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"Migrants' Access to Health: Exploring the Migrants' Interface with a Mission and a State Hospital on maternal health care provision in a Zimbabwean borderland"



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A thesis submitted to the African Centre for Migration and Society, School of Social Sciences at the University of the Witwatersrand in partial fulfilment of the requirements for the award of Master of Arts in the field of Migration and Displacement.

Supervisor: Professor Jo Vearey

October 2019

DECLARATION

I, Bothwell Vumai do solemnly declare that this research report is my own original and unaided work and that I have adequately acknowledged and referenced all the sources used. I also certify that thoroughgoing effort has been taken to ensure that the presentation of this work does not infringe academic and ethical regulations governing research protocols established by Witwatersrand`s Human Research Ethics Committee (Non-Medical). I further declare that this research report has not been submitted previously for any degree or examination at any other university.

Student Number: 1504657 **Research Ethics Protocol Number:** H18/09/32

Signature: *B. Vumai* **Date:** 03/10/2019

ACKNOWLEDGEMENTS

I would like to take this opportunity to immensely express my heartfelt gratitude to my supervisor, Professor Jo Vearey for her inspiration, belief in me and unwavering support, throughout the course of this project. You showered me with the much-needed inspiration, constructive engagement and support from the inception to the end of this project. Without your guidance, this project wouldn't have been a success. Words may not be enough to thank you for the sacrifices you made on your personal finances to fund travelling expenses in the data collection process. Your constant and steadfast communication with me during my field work in Zimbabwe kept me motivated and grounded. I am forever grateful and indebted to you!

To Dr. Makumbe, the Chipinge District Medical Officer and Mr. Madzaridzari, the Mt Selinda hospital administrator, I say thank you for availing me with the best opportunity and the best staff to work with during my period of data collection. Through your teams, it became easy for me to effortlessly gain access to the research participants.

My profound and heartfelt regards also go to the ACMS teaching and administration staff for availing me a very conducive learning environment that cultivated and enhanced me to successfully complete this project. I also sincerely thank the center for availing me with the DAAD scholarship for my Honors degree and a bursary under the Migration and Health Project Southern Africa (MaHp), funded by the Wellcome Trust for my master's degree.

I also extend my gratitude to my fellow colleagues at the ACMS namely Learnmore, Lynn, Marko, Richman and Patrick for the valuable support they gave me throughout the course of this journey. To my fellow brothers and comrades, Edward Govere, Tackson Makandwa, Wellington Mvundura, Stanford Mahati, Simbarashe Nyuke, Njabulo Chipangura and Godfrey Maringira, I say thank you all for your encouragement and belief in me. You were always there for me in my darkest academic hours. To my best friends Noreen and Melanie, thank you so much for all the company and lighter moments we had together.

Lastly, I want to express my gratitude to my family and my love Beauty Dliwayo, for all the unconditional love and support they rendered to me throughout the course of this project. I appreciate your tolerance to the competing interests between your need for my attention and the need to successfully complete this project.

Abstract

Zimbabwe has in the past been one of the major migrants -receiving countries in the region and boasting a vibrant health delivery system till the late 1990s. From the year 2000 upwards, the standards within the Zimbabwean Health Delivery System grossly deteriorated due to a plethora of issues relating to a prolonged socio-economic and political crisis in the country which led to massive brain drain of qualified medical professionals, shortage of drugs, dilapidated infrastructure among others thereby making the health delivery system one of the poorest in the world (Zakeyo, 2015; Banda, 2015; Zakeyo and Lange, 2015; Munodawafa et al., 2017). Current evidence shows that Zimbabwe has a maternal mortality rate of 614/100 000, neo natal mortality rate of 26/1000 and child mortality rate of 75/1000(Munodawafa et al., 2017; ZIMFACT, 2018), making it one with the highest maternal and neo-natal mortality rates in the region. Despite all this, Zimbabwean health care facilities continue to provide public and maternal health care services to refugee women and migrant women from Mozambique. Informed by the access to health and the maternal health delivery frameworks, the research thus seeks to unravel and explore the migrants and refugees` interface with a mission and a state hospital on maternal healthcare provision at a mission and a state-run hospital in Chipinge. It also seeks to explore how policies, legislative and institutional frameworks guiding mission and state-run hospitals shapes and impacts on the experiences of these Mozambican migrant women and refugee women in accessing maternal health care in a Zimbabwean borderland.

The study identifies Mt Selinda mission hospital and Chipinge District hospital (both in Chipinge and close to the border between Zimbabwe and Mozambique) as the case studies. Qualitative methodology was employed in the research process. Research participants were recruited through a non-probability sampling technique. Purposive sampling and snowballing were utilized in the selection of participants. The target populations of the study were Mozambican migrant women and refugee women seeking maternal health care in Chipinge health facilities, maternal health care providers and hospital administrators of the institutions understudy. Data was collected using the semi-structured interviews, in-depth interviews, extensive literature review and observations as the major research instruments. Data analysis was done through the thematic content analysis procedure

This research report carries a significant scholarly and empirical function of informing the government, related line ministries and the region on the need for well-informed health

programmatic responses to migration and access to public healthcare and maternal health care. It also serves to provide recommendations for improving accessibility and provision of maternal health services to migrant and refugee women as well as improving their health and wellbeing in this borderland community.

Key Words: Migration, Refugees, Maternal healthcare, Access to health care, interface, Infrastructure, Mission hospital, State-run hospital, Mozambican, borderland, Zimbabwe.

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List of abbreviations

ANC	Antenatal Care
CARMA	Campaign on the Acceleration in Reduction of Maternal Mortality in Africa
CEDAW	Convention on the Elimination of all forms of Discrimination
CESCR	UN Committee on Economic, Social and Cultural Rights
CSDH	Commission on the Social Determinants of Health
FBO	Faith Based Organisations
HRW	Human Rights Watch
HTF	Health Transition Fund
ICESCR	International Covenant on Economic, Social and Cultural Rights
IOM	International Organisation for Migration
MDG	Millennium Development Goals
MHC	Maternal Health Care
MNH	Maternal and Neonatal Health
MMR	Maternal Mortality Rate
MoHCW	Ministry of Health and Child Welfare
NGO	Non-Governmental Organization
PHC	Primary Health Care
PMCT	Prevention of Mother to Child Transmissions
RBF	Result Based Fund
SADC	Southern African Development Community
SDG	Sustainable Development Goals
UCCZ	United Church of Christ in Zimbabwe
UHC	Universal Health Coverage
U.N	United Nations
UNICEF	Unite Nations International Children`s Emergency Fund
UNHRC	United Nations Human Rights Committee
WHA	World Health Assembly
W.H.O	World Health Organisation

ZHDS Zimbabwe Health Delivery System

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1 CHAPTER 1 BACKGROUND

1.1 BACKGROUND AND STATEMENT OF THE PROBLEM

The reduction of maternal mortality remains one of the most important social and developmental challenges facing governments in many low-income countries. It has been noted that Zimbabwe bears a heavy burden of high maternal, neonatal and child mortality when compared to countries in other regions of the world (Banda, 2015; Zakeyo and Lange, 2015; Munodawafa et al., 2017). Statistics trends shows an increase in Maternal Mortality Rate (MMR) from 612 per 100 000 live births in the period in the 2005/06 to over to almost double the figure in 2009 (ZHDS, 2011; World Bank, 2012 and Zakeyo, 2016). Through the Health Transition Fund (HTF), a multi-million dollar capital injection into the Zimbabwean health sector by the World Health Organization(WHO), UNICEF and World Bank for the period 2009-2013, MMR significantly dropped by thirty-six percent such that by 2014, it stood at 614/ 100 000 live births (Zakeyo, 2016;1). Through the HTF, the country maternal health care access was improved resulting in the reduction of maternal and neo-natal mortality rates. However, such an improvement was not enough as the country failed to achieve the Millennium Development Goal for maternal health (MDG-5) which called for a three-quarter reduction in maternal mortality between 1990 and 2015 (Guliani, Sepehri and Seriux 2012). Considering the 2030 WHO Sustainable Development Goal 3 that calls for a reduction of the global maternal mortality ratio to less than 70 per 100 000 live births, and a national reduction of neonatal mortality rate to as low as 12 per 1000 live births (WHO | SDG 3), Zimbabwe thus have to scale up its efforts towards the realization of this goal.

There is a plethora of factors attributing to high MMR in Zimbabwe, chief amongst being the country`s prolonged political and economic crisis. Due to the political and economic instability that has rocked and haunted the country for almost two decades now, standards in the health delivery services have immensely deteriorated with health care providers becoming incapacitated to effectively and efficiently discharge their duties. This has led to a massive brain drain and a severe inadequacy of the much-needed drugs and infrastructure to ensure safe deliveries in hospital (Zakeyo and Lange, 2015). The high maternal mortality rates are noted to be attributed to what the World Health Organization refers to as "*the three delays*" and "these factors include the delay by women to seek care; delay due to difficulty in

accessing a health facility; and, lastly, the delay faced by a woman within a health facility(Zakeyo, 2016;1).

In spite of the challenges faced by the country`s health delivery system, Mt Selinda and Chipinge district hospital have always been and are still providing maternal health care to Mozambican migrant women refugee women who resides in the nearby Tongogara refugee camp. Mozambican migrant women migrate and commute from the Espungabera, Jameson, Messumbi and Muchenedza districts of Mozambique (Daimon, 2016), crossing the border to access maternal health care and other health services at Mt Selinda Mission Hospital run by the United Church of Christ in Zimbabwe (UCCZ) and the state run Chipinge District Hospital.

This research was prompted by the need to explore the migrants and refugee interface with a mission and a state hospital on the provision of maternal healthcare services in this borderland(district close to the frontier line separating Zimbabwe and Mozambique), explore the experiences of Mozambican migrant women and refugee women seeking and maternal health care services in Zimbabwe, the challenges they encounter in accessing services, perceptions and experiences of midwives, assistant physicians and medical doctors regarding service provision to these migrant and refugee women. The study identifies Mt Selinda hospital, a mission hospital established by American missionaries in 1892 and became fully operational in 1901 (Timberlake 2008) and Chipinge District hospital (government hospital) as the study sites. The area is located in the province of Manicaland in the eastern mountains of Zimbabwe (Timberlake 2008) cited in (Mapaure, 2012). The town, where Chipinge Hospital is located, lies approximately 170 kilometers, by road, south of Mutare, the nearest large city. Mt Selinda mission hospital is located in the same district, and a few kilometers away from the border that separates Zimbabwe and Mozambique. The area hosts the Ndau speaking ethnic group which has close links with the Zulu tribe of South Africa and the Mozambican migrants belong to this ethnic group. They also have strong family ties with some people on the Zimbabwean side (ibid). The mission hospital itself has a maternity home and a mid-wifery training facility. It thus provides maternal care services ranging from antenatal, delivery and post -natal care to both local and migrant mothers.

Due to the prevalence of commuter migration across the frontier border with high volumes of Mozambican maternal patients coming to seek health services on the Zimbabwean side, it is worthwhile to examine and explore the factors attracting maternal patients from the other side

of the border as well as understand the institutional frameworks guiding mission run and state-run health care facilities in their provision of care as well as assessing how this impacts on access to health in a resource poor environment, migration and international context.

1.2 RESEARCH QUESTION

In what ways does the access to health care framework and the maternal health delivery framework aid the understanding of refugee and Mozambican migrant women`s experiences in accessing maternal health care at a mission and state hospital in Chipinge district, Zimbabwe?

1.3 RESEARCH OBJECTIVES

This research is aimed at achieving the following objectives:

1. To investigate the motivations of Mozambican pregnant mothers seeking maternal health care in Zimbabwean health facilities and their choice or preference of hospital facilities.
2. To investigate the ideas and policies that guide mission and state run facilities in health care provision and explore how they shape the experiences of Mozambican migrant women and refugee women in accessing maternal health care.
3. To explore the different challenges faced by Mozambican and refugee maternal patients in accessing maternal care services at a Mission and State hospital in Zimbabwe.

1.4 RATIONALE

Numerous research has been carried out in Southern Africa on issues relating to the accessibility of health care services to migrants, although not extensive, presents a dominant narrative of South Africa as the only recipient of migrants in Southern Africa and has had a tendency to mainly focus on migrants therein (Chikanda & Crush, 2014; Zihindula et al.,

2015). This is well meaning and given the fact that South Africa is the largest recipient of asylum seekers in Southern Africa (Chikanda & Crush, 2014; Landau & Grant, 2007)). Existing research has placed great focus on public health care institutions with the mission based hospitals being overlooked (Vearey et al., 2018) yet they have been contributing a lot in improving marginalised population's access to health since the early colonial years (Widmer et al, 2011). As a result, little is known about the contribution of mission-based hospitals in their continued role in the post-colonial era not only in maternal health care provision to migrant communities but also to other health care services sought for by locals and other population groups. The tendency to overlook private players in health care provision has increasingly contributed to the dominant narrative that presents the South African Health Delivery System being generally cited as more hostile and highly xenophobic to international migrants (Zimbabweans and others from SADC countries) seeking health care in the country(Makandwa 2014; Vearey 2011; Zihundula, Meyer-Weitz and Akintola 2015). Arguably this situation has resulted in the demonization of the South African Health Delivery system and sanitisation of other migrant receiving countries which are under researched in terms of health care provision to migrants.

