different health care providers to pregnant women do not necessarily conflict as evidenced by the complementary role of these two (complimentary insofar as they achieve collectively desired outcomes, albeit in parallel and (mutually) exclusive means) in caring for women during pregnancy and childbirth.

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APPENDIX ONE



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Date: 2018-06-10

To whom it may concern

This letter serves to confirm that Brenda Muchabweyo is a PhD candidate in the sociology department at Rhodes University under the supervision of Professor Michael Drewett. May you kindly assist her with necessary services that she needs to conduct her study, her area of study is : **Maternal Health Care Services in Waiting Mothers' Shelters: the Case of Mawadza Village in Bonda, Manicaland, Zimbabwe**

Please notify Sociology Department Ethics Sub-committee should there be any challenges faced with the above named student. Your assistance is greatly appreciated.



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APPENDIX TWO

Telephone: 60624/60655
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Reference:
PROVINCIAL MEDICAL DIRECTOR
MANICALAND
P.O. Box 323
Mutare

28th June 2018

RE: SUPPORT LETTER TO CARRY OUT RESEARCH IN MANICALAND

Research Title: Maternal Healthcare Services in Waiting Mothers' Shelters: The Case of Mawadza Village in Bonda, Manicaland, Zimbabwe.

Reference is being made to the above named subject.

This letter serves to confirm that the Provincial Medical Director Manicaland province has no objection to the above mentioned study being conducted in Manicaland Province.

Yours Sincerely


Dr P T Mafane



PROVINCIAL MEDICAL DIRECTOR MANICALAND

APPENDIX THREE

Muwadza Village
Banda Mission
P Bag 3879
Mutema
26-06-18

Dear / Sir / Madam

I have beg to inform you that I have allowed
Brandon Muchabwya to work in Muwadza^v on her
PHD Degree in Zoology in Rhodes University for
as long as possible.

The degree has alot to do with women
health

Thanking you

R.A. Ramadza

V/HEAD R.A. RAMADZA
MADZA VILLAGE
MUTASA CENTRAL
DATE 26-06-18
SPSM *R.A. Ramadza*

APPENDIX FOUR



RHODES UNIVERSITY

Grahamstown • 6140 • South Africa

INTERVIEW SCHEDULE

Participant	Venue
Expectant Mothers	Waiting Mothers' Shelter
Expectant Mothers who have used the shelter previously	Participant Home
Doctors	Waiting Mothers' Shelter
Midwives	Waiting Mothers' Shelter/ Homes of the midwives
Nurses	Waiting Mothers' Shelters
Traditional Healers	Participant Home
Community Members	Community Meeting Points

Interview Guide for the Expectant Mothers

1. Is this your first pregnancy?
2. Did you stay in a waiting mothers' shelter (Dorm) during any of your previous pregnancies, and why?
3. Please describe in detail your experiences in the waiting mothers' shelter from the day you started waiting for delivery to the day you were discharged.
4. How was/is your relationship with the midwives? Do you feel close to them and willing that you deliver under their care?
5. Do you have one on one private sessions with doctors/or midwives or nurses?
6. Do you sometimes have male midwives in the shelter and how do you relate to male doctors?
7. How do you view and feel about your body when you are living with other women and under the care of midwives in that waiting mothers' shelter?
8. Do you have instances where you choose what you want to do regarding your pregnancy? For example practising by the use of hands to open the way for the child (*kuvhura nzira*) and many other practices women are taught from teenage hood
9. Do your partners/family/friends come to visit you during your waiting period and what is their view on you staying in the waiting mothers' shelter?
11. Have you ever suffered from any complications? How were they handled?
12. What are the fees of staying in the waiting mothers' shelter? Do you bring any provisions like blankets, food, firewood etc?
13. Do you think it was/is beneficial that you stay in a waiting mothers' shelter to await delivery?

Interview Guide for the Doctors

1. What is your general viewpoint about various medical systems on pregnancy and birth?
2. How many years have you been practicing in the maternity unit?
4. What is your experience with complicated births? How many have you attended?
5. What is your view about deliveries done outside hospital institutions?

6. What do you think are the factors that impede pregnant women from using the waiting mothers' shelter?
7. Does the waiting mothers' shelter policy allow traditional birth practices? Give reasons and views for the answer
8. Do you think there is privacy for the expectant mothers in the waiting mothers' shelter at Bonda Mission Hospital?
9. Are there any awareness programs put in place to raise awareness on the waiting mothers' shelter to Mawadza village community members?

Interview Guide for Midwives

1. How many years have you been practising?
2. Do you have a certificate from the Ministry of Health (MoHCC) or Zimbabwe Traditional Healers Association (ZINATHA) or any other board?
3. How many births are you attending now? Do you have a maximum?
4. Briefly tell me about your experience with emergency situations and where do you refer emergency cases?
5. Do you conduct childbirth education classes in Mawadza village? What is the importance?
6. How much freedom and decision making power do you allow expectant mothers to have before and during labour?
7. What is your view on the use of the waiting mothers' shelter at Bonda Mission? Is it of any importance that expectant mothers use this facility?
8. Are there any alternative birth attendance methods in the community and which method seems popular, and why?
9. Please explain the level of connectedness you have with the expectant mothers during delivery and how this is important to the expectant mothers?
10. What post-partum care do you offer to mothers who have just delivered?

