Whose Knowledge Counts?

A Study of Providers and Users of Antenatal Care in Rural Zimbabwe

THUBELEIHLE MATHOLE
Dissertation presented at Uppsala University to be publicly examined in Rosén-salen, Akademiska sjukhuset, Uppsala, Tuesday, January 24, 2006 at 09:15 for the degree of Doctor of Philosophy (Faculty of Medicine). The examination will be conducted in English.

Abstract

This thesis presents perspectives and experiences of different stakeholders and their ways of reasoning around pregnancy and pregnancy care. Data were generated from individual interviews with 25 health care providers, 18 women and 6 traditional birth attendants (TBAs) as well as 11 focus groups discussions with women, men and TBAs.

The challenges experienced by health care providers in their provision of antenatal care, while attempting to change antenatal care through routines proven to have medical value, are highlighted. Changing some long established routines, such as weighing and timing of visits, proved difficult mostly because of resistance from the users of care, whose reasoning and rationale for using care did not correspond with the professional perspectives of care.

Women also combined biomedical and traditional care. The women used the clinic to receive professional care and assurance that the pregnancy was progressing well and used TBAs, who are believed to have supernatural powers, for cultural forms of assurance and protection. The health care staff did not appreciate these aspects and discouraged women using TBAs. Midwives had problems to change routines of care because of their stressful working situations and the expectations of the women.

In addition, they described the paradoxes in providing antenatal care in the context of HIV and AIDS. The caregivers were aware of the magnitude of HIV and AIDS and yet did not have any information on the HIV status of the women they cared for. This also caused fear for occupational transmission. HIV/AIDS is highly stigmatised in this area and women used various strategies to avoid testing.

The study emphasised the need to broaden the conceptualisation and practice of evidence-based care to incorporate different types of evidence and include realities, knowledge and perspectives of not only the beneficiaries but also those implementing change as well as local knowledge. The necessity of reorganising the health care systems to accommodate the new challenges of the HIV/AIDS epidemic is also emphasised.

Keywords: Evidence-based care, HIV/AIDS, maternal health, midwifery, nurses, pregnancy, traditional birth attendants, Zimbabwe

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ISSN 1651-6206
ISBN 91-554-6430-0
urn:nbn:se:uu:diva-6251 (http://urn.kb.se/resolve?urn=urn:nbn:se:uu:diva-6251)
To my family and
all the childbearing women in Zimbabwe
This thesis is a result of the longstanding collaboration in reproductive health research between Zimbabwe and Sweden.

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UPPSALA
UNIVERSITET

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International Maternal and Child Health (IMCH)
Uppsala University
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List of publications

This thesis is based on the following papers, which will be referred to in the text by their Roman numerals:


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# Abbreviations

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<thead>
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<th>Full Form</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>GoZ</td>
<td>Government of Zimbabwe</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>MOHCW</td>
<td>Ministry of Health and Child Welfare</td>
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<tr>
<td>MTCT</td>
<td>Mother to Child Transmission</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>SAREC</td>
<td>Swedish International Development Agency</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations AIDS Programme</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>ZINATHA</td>
<td>Zimbabwe National Association of Traditional Healers Association</td>
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Prelude

The day I cried in the field

I want to start my thesis with a story of one of the women I interviewed, because while she represents a typical case of a woman using antenatal care (ANC), and the stories I was told by many other women, the case is also unique in one important way. The story illustrates the complexity and sensitivity of interviewing pregnant women in the context of human immunodeficiency virus (HIV) and raises difficult ethical questions.

I had made an appointment for an interview with a pregnant woman I met at a clinic. We arrived at her home in the afternoon, on a Thursday, a day when people in this area do not work in the fields for religious reasons. Her home was not very different from other homes I had visited in this area and comprised of a four room asbestos-roofed house next to another thatched house where the interview took place. Behind these were three smaller houses, one of which was being used as the kitchen as I could tell from the soot on the walls and roof. Behind the three smaller houses was a granary.

We found her husband seated under a tree, carving a wooden spoon. As our car came to a halt, the husband came to greet us, smiling as if we already knew each other, which I had come to recognise as a typical welcoming practice in this area. Two children, who had been playing in the yard, creating some pools of dust, also came to greet us. I was given a mat to sit on and the driver sat on a wooden chair. Formal introductions were made. After enquiring about our home areas and our totems, we then engaged in informal talk about the current situation in the country, during which time the wife joined us. She explained that she had seen our car while in church, where she had gone to deliver books, as she is the secretary for the women’s association in her church. We went over the introductions once again. We talked informally, focusing on her daily chores. She described her typical chores using what she had done on this particular day as an example, which started by a thorough cleaning of the home as this day is spent at home. She then went to fetch water and prepared food for the family before she left for the church. On her way back from church, she fetched more water from the borehole. She jokingly complained about the duties of a woman in a rural area saying, “there is no time to sit and rest, a woman only rests when she dies” She compared herself with urban women, whom she said had better life because they had less work.
After the greetings and informal conversation, we moved to the house where the interview took place. I explained the purpose of the interview and how we were going to do it. I then turned on the tape recorder. She said she was 30 years old, married with four children between 2-10 years. She had 11 years of schooling, which she said was not that bad for someone in a rural area except that she did not get the required grade in form 4 and had no money to supplement her examination grades. She had wanted to train as a teacher or a nurse.

Before marriage, she had worked as a storekeeper. Her husband used to work in Bulawayo where he lived in a “family house” that had been allocated to his father by the City Council. Initially, she lived in “town” with her husband but often returned to the rural home during the rainy season to help with farming of their 10-acre plot. When there was extra money, they hired someone to take care of the farming. She then returned to her husband in Bulawayo. “Yes that was then, the good old days”, she said with a sigh.

Her husband was now unemployed as his company closed and relocated in South Africa. At times, they do casual jobs at the school, clinic or township but had no major sources of income. At times when the harvests were poor, some donors like “iVision” (meaning the World Vision) provide food handouts “but some people are at times jealous you know”, she explained “at one time they tried to prevent us from getting our share because we had many cows and that I received some grocery from South Africa! Just imagine!”

She was pregnant with her fifth child. Her first visit to ANC was at 21 weeks of gestation but she explained that she now “goes to scale” (local expression for ANC visits) every month. Her first child was delivered at her parents’ rural home, where she had returned when she was seven and half months pregnant, as the custom is in this area. The other two children were born in town, while the fourth was born at the local hospital where she said she had stayed at the waiting shelter a week before delivery. She said the nurses at the local referral centre could be rough especially if one did not do what “they tell you to do, they are worse if you try to question them, they treat the ones they know better. At the local clinic, the nurses are different, they are good and friendly. I am now used to them, we visit each other”. She was now going to the clinic every month and wanted to be weighed during all the visits. She sees a TBA who lives in the neighbourhood who provides her with “mushonga wemasuwo”, a herb used for dilation, for which she said she has never experienced complications with her pregnancies.

On the HIV and acquired immunodeficiency syndrome (AIDS) situation in the area, she explained that she had noticed an increase in the number of people who were dying. The worst part was, she continued, “many people come from the urban areas when they are very sick and their parents take care of them, even if they are taken to the local hospital, they are discharged when they are still sick, they just come and are taken care of by their rela-
Some volunteers assist them. She mentioned that a number “come back for burial when they are dead and all this is because of AIDS, the number of people who die has increased...It was never like this before” she added with some sense of resignation in her voice. She added that the deaths had increased so much that there was a funeral almost every weekend and that “...young men complained about digging graves which was now too much for them”. According to her, everybody was worried about the disease, as the people “don’t know where it came from”. She explained how people speculate when somebody was sick, with illnesses such as diarrhoea, TB, herpes, or when they started getting thin. She explained that she did not want to lose weight and she eats a lot and checks her weight every time she goes to the clinic. “I have been watching over my weight and it is increasing well, so I am not worried, I am happy”, she added.

They have been taught about HIV and AIDS during health education sessions at the local clinic. She also listened to the radio programs on HIV. At this point her attention shifted to her children saying they were still very young and that she was worried, she was always worried about them. There were times when she would look at them and cry. There was a pause and she repeated that she was worried and then she broke down and cried. After some few minutes of sobbing, she composed herself and started explaining about her husband’s illness and hospitalisation at one time. He was tested for HIV and was found to be HIV positive. He never told anyone about it. He only told her about it a few months ago when she informed him that she was pregnant with their fifth child. She continued, in between sobs, “he had known about his HIV-status for the last 4 years and yet had not told me about it!” She had not been tested. This according to her was not necessary because she and other women had been told “if you have sex with an HIV-positive person you get infected right away. So I do not see the reason, why I should be tested because it is obvious I am HIV positive”. At this point, she sobbed heavily.

She further explained she was worried about her pregnancy, as she had seen some women dying after giving birth. She did not think that one could survive and the chances that both she and the baby will die were high, “you both die,” she added emphatically “and the baby dies” and I could see that she was scared and did not know what to do. She added that she was confused and worried. Her greatest worry was what would happen to her little children when she died also, because her husband would similarly die. She was worried that her children would suffer, at which she bursts out in tears again. She cried continuously, and I too broke down and cried with her.