It is in the interest of this research to unravel the experiences of migrant women seeking health care in Zimbabwe and to investigate whether the prevailing attitudes and perceptions of health care providers in South Africa are also prevalent in other migrant receiving countries as well as to ascertain whether these scenarios are only exceptional to South Africa. This research work therefore bears the potential contributing both academically and empirically to the migration-health discourse of informing national and regional responses to migration and access to health care as they will be inclusive of the forgotten zones of the region as well.

It is also of paramount interest as well to explore and investigate how policies, legislative and institutional frameworks governing the provision of care in mission run and state-run hospitals influences and shapes the experiences of refugee and migrant women in accessing maternal health care in Zimbabwe. Considering the fact that faith based or mission run hospitals are guided and influenced by a Christian and humanitarian ideologies that compels them to seek and serve humanity in a non-discriminatory manner and evangelize at the same time (Ferret, 2005; Widmer et al, 2011), their approach to the provision of care tends to differ with that of state run hospitals. Issues of borderlands, nationality and citizenship becomes insignificant in their service provision as opposed to the state run facilities where nationality

and border spaces are key and central in service provision(ibid). It is thus significant in a post-colonial state to investigate how mission based and state-run facilities view, receive and treat migrants from Mozambique and other refugee groups from around the region.

Despite having a battered Health Delivery System that is characterized by inadequate resources and inadequate medical personnel (UNICEF, UNFPA &World Bank 2012; WHO 2014; Zakeyo 2016), Zimbabwe provides health care services to refugees and migrants of Mozambican origins through borderline health facilities e.g. Mt Selinda mission hospital in Chipinge, Rusitu mission hospital in Chimanimani districts well a Bonda Mission Hospital in Mutasa. The issue of limited resources has thus become a dominant narrative in most migrant recipient countries, resulting in different responses to migration and access to health care. For instance, foreign nationals are viewed as posing a threat on its public health care delivery system and priorities are therefore set on satisfying the health needs of the local citizenry. This research as one of the few in Southern Africa to address the migration-health nexus through maternal health, it bears the potential of contributing to regional and global discourse of migration and access to health care in forced migration studies especially given that a human rights perspective has been adopted.

The alarming statistics of maternal mortality in the country (UNICEF, UNFPA &World Bank 2012; WHO 2014; Zakeyo 2016) and in Mozambique are of major concern. Mozambique is also one of the countries with the highest rates of maternal mortality in Southern Africa with a maternal mortality ratio (MMR) of 480 per 100,000 live births (Firoz et al., 2016). It has also a general network of healthcare facilities that are not only diminished but also more dispersed throughout the country which contributes to lack access to health care mostly by rural population seeking care (Dengo; 2012). This is further worsened by a low ratio of health staff worker to the total population with a doctor/patient ratio of 0,03/ 1000 and a nurse-patient ratio of 0,21/1000(WHO 2004,11; WHO 2009,4; Dengo, 2012:33; Dgedge et al., 2014; Firoz et al., 2016). There is therefore a greater need for coordinated efforts at national, regional and global to improve maternal health and the health and wellbeing of pregnant mothers. Failure to prioritize the health and well-being of mothers does not only impedes development at all levels, but it is essentially a breach of the fundamental right of individuals to “life and the right to the highest attainable physical and mental health, and the special protection of mothers during a reasonable period before and after childbirth that should be accorded” (Makandwa 2014; 23).

1.5 DELIMITATIONS OF THE STUDY

The study was carried out in Chipinge District and the focus was on maternal health care service provision to migrant and refugee women at Mt Selinda (mission) hospital and Chipinge District (state run) hospital. Both hospitals are in Chipinge- a borderland or zone between Zimbabwe and Mozambique. Respondents were drawn from migrant and pregnant women in the maternity home (awaiting delivery) at the hospitals, refugee pregnant mothers residing at Tongogara refugee camp, migrant women who commute from Mozambique to access maternal health care at the aforementioned institutions, local pregnant mothers, health care providers and administrative officials in these institutions. Engaging all stakeholders involved in the day-today operation of the hospitals helped ensure a balanced study and allowed for an objective analysis of the subject under consideration.

1.6 DEFINITION OF TERMS

Migrant refers to any individual who resides temporarily or permanently in a country or community where he or she was not born and has obtained some form of significant social ties to this country (Vearey and Nunez, 2010).

Migration is a process of population movement/mobility, whether within a country or across an international border (Perruchoud, 2004; Vearey and Nunez, 2010).

Cross-border migration refers to a mix of circular, permanent and transit migration that involves crossing a national border (Mazars, Rispoli and Vearey, 2013).

Maternal service refers to a "service provided to women during the prenatal, labor and postnatal period. Prenatal health care includes health education and promotion, and interventions that minimize complications during pregnancy, delivery and the post-natal period. Post-natal health care includes helping a woman recover from childbirth and advice given on new-born care, nutrition, breast feeding and family planning methods" (Zakeyo, 2016; 9).

Service accessibility refers to the "spatial distribution of services in relation to the distribution of the needs of people" (Zakeyo, 2016; 10).

Service availability is defined as, the availability and adequate supply of maternal services (Gulliford, Figueroa, Morgan, Beech & Hudson, 2002).

Antenatal care is the routine health control of presumed healthy pregnant women without symptoms (screening), so as to diagnose diseases or complicating obstetric conditions without symptoms and to provide information about lifestyle, pregnancy and delivery (Browne et al, 1960; WHO, 2009)

Post-natal care refers to the care given to the mother and her new-born baby immediately after the birth and for the first six weeks of life (WHO, 2013)

Access to health refers to the use of individual health services characterized by affordability, availability, accessibility, accommodation and acceptability, to achieve the best health outcome (McLaughlin and Wyszewianski, 2002; 37).

1.7 ORGANIZATION OF THE REPORT

The research report is categorically structured into six chapters. This current chapter has presented the background and orientation to the research. The second chapter of the research report focuses on literature review relating to migrants' access to healthcare and utilization of health care services within border spaces, the migration-health nexus at global and regional lens, maternal health care policies guiding the provision of maternal care services in Zimbabwe and the role of faith based organizations in the provision of health care. The chapter also discusses the conceptual frameworks that informed the research and interpretation of research findings. Chapter three presents the research design and methodology guiding the study, research experience and limitations are presented in chapter three of the research report, while the fourth chapter provides the presentation and discussion of research findings under different themes identified during data analysis. Chapter five presents an analysis of the legal and policy instruments guiding and regulating maternal health care provision in Zimbabwe. The last chapter provides the summary of key findings, conclusions drawn and the recommendations.

2 CHAPTER 2 LITERATURE REVIEW

2.1 INTRODUCTION

A large body of literature relating to migrants` health care needs exists, but most of it pays insufficient attention to access to maternal health care specifically. The following section provides the literature review and conceptual background to the study. Greater focus is placed on the main: the migration – health link at global and regional lens, maternal health access in general, the role of faith based organizations in health care provision, utilization of health care services in border spaces, the legal and policy context of maternal health care provision in Zimbabwe.

2.2 THE MIGRATION-HEALTH NEXUS AT GLOBAL LENS UNRAVELED

At global level, migration has been recognized as a global public health priority that should be fully be engaged with at all level to ensure the achievement of Sustainable Development Goals (IOM, 2017; Wickramage et al., 2018). The adoption of the 2008 World Health Assembly resolution on migrants, which calls upon member states to promote equitable access to health promotion, disease prevention and care for migrants (Ghent 2008, World Health Assembly 2008), was a clear gesture signaling the importance of migration and health as a drivers of sustainable development. This is depicted and signified by the specifications of the World Health Assembly(WHA) Resolution priority areas that is: to avoid disparities in health status and access to health services between migrants and the host population; to ensure migrants' health rights; to put in place lifesaving interventions so as to reduce excess mortality and morbidity among migrant populations and to minimize the negative impact of the migration process on migrants' health outcomes (WHO, 2010:10)

Of great importance was the 2nd Global Consultation on Migration and Health held in Colombo, Sri Lanka(2017) which placed greater emphasis and call to ensure an equitable access to health services (Universal health coverage) for all irrespective of one`s legal status in a country(Wickramage et al., 2018). The Colombo statement is thus a valuable political commitment by countries acceding to it to advance the health of migrants. The Colombo statement is guided by the recognition of the right to health for all, including migrants (Guiding Principle 1), the need to improve migrants' health based on non-discrimination

policies and strategies (Guiding Principle 2), so as to fully harness the developmental prospects for migration (Guiding Principle 4) whilst avoiding public health costs due to negligence (Guiding Principle 5). Countries therefore pledged to continue the implementation of the WHA Resolution on health of Migrants and to mainstream migrant health into key national, regional and international agenda.

The World Health Assembly resolution and the Colombo convention documents are thus founded on the development of migrant sensitive health systems; enabling policy-legal frameworks; greater need for the monitoring migrant's health as well as establishment of partnership, networks and multi-country frameworks(Wickramage et al., 2018). Global health policies thus transcend and influence regional and national health policy responses even in the global south.

The health of migrants continues to receive attention on the international arena and frameworks. The WHO Global Action on health of refugees and migrants to be adopted in 2019 is yet another framework that sets out priorities and action on improving the health of migrants.

2.2.1 THE MIGRATION-HEALTH NEXUS IN THE SOUTHERN AFRICAN CONTEXT

In Southern Africa, the link between migration and health is as important as in the global north. Migration is a key determinant of health that requires to be addressed and managed in an appropriate and healthy manner (Macpherson and Gushulak, 2001; Anarfi, 2005; Vearey, 2011 and Makandwa, 2014). Inability to manage migration and health in both the global north and the global south has thus had undesirable consequences on the health of migrants. It has been noted that migrants have historically been subjected to poor health owing to inability to access positive determinants of health within the Southern African Development Community (SADC) region (Vearey, 2013; Makandwa, 2014). Resultantly, many migrants inadequately access health care service in most destination countries. One of the key migrant group the suffers the most from exclusion in the access of public health care are the young reproductively active women and young women, this places the well-being and health of pregnant mothers and infant health in jeopardy thereby impeding development in the region(Makandwa, 2014).

In most cases, the migration-health linkage is a highly politicized one. Hanefeld, Smith, Lunt and Horsfall (2014) acknowledge the impact of global increases in human mobility on health systems as a highly political issue in recipient countries. The sub-Saharan Africa is no exception to it. In southern Africa, South Africa (SA)in particular is the greatest recipient of migrants, refugees and asylum seekers from the Southern African Development Community (SADC), a region with high levels of migration, high communicable disease burden and struggling public healthcare systems (Crush and Williams 2005; Vearey 2014). Because of its economic prowess, it attracts lots of migrants from all over the globe and the neighboring countries in the region and as a result, politicians feel the country`s public health delivery system is highly strangled due to high influx volumes of migrants and refugees coming in. Migration is therefore seen as threat and migrants are often seen as overburdening the public healthcare delivery system of the hosting countries in the region irrespective of their progressive constitutions that embraces the notion of free primary healthcare to all (Vearey,2014). Practical limitations on the interpretation of constitutional provisions in many countries thus makes their public health delivery systems less inclusive and as a result, non-nationals face access challenges, and healthcare responses do not engage with migration (ibid).

The impact of migration on public healthcare system thus remains controversial with conventional assumptions informing health responses instead of evidence-based and research informed responses. Such discourses include the continued unjustied portrayal of international immigrants as carriers and vectors of diseases who continuously pour in South African health care facilities, resulting in them placing excessive pressure on the limited resources that are meant for local citizens` consumption (Vearey 2011; Makandwa 2014; Vearey, Modesenyama and Hunters-Adam 2017). It is upon such assumptions that exclusionary tendencies and in extreme situations xenophobia manifests within the public health care delivery system resulting in migrants failing to access the much needed care.

The impact of migrants` exclusion is immensely felt by female migrants in the sense that they often face social and structural barriers in navigating and negotiating access to health care in destination countries and this negatively affects their reproductive health (Dias et al, 2010). For instance, one`s immigration status and inadequate documentation and financial challenges may lead to access denial to health care services and this compromises the health of migrant women and their new born. Denying an individual access to health is thus a gross violation of that individual`s right to health. Their plight is further worsened by lack of social

support on their arrival in a host country and in some cases leads to maternal depressions as mentioned by Makandwa (2014). He emphasized on the need for strong of financial and emotional support for pregnant migrant women indoor to cope up with threatening circumstances that may expose them to maternal and health complications (ibid).

However, the assumption that migrants exert excessive pressure on limited public health resources on hosting countries is far exaggerated. Research has revealed that the costs of providing services to migrants in South Africa is statistically insignificant for cross border migrants due to the fact that international migrants constitute only 3.3% of the total population in South Africa (Vearey 2014; 2). Putting into consideration that South Africa is the economic hub of Africa and the greatest recipient of migrants in the SADC region (Crush and Williams, 2005) yet only 4% are international migrants, it adversely means that other countries in the region have less population of migrants. This therefore proves that cross border migrants are very few compared to internal migrants hence the assumption that migrants overburden health systems of destination countries are misinformed as it pays particular attention on cross border migrants when it is in actual factual that internal mobility places the greatest developmental challenge on local and national government (Vearey 2014).