Interview Guide for Nurses (Sister in Charge)

1. How much experience do you have in practice with new-born babies?
2. What are your views on various medical systems pregnancy and childbirth?

3 What are your views on the existence of different health care systems in the village and how has this affected maternal health care in the village?

4. What are the facilities available for expectant mothers in the waiting mothers' shelter that you think are helpful to all women during prenatal and post natal care?

5. What do you think are some of the reasons that influence the use/non-use of the waiting mothers' shelter at Bonda Mission Hospital?

6. Are there any community awareness raising programs that on safe delivery that are conducted in the village?

Interview Guide for Traditional Healers

1. What is your view point on different health care systems on pregnancy and childbirth?

2. How many years have you been practising and how many births have you attended?

3. What is your child birth education and how is it important to village members?

4. What is your view on the availability of various maternal health care systems in the village?

5. How has been the traditional childbirth system embraced and preferred by community members?

6. How do you handle emergency cases and complications?

7. Do you think the waiting mother' shelter at Bonda Mission Hospital has been beneficial to pregnant women in the community?

Focus Group Discussion Questions Guide

1. Do you know about a waiting mothers' shelter that is at Bonda Mission Hospital?

2. Do all the community members go and stay in the shelter when they are due for delivery?

3. Do you think the facility has been useful to the women in the community?

4. What is your view on traditional birth practices in the shelter?

5. What do you think are some of the reasons why women use or do not use these facilities?

6. What are some of the challenges faced by community members in accessing the waiting mothers' shelter?

APPENDIX FIVE



RHODES UNIVERSITY

Grahamstown • 6140 • South Africa

Dear (Participant)

I am doing research at Rhodes University. The focus of my research aims to understand the experiences and perceptions of expectant mothers during prenatal, intra-, and postpartum care in relation to their use or non-use of a Waiting Mothers' Shelter within a medical pluralistic village, where hospitals and maternal health care facilities are not proximate. It will focus on Mawadza Village in Mutasa District in Zimbabwe as a case study. This research has received ethical approval from the Rhodes Sociology Ethics Review Committee and the Rhodes University Ethical Standards Committee.

I would like you to consider participating in my research that looks at Maternal Health Care Services in Waiting Mothers' Shelters: the Case of Mawadza Village in Bonda, Manicaland, Zimbabwe

The process will mean that I will meet to tell you more about the research. Once you have consented and signed some forms and agreed to participate, I will do interviews/Focus Group Discussion with you.

- 1) Pregnant Mothers-In the first interview, I will ask you some questions about yourself and your experiences and perceptions of the Waiting Mothers Shelter at Bonda Mission Hospital in relation to the use and none use of the facility.
- 2) Key informants Doctors/Nurses/Midwives/Traditional Healers- I will be asking you about your views about the use and none use of the Waiting Mothers Shelter
- 3) Community members I will hold Focus Group Discussions with you so that we discuss on your views about the reasons for the use and none use of the Waiting Mothers' Shelter at Bonda Mission Hospital by community members. Our talk will be recorded and the information will be included in my research. To protect your identity, I won't use your real name.

The interviews will take place at the Waiting Mothers Shelter at Bonda Mission Hospital for the Expectant mothers; the expectant mothers who are out of the shelters will have interviews in

their homes. The community members will have the Focus Group Discussion at the community strategic meeting points and refreshments will be offered during the discussions. Throughout the project, your identity will be protected by using a different name. Finally, once the research has been completed and thesis has been written, a feedback session on the findings will be provided to the Bonda Mission Hospital Waiting Mothers Shelter to which all the participants will be invited.

Whether or not you agree to participate in this research the services you receive from Bonda Mission Hospital Waiting Mothers' Shelter will not be affected. If you are interested in participating in this research, please fill in the slip below and give it to the responsible authorities at Bonda Mission Hospital so that I can make contact directly with you.

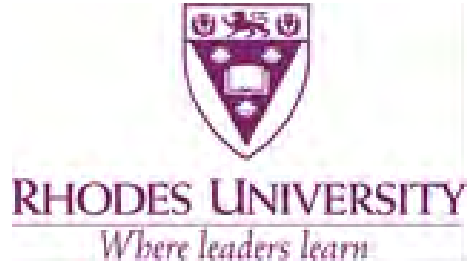
Many Thanks

Brenda Muchabveyo

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muchabveyobrenda@gmail.com/15m5629@ru.ac.za

APPENDIX SIX



Participant Consent form (Interviews)

Name of researcher: Brenda Muchabveyo

Brief description of the research topic: Maternal Health Care Services in Waiting Mothers' Shelters: the Case of Mawadza Village in Bonda, Manicaland, Zimbabwe

Declaration

1. I confirm that the purpose of the research and the nature of my participation have been explained to me verbally or in writing.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason - however I commit myself to full participation unless some unusual circumstances occur, or I have concerns about my participation which I did not originally anticipate.
3. I understand that data collected during the study, will be used by the researcher and that my personal details gathered during this research, especially my name or identity, will be kept private.
4. I agree to be interviewed and to allow audio or video recordings and transcriptions to be made of the interview.
5. I have been informed by the researcher that the tape recordings will be erased once the report is written.

Signature of participant:

Signature of the researcher:

Date:

APPENDIX SEVEN

Expectant Mothers in the Waiting Mothers' Shelter