I too was confused and did not know what to do or what to say to her because my attempts to comfort and persuade her to visit the clinic where she could get help was futile. I had tried what is usually said in the ethical clearances that such cases should be referred for help in appropriate institutions. This was a much more complex case. The problem was that the woman did
not want to have her status known, especially in the local area and therefore could not use local caregivers and counsellors. I stopped the interview at this point in order to put my energies into comforting her. I reminded her that she might after all not be infected, as she has never tested herself. I persuaded her to go for testing but this seemed to make her cry even more.

I tried to explain to her that she would have a chance to discuss this with caregivers at the clinic. She was however, adamant that she would not go for testing because if she did, the information would leak and people would know. She did not want anyone to know. She and her husband had agreed not to tell anyone. She did not tell the family members or the nurses at the local clinic. She made me promise that I would not inform the nurses at the clinic. She also said she prayed everyday that God would make her live longer to take care of her children. She however found it difficult to forgive her husband, for bringing the disease home, but added that her husband also appeared worried and stressed: he spent most of his time alone and had turned to drinking heavily as if to drown his sorrows. Although the husband looked healthy, she was worried about him.

I then persuaded her to seek help from people living with AIDS or go to a voluntary counselling and testing (VCT) centre outside her home area. I told her about prevention of mother to child transmission (PMTCT). I waited for about half an hour to let her settle down. At this time, her son brought some tea for us but left immediately.

Later when I reflected on this interview situation, I had sleepless nights for days. I thought about this woman a lot. I blamed myself for not being helpful enough, that maybe I should have done something to help, but I did not know what. I could not discuss this with anybody in this area. There was no advice from the ethical instructions on what one had to do in cases where the research participant has a stigmatised problem, where not being known was the solution, cases where health professionals and counsellors were not trusted to maintain confidentiality, where family members were not a solution either. How could I as a researcher deal with such a problem?

Two weeks later, I accidentally met the woman at the township. She recognized me and called at me from a distance to express her gratitude that she had spoken to me about her situation. She told me she felt such relief after having spoken to me that she had gathered courage and was planning to travel to Mutare to seek help where her sister lived. I was relieved as well and on reflection, this case suggested that interviews could have a relieving role in such situations.

This was a typical case of a pregnant woman in the study area and illustrated the complex interplay of factors in seeking and providing ANC in contexts of poverty and HIV and AIDS. The concerns of women and the shortcomings of the health care system were highlighted. This story furthermore demonstrated how HIV stigma creates dilemmas for people, families and married couples, both infected and affected by HIV. In spite of living in
a large compound, surrounded by relatives, the woman or the couple cannot disclose their HIV status for fear of being stigmatised and isolated. Health care too is out of bounds for the same reason, and a stranger appears the only acceptable listener.

Thus, HIV and AIDS locks people into silence, isolation and slow death. While the woman worries herself to death because of her children, the husband may drink himself to death. Despite the silence on the part of the people with HIV and AIDS, speculation about symptoms, such as wasting, is used to identify those who are suspected of being HIV positive. This creates more fear and strategies such as avoiding HIV testing, eating more, and checking weight are used. In the context of ANC, weight has therefore assumed new meanings and importance. Weighing during ANC visits has become necessary as an indicator of well being, and for communicating well being.
Introduction

The need for inclusive antenatal care

Historically, decisions about health care delivery have been within the domain of professionals and health officials. Although professional groups are dedicated to ensuring the quality of health care, it has been observed that the women’s voices are noticeably absent from health service planning and evaluation (Gerein et al., 2003; Taylor & Dower, 1997). Taylor and Dower (1997) noted that the health care system, like other human service organisations, is not an ‘inanimate structure’ but rather an interdisciplinary grouping of many stakeholders. As providers and users of care, traditional birth attendants (TBAs) and women have opinions and experiences often not taken into account in the formulation of health policies and priorities (van-der-Geest, 1997). According to the constructivists theoretical framework (Guba & Lincoln, 1989), it is necessary to include different stakeholders, in this case women, men, TBAs and professional health caregivers, who construct their world from their own perspectives. It is necessary to understand the different perspectives in order to influence health care. This implies taking account of the social contexts within which services are provided.

Family members in most societies play an important role in the support of women during pregnancy and childbirth. Female relatives typically assist mothers with birth and the care of the newborn, whereas the role of male relatives, particularly husbands, may involve giving permission and financial support when needed (Gerein et al., 2003). Men in Zimbabwe rarely go to ANC clinics and therefore have little knowledge about the risk factors that women are normally taught during health education sessions. The inclusion and participation of men in maternal health care is necessary, because of their major role in care seeking decisions. In Senegal for instance, more than 50% of decisions regarding female treatment are made by men (Ensor & Cooper, 2004). In a number of South Asian societies, the mother-in-law dominates decisions on childbirth and care related to pregnancy, particularly in early pregnancy (Piet-Pelon et al., 1999). The TBA is also vital in influencing care-seeking behaviour. In Rajasthan (India) more than 90% of women who did not comply with referrals, were advised against using those referrals by the TBAs (Hitesh, 1996).
Therefore, as users of ANC both men and women’s voices need to be heard by health care providers and policy makers to ensure appropriate and quality health care delivery to women (van-der-Geest, 1997). This qualitative study of different stakeholders aimed at understanding the meanings attached to pregnancy and the care of pregnancy, in part to identify possible areas of intersection with implications for theory and practice.

Background to antenatal care

Antenatal care is widely used as a strategy for improving maternal health by preventing and treating pregnancy related conditions and detecting risk factors that could lead to complications during pregnancy and delivery. The Safe Motherhood initiative for example, recommends the use of Risk Approach as a means of reducing maternal mortality (Yuster, 1995). In this model, women with a high probability of complications during pregnancy or delivery must be identified and referred to a health facility for special monitoring and delivery in a maternity ward. However, the success of this method depends on adherence by both the health care providers and the users, i.e. the extent to which targeted women, accept and follow the advice from health care providers.

Antenatal care strategies used in poor countries, where most births occur at home, were modelled on those in industrialised countries, where almost all births are institutional. In its current form, ANC may not be effective in ensuring maternal health and achieving safe motherhood goals in a rural setting of a low-income country. Institutional ANC with skilled professionals for all women remains a distant reality in low income countries and TBAs remain the main obstetric care providers for most women (Carlough & McCall, 2005; Hountondji, 2002). Approximately 53 million women deliver their babies alone or with the help of a family member, a friend or a TBA in low-income countries. In Zimbabwe, 30% of women give birth at home (MOHCW, 1997). Recommendations for the integration of TBAs into the formal health care system have thus been made (Jordan, 1992) and governments and non-governmental organisations (NGOs) have invested in TBA training.

It however appears that TBA training has not equipped TBAs with adequate resources and skills in ways that enable them to reduce maternal mortality and morbidity. In Zimbabwe for example, TBA training largely focuses on making home deliveries cleaner and safer by offering basic skills (MOHCW, 1997). Although this is a sensible step in meeting the health care needs of women, TBA training does not appear to provide an enabling environment to make it possible for the TBAs to effectively use the skills in which they are
trained. The training guidelines used in Zimbabwe reflect the international
generalized guidelines. These guidelines are designed for imparting skills
and knowledge to TBAs on for example: general hygiene and maternal and
child health care; to encourage referral of women to the health centre after
delivery; and to recognize and to refer women considered to be at high risk
and likely to have complications to hospital (MOHCW, 1997). TBAs are
also used in programmes such as immunization and family planning.

The value of TBA training is questioned (Davis-Floyd, 2000) and critics
have argued that the training has failed to consider culturally based knowl-
dge and practice when designing and conducting the training, despite wide-
spread understanding of the need (Houston, 2000). A number of studies sug-
gest that the TBA training has failed to create respectful working relations
between professional providers and TBAs or before developing the training
material find out how TBAs take care of pregnant women and for what rea-
sons (Jahn et al., 2001; Stephens, 1992). TBA knowledge is rarely incorpo-
rated as part of evidence-based practice. The emphasis on training and up-
gradng of TBAs by exclusively imparting biomedical knowledge is being
challenged with a call to explore how integration of the two could be more
inclusive (Davis-Floyd, 2000; Odora-Hoppers, 2002; Putney & Smith, 1989
Smith et al., 2000). The term biomedicine is used in a broad sense to include
the professionals, institutions and practice of what some refer to as western
medicine. It has been argued that although biomedicine has made major
technological advances, it has shortcomings in social and human quality of
care (Freeman & Motsei, 1992; van-der-Geest, 1997). This is reflected in the
impersonal ways health care providers may act in relation to patients
(Jewkes et al., 1998; Nyazema et al., 1992), the brief or inadequate explana-
tions associated with diagnostic and other procedures (Freeman & Motsei,
1992) and its concentration on the purely medical aspects of health care
(Oakley, 1984).

Traditional medicine (here used to mean indigenous medical practices) con-
tinues to be used not just because of resource scarcity but also because it
offers an explanation to health and disease not available in biomedicine.
Traditional healing involves the whole person and sometimes family and
kinship networks and refers to the indigenous form of care in Zimbabwe, as
is in many parts of Africa, where according to the cosmology, illness or in-
deed any misfortune is considered to be due to breakdown of social rela-
tions. This has implications for the care sought and the treatment offered;
because of the belief in the importance of social relations, care is more holis-
tic and does not only include the biological aspect of the patient, but takes
care of the social, psychological and spiritual aspects as well (Freeman &
Motsei, 1992; van-der-Geest, 1997). Traditional healers are moreover con-
sulted for both cure and prevention of disease and other misfortunes, such as
loss of a job, and protection against harm arising from the breakdown of social relations, believed in many societies in Africa to be the cause of illness which can only be treated by specifically skilled healers (Freeman & Motsei, 1992). This area of traditional care was termed as “witchcraft” during the early interaction with western medicine.