The healthy migrant effect hypothesis (Lu, 2008; Kearns et al., 2016) puts it quite clear that migrants make little use of health care services in host communities. It is only the denial and delayed access, and their living and working conditions that leads to more migrants wanting healthcare (Vearey 2014, Vlahov and Galea 2002). Additionally, the 'healthy migrant effect' hypothesis acknowledges that migrants have a health advantage/ benefit over the host populations on arrival and their health deteriorates with time spent in those host communities (Lu 2008, Kearns et al 2016, Mathee & Naicker 2016). It also reflects on the positive selection of migrants to move (Vearey 2014), a motivation influenced by one being healthy himself or herself. This also shows that international migrants do make little use of the health services of the host community as they are healthier and less than the host population. However, the use of the health services by migrants (international) increase with time spent due to exposer to negative determinants of health. The context in which people move, the places they pass through and the places they inhabit on arrival (which are referred to as "spaces of vulnerability" by Vearey and Nunez (2010). Migration and mobility is thus complex and it is this complexity that SADC health programmatic interventions should address.

From a human rights and social equity perspective, migrants are affected by social inequalities and are likely to go through several experiences during the migration process which put their physical, mental and social well-being at risk (Davies et al 2006;1). In this regard, they often face poverty and social exclusion, which has negative influences on health, especially in countries of transit and destination. Service accessibility, availability and the degree of service acceptability in these transit and destination countries thus impacts on the health of migrants (ibid; 1). Migrants face specific difficulties with respect to their right to health. These health care services may be inadequately covered by state health systems and unaffordable health insurances; cultural barriers; difficulties accessing information on health services and health-related issues. Undocumented migrants are often denied access to public health services or are reluctant to use services that are available to them for fear of being deported (Gushulak 2009). Even those migrants with legal entitlements to health care may face various obstacles to utilizing these services. (Davies et al, 2009). In addition, the migration journey itself can pose significant health risks, particularly for migrants in an irregular situation (ibid; 2). The healthcare policy responses thus do not adequately engage with patient mobility and migration and this therefore calls for multi-stakeholder and multi-sectoral cooperation to address social determinants of migrants' health and ensure migrant friendly services (Vearey 2017; 1). With regards to South Africa, the establishment of the Johannesburg Migrant Health Forum (in 2008), the work its doing to ensure relative information regarding challenges facing migrants in accessing health services are mitigated. It is in the hope of this work that there will be establishments of this sort in Zimbabwe at some point in time as well just as South Africa did. This is clearly typified by the incorporation of the 2008 World Health Assembly resolution on the migration, which called upon member states to promote equitable access to health promotion, disease prevention and care for migrants (Ghent 2008, WHA 2010) in the South African constitution. This is evidenced by adoption and enactment of the NHA, which provides for access to health care by all in South Africa irrespective of nationality or legal status. This includes involves provision of free health care to all pregnant and breastfeeding mothers as well as infants below the age of 6 years of age, free primary healthcare for all, and free emergency care at the point of use for all (ibid). It is yet to be observed if other migrant receiving countries in Southern Africa (with Zimbabwe in particular) have and to what extent they have embraced the same principles.

2.3 EXPLORING MATERNAL HEALTH

Maternal health remains an under researched area regionally and globally. None of the few researches done around maternal health care access in Zimbabwe (WHO, UNICEF, UNFPA & the World Bank, 2012; Zakeyo, 2016) has paid attention to international migrants and refugees` access to maternal health care. The ever increase in migrant maternal patient population(of Mozambican nationality as well as those of different nationalities residing in designated refugee camps countrywide) accessing maternal health care services in the borderland area therefore signifies a greater need of empirical scholarly work to meet the strategical and medical demands relating to prenatal care, delivery and post-natal health. It is of great importance to note that mission hospitals that are run by Faith Based Organizations (FBOs) have been instrumental in ensuring adequate provision of health care services to the most underprivileged and marginalized societies. However, there is little academic work that fully acknowledges the vital role that these faiths and mission-based organizations have played in complementing government efforts to eradicate human morbidity and reduce maternal and neo-natal mortality. It is on this premise that this study found it worthy to discuss the relevance and the role the FBOs do play in ensuring the attainment and adequate accessibility of quality health care services in Africa.

The Millennium Development Goals (MDGs) of 2000 acknowledged the improvement of maternal health as a matter of global concern and in that regard; it was placed as one of the fundamental pillars of the Millennium Development Goals (MDGs) (Makandwa, 2014). The promulgation and adoption of the Millennium Development Goals at the United Nations millennium summit in 2000, saw 192 United Nations member states and more than 23 international organizations agreeing to accelerate global progress in development by 2015(Widmer et al 2011). All member states and many international organizations strengthened their resolve and commitment to MDG 4 and 5 that focus on reducing child mortality and improving maternal health respectively (UN, 2000). The World Health Organization identified maternal conditions as the leading causes of mortality and disability in low income countries, with estimates indicating that in Africa, more than 300 000 women die from pregnancy related conditions each year and 4 million new-born die within the first four weeks of life (WHO 2009, WHO, UNICEF, UNFPA and World Bank 2008). According to Campbell and Graham (2006), “these deaths that do occur in poorest and most

disadvantaged population groups are largely preventable through timely prenatal care, skilled delivery, post-natal care and emergency care in the event of complications".

The achievement of goal 4 and 5 of the MDGs in Africa thus require innovative approaches to service delivery and the establishment of inclusive partnerships so as to improve women and children`s access to the much-needed care (Yadamuseren, Merialdi, Davadorj, Ruquejo, Betran, Ahmad et al 2010). The launch of the UN Global strategy for Women and Children`s Health in 2010 thus compelled and enabled national governments, bilateral and multilateral donors to make concerted efforts, aligning their priorities as well as strengthening their resolve towards improving the health of mothers, new-born and children. Embraced in this strategy as well was a call for the engagement of the civic society to play a critical role of educating, mobilizing and advocating for an increased attention and investment in women and children. Gill and Carlough (2008) identified the development of stronger partnerships between Faith Based Organizations (FBOs) and the public health community including policy makers as a potential strategy for reducing maternal child mortality in high burden countries.

In terms of maternal health care provision in Africa, health services are provided through a pleural health care system, made up of multiple health care providers. This consists of government clinics and hospitals, mission and private hospital , traditional healers as well as community birth attendants(Mallet, 2014). Their relationship, coordination and competition considerably vary from country to country and in so doing they aid the quality of health care provision (ibid). Though the state is the major service provider, the faith based plays an important role in complementing government efforts. The following section is shall discuss the role being played by FBOs in accelerating and ensuring the attainment of health care services in marginalized communities.

2.3.1 ROLE OF FAITH BASED ORGANIZATION IN THE PROVISION OF HEALTHCARE IN AFRICA

Faith-based organizations (FBOs) play a crucial role in the global effort to promote health and wellbeing of humankind among the most disadvantaged populations in the world. It has been noted that a myriad of people in Sub Saharan Africa identifies themselves with the two world most religious sects that is Christianity and Islam, with the almost 75 % of Africans

having much trust in their religious leaders (Ferret 2005). Engaging the religious sector thus influence faith inspired health services which would definitely be effective in addressing challenges associated with maternal and child health in Africa, a continent that has unprecedented rates of maternal mortality rates (ibid). Their perspective and philosophy on nationality, humanity, human mobility, healthcare access and provision to all sometimes is at variance with that of the state providers.

Influenced by a Christian and humanitarian ideology, mission hospitals are compelled to seek and serve humanity in a non-discriminatory manner and evangelize at the same time (Ferret, 2005; Widmer et al, 2011). Issues of borderlands, nationality and citizenship becomes insignificant in their service as opposed to the state-run facilities where nationality and border spaces are key and central in-service provision(ibid). It is thus significant in a post-colonial state to investigate how mission based and state-run facilities view, receive and treat migrants from Mozambique.

In Africa, the work of FBOs had been originally concentrated on evangelism, building schools, building health care institutions and training workers to ensure that health care services are easily accessible by all (Widmer et al 2011). Their scope of recent has shifted from that and is now considered healthcare providers in -lowest resource settings. The contribution of FBOs has resulted in increased access to Maternal and New-born Health (MNH) services worldwide (Chand and Patterson 2007, Widmer, Betran, Merialdi and Karpf 2011). This is true of Mt Selinda hospital, a mission hospital facility located in a peripheral zone along the border that separates Zimbabwe and Mozambique. The mission hospital`s establishment commenced in 1892 after the American Board of Commissioners for foreign missions was granted permission to establish it by Cecil John Rhodes, the then leader of the British South African Company – settler government in control at the time (Timberlake 2008). In 1901, the American Board Mission finally established the mission to cater not only for health needs of the locals but also educational and to serve as an evangelical center to spread Christianity (ibid).

In developing countries, Faith-based health care facilities provide a significant percentage of health care services (Widmer et al (2011). In Zimbabwe, FBOs have networks that reach marginalized and even the most remote communities and many of them are well positioned to promote demand for and access to MNH services (Chand and Patterson, 2007). Partnerships among FBOs and other stakeholders such as state-run clinics and hospital proved critical in

promoting and delivering improved MNH services. Such partnerships increased the quality and quantity of services, access and ensure their sustainability - influencing behaviors at the community, family and individual levels (ibid). Most mission hospital through their ties with their mother bodies in Europe and in the west are better equipped in terms of infrastructure and human resources. This is significant in their partnership with the state in providing quality health services. Widmer et al (2011) mentions that most mission hospitals serve as referral points for many primary healthcare institutions in Africa.

A study that was carried out by the Ecumenical Pharmatical Network in collaboration with the WHO between 2003 to 2005 found out that approximately 40% of healthcare institutions and facilities in the Sub-Saharan Africa are operated by FBOs and that the faith based drug supply organizations are fundamental to the provision of essential medicines to remote and rural areas practically when bottlenecks occurs in the management and procurement of government supplies (Banda, Ombaka, Logez and Everard 2003). In Zimbabwe, FBOs proved to be important partners of the public health system, as evidenced by numerous health care service centers manned and run by faith-based organizations. Missionary work done by numerous faith-based denominations in the country is proving to be key in the improvement of the entire national health delivery system. Typical examples of mission hospitals established in the remote parts of the country include Mt Selinda mission hospital in Chipinge district, run by the United Church of Christ in Zimbabwe (UCCZ), Rusitu Mission Hospital and Mutambara Mission run by the Methodist church in Chimamani district, and Bonda Mission Hospital run by the Anglican Church in Mutasa district. All these mission hospitals are accessible to both locals and migrant populations not only due to their proximity to the frontier borders separating Zimbabwe and Mozambique but also to the fact that they were established to assist local people –the black population in the peripheral zones during the colonial era. They continued to offer this health care service from the post-colonial era up to the present day.

2.4 SUSTAINABILITY OF CHURCH MISSION HOSPITALS

The sustainability of mission hospitals hugely relies on external funding from their mother bodies and other donor aid and humanitarian organizations. This places them in a competitive advantage over state run hospitals that are in most cases underfunded in Africa (Widmer et al, (2011). However, in countries with strong financial, economic and political institutions, state run hospitals performs at par or even better than mission hospitals. It is only in the poorest economies where mission hospitals are far exceptional than the state-run ones. Hearn (1998) is of the view that the difference in terms of service provision between state run and church mission hospitals is that mission or faith based run hospitals enjoys the privilege of external capital injection that enables them to secure and maintain better infrastructure and retain its work force through the provision of incentives. This capital injection thus acts as the lubricant or the 'axis mundi' that keeps the hospital operations in a continuous and efficient motion, a feature that attracts many maternal patients to seek care in their facilities. In instances where there is no external funding, mission hospitals suffer the same predicament with the state –run health care facilities.

In relation to the governance and mission hospitals in Zimbabwe, it has been noted that,

> *"the shift in the governance of most church mission hospital facilities from international churches to local churches and government, has resulted in reduced capital injection from international funders and this also has negatively impacted on the missionary work instituted by the missionary pioneers"* (Zakeyo 2016; 36).

To this effect, mission hospitals are now struggling to sustain their systems in good shape as well as providing comprehensive health care due to reduced funding from their mother bodies as well as excessive influence from local government bodies. Among the challenges they face include incapacitation to hire and retain the best health practitioners due to relatively lower remunerations in comparison to their regional and global counterparts as well as maintaining the infrastructure in good shape. Incapacitation has thus influenced many health care practitioners to opt out for greener pastures leaving them with inadequate skilled practitioners to attend to the health needs of the citizenry. This has a dreadful impact on maternal health delivery outcomes since many as evidenced by an increase in maternal mortality rates in the country.