With the introduction of biomedicine in many societies in Africa, people now make choices between the two depending on what they view to be the cause of an illness (Nyazema et al., 1992; Simmons, 2000). In a study on perceptions and use of drugs in Zimbabwe, the participants distinguished between illnesses with natural and unnatural causes: most chronic and acute diseases such as a cough, a cold, abdominal pains, were perceived to arise from natural causes including an unhealthy physical environment (Nyazema et al., 1992). People sought biomedical care for illness so defined. Other diseases, such as sunken fontanelle in infants and mental illnesses, were considered to arise from unnatural causes for which reason traditional medicine was used. Traditional medicine was thus reported to provide an explanation why a particular illness befell a person at a particular time, the question being ‘why me’? Only traditional healers were believed to have the powers to treat diseases from unnatural causes, including breakdown of social relations. Another advantage of the traditional care mentioned was that payment could be in cash or in kind and paid over a period of time (Nyazema et al., 1992).

Nevertheless, the continued use of traditional medicine is not without challenges. Contrary to what is believed, it is neither always easily accessible to the users nor cheap. There are many types of healers including herbalists, diviners, prophets or faith healers and TBAs; thus, there can be a good deal of referral among them. In some cases, a healer may only diagnose and refer the patient to another healer for treatment. This means that as in hospitals where patients are asked to return for further treatment or for tests, users of traditional medicine similarly make a number of visits for one disease episode. Users often travel long distances to healers unknown to them, for reasons similar to those that lead to by-passing of rural health facilities (Ahlberg, 1991). Given that at least one family member accompanies the patient, both transport and treatment costs in traditional medicine can be as prohibitive as it is in government and private hospitals. Apart from costs, women categorised as being at high risk from a biomedical perspective may be prevented from seeking care in time (Mbaruku, 2005) or may be given improper medicine (Nyazema et al., 1992) due to the way the healers work.
Demographic and health indicators in Zimbabwe

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<td>11.6</td>
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<td>Population growth rate %</td>
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<td>1.7</td>
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<td>Female life expectancy (years)</td>
<td>58</td>
<td>63</td>
<td>61</td>
<td>37-42</td>
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<tr>
<td>Male life expectancy (years)</td>
<td>54</td>
<td>61</td>
<td>59</td>
<td>38-43</td>
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<tr>
<td>Crude birth rate/1,000</td>
<td>47</td>
<td>42</td>
<td>31.6</td>
<td>30</td>
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<td>Crude death rate/1,000</td>
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<td>17</td>
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<td>Total fertility rate per woman</td>
<td>7</td>
<td></td>
<td>4.29</td>
<td>3.6</td>
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<tr>
<td>HIV/AIDS prevalence rate (15-24 years)</td>
<td></td>
<td>8-12</td>
<td>25</td>
<td>24.6</td>
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<tr>
<td>Maternal mortality ratio per 100,000</td>
<td>243</td>
<td>283</td>
<td>458</td>
<td>610</td>
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<tr>
<td>Child mortality &lt;5 per 1,000, female/male</td>
<td></td>
<td>75</td>
<td>77</td>
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Maternal health care in Zimbabwe

The health care system in Zimbabwe is characterised as pluralistic, because of the co-existence and concurrent use of traditional and biomedical practitioners. As indicated above the traditional healers including TBAs continue to play an important role in the provision of health care (Mukumbura, 2000) and is popular for conditions such as infertility (Mutambirwa, 1989) and mental health, as well as those diseases believed to be incurable through biomedicine (Nyazema et al., 1992). Of late, however, due to the high exodus of staff, high hospital costs and shortage of essential drugs many people are forced to seek traditional care (Chimhete, 2003; Mukumbura, 2000; Neube, 2003).

The state and use of traditional medicine

Despite official recognition of traditional healers and an official policy of inclusion, not all aspects are included. Although TBAs are being integrated in the health care system through TBA training, the Witchcraft Suppression Act introduced in 1899 remains in tact, despite calls by the Zimbabwe National Traditional Healers Association (ZINATHA) to have the act amended (Clever, 1998). Official use of traditional healing was outlawed under this legislation and all the healers were regarded as ‘witchdoctors’ (Simmons, 2000). Colonial governments moreover supported medical missionary efforts to severely curtail the practice of traditional healers, who were regarded as backward, primitive, heathen, and illegal (Bujo, 1990).
In the context of modernisation discourses and practice, traditional healers were lumped together as ‘witchdoctors’ (Simmons, 2000). This attitude is still reinforced by some medical professionals and the educated elite (Freeman & Motsei, 1992) and there have been a number of arrests for witch hunting (Herald, 2005a; Simmons, 2000). The witch is a spiteful person who operates in secret to harm others (Middleton & Winter, 1963), but traditional healers such as diviners diagnose the cause and recommend a course of action. This may involve rituals and sacrifices to amend social relationships and entails identifying persons who for various reasons may want to harm the sick persons or omissions and commissions within the family system.

Traditional birth attendants in Zimbabwe are recognised by the government and they are widely used by rural women (Wintergreen, 1998). The commonly accepted definition of a TBA is that she is a person (normally a female), who assists women during pregnancy and delivery (Hansson, 1996). Traditional birth attendants attend to women in their homes and often have little or no formal education and often learn their skills from other TBAs in the family or neighbourhood or by attending to their neighbours or relatives during pregnancy and birth.

Biomedical care

Provision of maternal health in rural and urban Zimbabwe varies in a number of ways. Unlike in urban areas nurses and midwives in rural areas may for example, care for their patients without the benefit of support staff or sophisticated equipment (Mbaruku, 2005; Mbizvo et al., 1994) and at times they handle critical or emergency cases without the help of a specialist. The poor infrastructure, including transport problems, fewer health care providers and limited technological resources, furthermore inhibits access to health services especially for pregnant women.

The most common sources of biomedical care for pregnancy and childbirth are government-supported health centres and missionary owned health institutions. Both ANC and delivery services are provided free at local health centres but women are supposed to pay for higher level care at the district hospitals. Women are expected to report to the nearest health centre early in the pregnancy, preferably before the 12th week and those found to have risk factors are referred to the district hospital. Larger facilities have established waiting shelters for women living long distances away, are likely to have complications or risk factors, or to await labour from the 37th week (Nhindiri et al., 1996). Women using the shelters provide for their own personal needs including food.
Despite availability of service and knowledge of benefits of early visits, many women make their first visit late in pregnancy and may attend ANC only once during an entire pregnancy (Mathole et al., 2004). While more than 90% of pregnant women attend antenatal clinics, many deliveries take place outside the formal health care system (Nhindiri et al., 1996). A maternal mortality survey in 2002 revealed that more than 30% of women in rural Zimbabwe delivered at home (MOHCW, 1997). Although this may be due to inaccessibility to health care facilities or poor quality of care, little is known about how pregnant women consider the use of ANC.

HIV and AIDS and maternal care

The HIV epidemic presents challenges to the effective delivery of health services. In many hospitals in Zimbabwe, most of the beds are occupied by patients with AIDS-related diseases. AIDS is currently the most common cause of death in young adults; HIV/AIDS prevalence is currently estimated at 24%, and about 29% of pregnant women are believed to be HIV positive (MOHCW, 2000). Mother to child transmission (MTCT) is a major issue in the provision of maternal health (Munjanja, 2000). Ideally, anti-retroviral drugs during pregnancy or postnatal should prevent transmission from mother to child and prolong the life of the mother. In Zimbabwe, as in many countries in Africa, women however have no access to such drugs for continued use beyond pregnancy and the immediate postnatal period, the focus is therefore on the baby rather than the mother. It is in such contexts, where medicines are not available when needed, that AIDS is most demonstrably a disease of poverty (Farmer, 1995).

Preventing infection or ensuring that women avoid being infected before they are pregnant remains a priority, and VCT is one of the nationally adopted strategies as a policy for prevention. The ANC period offers an opportunity for VCT, as about 90% of women in Zimbabwe have at least one contact with ANC clinics (Munjanja, 2000; Rutenberg et al., 2003); however, HIV testing services are unavailable for most rural women and the majority of pregnant women do not know their HIV-status (Duffy, 2005).

Another major setback is the way HIV/AIDS has been handled. In contrast to other sexually transmitted infections (STIs), such as syphilis, which is tested as part of the standard ANC routines, testing for HIV is still not part of the normal routines. The practice of contact tracing used for STIs (Faxelid et al., 1994) does not therefore apply to HIV cases. Moreover testing and contact tracing has been discouraged in order, as is argued, to avoid violating the human rights of HIV infected people (MOHCW, 1999). The omission of the contact tracing approach to AIDS care has been described as responsible
for the escalating stigma that affects prevention, treatment and care (Patient & Orr, 2004).

During the last few years, concern over HIV related stigma has increased (Duffy, 2005; Messer, 2004), yet visible change has remained slow, affirming the enduring strength of stigmatisation. The public response to HIV and AIDS affects how people view themselves. It has been observed that the stigmatisation process usually begins with the community’s response to a person with HIV: eventually the person comes to expect such reactions and anticipate them before they occur and even if they do not occur (Duffy, 2005). People “feel shame”, not because of the cultural meanings of illness, but rather in response to the reaction or attitude of family members, the community and health professionals. For instance, the couple in the prelude story are caught up in a system that leaves them isolated and suffering in silence, as they fear the negative reactions of their families.