2.5 BORDER SPACE(S) AND HEALTH CARE UTILIZATION

The utilization of border spaces between countries is one of the highly contested debates with high unprecedented levels of migratory patterns across borders leading to variability in demographic structures and associated social, economic and public health implications (IOM, 2013). A research carried out on cross border populations in East Africa reflected poor health and epidemiological profiles characterized by a heavy disease burden associated with social and economic vulnerabilities (Ford and Chamratrithirong 2012). It has also been noted that the health and social problems experienced by border communities are multi-faceted including not only infectious and non-infectious diseases but also poverty, poor housing settlements, shortage of safe water and unhygienic sanitary conditions (IOM 2013). As a result, diseases such as malaria, diarrhea, HIV and other sexually transmitted infections becomes a major public health problem in cross border communities (Moroka and Tshimanga 2009; Montague, et al. 2011; Ford and Chamratrithirong 2012). Migration thus is a key determining factor that requires an appropriate strategy and coordinated regional and interstate programme responses since migration-health concerns are not restricted to national or even regional borders (Macpherson and Gushulak 2001; Crush et al, 2005; Vearey 2011; IOM 2013). As a way of mitigating and combating negative health consequences of migration in these border communities, a greater need for commitment is called for from states with proper coordination and collaboration of all actors, along with strategy and policy development combined with implementation frameworks and advocacy around inclusive and equitable services (Ford and Chamratrithirong, 2012; WHO and IOM ,2010).

Border areas are also conceptualized as ‘spaces of vulnerability’ especially when considering the migration phases i.e. individuals’ transit through border spaces, moving in, leaving and returning to their places of origin (Ford and Chamratrithirong 2012; IOM 2013). The assumption is furthered by the fact that border spaces are made up of diverse and heterogeneous population groups with some seeing the “border space” as transitory while for it is home for others (Vearey et al. 2011). From this setting, the border area is therefore an ‘interactive space” that involves both one-off and repeated encounters between different groups (sedentary population and different migrant categories) interacting variously, each with potentially different health determinants, needs, and levels of vulnerabilities (ibid). It is in the interest of this research therefore to unravel the way the border space between Zimbabwe and Mozambique is utilized.

2.5.1 THE ZIMBABWEAN-MOZAMBICAN BORDER

The Zimbabwe–Mozambique border is one of the most unique but less-researched borders in Southern Africa. Little research that has been done along this border, focused mainly on the criminology and technologies of smuggling and border control (Pophiwa, 2010; Machaza 2011). It is of great interest to study this border space from a health care seeking perspective- an approach quite different from notions of smuggling of goods and criminology. It is worthy-noting that there is a high prevalence of both formal and informal commuter migration taken by citizens of both nationalities across the frontier border with Mt. Selinda in Chipinge and Rusitu in Chimanimani on the Zimbabwean side lying adjacent to Espungabera, Chambuta, and Maridheya on the Mozambican side (Daimon, 2016b). Just like in many other African borderland zones, the Zimbabwe–Mozambique border consists of Shangani speaking people on the Espungabera part of Mozambique and partitioned homogenous Shona ethnic communities on the other side living adjacently in different nation-states (ibid). The communities thus overlap, and the border is arbitrary. He further noted that these communities are aware of the legalities of the border, but they consciously and systematically choose to ignore its juridical functions to exploit the various socio-economic and cultural benefits found on either side. He therefore had this to say;

> *Commuting along and across the frontier border thus flourishes due to the prevailing subtle subaltern ethno-nationalism amongst the communities that defy official norms of sovereign nation-statism and state control. The border is therefore viewed as an imaginary boundary; a transnational environment or frontier where socio-economic-cultural inter-connections are made without restrictions* (Daimon, 2016;14)

As a result, many commutes daily on foot using illegal crossing points scattered along the mountainous boundary. While Daimon (2016), did not fully unpack the experiences of Mozambicans seeking health care in Zimbabwe, He made it clear that those in Mozambique prefer shuttling to the better Zimbabwean schools and hospitals across the border, while those in Zimbabwe conduct kinship rites, shopping/trade and engage traditional authorities in Mozambique, making the frontier border highly fluid and elastic. In the process, the Zimbabwe– Mozambican border has been reduced to an artificial and arbitrary boundary which does not respond to what the local people believe to be rational boundaries. The utilization of the border space is thus not only for the purpose of seeking health care but also

necessary basic needs such as education and food security just as the Beit Bridge -Musina border area.

There are also examples of global cases that resonate well with the activities along the Zimbabwe–Mozambique border exist. Examples include the indigenous people spanning the border between Venezuela and Colombia in Latin America and the communities straddling the French and German border in Europe (Daimon 2016). African cases include the likes of Ketu Yoruba spanning the Nigeria–Benin border, the Baatonu of the Nikki kingdom of Borgu on both sides of the Nigeria–Benin border (Akinwunmi 1995; Asiwaju and Bach 1999, 30). Other trans-border peoples have experienced stricter state control emanating from national disputes/conflicts as exemplified by Iraq and Kuwait, Armenia and Azerbaijan, Ethiopia and Eritrea, Israel and Lebanon, Israel and Palestine, Greece and Turkey, Serbia and Bosnia and Croatia (Donnan and Wilson 1999, 3). Within the African communities, including the Shona on the Zimbabwe–Mozambique border, memories of a common allegiance to the same pre-colonial state are often retained, and these strengthen feelings of solidarity on both sides of these African boundaries which contradict the official norms of a nation-state (Duri 2011).

2.6 THE ZIMBABWEAN HEALTH DELIVERY SYSTEM

The health delivery system in Zimbabwe falls under the governance and management of the Ministry of Health and Child Welfare and it has four hierarchical levels in its organogram ranking from the least specialized to the most specialized (Zakeyo, 2016; ZIMFACT, 2018). The hierarchy in the system also serves and denotes the referral processes from a lower tier to the highest tier of health care provision in the land (Chiremba, 2013). Fig 1 below clearly demonstrates how the health system structure is structured in Zimbabwe.

2.6.1 Fig 1: The Zimbabwean Health Delivery System structure



Source: ZimFACT (2018; 3)

The public health service delivery system in Zimbabwe is organized in a four-tier level hierarchy, functioning as a referral chain from the least to the most specialized (MoHCW, 2010; Zakeyo, 2016; ZimFACT, 2018). The system is designed in such a way that a maternal or any other patient is to present herself at the primary level first and then be progressively referred to the Secondary, Tertiary or Quaternary levels depending on the complexity of illness (MoHCW, 2010). However, practically the referral chain has broken down, with all referral hospitals replicating the work of the Primary level with almost 75% of maternal patients at central hospital self-referring themselves (ZimFACT, 2018). The major reason patient's by-pass the other levels is their perception of poor-quality health services associated with these levels of health care provision. This is not only about their perceptions, it is in actual fact that the Zimbabwean health delivery system has been operating at its lowest ebb in the past two decades owing to the prolonged socio-political and economic crisis that rocked the nation, a situation that left the government incapacitated to efficiently, economically and effectively run the public health delivery system. (UN Zimbabwe, 2013; Zakeyo, 2016).

2.6.1.1 THE PRIMARY LEVEL

The primary health care level is the most peripheral unit of the health delivery system and it consists of a network of health centres and community and village health workers who are the key link and the first point of contact between communities and the local health services. Its main components include maternal and child health services; health education; nutrition education; and food production: expanded programme in immunization; communicable diseases control; water and sanitation; essential drugs programme; and the provision of basic and essential preventive and curative care (MoHCW, 2010). Zakeyo (2016) mentions it as the machinery through which health programs are executed in the country. The village and community health workers play a key role in the promotion, education and prevention and mobilisation of both individuals and communities to seek early treatment on both communicable and non-communicable diseases at the nearest rural clinic (MoHCW, 2010). Their work also extends to treatment of simple conditions, disease surveillance in order to enhance health information systems. Of great importance in the primary health care level is the establishment of the Community Based Distributors whose functions include the promotion and provision of family planning services through the supply and re-supply of contraceptives to eligible clients (ZimFACT, 2018).

All the health care facilities in in the primary level bracket thus play a pivotal role in the delivery of essential maternal health services such as antenatal care, post-natal care as well as the prompt referral of mothers with complicated pregnancies (MoHCW, 2010; Chiremba 2013; Zakeyo, 2016). According to ZimFACT,

> *"The Rural Health Centres (RHC) provide basic but comprehensive promotive, preventive, curative and rehabilitative care, concentrating on mother and child care including antenatal care, delivery of uncomplicated births, family planning, child health and nutrition, routine immunization for children and anti-tetanus immunization for child-bearing women, environmental sanitation, especially in relation to small-scale water supplies and excreta disposal systems, control of communicable diseases , other specified problems including mental illness, eye diseases and physical and mental handicap, and general curative care including oral health"*
>
> (ZimFACT, 2018; 3).

However, the Primary Health Care level has been highly affected by the economic challenges facing the government and this has resulted in communities having limited Village Health Workers, inadequate supply of basic medicines from local health clinics. It has also been reported that there is limited number of midwives in the rural health clinics who will not be able to cope up with high workloads. This compromises the quality of care given to expecting mothers. There is therefore a greater need for capacity building and training of more of village health workers to cope up with the community maternal and neonatal challenges. This will be vital in ensuring the realisation of the desired community and national maternal health outcomes.

2.6.1.2 THE SECONDARY LEVEL

This is the second category in the four-tier level system, and it consists of District Hospitals. It is estimated that there are approximately 164 district hospitals countrywide (Zakeyo; 2016). Their main function is centred at the provision of comprehensive preventive and curative services to all patients as well as to provide referral and supervisory support to the network of Rural health Centres and clinics within the designated districts (ZimFACT 2018). These District hospitals serves a catchment area and patient constituency of approximately 140,000 people (ibid; 4). It is at this level that maternal patients have their first contact with a

medical doctor within the health delivery system (MoHCW, 2010). Most of the District Hospitals do have mid-wife training facilities-a true case of Mt Selinda hospital which has a mid-wifery school. It is important to mention Mt Selinda mission hospital and Chipinge District Hospital are both in this category though they are run differently. Mt Selinda also receives patients from surrounding rural health care centres and clinics and in those cases that requires further management, it therefore refer to Chipinge District hospital. In as far much as maternal health care provision is concerned, the District Hospitals provides services such as, "surgical procedures including Caesarean section; safe blood transfusion; comprehensive obstetric and new-born care; and comprehensive management of childhood illness including pediatric emergency care" (Zakeyo,2016; 38). In cases of extreme maternal complications, district hospitals refer to Provincial Hospitals which are the third level in the hierarchy of the health delivery system.

2.6.1.3 THE TERTIARY LEVEL

This third level consists of provincial hospitals that provide referral support to district hospitals (MoHCW, 2010; Zakeyo, 2016; ZimFACT, 2018). All provincial hospitals in Zimbabwe train general nurses and mid-wives. In these provincial hospitals, there are specialist doctors and medical practitioners. Specialized health services provided in these hospitals include, "caesarean section; blood transfusions; comprehensive management of pediatric emergency care; and surgical cases referred from district level" (Zakeyo 2016; 39).

2.6.1.4 THE QUATERNERY LEVEL

The fourth level consists of the central hospitals and these are the highest in the referral chain. They provide the most specialized maternal health care services and other health related services in the country (MoHCW, 2010). There are only five central hospitals in the country (refer to Fig. 1). Medical specialists operating in this category include, "obstetricians, gynecologists, neonatologists, pediatricians and pediatric surgeons" (Zakeyo, 2016; 39).

2.7 THE POLICY AND LEGAL CONTEXT OF MATERNAL HEALTHCARE PROVISION IN ZIMBABWE

There are numerous pieces of legislation and policies that governs the provision of maternal health care in Zimbabwe. The foundation of these policy and legal frameworks guiding access and provision of maternal care lies in both international and regional treaties, all aimed at safeguarding and ensuring universal attainment of basic human rights by all. These human rights according to IOM (2013) are a universal birth right of every individual to be treated equally regardless of one`s citizenship, class, gender or color. The country itself is a signatory to various regional and international conventions and it`s committed towards achieving goals and objectives of such conventions. All the regional and international protocols and conventions to which Zimbabwe is a signatory emphasizes on the obligation of member states to ensure,

> *"the right to health, right to life, right to be free from cruel and inhuman and degrading treatment and non-discrimination when it comes to accessing health care services….as well as protection of individuals from arbitrary and preventable loss of life, including the obligation to protect women's right to life in the context of pregnancy and childbirth"* (Makandwa, 2014;23).

Zimbabwe`s commitment and dedication to regional and international treaties aimed at improving maternal health care is exhibited by the adoption and enactment of several enabling pieces of legislations that are outlined and discussed in chapter 5.

2.8 THEORETICAL FRAMEWORK AND CONCEPTUAL FRAMEWORK

The study draws upon conceptual frameworks from various disciplines in order to answer the questions developed. Two frameworks that integrate have been adopted, that is the access to healthcare framework(McIntyre, Thiede and Birch 2009) and the maternal health service delivery framework(Zakeyo, 2015). These frameworks will help provide and satisfy the researcher`s quest to understand the migrants and refugees interface with a state and mission hospital on maternal health care provision in border spaces and how their experiences are influenced by the legislative and institutional policies that guides mission and state run hospitals in their service provision.

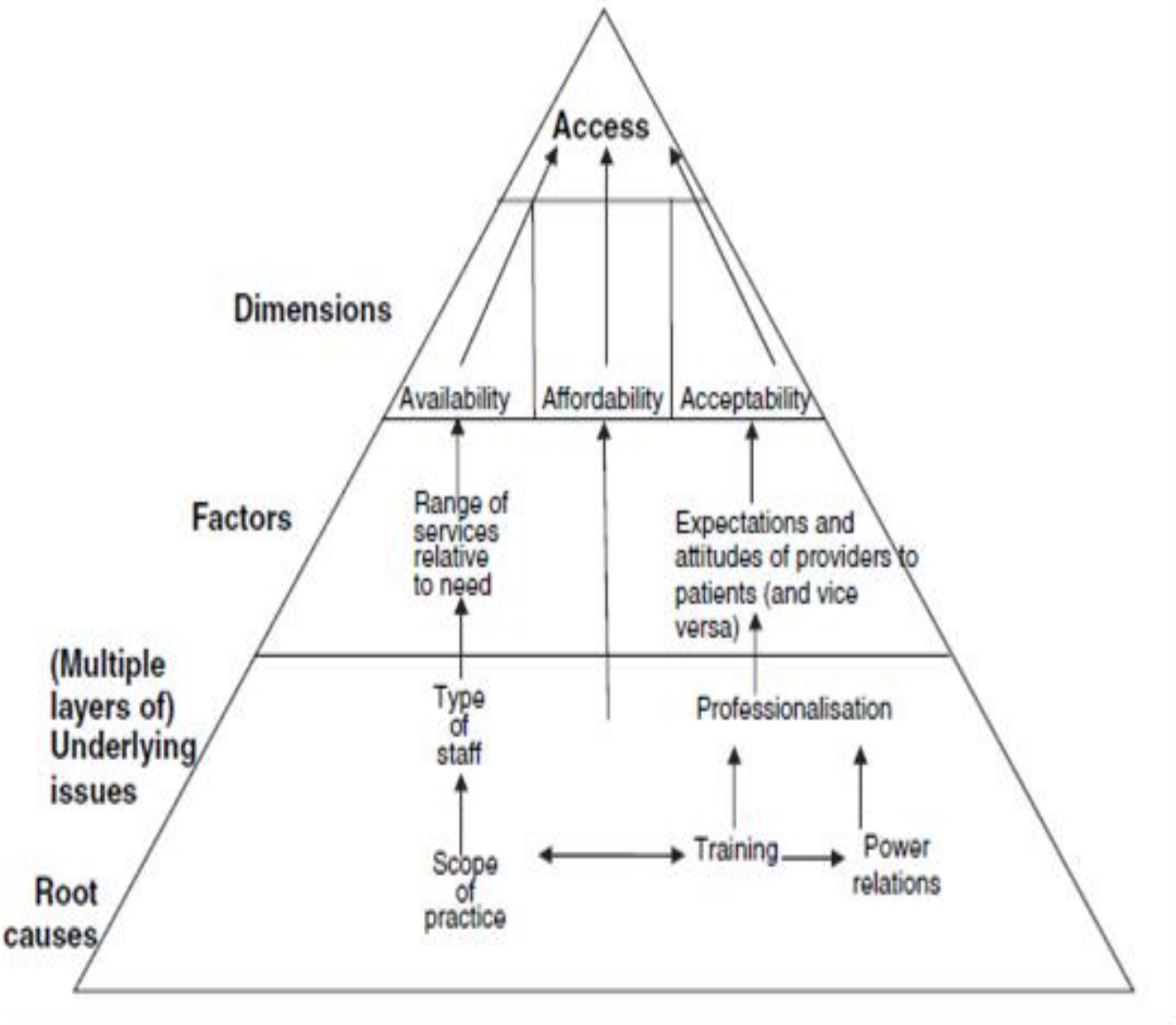
2.8.1 ACCESS TO HEALTH CARE FRAMEWORK

Access is an important health concept that deserves a standardized and precise definition (Christian, 2014). Govere (2017), drawing from (Hall, Lemak, Steingraber, & Schaffer, 2008; Oliver & Mossialos, 2004) mentions that there is no universally agreed definition of access that exists. However, with the concept remaining a largely contested and loaded one, it remains a complex notion as exemplified in the diverse interpretations of the concept across authors and its definition varies and changes with time as well as context (Levesque, Harris, & Russell, 2013). An extensive analysis of access therefore requires an exhaustive definition that serves as a reference point from which to build a theoretical framework (Ware, 2013).

In a bid to provide a comprehensive overview of access, the study adopts the access to health care framework as described by Thiede, Aweongo, Mclntrye and Mooney (2007) and later used by McIntyre, Thiede and Birch (2009). In doing so, this work assumes the central argument that access to healthcare is the ability of individuals to timely make use of health care services they require in a prompt manner hence the collaboration of the health care system and the clients is key. The axis or central argument in the access to health care framework revolves around the interactions and interconnections between the health care systems themselves and their clientele constituencies as well as the degree of power at the client`s disposal to exercise their agency and freedom in the manner they utilise available health care services (McIntyre et al. 2009; Makandwa, 2014).

There is an acknowledgement on the existence of numerous definition of access to health care among scholars and researchers (Peters et al, 2008) but what is key is that there is consensus on the fact that the concept of access to health care has much to do with the prompt and appropriate utilisation of health services in relation to need. Access to health care according to McIntyre et al (2009) is best understood under three key components that have a reciprocal connection between them though addressing distinct issues. These three broad components namely availability, acceptability and affordability are clearly illustrated and subtly discussed in much more detail below;

2.8.2 Fig 2: THE ACCESS TO HEALTH CARE FRAMEWORK



Source: McIntyre et al, (2009:190).

The three dimensions of access described in the framework: availability, affordability and acceptability– combined, are vital tools in providing a comprehensive understanding of the migrants` experiences and interface with a mission and a state hospital on maternal health care provision in Zimbabwe.

2.8.2.1 Availability

Availability, is sometimes taken to mean physical access and has to do with the relationship between the quantity and type of existing services and the volume and type of needs of the client system (Penchansky & Thomas, 1981). Mclntyre(2009) establishes that the availability component of access mainly captures supply-side aspects of health resources and often enjoys the highest top of the mind recall when policy-makers evaluate access.

In Thiede et al (2007), the dimensions of accessibility and accommodation are merged into the dimension of availability, thereby expanding the latter beyond the simplex supply-side issues. Availability can be taken to imply that health services are located in the right place and found or reachable at the right time, when needed (Thiede et al., 2007). The accessibility aspect, as understood under the dimension of availability, seeks to determine the place of supply relative to the location of the client. It involves a set of varied issues ranging from client transportation resources, distance and travel time to health facilities, and transport cost (Penchansky & Thomas, 1981). Accommodation also falls under the dimension of availability and pertains to clients' perceptions of the appropriateness and suitability, particularly in regard to the way in which services are organized and delivered (Penchansky & Thomas, 1981). Examples encompass appointment systems, hospital/clinic details and operating hours, among many other factors rarely taken into account in literature (McIntyre et al., 2009).

Despite the dimension of availability being an essential aspect of access, it is inadequate enough – to guarantee that individuals with health needs are empowered to utilize the existing services (Christian, 2014; McIntyre et al., 2009; Oliver & Mossialos, 2004). That being the case, the other two main dimension of access may need to be taken into consideration to allow for a comprehensive understanding of the concept of access vis-à-vis any given health system.

2.8.2.2 Affordability

Affordability, sometimes referred as financial access, has to do with the costs of health care and medical aid in connection with the income of clients (Penchansky & Thomas, 1981). It concerns the client's perception of value-for-money and their understanding of prices, total costs and possible credit arrangements (Thiede et al., 2007). In simpler terms, affordability relates to costs incurred by individuals when accessing health care services in relation to statutory provisions and measurements household income (Makandwa, 2014). This (affordability) dimension has been found to be dominant in discussions surrounding the equity of health care (Thiede et al., 2007, p. 109). According Christian (2014) a relational aspect of the affordability dimension links health care costs and the household or individual's ability to pay for services and is also linked to the broader topic of health care financing. The opportunity cost of ill health in terms of earning capabilities is another significant aspect of affordability, especially for the poor (Christian, 2014; Levesque et al., 2013; McIntyre et al., 2009).

2.8.2.3 Acceptability

According to (McIntyre et al., 2009) acceptability relates to the provider- client interactions are managed and leading to a creation of trust and promotion of demand for a health care service. In other words, it is an output on the evaluation of provider` attitude upon rendering a service in relation to the client`s perceived expectations on care. In some instances, it is also referred to as cultural access and concerns client attitudes about the personal and professional characteristics of health care providers in comparison with the real characteristics of existing health care providers. Acceptability is often a more important dimension than availability when it comes to explaining whether clients seek health care and where clients seek health care (Ware, 2013). This relationship also works in reverse, capturing health care provider attitudes regarding what they consider acceptable client characteristics (Penchansky & Thomas, 1981).

The acceptability component is also linked to plural healthcare utilization, particularly the incorporation of traditional indigenous approaches to healing and western medicine. Unlike conventional frameworks of access, the theoretical framework underpinning the present study provides insights into a common phenomenon that most people experience – that is, how

families navigate a plural health system in seeking health care. Several scholars note that health-seeking seeking behaviour is a socially negotiated process where individuals work within their cultural, financial, social, and geographical contexts, to determine the type of health services they need (Diaz et al., 2013; Geldsetzer et al., 2014; Scott, McMahon, Yumkella, Diaz, & George, 2014). This relates well to Makandwa's argument that,

> *"…in considering the factors that influence that utilization of health services, the characteristics of services and resources are not enough for use or non-use of the healthcare system, there is need to also consider the potential consumer's willingness to seek care. This according to them depends on one's attitudes towards and knowledge about healthcare and the social cultural definition of illness or condition one has learned"* (Makandwa, 2014; 37).

In addition, Govere (2017) notes a number of studies that has shown that, in the absence of adequate health care, individuals and families devise and seek care from multiple sources, including religious leaders, home treatment, facility-based providers, herbalists and drug peddlers (Giovanella, Vaitsman, Escorel, Magalhães, & Costa, 2002; Meurk, Broom, Adams, & Sibbritt, 2013; Moshabela, Schneider, Silal, & Cleary, 2012; Scott et al., 2014; Slikkerveer & others, 1990; Weerasinghe & Fernando, 2011).

2.9 THE MATERNAL HEALTH SERVICE DELIVERY FRAMEWORK

The study also situates itself in the maternal health service delivery framework. Developed by Zakeyo (2016), the framework explains and illustrates what constitutes an efficient maternal health service delivery system as well as what is deemed quality in maternal health service delivery. It further elaborates on what constitutes a good health delivery system. In this framework, policy and legal frameworks are cited as having greater influence on how health care institutions functions and serve their patient constituencies. In this regard, access to health is defined by rules and regulations. Such rules and regulations revolve around cost of service, conditions upon which a service id rendered among other issues. The conceptual framework also illustrates and elaborates on the impact of statutory and regulatory instruments on the quality of maternal health care provision within a system. The manner and degree in which services are accessible and available are thus dependent on the regulatory and policy provisions that guide health care institutions in the discharge of their mandate.

Zakeyo (2016) acknowledges the nature of ownership and hospital management as having a direct implication on the quality and the cost at which services are availed to the clients.

Below is an explanation of how service accessibility, service availability, infrastructure and management is circumscribed in, and influenced by the policy and legal framework and how this affects the quality of maternal service delivery.

2.9.1 Accessibility

Accessibility of maternal health care services in this framework has greater bearing on the nearness of a facility to those in need of a service, the cost associated with acquiring the service in terms of transport to the facility as well as paying for the service itself (Zakeyo, 2016). In a broader perspective, accessibility relates to equitable distribution of health care services across the divide including the underserved populations. The location of a maternity health care facility thus has to be close to the patient constituency so as to attract many women to utilise services provided there. How distant or proximal a maternity facility is, coiled with transport and user related fees thus determine the rate of service utilization. Stekelenburg *et al.*, (2004) alludes that women`s decisions and choices to utilise maternal services at most maternal health care facilities are mainly informed by the distance to be travelled the facility , the cost of accessing such a service and perceived quality of services provided . For instance, if a health care institution is situated in a remote area and is difficult to reach out, there will be underutilization of prenatal care services as well increases in home deliveries without professional midwives administering the process leaving the new-borns and their others at risk.

2.9.2 Availability

Under this framework, “availability of maternal health services is determined by whether a maternal health facility has all the needed services, which range from having a variety of contraceptives, antenatal services, post-natal services, to providing guidance when giving birth” (Zakeyo 2016;13). Shortage of the above mentioned thus negatively impacts on not only societal but national maternal health outcomes to a larger extent. The availability component in this framework is also viewed to be dependent on the policies and institutional

provisions that guides and regulates the provision of maternal health care services. The cultural and religious background of communities is also taken note as they are also critical in the dissemination of information and active uptake of maternal health care services.