A diagnosis of AIDS brings considerable physical and emotional suffering, especially in contexts where access to antiretroviral medications (Duffy, 2005) or proper diet is limited for most people, due to poverty. With increased poverty and a deteriorating health care system, the emotional trauma created through stigmatisation only intensifies the suffering. This vicious circle is illuminated in the story quoted in the prelude. Stigmatisation results in silence, thus, allowing the stigma to gain more influence and produce greater suffering (Duffy, 2005; Messer, 2004).

Introducing evidence-based antenatal care in complex contexts

There is currently an ongoing debate on the ideal structure of ANC. When the first ANC programmes were designed in Europe in the first decades of the 20th century, they were directed mainly to women living in socially difficult conditions, and had as a definite objective to improve maternal and perinatal outcome for the least privileged groups (Lindmark, 1992). Gradually, the programmes were expanded to include more specific screening procedures to detect defined medical problems in the entire pregnant population.

As maternal and perinatal outcome dramatically improved in the industrialized parts of the world, ANC was given much of the credit without sufficient evidence of its exact benefits. This system of ANC has now been challenged, primarily in countries with the most favourable maternal and perinatal health indicators. The system is also challenged in low income countries (Majoko, 1995; Munjanja et al., 1996; Villar et al., 2001) including those in the Afri-
can region, where ANC modelled on that from industrialised countries was introduced in the 1930s (van-den-Broek, 2003).

The challenge is part of a trend demanding scientific evidence in medical interventions and arises from the realisation that there is lack of substantive justification for many of the medical procedures in ANC (Lindmark, 1992; Villar et al., 2001; Villar & Khan-Neelofur, 2000). Reducing prenatal visits is for example, one of the routines in ANC being recommended. In traditional ANC, women are expected to report early in pregnancy, the assumption being this enables care providers to identify risk factors and to refer women to appropriate levels of care. The conventional model requires women to make monthly visits in the first six months, a visit every 2-3 weeks in the next two months, and thereafter, weekly visits until delivery.

The new ANC model recommends goal-oriented visits, more spaced than the conventional model (Villar et al., 2001; Villar & Khan-Neelofur, 2000). Routines with no proven scientific value, such as weighing, should be omitted and the number of visits should be reduced. It was assumed that reducing visits would save time and enable health care providers to spend more time giving women adequate information on risk factors and how to deal with emergencies (Majoko, 1995; Murira et al., 1997; Villar et al., 2001) and on delivery, breastfeeding and family planning.

The new model appears as effective as the traditional one with regard to specified maternal and perinatal outcomes and does not negatively affect maternal and perinatal outcomes (Munjanja et al., 1996; Villar et al., 2001). Other studies, comparing the traditional with the reduced visit schedule (Sanders et al., 1999; Sikorski et al., 1995), have nevertheless observed that while health care providers and women users are generally satisfied with the care received, in some cases women have expressed concern over the spacing of visits.

In spite of the successes described in these studies there is increased knowledge about the limitations of evidence-based medicine, particularly its underestimation of the complexity of social contexts in which it is implemented (Crawford et al., 2002; Freeman & Sweeney, 2001; Trinder, 2000), and that it devalues the humane and social aspects of clinical practice (Lipman, 2000). Trinder (2000), for example, argues that scientific/clinical evidence should incorporate other types of evidence and knowledge, including organisational structures and social contexts. It should also incorporate the personal and professional experiences of the healthcare providers which influence the process of implementing clinical evidence (Freeman & Sweeney, 2001). A study in the UK, illustrated how doctors’ personal and professional experiences, their knowledge and their relationship with pa-
In an attempt to explain the intersecting perspectives observed in this study and the critique of evidence-based medicine, the ideas advanced within the constructivist’s theoretical framework were deemed appropriate. A basic idea within this framework is that the world is constituted of multiple and competing versions of truth and realities and that ways of understanding are socially constructed in interaction with the contexts in which they occur. The actors therein create their orders of vision as they move through a social landscape of culture and science, continually interacting and engaging in dialogue and at the same time changing their contexts. The concern is thus use of strategies in knowledge creation that also acknowledge and engage stakeholders of different perspectives in ways that help them to not only make sense of their experiences but also consider the perspectives of others. Guba and Lincoln (1989) advocate the use of methods of evaluation, which include perspectives of different stakeholders, this is a departure from traditional methods that often allow some perspectives to be viewed as more legitimate than others (Guba & Lincoln, 1989).

The tendency to view certain perspectives as more legitimate is a subject addressed by other researchers (Chambers, 1983; Nygren, 1999). Chambers (1983) for example, criticises the commonly held view that knowledge acquired through formal training and education is superior, modern and scientific, and that the uneducated are less knowledgeable and in need of being modernized. The importance of acknowledging the knowledge of local people and of learning from their experiences and realities is emphasised (Chambers, 1983).

Similar to Chambers, Davis-Floyd (2000) criticises the way TBAs are trained, using what he calls the “authoritative” biomedical knowledge, which ignores TBAs’ own knowledge and perspectives. The issue is also taken up by Jordan (1992) in the area of childbirth as the authoritative knowledge, or the knowledge on the basis of which decisions on maternal and child care are made (Davis-Floyd, 2000). With biomedicine as authoritative knowledge, these modes of thought imply that traditional practitioners are backward and their methods of dealing with childbirth are dismissed as unscientific and irrelevant (Jordan, 1987), as if they are unfounded and based on superstitions. It is moreover assumed that because this knowledge is not documented, it cannot be modern or scientific (Hountondji, 2002).

In view of these critics and in the context of this thesis, methods were sought that not only acknowledge the existence of multiple perspectives and knowledge, but to investigate their interplay by including different stakeholders,
and using different qualitative methods (Guba & Lincoln, 1989; Thorne et al., 2004). Qualitative methods were used to illuminate the variety of meanings attached by individuals to particular events or issues (Kitzinger & Barbour, 1999), whether they arose from their professional backgrounds and training or from personal experiences as constituted in the contexts within which they occurred and in interaction with others and cultural and scientific knowledge. The study is, in this context, based on the naturalistic inquiry as initially described by Lincoln and Guba (1985) and further elaborated by Thorne’s (2004) interpretive description, and can provide an understanding of how these different perspectives give rise to particular conflicts (Lincoln & Guba, 1985; Thorne et al., 2004). The interpretive description acknowledges the existence of socially constructed multiple realities that are complex and contextual (Thorne et al., 2004) and provides more than just mere description of a phenomenon, in that it allows for more exploration and interpretation to uncover meanings and explanations with implications not only for theory but also for practice.
The general aim

The aim was to study the perspectives of different stakeholders and their ways of reasoning around pregnancy and pregnancy care in order to gain insights into factors with implication for theory and practice of ANC.

Objectives

- To investigate the perspectives of women and their reasoning for the use of ANC and the meanings of specific routines. (Paper I)
- To investigate the experiences of professional healthcare providers in their general care of pregnant women and in the context of attempts to introduce new ANC routines. (Paper II)
- To analyse the experiences of health care providers and their reasoning in providing care for pregnant women in the context of HIV and AIDS. (Paper III)
- To explore the role, knowledge and perspectives of the traditional birth attendants in the care of pregnancy and childbirth. (Paper IV)
Methods and the research process

This study was undertaken in the context of the proposals and actual attempts to change ANC routines as part of a new trend to base medical interventions on scientific evidence. In line with these trends, a randomised control study was conducted in a rural district in Zimbabwe, to introduce a goal oriented ANC package (Majoko, 1995). The preliminary analysis indicated that it was difficult to change established routines or to get women and health care providers to accept more spaced visits and to have only routines proved to be medically effective. The aim of the current research was to explore the perspectives of women as well as health care providers, their experiences and their views and meanings of ANC. Different qualitative methods including focus group discussions (FGDs), interviews and observation were combined in an iterative process using interpretive description as a frame of inquiry and analysis. Qualitative methods allow a deeper understanding of the world as seen by the respondents, their point of view and their experiences (Maxwell, 1996; Patton, 2002).

The study design

Different qualitative methods were combined, and an emergent and analytical design allowed relevant issues arising to be incorporated into the research process.

The study started with a workshop in 1999 compromising of 23 health care providers from clinics involved as study and control clinics in a randomised control trial aimed at changing ANC routines (Majoko, 1995). The purpose of the workshop was to generate information concerning the experiences of the health care providers who had participated in the randomised control trial. Issues generated, for example, on work organization, local beliefs and practices during pregnancy and childbirth and the role of the TBAs, prompted the need to continue with this qualitative research and were useful in subsequent decisions, not only on the issues to include in the study, but also on data collection strategies and the research participants.

Through this analytical process, ANC was found to be not just a world of professional providers but also a world where different stakeholders, differ-
ent perspectives and systems of knowledge intersected. Health care providers described how they interacted with the women seeking care and acknowledged the popularity of TBAs in the care of pregnancy and childbirth in the study area, but also expressed conflicting views about TBAs and their work. A complex picture in the use and provision of ANC emerged, prompting the inclusion of different stakeholders and use of qualitative methods suitable for understanding complex contexts, meanings, experiences and perspectives of the research participants. FGDs with TBAs and women raised issues that necessitated inclusion of men, in part to explore their role in family decisions in the care of pregnancy (see Figure 1).