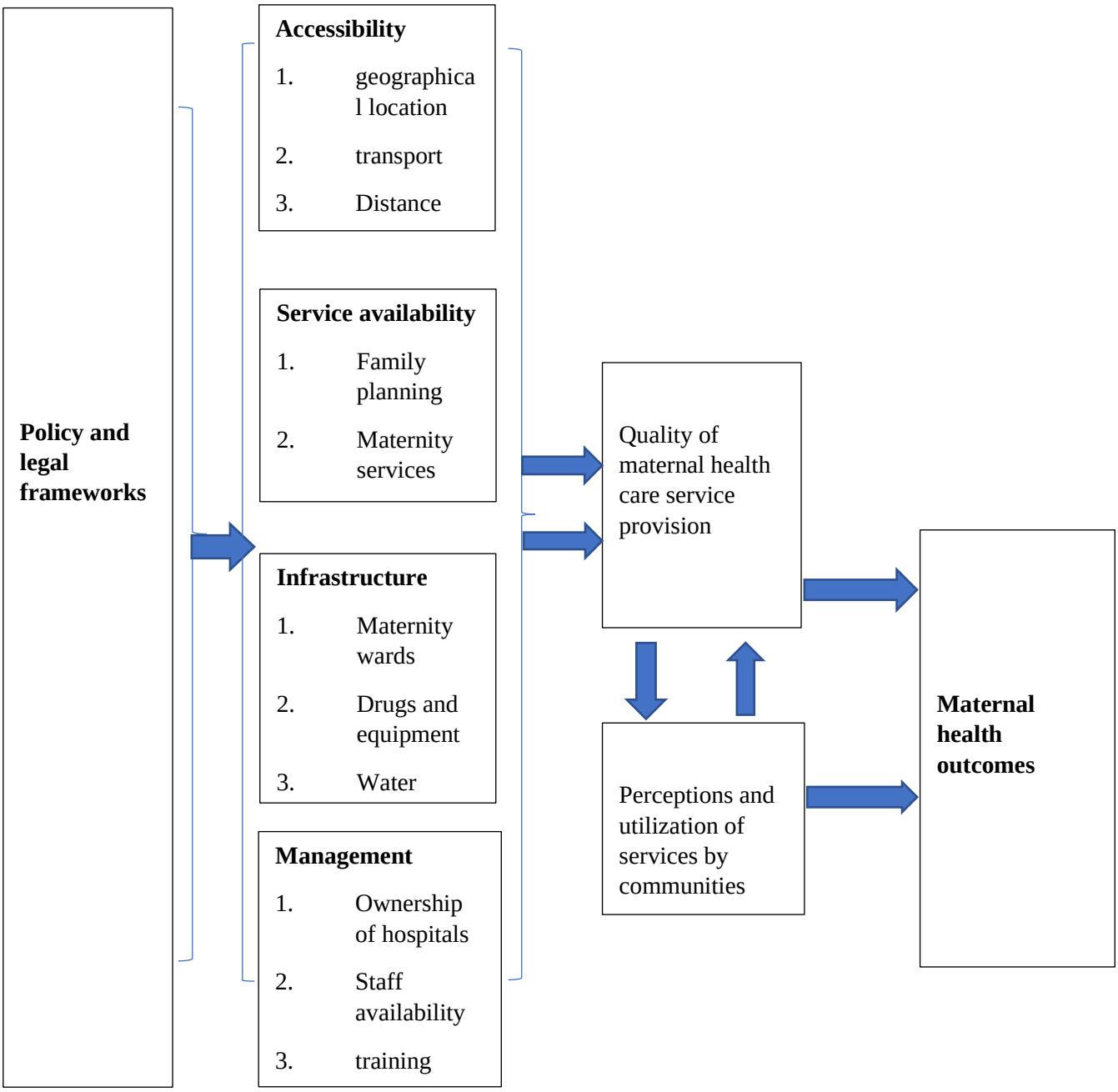
2.9.3 Infrastructure

This refers to all the required inputs to ensure a smooth flow of activities and operations at the hospital facility. These include maternity wards, electricity, and water and storage facilities among others. Under this framework, the way infrastructure is governed, managed or procured has an impact on the efficiency of health care delivery within a system. Zakeyo (2016) thus mentions the impact of policy and legal framework on the importation and procurement and administration of drugs on the resultant maternal outcomes. An enabling policy and legal framework would thus guarantee an efficient health delivery system with adequate infrastructure in terms of medical equipment, drugs, power backups as well as efficient transport services to enable hospitals to operate optimally.

2.9.4 Management

Management under this framework relates to the routine day to day organisation and coordination of activities at hospital facilities in order to realise set targets and goals. According to Zakeyo (2016), the management component concerns not only the ownership of hospital facilities but also the style of management and the paths or protocols in which decisions are passed. For instance, in state owned /run hospitals, there is too much bureaucracy and management style usually takes a top-down approach, relying much on government provision of funding while in mission based hospitals take a form of a bottom up kind of management style, relying on funding and support from overseas mother bodies-placing them in a better position to retain qualified professional and procure better infrastructure than state owned hospitals (ibid).

2.9.5 Fig 3: THE MATERNAL HEALTH SERVICE DELIVERY FRAMEWORK



Source: Zakeyo (2016; 12).

CHAPTER THREE

3 RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the various methods used to explore migrants` access to health and their interface with a mission and a state-run hospital within a borderland community. The chapter also covers the various strategies I employed in sourcing data from selected participants. All in all, it highlights and discusses the broader research design and approach, study context, sampling methods, research instruments, method of data analysis and ethical issues considered during this research.

3.2 Research question

The research is aimed at answering the following question;

In what way does the access to health care framework and the maternal health delivery framework aid the understanding of refugee women and Mozambican migrant women`s experiences in accessing maternal health care at a mission and state hospital in Chipinge district, Zimbabwe?

3.3 Research objectives

Research objective	Research instrument
1. To investigate the motivations of Mozambican pregnant mothers to seek maternal health care in Zimbabwean health facilities and their choice or preference of hospital facilities.	• In-depth interviews with the migrant pregnant mothers seeking care at the facilities understudy
2. To investigate the ideas and policies that guide mission and state facilities	• desk top review of international, regional and national health policies

in health care provision and explore how they shape the experiences of refugee women and Mozambican migrant women in accessing maternal health care	guiding maternal health care provision in Zimbabwe • literature review on migration and access to health • In-depth interviews with maternal health care providers(nurses) • Key informant interviews with hospital administrators, matrons and heads of maternal health units • In-depth interviews with the refugee and migrant women accessing maternal health care services at Mt Selinda and Chipinge District hospitals
3. To explore the different challenges faced by refugee and migrant maternal patients in accessing maternal care services at a Mission and State hospital in Zimbabwe.	• In-depth interviews with the maternal patients • Direct observations

3.4 RESEARCH APPROACH

The research was moulded within the qualitative method of enquiry. This was considered the best approach due to the explorative nature of the subject under study. The qualitative approach is adopted as it provides a rich foundation upon which meanings can be derived from words in relation to peoples` experiences (Denzin and Lincoln (2003). Creswell (1998), mentions that qualitative research approach is contextual, and it offers access to a valuable deeper and rich understanding of people`s lives and behavior, including some knowledge of their subjective experiences. This research required gaining insight and understanding of maternal health care provision by a mission and a state-run hospital to a refugee and migrant community within a Zimbabwean borderland. This settles well with the definition of

qualitative research design as, “an approach that seeks to understand meaning that people construct” (Merriam, 2003; 3). Through this approach, researchers are enabled to unravel and gain insights into the societal realities through closer interactions between them, the researched and their community (Makandwa, 2014).

Furthermore, Holloway & Wheeler (2002:30) defines qualitative research as, “a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the way in which they live.” This concurs well with the assertion that qualitative research implies a “direct concern with experience ‘lived’ or ‘felt’ or undergone.” (Sherman and Webb (1988:15). In other words, qualitative research methodology allows researchers to gain an in-depth and rich understanding of experiences felt and lived by participants. I therefore made use of this research approach to explore the perspectives, behaviours, feelings and experiences of refugee and migrant women accessing maternal health care at a mission and a state-run hospital in a Zimbabwean borderland hence getting an insight of what lies at the core of their lives. Through this approach as well, perceptions, feelings, behaviours, understanding and interpretation of policies by maternal health care providers in the facilities understudy were well explored. This dwells well with the contention by Denzin & Lincoln (2005) that qualitative research techniques should examine things in their natural setting in endeavouring to comprehend or interpret phenomena in terms of the meanings that individuals convey to them. This strategy was therefore of great significance as it accorded me the best opportunity to gain insight into reality as understood and experienced by both maternal healthcare providers upon discharging their mandate and also those of refugee and migrant women accessing maternal health care services in this borderland health facilities,.

More so, the research approach is the most suitable for gaining insight into an unexplored situation, individual or phenomenon (Legard, Keegan and Ward (2003). It also allows for a laborious investigation of phenomena from a holistic point of view that can lead to greater understanding of the experiences of the instrument of inquiry (Babbie, 2004; Creswell, 2013). As such, qualitative approach is appropriate for the purpose of exploring, in-depth, the experiences of Mozambican (migrant) maternal patients and refugee maternal patients in accessing health care services from pregnancy to post- natal care in mission and state hospitals within a Zimbabwean borderland, the perceptions of medical professionals and other health care providers regarding the provision and challenges faced in providing maternal health services to this migrant population. A total of 30 semi-structured interviews scheduled were conducted(20 with refugee and migrant pregnant mothers who were

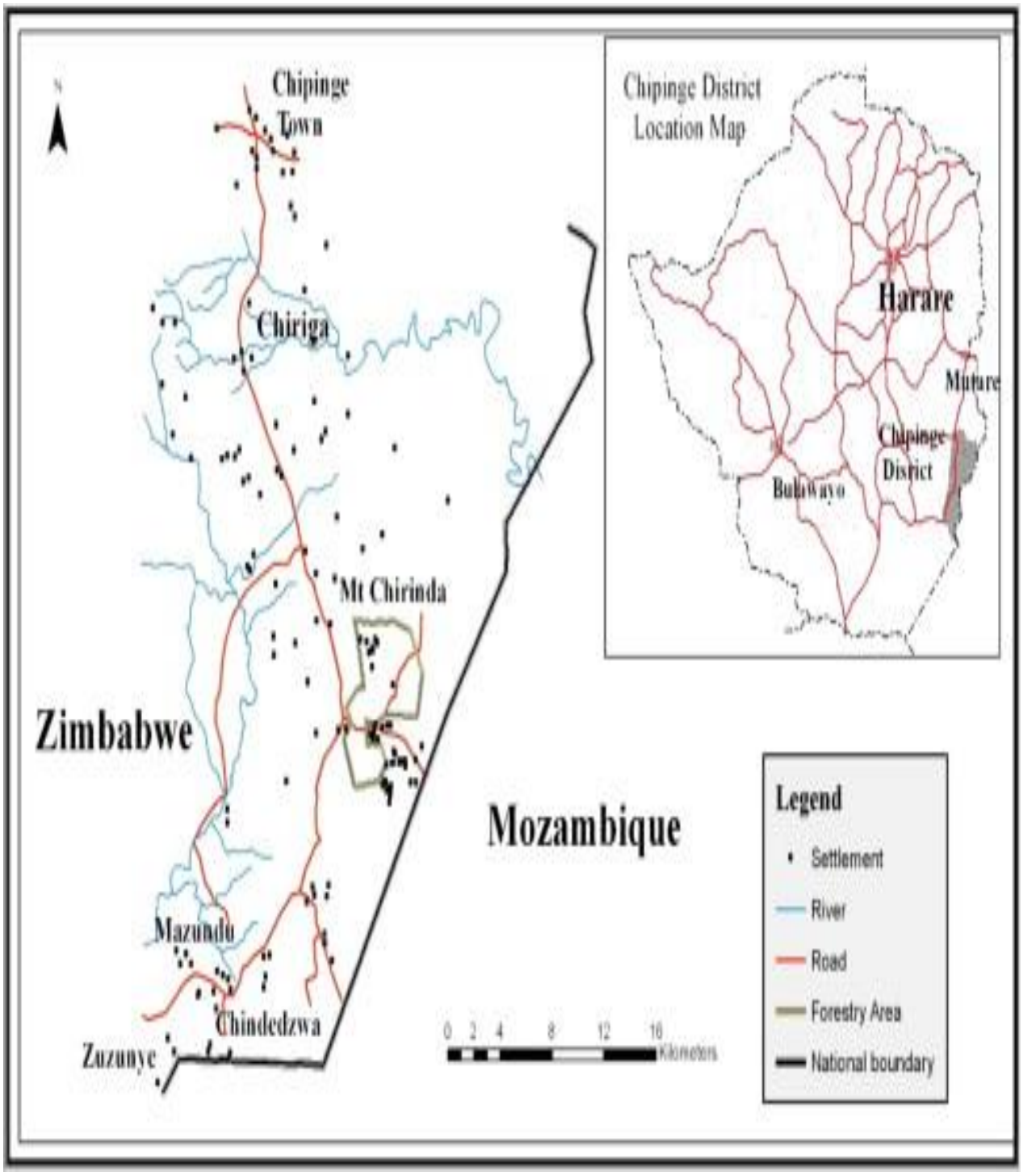
accessing maternal health services at MT Selinda and Chipinge hospital, 4 with maternal health care providers and 6 key informant interviews were conducted with the hospital administrators, matrons and heads of maternal health units at both institutions.

The qualitative approach was also utilized as it enabled the researcher to understand, write and present a detailed report on a social problem affecting a particular refuge and migrant community within a Zimbabwean borderland. This is in line with the definition if of qualitative research as, " an inquiry process of understanding a social or human phenomenon based on building a complex holistic picture, formed with words, reporting detailed views of informants and conducted in a natural setting" (Makandwa, 2014; 42). In so doing, the researcher was enabled to re-tell the realities faced and experienced by both health care providers and Mozambican migrant and refugee women in utilizing care from time of pregnancy up to post-natal care (Makandwa 2014). For instance, the approach was also effective in examining the way migrant pregnant women navigate and negotiate their way into Zimbabwe`s health care institutions, the quality of maternal health care provided to them and recommendations.

3.4.1 STUDY AREA

This study was conducted at Mt Selinda mission hospital and Chipinge District hospital. Both health facilities are in Chipinge which falls under Manicaland province (refer to map below) Chipinge district is also a border community proximity to the border between Zimbabwe and Mozambique. Mt Selinda hospital is about 13 kilometers away from the frontier border that separates Zimbabwe and Mozambique while Chipinge district hospital is about 33killometers away (Marta, 2014). Most of the migrant women who seek maternal health care services at the facilities understudy come as far as from Espungabera district, the Mossurize District and Maridheya, all in the Manica Province of Mozambique (Marta, 2014). The language spoken on either side of the border is chiNdau and shangani (ibid). Refugee pregnant mothers included in the research were from DRC, Rwanda and Somalia and were coming from Tongogara refugee camp located in Chipinge as well. This study focused on migrants` interface with mission and state hospitals in accessing maternal health care services, the experiences and challenges of refugee and migrant Mozambican mothers in accessing maternal health care services in Zimbabwe. Carrying out this research in this borderland community made it easy to locate participants.

3.4.2 Map of Chipinge District, Manicaland province, Zimbabwe



Source: Barker (2019)

3.4.3 COMMUNAL ENTRANCE

My point of entrance into field work was through my contact with the Mt Selinda hospital administrator Mr. Madzaridzari, the one with whom prior permission to carry out research at the facility was sought from. The request to carry out the research at this facility was submitted on the 4th of May 2018 and permission in form of an approval letter was granted on the 5th of May 2018(refer to appendix K). The researcher took with him the ethics clearance letter from the Wits ethics committee (Protocol Number H18/09/32) with an attached research commencement notice to Mt Selinda hospital administrator on the 18th of November 2018. On the 19th of November, I was introduced to the matron, head of maternity ward and all the hospital staff at breakfast meeting. The following morning, the researcher was introduced to the research participants so as for them to familiarize themselves with the researcher. The researcher was also allocated a room to operate from during the period of research.

For Chipinge district hospital, permission was sought on the 4th of May and approval letter was granted by Dr Makumbe who also serves as the District Medical Officer of the Chipinge on the 6th of May (see attached appendix J). Notice of research commencement date attached together with the Wits ethics clearance letter was handed in on the 27th of November and the research commenced from the 3rd of December 2018. I was introduced to the matron, sister in charge of the maternity ward and the rest of the hospital staff present on the day. The assistant sister in charge, Sister Hlatshayo introduced me to the intended research participants during their morning antenatal care and exercise sessions. In this interaction, the researcher explained the purpose of the research and the processes that were going to be involved.

After participants went through the participant information sheet, agreed and signed the consent forms, in-depth interviews were conducted with the aid of an audio taping device. The researcher would also make field notes in the process. The same was also done for key informants who were approached at their own times of convenience to partake of the research process. Data collection was concurrently done over a period of almost three weeks at Mt Selinda hospital and Chipinge district hospital.

3.4.4 SAMPLING PROCEDURE

Sampling is the procedure for selecting the required number and characteristics of a given population to be included in the research (Onwuegbuzie and Leech (2007). For the purpose of this study, purposive sampling procedure was used. Purposive sampling is a non-probability sampling method involving a deliberate inclusion of participants with set experience or knowledge needed by the researcher (Neuman, 2000; Bettmann, Penney, Clarkson Freeman, and Lecy, 2015). Under this technique, the selection of participants lies on the researcher who then decides what ought to be known and sets out to find participants who can provide information by virtue of their knowledge or experience (Bernard, 2002). In this case, I purposively selected participants from a contingent of Mozambican pregnant mothers and refugee mothers who were coming for antenatal care and regular checkups, those who had recently delivered and those who were coming for post-natal care services as well as child immunization at Mt Selinda and Chipinge district hospital. Most of these mothers were residing in the maternity home shelters available at these facilities. Maternal health care providers (nurses, midwives and doctors) as well as those in administrative capacities (matrons, heads of maternal health care units and hospital administrators) of both health care facilities were purposively selected too. The selected ones contributed fully in the research process by confiding the information sought after by the research regarding the extent to which the existing legislation and policies governing the provision of care in Zimbabwe impacts on migrants and refugee utilization of care as well as shaping the lived experiences of refugee and migrant women in accessing maternal health care services at a mission and a state run hospital in a Zimbabwean borderland.

I also employed snowballing sampling technique in the recruitment and selection of research participants. Snowballing is a process through which a researcher gets participants through referrals from other participants (Barbie and Mouton, 2001). This sampling technique is instrumental in instances where the already sampled cases have knowledge of others with similar characteristics being studied (Govender, 2012). Congolese refugee pregnant mothers and Mozambican pregnant mothers referred me to other potential participants of their origin at both Mt Selinda hospital and Chipinge District hospital. I was also able to build new social networks that endeared me to the community and the administrative ranks through participation in their routine day to day social interactions. As a result, more people were interested to voluntarily participate in the research and refer me to other potential

participants. For instance, I was referred to the District Medical Officer for in-depth discussion on implications of migration on health infrastructure in the district by the administrator of Mt Selinda hospital. This relates well to Bernard`s explanation of snowballing as a means by which researchers use key informants to locate one or two informants and these will recommend or direct him to other potential participants in the community (Bernard 2006). The sample obtained was thus able to give a balanced report on both the client and provider perspective on the provision of maternal health care services in the institutions and community understudy. A total of 30 participants (20 refugee and migrant maternal health seekers, 2 matrons, 4 nurses, 2 heads of maternity wards and 2 administrators) had been proposed to be interviewed. All of them were interviewed.

3.4.5 TARGET POPULATION

Target population according to Cresswell is "the total number of individuals with certain characteristics of interest to a researcher (Cresswell, 2003; 32). In other words, target population is the units from which the sample is taken or a group upon which researchers wish to generalize findings. The target population of the research were refugee and migrant pregnant mothers aged 18 and above, either residing in the maternity homes at MT Selinda hospital and Chipinge district hospital or commuting from outside for the sole purpose of seeking maternal health care services at these health care facilities. Those under the age of 18 were excluded from participation for ethical reasons. The target population also included maternal health care providers (maternity ward nurses) including heads of department and the hospital administrators. All the above were interviewed by means of semi structured and in-depth interviews. The table below illustrates the composition of the sample.

3.4.6 POPULATION SAMPLE

Mt Selinda hospital	No. of participants	Chipinge Hospital	No. of participants
Hospital matron	1	Hospital matron	1
Admistrator	1	Administartor	1

Sister in charge (maternity ward)	1	Sister in charge (maternity ward)	1
Nurses	2	Nurses	2
Migrant mothers awaiting delivery	10	Migrant mothers awaiting delivery	10
Total			**30**

3.4.7 RESEARCH TOOL

The study made use of a semi-structured interview schedule for data gathering. Questions on the interview schedule were open-ended and this ensured that the interviews undertaken were very interactive. An interview schedule allows the interviewer to be flexible, informal, and conversational during the interview (Brinkman, 2014). Questions on the interview schedule were designed in such a way that they reflect the aim, objectives as well as the theoretical framework of the research study (Brinkman, 2014; Kivnick & Murray, 2001; Turner III, 2010). The following issues were explored during the interviews: general understanding of maternal health access, service provision in the border space and experiences when seeking maternal health services and recommendations. A copy of the research tool is provided in Appendix D.

3.5 DATA COLLECTION

3.5.1 Semi-structured interviews

This method was key in the collection of primary data. An interview guide consisting of well-structured questions that was in place (see Appendix H) guided the research process and enable the researcher to acquire the much needed data relating to the migrants experiences in accessing maternal care services in Zimbabwe , challenges faced as well as their perceptions on the nature and manner in which services were rendered to them. These semi-structured

interviews as explained by Whiting (2008) consist of predetermined questions with mostly fixed order but allow the flexibility for adding further questions for clarification during the interviews. Doody and Noonan (2013) notes that semi structured interviews allow much flexibility around the sequence of questions to be asked and often give more room for the interviewer to allow the respondent to speak more broadly about the topic under consideration.

The choice of using semi-structured interviews was influenced by the fact that the researcher had a specific and clear agenda that was being sought to be understood (Cohen & Crabtree, 2006; Doody & Noonan, 2013; Noor, 2008; Pathak & Intratat, 2012; Whiting, 2008). The method through a direct interface between the researcher and the participant creates a favorable platform upon which all questions are answered comfortably unlike in a group situation (Makandwa 2014). Lastly, semi-structured interviews were chosen since they allow the researcher to gain control during the interviewing process (ibid). The researcher worked to ensure that the reliability of the study was enhanced by asking study respondents standardized questions throughout the entire interviewing process (Brinkman, 2014).

These interviews were conducted between November 22 and December 15, 2018 at Mt Selinda mission hospital and Chipinge district. Most of the interviews were conducted in chiNdau /Shona which is the spoken language in Chipinge and the Espungabera part of Mozambique (as well as the researcher`s native language) and then translated into English. For the health care providers and administrators, interviews were conducted in English. Each interview lasted between 15to 30 minutes under a tape audio recorder and later translated verbatim (N=22). This was vital for the use of direct and precise quotations during data analysis – thereby enhancing the trustworthiness research results (Elo et al., 2014). Field notes were noted down for those participants who reserved their right to be audio taped in order to protect their privacy and confidentiality (Whiting, 2008).

3.5.2 Direct observations

The researcher also utilized direct or naturalistic observation as an alternative and supplementary way of gathering data. Observations are key in data collection as they complement other data collection methods such as in-depth interviews. Welman et al, (2005) mentions that researchers do not have to solemnly depend on one method when collecting

data as some responses might be misleading hence there is need for the researcher to take note of the behaviors and attitudes of the respondents and their environment. As such, the researcher could not forego the environment, provider-client interactions, the hospital facilities themselves, the condition of the maternity wards and equipment therein among many other things that I was able to take note of without inquiry from anyone. The observations made together with field notes were very key in stimulating an environment for further probing on some certain aspects arising from the interviews. This direct observation means also provided the researcher with direct access to the social phenomena under consideration (Mehl, Robbins, & Deters, 2012; Patton, 2005). Govere (2017) citing from (Bordens & Abbott, 2002; Campos, Graesch, Repetti, Bradbury, & Ochs, 2009; Guba & Lincoln, 1982; Mehl et al., 2012) notes that, instead of solemnly relying on some kind of self-report – that is, what participants had to say during the semi-structured interviews, the researcher has to observe and record what he saw on the ground. Some significant observations made by the researcher during the data gathering phase include: the unsafe routes that women use when negotiating their way to Zimbabwean health facilities from Mozambique, the conditions of care they are subjected to in Mozambican health facilities, the unbearable heat pregnant mothers deal with on a daily basis, long waiting times and queues at the clinic.

On the other hand, taking or recording field notes was very vital as well. Notes were taken down to remember and record observations and certain behaviors as well as articulating on my reflections on research participants during and after data collection. Field notes are thus an integral element of this research as they supported in constructing thick, rich descriptions of the study context, encounter, interview and document's valuable contextual data thus enhancing a rich context of analysis (Cresswell, 2013). I took time to go through the jotted field notes after data collection and think through them and this was significant as it informed my data analysis.

3.5.3 Literature review

The researcher also used extensive literature review in gathering data. An extensive literature searches on migration, access to health, maternal health care provision to migrant communities, regional and international policies and enabling frameworks that regulates health care access and provision, role of faith based organizations and the government in the

provision of health care services was done and this was vital in framing the conceptual frameworks that guided the study. However, there appeared to be limited published literature on faith/church-based mission hospitals maternal health care provision to migrant populations.