The study site

The study site was in Gutu district, situated 225km southeast of Harare, which has a population of 230 000 inhabitants, is served by 25 health facilities: 1 district hospital, 18 health centres, and 6 larger health centres with inpatient facilities, three of which are mission facilities. Rural health centres offer mainly outpatient services but have up to four beds for 24-hour observation and a few postnatal beds. According to government policy, a rural health centre is supposed to be run by a trained midwife, a nurse and a nurse aid (MOHCW, 1994), but in reality, most clinics only have, on average, one state certified nurse. The TBAs provide care from their homes, but they are expected to refer the women in their care to the health centres.
Figure 1. The above figure illustrates the research process. The rectangles show the research methods used and the number of participants. The information in the ovals is a summary of the major issues that were used for subsequent sampling and research methods.
The data collection methods

FGDs, individual interviews and observation were combined. The three methods supplemented each other. While interviews are suitable for generating information on personal experiences, FGDs generate data on general opinions, and through the dynamics of group interaction potentially help participants to reflect on different dimensions of the phenomenon being discussed (Kitzinger & Barbour, 1999; Patton, 2002). Data was collected between 2000 and 2002 (Table 1).

Focus group discussions

Focus group discussions were chosen in part to gain maximum variation of answers with adequate depth from the dynamics of group interaction (Kitzinger & Barbour, 1999) and to identify group norms or a range of views which result from the interaction within a group (Kitzinger & Barbour, 1999; Patton, 2002). The interaction among group participants can provide valuable, sometimes unexpected, information and understanding (Krueger, 1998).

Eleven focus groups were held with TBAs, women and men. The FGDs with TBAs for example, unravelled a very complex world of providing both physical and spiritual care; a world often presented as simply traditional birth attendants. The group interactions here revealed how the TBAs work, how they co-operated, and how they competed with each other. In all focus groups I was the moderator. After explaining the purpose of the study and assuring the participants of the confidentiality of data, that the tapes would be destroyed after completion of the study and no name would be revealed, the moderator facilitated the flow of the discussion. Key questions covering major areas on the experiences of professional caregivers, women, men and TBAs regarding pregnancy and the care of pregnancy, as well as their views on pregnancy and childbirth, guided the discussions.
Table 1. The study participants

<table>
<thead>
<tr>
<th>Paper</th>
<th>Method</th>
<th>Participants</th>
<th>Age range</th>
<th>Other characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>FGDs</td>
<td>3 groups with women</td>
<td>19-46</td>
<td>44 ANC women</td>
</tr>
<tr>
<td></td>
<td>Interviews</td>
<td>11 women</td>
<td>19-46</td>
<td>24 husbands of ANC women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 groups with men</td>
<td>24-52</td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>FGDs</td>
<td>5 groups with TBAs</td>
<td>36-72</td>
<td>43 of the 48 TBAs trained, years of experience ranged from 1-36</td>
</tr>
<tr>
<td></td>
<td>Interviews</td>
<td>6 TBAs</td>
<td>3 groups with men</td>
<td>29 husbands of ANC women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18 women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II, III</td>
<td>Interviews</td>
<td>25 nurses</td>
<td>18-67</td>
<td>6 state registered nurses, 10 state certified nurses, 8 trained in midwifery, 7 nursing students. Years of experience ranged from 0.5-30 years</td>
</tr>
</tbody>
</table>
Participants in two of the women’s FGDs and one of the men’s groups were recruited with the assistance of the health care providers from among women attending the ANC clinic and their husbands. Participants for the other three groups (1 with women and 2 with men) were recruited through a village health worker and a kraal head.

Five FGDs comprising of 7, 10, 12, 8 and 11 traditional birth attendants in the respective groups were conducted to gain insight into the world of TBAs, their care of pregnancy and childbirth as well as the way they experience the TBA training. Three of the FGDs took place at community halls and the other two at two health centres.

**Interviews**

Interviews were conducted with 25 caregivers, 18 women and 6 TBAs between 2000 and 2002 to explore personal experiences, meanings of pregnancy and pregnancy care. The TBAs, as well as the women interviewed, were purposefully selected from among those who participated in the FGDs. Interviews were held at a mutually agreed place and time, usually the participant’s home or at a clinic. A topic guide assisted the probing of specific issues and allowed inquiry about a range of areas of individual experiences.

The 18 caregivers, selected from participants in the initial workshops, included: differing length of experience; different ages; those who expressed strong opinions, whether positive or negative, about the changed routines; and those who discussed issues differently from others, for example, they worked well with TBAs as well as those from clinics more hostile to the randomised control trial.

There was at least one interview with a health care provider from all the health centres that participated in the randomised trial. The scope of the interviews included questions on experiences and views of the caregivers on implementing the proposed changes, their working environment and the challenges they encountered at work. During the interviews, HIV and AIDS related issues were spontaneous and well articulated. A second interview was therefore conducted with nine of the caregivers who had not articulated the HIV/AIDS issues well in their first interview.

An additional seven caregivers were selected for further interviews on issues of HIV and AIDS and were mostly from those newly employed or transferred into the study area after the previous data collection phase in 2000. In total, there were 25 caregivers and 34 interviews. The interview questions focused on the HIV/AIDS, testing, stigma and the caregivers’ experiences in providing care in the context of HIV and AIDS.
Eleven women selected from those who participated in the FGDs were interviewed to allow them to elaborate on issues such as use of traditional health care, faith healing and the new ANC routines, which featured in the FGDs, and their own personal experiences regarding care during pregnancy. Some interviews were conducted within the clinic setting (in the women’s waiting rooms or under a shade), and others took place at home.

The six TBAs interviewed were selected from those participating in the FGDs, and the selection criteria were: work experience; self-reported popularity, gauged by the number of women they said they had attended; attendance at TBA training; and those reporting to have healing powers. All participants agreed to be tape-recorded and three of them requested for a replay of the tape, which gave further opportunity for probing and clarification on some of the issues arising in the interviews: the interviews lasted between 60 and 90 minutes. The number of participants was not pre-determined and interviewing continued until saturation occurred, that is when no new data was revealed (Kvale, 1996; Patton, 2002).

**Observation**

Throughout the research process, observations were made to gain knowledge especially on the interaction between the caregivers and pregnant women during ANC visits. In particular, the interaction during the health education sessions, the process the women went through at the clinic, including the behaviour of women concerning changed routines such as weighing were observed, which enabled interactions to be studied undisturbed or as they naturally occurred (Morse, 1996). Through direct observation the researcher was better equipped to understand and capture contexts within which people interact and could also learn about sensitive subjects that the participants might not be willing to disclose in group discussions or interviews (Patton, 2002; Polit & Hungler, 1999).

Observations were used to describe the physical and the social environment of the participants and to enhance understanding of the circumstances under which they lived and worked. Observations were documented in field notes during and immediately after the observed occasions and situations. The field notes contained references to interaction patterns, descriptions of the surroundings – the physical place, people, emotions, and events.
Ethical issues

Ethical approval was obtained from the Medical Research Council of Zimbabwe and the Research Ethics Committee of the Medical Faculty, Uppsala University in Sweden. The women, TBAs and nurse/midwives were asked for their consent to participate in the study after being told about the study objectives and methods used. The participants were given the opportunity to change their minds about being interviewed before each interview or FGD. In order to ensure confidentiality and anonymity, each participant’s real name was changed to a number.

Data analysis

Data analysis was a continuous process in this analytical or emergent design. The audiotaped interviews and focus group discussions were finally transcribed and translated from Shona to English to make data accessible to non-Shona speaking members of the study team. To ensure quality and to minimize loss of meaning and data the translated transcripts were read and corrected by a linguistic expert in both Shona and English. Ambiguous or unclear parts of the translation were back translated from English to Shona to examine comparability and assure accuracy. Data were analysed using standard techniques for qualitative data (Thorne et al., 2004).

To identify words, segments and units with relevant meanings, the transcripts were read several times (with frequent listening to the original tapes). Each individual transcript was repeatedly read and statements that reflected participant’s experiences and perspectives of important aspects of pregnancy and childbirth as well as use and provision of ANC were noted. These statements and phrases were marked and assigned a code. The coded units were then grouped into related categories, which were compared and searched for new associations, meanings and relationships among and within the data from which the themes presented in this thesis were developed (Hallberg, 2002; Patton, 2002; Strauss & Corbin, 1998) (Figure 2).
Figure 2. An example of the analysis process
Findings

Women’s reasoning around use of ANC and their views on specific routines (Paper I)

A number of factors were found to influence the use of ANC in ways that prevented women from adhering to some of the changes proposed as evidence-based or ANC generally. Most problematic appeared, for example, to be proposals for reducing the number of visits during a pregnancy and to omit the weighing routine. Cultural beliefs and ideas about pregnancy and childbirth as well as age, parity and experience of women all had influence on the use of ANC. The main concern for women, in particular the younger ones, was to be assured of the wellbeing of the baby they were carrying: they thus preferred closely spaced visits. They reasoned that too spaced visits would make it difficult for health care providers to identify and deal with complications that may develop over a longer period. The older women who had had more than one pregnancy without professional assistance on the other hand reasoned they had enough experience and used ANC least. They implied all their pregnancies would have similar outcomes. Reporting time in pregnancy however seemed to be complicated by the local belief systems, defining when a pregnancy can be reported. The early weeks of a pregnancy were believed to be ‘vulnerable’ to harm, which may arise from causes related to ‘witchcraft’. This is thus a period when people in this area believed the pregnancy should be stabilised, a form of care that could only be offered by traditional healers, be they TBAs, diviners or faith healers.

Contrary to the proposals to omit weighing, women in this study wanted to be weighed at all the visits. When weighing was not provided, the women used a number of strategies to ensure they were weighed. The importance or the meaning of ANC was reflected in the way the visits to ANC are just referred to as ‘going for scale.’ Weighing to the women had meanings and value, different from those recognized by biomedicine. Weighing for women not only signified that everything was going well, but it was also an issue over which women conversed with their friends. Moreover, as the case in the prelude suggested, weight in pregnancy acquired new meanings in the context of HIV and AIDS. Women feared being seen to lose weight, which would be interpreted as a sign of having AIDS. The health care providers complied with women’s expectations by weighing them without recording it in the cards.
Referral to higher levels of care especially for women considered to be at risk was a common routine in ANC. The level of compliance could however be low for a number of reasons including: lack of financial resources; logistical problems such as lack of telephone services and transport; poor quality of service at the referral centres; negative attitudes of the health care providers; and fear of caesarean deliveries. Some women who had been referred to hospital, sought care from the TBAs instead, especially those believed to have supernatural powers whether church-based prophets or indigenous diviners and healers.

Blood testing was another ANC routine that seemed to have assumed new meaning in the context of HIV and AIDS. The women expressed fear that their blood was being tested for HIV without their knowledge or consent. Lack of proper explanation during ANC routines made women suspicious and husbands similarly opposed and feared that HIV tests would be performed on their wives. One health care provider narrated a case of a husband who had confronted and threatened to report the health care providers to the higher authorities for supposedly testing his wife without his consent.

The complex and stressful situation of the caregivers (Paper II)

This paper described the perspectives of nurses and midwives as well as their experiences in providing ANC in the study area and within the context of the attempts to change ANC routines. The paper also discussed the difficulties the staff faced due to resource constraints. Paradoxically, according to the caregivers the work situation had become increasingly stressful and frustrating because of mass exodus of staff, although some of the changes were expected to ease the work situation. The difficulties in coping with the workload negatively affected interaction between the caregivers and the women. The caregivers had little time for individual discussions with women and health education lectures for groups of women attending ANC continued to be the main form of interaction. The lectures focused mainly on the biomedical knowledge of pregnancy and care of pregnancy, for example possible complications, and exercise during pregnancy. The caregivers discouraged women from performing heavy work and consulting TBAs. Because of the pressure of work, the caregivers reflected little on the experiences the women described during health education sessions, and at times the interaction was described as hostile with the caregivers having little patience with the women.

Changing some of the long established routines such as weighing and visits proved difficult mainly because of resistance from the women, of whose
reasoning and rationale for using the care facilities differed from the reasons and rationale of the biomedical professionals. Caregivers generally accepted the rationale of reduced visits but experienced pressure, especially from the younger women who implied that the five-goal oriented visits did not meet their perceived needs of care and used a number of strategies, such as seeking care in between agreed dates, for ANC visits. The women also demanded to be weighed and this made it difficult for the caregivers to omit. Other than the pressure from the women, some of the providers were themselves unconvinced about omitting weighing, a long established routine they had not only been trained to do but was also simple for women to do themselves.

Provision of ANC in the context of HIV/AIDS
(Paper III)

The challenge faced by health care providers in the face of HIV and AIDS emerged rather unexpectedly. It was therefore decided to include a study on the experiences of caregivers in these contexts. The caregivers described a complex situation of work where they were aware of the magnitude of HIV and AIDS from the official statistics and the media, as well as from the increases in the disease and deaths of women, children and colleagues around them. However, they expressed enormous frustration at not knowing the HIV status of the individual women they cared for: for the caregivers, this was said to be a source of fear from occupational transmission as they were aware of the likelihood of encountering HIV-positive women during antenatal routine visits and delivery. Inadequate supplies of gloves also increased their feeling of vulnerability to HIV infection.

Stigma and resource constraints were described as the major reason why women did not avail themselves for testing. HIV is highly stigmatised and women were said to use a number of strategies to avoid testing: some of the women referred for testing did not go; some accepted to be tested but never collected their results; and some of those who collected their results destroyed the cards.

The use of universal precautions was said to be problematic, not only because of resource constraints which meant that the caregivers had no access to preventive items such as the gloves, but also because of the social relations, especially where strong relations had developed between the caregivers and women. Contradictory information from official sources and the media on HIV and breastfeeding was said to present challenges especially in the routine health education as the caregivers were confronted by women who felt that their HIV status was being used as example in the health education sessions.
The complex world of TBAs in the provision of ANC (Paper IV)

The TBAs described themselves as counsellors, community teachers and advisors of women and pregnant women in particular. They provided women with advice on general care of pregnancy. Their accessibility and pleasant way of interacting with women made them popular. The accounts of the traditional birth attendants, women and men indicated that the women combined TBAs and professional care. The women used the clinic to obtain professional care and assurance that the pregnancy was progressing well. They then consulted the TBAs, believed to have supernatural powers, for both physical and spiritual needs of assurance. In this area, stabilising pregnancy especially in the early stages, in order to avert any harm that may arise from causes believed to be related to social breakdown of relationships and interactions were a major function in the indigenous care system. The TBAs moreover were thought to play a central role in helping women to avoid a caesarean delivery, a biomedical intervention that appeared to cause a great deal of anxiety for the women.

However, TBA training during all the years it has been implemented has not incorporated the key issues or knowledge that shape women’s health seeking behaviour. Training has focused on imparting biomedical knowledge and skills in maternal health care, such as identifying and referring women at risk. This was expected to strengthen the role of TBAs in reducing maternal and infant mortality and morbidity through improved practice; however, the TBAs expressed the dilemmas and challenges faced when implementing the skills acquired for example, referring women categorised as being at risk. Some of the reasons mentioned for not referring women included logistical problems such as lack of transport and prohibitive transport costs and unpleasant encounters with professional providers. More significantly was the fear of operation on the part of women who resorted to delaying tactics and came too late for the TBAs to refer them. The TBAs practiced a referral, where cases considered difficult were referred to other TBAs, whether church-based prophets or indigenous practitioners, known to have various important skills.
Discussion, conclusions and implications

This study was about the provision and use of ANC in a rural area in Zimbabwe and was concerned with the interaction between different social actors including professionals and lay women as well as different health care providers, health care professionals and policy makers and researchers. The study moreover analysed the intersection of different knowledge, health care professional practice, evidence-based medicine, indigenous medical knowledge and women’s experience and relational based knowledge. In this way, pregnancy and childbirth was a site of complex intersection of different actors, knowledge and power.

However, in trying to explain the implications of this study, it was important to emphasise that it was based on qualitative methods that could not be generalised in the conventional meaning (Kvale, 1996; Lincoln & Guba, 1985). The aim was instead to gain a deeper understanding about a complex phenomenon (Marshall & Rossman, 1989), rather than demonstrating how representative it was in the conventional sense. This is not to say qualitative studies cannot be generalised, but that different criteria are used. According to Guba and Lincoln (1989), qualitative studies can be transferred to other settings or groups if there is sufficient descriptive data of the research setting or context and an audit trail of the process of the inquiry. The responsibility of the researcher is to provide adequate information or ‘thick’ description to enable any reader who is interested in making a transfer to reach a conclusion about their contexts (Guba & Lincoln, 1989; Kvale, 1996; Patton, 2002; Polit & Hungler, 1999). It is important to mention that a number of studies on maternal health have been conducted in the same area and these studies provide a general picture of the socio-demographic situation of the study setting (Majoko, 1995; Mbizvo et al., 1994; Nilles, 2001; van-den-Heuvel et al., 1999).

From a methodological point, two experiences encountered during fieldwork will be discussed as a reflection on both contextual specificity, and situations that could be encountered in many interviews. The first was an encounter with the TBAs. During an interview with one TBA, and perhaps because of the questions the researcher asked which may have indicated to her a lack of knowledge of traditional care, she decided to show to the researcher the place in the bush where the herbs grew. Many times the TBAs made com-
ments such as 'you educated town people! You do not know your tradition; you think you are too educated to use the traditional herbs. You should learn about them, you should learn about your culture'. The TBAs admonished the interviewer for apparently neglecting this knowledge, adding that this is the way the educated from urban areas behaved. In retrospect, the TBAs raised a very basic concern where the modernisation process had also meant exclusion of indigenous knowledge in the ways described by Odora-Hoppers (2004). These issues are also raised by Chambers (1983) in that school education is equated with modernity and local knowledge with backwardness.

The second experience was represented in the case of the woman in the prelude and was to do with ethical issues in research. As is commonly the case, this research was reviewed by research ethical committees in both Zimbabwe and Sweden, before it was undertaken. Questions raised in the ethical review procedures are what the researcher should do when a case needing counselling or other types of support is encountered during interviewing. The researchers usually provide information on the professionals they would contact or refer the concerned research participant to if necessary. As was uncovered in this interview situation, there is rarely advice for a situation where referring the respondent to professional care was not the solution. The way the effect of HIV and AIDS related stigma emerged raised questions, not only on the ethical issues and considerations, but also on research and health care practice in the context of HIV and AIDS. To what extent can an interview situation be used to meet the emotional needs of research participants in such a sensitive and stigma-laden situation? What is the implication of stigma on how research on HIV and AIDS is conducted? What does it mean to just advise women to seek care or VCT? How is the stigma constituted? Does the way HIV and AIDS care is organised contribute, as Patient and Orr (2005) imply, to the escalation of stigma? The way the women and men in this study expressed a fear of HIV testing at local facilities suggested the structure of the caring situation was a factor in stigmatisation.

The study was undertaken in the context of the current discourses and practice of evidence-based care. Evidence-based medicine emphasizes the need to base clinical decisions and interventions on the current best available scientific evidence, preferably gathered using methods such as randomised control trials or meta-analysis (Lipman, 2000). In the case of ANC, studies suggest that it is possible to change certain routines, such as reducing the number of ANC visits, to achieve similar perinatal outcomes (Lindmark, 1992; Munjanja et al., 1996; Villar et al., 2001). Excessive visits are considered an unnecessary burden on the health care system and for women, especially, in resource constrained low-income countries.
This form of evidence has however been criticized for elevating experimental evidence to primary importance over other forms of evidence (Cohen et al., 2004). Trinder (2000) argues for incorporating contextual knowledge, such as the community organizational structures, the personal and professional experience of health care providers, or, what Guba and Lincoln (1989) would call taking account of pluralistic values. A number of observations in our study highlighted these points.

The concern of the evidence-based care with regard to resource constraints was elaborated in both this study and others (Trinder, 2000). The poor working conditions, the shortage of drugs and staff described in this study are common in Zimbabwe (Chinowaita, 2002) and had an impact on implementing the recommendations. Similar results are reported from Kenya, where 30 facilities experienced problems with staffing, equipment and essential drugs (Rogo & Aloo-Obunga, 2001). The problem of nurse shortages has also been acknowledged as a global problem, mostly because fewer people are interested in the nursing profession (Hsia, 2002).

The health care providers described a work situation where merely changing routines, with the hope that this would release time and resources for better interaction between caregivers and women, and for women to perform activities more useful for their livelihood and their families, was not enough. The way the women reacted for example, when the weighing routine was omitted, implied that their concept of ANC was different from that conceptualised in evidence-based ANC. Moreover, the staff situation, the dynamics and paradoxes of dealing with many parallel programmes, insensitive policies of recruitment and transfer of staff and women who presented pregnancy much later than stipulated in the ANC routines, was more complex than envisioned in evidence-based medicine.

In these types of complex and paradoxical contexts, it appeared that encounters between staff and women were often constrained. Such constraints and apparently hostile attitudes of the staff contravene the principles of nursing and midwifery (Bryar, 1995). Whatever the case in the context of this study, staff attitudes are affected compliance to the referral procedures on the part of both the women identified to be at risk and the TBAs who were expected to refer them. The factors that created negative attitudes among staff, combined with local systems, beliefs and fear of caesarean delivery – was part of the knowledge that did not appear to feature in professional health care or in the training of TBAs. This therefore meant that women opted to be delivered by TBAs, who had been trained to refer such women for professional care. Although this was not the focus of this study, women nevertheless, used strategies such as presenting labour at a stage where TBAs had no choice but to attend them: the use of such strategies, suggested women preferred the
services of the TBAs. A study in Syria observed that women preferred TBAs because of their accessibility, better treatment and respect they are shown (UNFPA, 1996). Preference for TBAs was also reported in a study in Bolivia, mostly because of doctors ill-treatment of women (UNFPA, 1996), and in India (Stephens, 1992) and Uganda (Ndyomugyenyi et al., 1998) for economic reasons. In a group of Swedish women, lack of respect emerged as a core category on why women do not comply with routine mammography screening (Johansson & Berterö, 2003). The women participating in the Swedish study wanted a screening process that has a gentle and more humane examination that shows respect for women.

Other issues highlighted in this study similarly suggest the implications of ignoring local knowledge when introducing change. Women are, according to ANC routines, expected to report pregnancy early, the assumption being to enable health care providers to identify risk factors and to refer the women to an appropriate level of care (Majoko, 1995). Although a noble ideal, especially for areas where maternal health status is poor, women in these areas avoided presenting pregnancy early because of the belief that the pregnancy and the woman are most vulnerable to ‘witchcraft’ during this early period. This perceived need for the pregnancy to be stabilised required the TBAs cultural knowledge. The belief about the early period in pregnancy had implications for the implementation of the recommended five-goal oriented ANC package, as women came for their first visit long after the stipulated time. Similarly, health care providers found that the number of visits related mostly to the fact that women came for their first visit later than what was recommended.

The women similarly continued to demand to be weighed and even used some strategies to ensure it was done. Although omitting the weighing routine is recommended, its value and meaning for women is evidently clear in that visits to antenatal clinics in this community are simply called ‘going for scale’ (Mathole et al., 2004). Conflicts arising from the use of authoritative knowledge while ignoring other types of knowledge has been observed elsewhere (Crawford et al., 2002) and the importance of including the users of care in reviewing and changing ANC has also been emphasised (Cohen et al., 2004).

TBA training, which is based on the recognition of the important role they play in the care of pregnancy and childbirth, appears to have prioritised imparting biomedical knowledge. The focus is to train TBAs to recognise women at risk in order to refer them and to also make home deliveries cleaner and safer (MOHCW, 1997). While this is important, especially in areas where maternal and infant mortality are high, failure to incorporate why TBA care is popular or makes sense to the users partly explains the
TBAs’ failure to comply with their training, for example, referring women at risk to the health centres.

Resource constraints were also identified as another key problem presenting difficulties for TBAs to refer women, especially in emergencies. Although these studies did not focus on the impact of TBA training on the improvement of the ANC, the question could still be asked: does this type of intervention represent a double loss, that is, investing to achieve a certain goal but achieving nearly the opposite? The attempts made for integration of biomedical and traditional care of pregnancy and childbirth appear problematic for not including, or for ignoring, the cultural basis and practices in pregnancy care. As a result, the integration through TBA training hybridised the different types of knowledge in ways that do not meet the goals of reducing maternal and infant morbidity and mortality. On the contrary, the two systems continue existing in parallel but in less effective ways for the users.

The importance of skilled assistance at delivery is an important contribution to improved pregnancy outcomes (de-Bernis et al., 2000), but is on its own inadequate. In a population survey on reproductive health in rural Malawi, perinatal mortality estimates are similar for nurse midwives and untrained traditional birth attendants in the community (van-den-Broek, 2003). The researchers emphasise the importance of providing health facilities and hospitals with essential obstetric care facilities and an effective and timely referral system for trained staff to achieve better results.

The health care providers in Gutu experienced similar problems because of the deterioration of the health care system, which compromised their effectiveness. This was also a source of frustration to the skilled personnel working in public institutions where resources were scarce. The deterioration in the health care system is also identified as a source of stress in Nicaragua (Cruickshank, 2000), hospital fees, drug shortages, transport problems are all identified as major barriers in accessing care. Building effective referral systems is therefore critical for ensuring that women who need emergency attention are able to obtain it. A number of maternal deaths occur because women with obstetric complications fail to receive appropriate care soon enough to save their lives (Donnay, 2000; Jahn et al., 2000; Mantel & Moodley, 2002).

HIV and AIDS have created yet another challenge in the provision of maternity care, particularly given the resource situation already mentioned above. Besides becoming a major cause of maternal deaths, (Kruger & Bhagwanjee, 2003; Majoko et al., 2001), HIV/AIDS infection is also reportedly a major source of paediatric infection (UNAIDS, 2002) with health caregivers continually exposed to the risk of occupational transmission.
The spontaneous way the issue of HIV and AIDS emerged in this study in Gutu was interesting. The concerns of women users of care at the beginning of the study, especially their strategies for avoiding routines such as blood test because of fear of being tested for HIV (Mathole et al., 2004), suggests just how complex the issue has become. Moreover, the difficulties expressed by the caregivers are an indication of a complexity that does not seem to be comprehended in policies of prevention and care. This was true especially in the light of the knowledge about the prevalence of HIV and AIDS from official statistics and the media and at the same time not knowing the HIV-status of individual women they care for. Additionally, the strategies applied by women to avoid being tested or disclosing their HIV-status and also the inability of the caregivers to use the recommended universal protection to preserve established social relationships with the women and the community members.

The way stigma, fear of discrimination and isolation emerged from this study suggested not only the complexity, but also more importantly the areas which could be addressed, including how caring situations reproduce stigma. Health education during pregnancy may for example need reconsidering for two reasons. Firstly, from the way the women, who may have disclosed their status to the caregivers, reacted to the health education sessions with the view that their own status was used by the caregivers in the education, suggests the need for new approaches in such local contexts. Secondly, the case of the woman in the prelude presents another problem, namely a paradox of the public health model, where information is given to a silent public with little reflection on whether the targeted people understand or can use the knowledge. The public health model has been criticised for emphasising education and its assumption that ‘information is everything’ (Basu, 2003). In the process, the public health model ignores circumstances in people’s lives and their cultural, political and economic contexts. Basu’s arguments are supported by Sinding’s (2005) critique of the ABC (abstinence, being faithful and condom use) strategy, now increasingly used in HIV prevention, and similarly questions the public health model. According to Sinding the ABC strategy can be misleading (Sinding, 2005). Married women who are faithful might not have the power to refuse sex or have no skills to negotiate condom use with their husbands.

The story of the woman in the prelude of this thesis illustrated how better use of available knowledge could prevent infection. Existing knowledge suggests that the risk of getting HIV infection from a sexual contact is low (Padian et al., 1997) unless there are other co-factors such as STIs. If the woman had been well informed, her chances of being tested or using a condom to save her life and that of the baby could have been high. As argued by Ogden & Nyblade, information should include not just how HIV is transmit-
A review of the meaning of stigma in rural Zimbabwe demonstrates how HIV/AIDS results in stigma, suffering, shame and silence (Duffy, 2005). It is shown that ill treatment and discrimination resulting in isolation, fear and victim blaming are common. This implies that HIV/AIDS is not disclosed to the partner or to the health care providers and the cycle of infection and stigma continues. In the case of the husband in the prelude, only when the wife became pregnant did he disclose his HIV status to her. Such experiences question the current official policy on HIV/AIDS, where spouses are only encouraged to inform their partners, but are not legally bound to do so (MOHCW, 1999). This policy is expected to protect the rights of HIV positive people: however, in the context of stigma and silence observed in this study such a policy infringes on the rights of uninfected people, especially sexual partners. The policy should put more effort into understanding the dynamics of stigma, how it is reproduced or constituted in order to protect the rights of the infected people and not make the uninfected partners more vulnerable to the risk of infection. These issues are addressed by women’s groups in Zimbabwe who have urged the Government to formulate legislation that compels spouses to reveal their HIV status to each other (Herald, 2005b). In this way, the women’s groups argue in the same way as Sinding (2005), that marriage is a major risk factor in HIV transmission. The Sexual Offences Act (2001) makes it an offence to knowingly transmit HIV infection; however, most people do not know about this Act and no serious effort has been made to publicise it, leave alone to put it into practice.

According to Patient and Orr (2004), the healthcare structure reinforces and reproduces stigma (Patient & Orr, 2004). They use an example of the procedures at a VCT facility, where people gathered in a waiting room know why everyone is being tested. One can ask whether no lessons have been learnt from the family planning programmes where women have evaded using clinics near their homes in order to avoid being identified (Ahlberg, 1991).

The above scenario and the case of the woman in the prelude question some of the success stories being increasingly reported. A study in Zimbabwe on the feasibility of implementing PMTCT program in a rural setting indicated high acceptability rate (above 90%) of HIV testing among women using ANC (Perez et al., 2004). The success of the intervention could be attributed to the availability of drugs to reduce mother to child HIV transmission, use of rapid HIV testing and inclusion of HIV testing as part of the ANC routines. In addition, there were resources from the project that are not always available in the health centres, for example, additional staff were employed and women were monitored systematically. The question however is how
such experimentally designed interventions can be transformed into day-to-day practice in the context of stigma and budget constraints common in the situations described. Similar observations about the limitations in the transferability of experimentally designed interventions have been made on HIV counselling in South Africa (Rohleder & Swartz, 2005).

In conclusion, and on reflecting on the way different stakeholders reason around maternal health care, this study raised the importance of using methods that enhance the understanding of the meanings and associations that people have about their health and health care. The study suggests the need to broaden the conceptualisation and practice of evidence-based care. There is an urgent need to incorporate different types of evidence and to include realities, knowledge and perspectives of not only the beneficiaries but also those implementing change, that is, evidence should not just comprise of biomedical knowledge.

A major assumption in integrating the two systems is the improvement of pregnancy outcome and health of women by mitigating effects that could arise in the way users combine the two systems. It is however necessary to have a more balanced integration, where a reflective dialogue should enable professional health care to enhance rather than suppress the cultural knowledge for which TBAs are popular as this study indicates.

The experiences of the woman in the prelude, other women in the study, and caregivers raise questions regarding how HIV/AIDS education or health education in general can be more effectively organised and the need to address stigma and contextual issues such as efficient use of available resources. The data indicate that there is need to develop the VCT to include the STI model of partner notification in HIV/AIDS.

The problems experienced by the caregivers moreover demonstrate that provision of maternal care will not be effective without some reorganisation of the health systems to accommodate the new challenges of the epidemic. The contextual problems experienced by health care providers in this study highlight gaps in the health care organisation in Zimbabwe that need to be addressed if maternal health care should meet the AIDS challenges. What seems necessary is a reflective approach in the training of health caregivers, developing competence in promoting community participation and collaboration in areas such as HIV counselling and education, and in working with traditional care and practices.
Acknowledgements

Many individuals and organisations have contributed to the completion of this study. I therefore want to start by thanking everyone who has contributed in whatever way. I deeply appreciate your efforts and contributions and all the support you gave me throughout these years. I apologise that it is not possible to mention each person individually but I would like to express my sincere thanks to the following:

The health care providers (the nurses, midwives and TBAs), women and men who participated in this study, you were always willing to create time for me, even when you were so busy. I learnt a lot from your experiences you shared with me through the interviews. I am also grateful for the assistance I received from the Reproductive Health Manager in the MOHCW, the District health officials, the District Administrator and Rural District Council officials who were helpful and supportive throughout my data collection period.

My supervisors, Professor Gunilla Lindmark and Professor Beth Maina Ahlberg, no special words can express my deep and sincere thanks to all the support you gave me, your professional guidance, and the constructive criticism, the wisdom and friendship we shared.

Professor Beth Maina Ahlberg, my main supervisor, you trained and guided me throughout the research process right from the field to producing this book. I will always remember that ‘red colour’ in my drafts. Your brilliant competence in qualitative research and hard work has been invaluable. It was great to have a supervisor like you. ‘Asante Sana!!’

Professor Gunilla Lindmark, my co-supervisor, your critical analysis and reflection and advice on reproductive health is greatly appreciated. Thanks for the confidence you had in me. I almost gave up because of all the technical hitches and the funding problems I experienced during my studies, but you were a source of encouragement and you gave all the support I needed throughout. ‘Tack så mycket!!’.
Franz Majoko, my project leader and colleague, thanks for all your support during the fieldwork and your comments and contributions during the write up of my articles. I am also grateful for all the support from the Department of Obstetrics & Gynaecology, University of Zimbabwe. Ms Singatshe Ndlovu and Chiedza Luberto for help with all the logistical and practical issues during the data collection period. The help of Irene Zhanda and L. Shumba who guided me during the fieldwork is acknowledged and greatly appreciated. Thanks also to Mr D. Mamundo who was driving us around during the fieldwork.

Dr Munjanja, thank you for all the time you spent on reading the cover story of my thesis, the constructive feedback you gave me was very valuable.

All staff and colleagues at the Department of Women’s and Children’s Health, Section for International Maternal and Child Health (IMCH), for their support and friendship. Special thanks to Pia Olsson, Martha Garrett and their families for the moral support and all the help they gave me. I will always remember the special dinners and social functions we had at your homes. Thanks to Kristine Eklund for all your support and help with the computer. Ann-Christin Lindqvist your support is greatly appreciated.

Karin Törnblom, I do not even know how to thank you, you were so great to me. I admire your efficiency in your work. Keep up the good work!! I will miss you.

The qualitative research group at IMCH (Pia, Magdalena, Amal and Wangiku), your comments and contributions were invaluable and very helpful. Thanks for all the moral support and all the ‘giggling’ we shared.

Professor Catherine Odora Hoppers, Assistant Professor Ingrid Mogren and Associate Professor Tanja Tydén, I am very grateful to the detailed comments and suggestions you made during the half time seminar. They were very helpful in the write-up of the thesis.

To Pelle’s family, Hans and Eric, thank you for providing me with a second home and family here in Sweden. Your hospitality, kindness and all the support you gave me and my family is greatly appreciated. May God bless you.

Dr Nonto Nemarundwe ‘ngiyabonga eNdlovu mama’ for all you did for me and the good moments we shared while in Sweden and all the support you gave to my family back home. I am finally coming home for good.

My colleagues and other PhD students I shared an office with, Ilze Viberga, Jeremiah Chikowore, David Urassa, Margareta Larsson, Gunilla Aneblom,
Iryna Mogilevkina, thanks for all the support. Life in that ‘cell’ was never the same every time you were there. I enjoyed all the debates and experiences we shared. Ilze, my family will always remember you for all those special gifts you sent them, thank you very much. To Hanna Eneroth, Waheedul Hoque and Anisur Rahman, thanks friends for the moral support. I am passing on the ‘relay button stick’ to you. Good luck. Mosotho Gabriel, thank you for your constant support and encouragement.

My parents, sisters and brothers and my in-laws and friends in Zimbabwe I thank you for all the support you provided especially my family during my absence. Special thanks go to my parents, my in-laws and my sisters and brothers ‘labantwana’. MaMkandla ‘ngiyabonga kakhulu’ for all you did for my family. The Tshuma family, the Nkiwane family, Tauzeni family, Sabwa family, Mazango family, Ngono family, Mtambo family and Sibanda family, you have been very helpful.

To my loving husband Sam ‘ngiyabonga mfowethu’ for all the support, taking care of the kids and running that home in my absence. You can now also graduate. To our beautiful girls Vuyelwa and Sharon ‘Mum is now coming back home for good’. Thanks for your understanding girls: I promise that we will have a lot of quality time together.

Sida/SAREC, The Swedish Institute, In Develop, Department’s of Women and Children’s Health, thank you for providing financial support for this work.

My God, you have always been my pillar of strength. Thank You so much.
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