3.6 RESEARCHER EFFECTS

All the participants interviewed were Mozambican immigrants except for two Congolese pregnant mothers were purposefully selected for this study. Most of them could understand chiNdau so the interviews were conducted in chiNdau. English was also used for the convenience of the Congolese participants as well as the maternal health care providers at both health care facilities. The fact that the researcher was a Zimbabwean, fluent in the language they were familiar with, together with his good interaction with both them and the hospital personnel as well as confidentiality assurance enabled the participants to be as free as possible to open up on their inner most feelings regarding interface and experiences in accessing maternal health care at both facilities. For key informants, the fact that the researcher is coming from a reputable institution outside the Zimbabwean borders made them find the research as of vital importance and this enabled them to freely express their concerns and experiences in servicing the migrant constituency as well.

Time factor, may be did influence some interviewees as they participated in an activity that they would not have set time aside for, but the fact that they all voluntarily participated after I had asked them for their time should have minimized time factor influence on quality of data collected.

3.7 DATA ANALYSIS

Data analysis is a process for obtaining raw data and converting it into information useful to answer questions, test hypotheses or disprove theories as well as enhancing decision-making by users (Judd and Gray 1989). It also entails description, interpretation and evaluation (Wolcott, 1994). In this process, data is inspected, cleansed, transformed, and modelled for a specific goal of discovering useful information, informing conclusions, and supporting decision-making (Xia and Gong 2015). In this research, thematic content analysis was

employed during data analysis. Neuendorf (2016) defines thematic content analysis as the process whereby the raw data is grouped into a list of common themes as expressed in actual words by the respondents in the study. This definition concurs with that of Barbie and Mouton (2001) in which thematic content analysis is defined as a process where emerging interconnected themes are categorized and the write up of the research findings is guided by these emerging themes. Braun and Clarke (2006) further notes that thematic content analysis involves organizing and describing one's research data set in detail and frequently goes further to interpreting various aspects of the research topic

Thematic content analysis was deemed appropriate for data analysis as it allowed the researcher to organize raw data into tangible units of information and to group related categories and themes into subthemes. The process entails the placement and categorization of data into themes developed from the commonality or recurrence of similar responses from participants Anderson (2007). This was simultaneously done alongside data collection to reduce excess piling of raw data as advised by Makandwa (2014). I also chose this approach because it provides insightful analysis that answers research questions (Braun and Clarke, 2006). It aided in complementing my research question by enabling an investigation of the interview data from a data driven perspective based on coding in an inductive way and from the research question perspective checking if the data were consistent with the research questions and providing ample information (Judger, 2016:3). Themes were therefore examined basing on the context of my research question, research objectives and the access to health care as well as he maternal health delivery conceptual frameworks. All interviews recordings were transcribed verbatim and precisely translated by the researcher.

The researcher analyzed the data following Braun and Clarke model (2006). The model provides a detailed account of six different phases followed when conducting thematic content analysis which consist of the six following phases; familiarizing oneself with data, generating initial codes, searching for themes, reviewing the themes, defining and naming the themes and finally, producing the report.

3.8 ETHICAL CONSIDERATIONS

Research ethics are a set of rules, values and norms that regulates the conduct of researchers when conducting research and these are to be adhered to at all cost (Moyo 2010). Every

academic research must be academically sound and ethically relevant (Jacobsen and Landau 2003:185). Ethics has thus become a basis for conducting effective and meaningful research (Neumann, 2005). As a researcher, I was aware of my obligation to be mindful of my ethical responsibilities to participants. Such responsibilities include the primary duty of protecting the welfare of the research participants, encompass the principle of informed consent, debriefing of participants, respecting participants' right to withdraw from research, maintaining confidentiality and anonymity of data as outlined by Leaning (2001; Jacobsen & Landau, 2003; Mackenzie, McDowell, & Pittaway, 2007; Crosswell, 2017). Drawing from these principles, I therefore sought to maintain high standards of professionalism and research ethics principles.

3.8.1 The principle of informed consent

This principle emphasizes the need for researchers to explain to participants, their obligations and responsibilities of participating in the research at the beginning of the study (Neuman, 2005). The participants were well informed and briefed on the purpose of the research and the outset of every interview, I made clear to respondents that their participation was voluntary and should they wish to withdraw from the research, they were free to do so and nothing was to be held against them in any way. Respondents were also informed that they could withdraw from any question/s which they feel uncomfortable with answering. All this information was provided on the participant information sheet – handed to every participant before the commencement of the interview. See attached appendices E, F&G.

3.8.2 Integrity

This principle calls for social science researchers (sociologists) to be honest, fair, and respectful of others in their professional activities including research, practice, and service (Crossman 2017). Furthermore, sociologists do not knowingly act in ways that jeopardize either their own or others' professional welfare hence as a researcher (ibid). I conducted my work in ways that inspired trust and confidence and not knowingly make statements that are false, misleading, or deceptive.

3.8.3 Approval of studies by institutional ethics committee

Before engaging in fieldwork, an application letter for ethics clearance was submitted to the Human research Non-medical ethics committee. Upon satisfaction of the committee, I was issued with the clearance letter (Protocol Number: H18/09/32) on the 23rd of October 2018 (see Appendix L). In Zimbabwe, permission to conduct the study was sought from the Zimbabwean Ministry of Health and Child Welfare and permission was granted by the District Medical Officer (Chipinge District) as well as by the Hospital Administrator of Mt Selinda Hospital. This was done after the researcher was referred to seek approval to conduct research in this district by the Manicaland Provincial Medical Director`s office (please see attached the Appendices).

3.8.4 Respect for People's Rights, Dignity, and Diversity

It is vital to respect the rights, dignity, and worth of all people when conducting research (Crossman 2017). She further noted that researchers should strive to eliminate bias in their professional activities, should not tolerate any forms of discrimination based on age; gender; race; ethnicity; national origin; religion; sexual orientation; disability; health conditions; or marital, domestic, or parental status. Research ethics thus universally underpins researchers to respect the rights of individuals and treat them with dignity in in all their diversified settings (Welman et al., 2005). There is thus a greater need to be sensitive to cultural, individual, and role differences in serving and studying groups of people with distinctive characteristics (ibid). In this research work, I acknowledged and preserved the rights of others to hold values, attitudes, and opinions that differed from my own. I ensured respect for the dignity, moral and legal rights of the research participants, some of whom were vulnerable and marginalised by demonstrating high levels of humility through my actions, language and interaction, with neutrality and tolerance as driving principles of the researcher so as to refrain from imposing personal values to participants.

3.8.5 Protection and welfare of participants

In the context of research ethics, harm may be broadly defined to include extreme physical pain or death, but also involves such factors as psychological stress, personal embarrassment

or humiliation. According to Babbie (2004), protecting participants from harm is a key consideration in any research undertaken. To ensure protection and welfare of participants, arrangements for supportive counselling services were made with the staff at Mt Selinda hospital should any participant feel that they need counselling services as a result of having participated in the study.

3.8.6 Maintaining confidentiality and anonymity of data

According Mattison (2000), this principle entails and compels the researcher to keep confidential whatever information obtained in the research unless the participant has agreed and given consent of publishing the information before the research begun. With the permission of respondents, interviews were tape-recorded, and no one had access to the information except my research supervisor. To ensure that this principle was well upheld, the researcher used pseudonyms to maintain privacy.

3.9 LIMITATIONS, POSITIONALITY AND FIELD EXPERIENCE

Despite a careful planning for this research, I encountered several challenges in the field work process. My gender and position as a male researcher doing a field enquiry on a maternal health care seeking and lived experiences of refugee and migrant Mozambican pregnant mothers might have brought an element of discomfort on women to freely share their experiences with me. This was worsened by the setting of the research area- the Ndau and shangani speaking clan where it is uncommon for women to discuss their maternal and matrimonial issues with ‘strange’ men hence to some this was a dreadful miscarriage/ breach of cultural and traditional values. As a result, some refused to participate outside the consent of their spouses. Carling et al. (2013) mentions gender position or profession of the researcher as a fundamental element of social identity that affects the experiences of sameness or difference, placing the researcher as an outsider. This was true of my case considering that I was a male university student enquiring about the maternal health care seeking experiences of refugee and migrant women in a Zimbabwean borderland context. This alone placed them in a compromised position to freely open during interviews. My positionality was therefore a matter of concern. According to Carling (2013; 2), positionality

in qualitative research alludes to the way the researcher`s characteristics affects both substantive and practical aspects of the research process from the nature of the questions asked through data collection, analysis and writing, to how findings are received. In my case, redemption came through the assistance of the matrons and heads of maternity wards who would introduce me to women seeking maternal health care services at the facilities during routine daily educational and checkup sessions. My continuous visibility on the premises and social interactions with the health care providers together with referrals by fellow migrant and refugee women to those close to them stimulated confidence and trust between me and the research participants.

Furthermore, the researcher was also constrained by some of the participants denied their consent to audio-recording and photo shooting. Despite having clearly explained the purpose of the research, some participants requested not to be audio tapped citing mysterious events of witchcraft that are common in the area. This might have led to a significant loss of data. However, the importance of this should not be overemphasized as the researcher was able to take down field notes during the interviews.

Lastly, the study was time consuming and expensive. This owes to the fact that the research area is beyond the borders of South Africa and is remote. A lot of money was spent on travel, accommodation, and food during the data gathering phase. The researcher had also to go to the other side of the border i.e. going to Espungabera district of Mozambique via the border post as well as the informal channel in a bid to furnish myself with a deeper understanding of the manner in which they navigate their way to Zimbabwean health facilities.

3.10 CHAPTER SUMMARY

Informed by the research objectives, the chapter gave a whole synopsis of the whole research approach adopted by the researcher for the purpose of research project. The chapter has explicitly outlined the way participants were recruited, the methods used to collect data as well as the manner in which data was analyzed. It also presents the researcher`s reflection on his personal field experience and the ethical considerations he had to deal with while in the field of study. This chapter therefore sets the precedence for chapter 4 that will provide a presentation and discussion of the findings.

4 CHAPTER FOUR: PRESENTATION OF FINDINGS AND DISCUSSION

4.1 INTRODUCTION

This chapter provides the presentation and discussion of the research findings. The qualitative data that was collected through semi- structured interviews, direct observations as well as written field notes provided an insight on the migrants and refugee women's experiences in accessing maternal health care at Mt Selinda mission hospital and Chipinge (government) hospital. Key informant interviews were also used to gather data from the health care providers at the selected health care facilities on their perceptions and their experiences in their provision of health care to refugee women and migrant Mozambican pregnant mothers. This data was analysed using thematic content analysis. Descriptive statistics were also used to analyse the demographic information of the research respondents. In this chapter, quotations in direct verbatim from the interview transcriptions for both key informants and the migrants themselves shall be used in the presentation of the findings.

4.2 DEMOGRAPHIC PROFILE OF RESPONDENTS

This section provides the biographic background information of the respondents in terms of age, nationality and place of residence during time of research. A greater percentage of the respondents were all Mozambican origin and were fluent shangani/Shona-speakers. It was also interesting to note refugee women from the Democratic Republic of Congo (DRC), currently residing at Tongogara Refugee Camp who were also seeking maternal health care services at Chipinge district hospital. These women were either staying in the maternity shelter facilities available at the hospitals understudy or were coming to seek care services from home during the time of research. The researcher assigned pseudonyms to protect the identity of participants. The age range for those who participated ranged from 20 to 39 years old as shown below.

4.2.1 DEMOGRAPHIC DETAILS OF MIGRANT& REFUGEE WOMEN

RESEARCH PARTICIPANTS (N=20)

Participant Pseudonym	Age	Nationality	No. of children delivered at a Zimbabwean hospital	Name of hospital attended
0ppah	20	Mozambique	1st pregnancy	Mt Selinda
Greater	26	Mozambique	3	Mt Selinda
Mellania	22	Mozambique	2	Mt Selinda
Rudo	26	Mozambique	2	Mt Selinda
Nomsa	33	Mozambique	4	Mt Selinda
Epiphania	30	Mozambique	2	Mt Selinda
Sherry	28	Mozambique	3	Chipinge district
Effie	25	Mozambique	3	Chipinge district
Lydia	38	Mozambique	7	Mt Selinda
Sarah	24	Mozambique	2	Mt Selinda
Violet	35	Mozambique	4	Mt Selinda
Spiwe	26	Mozambique	3	Chipinge district
francesca	21	Mozambique	2	Chipinge district
Myambi	32	DRC	3	Chipinge district
Glenda	31	DRC	3	Chipinge district
Gracia	22	Mozambique	1st pregnancy	Chipinge district
Nicolette	23	Mozambique	2	Chipinge district
Mapepo	30	Mozambique	3	Mt Selinda
Annesia	27	Mozambique	4	Chipinge district
Philda	39	Mozambique	5	Chipinge district

4.2.2 SUMMARY OF KEY INFORMANTS

Professional	Mt Selinda hospital	Chipinge District hospital
Sister in charge (maternity ward)	1	1
Matron	1	1
Hospital administrator		1
Nurses (maternal care providers)	2	2
Total		**9**

4.3 THEMES AND SUB THEMES

4.3.1 Themes and subthemes

MAIN THEME	SUB- THEMES
Motivation to seek care and preference of hospital facility	• Accessibility of the hospital facility • transport costs • availability of infrastructure • cost of service • availability and quality of service
Experiences when accessing maternal health care	• negative nurse-patient interactions • Language /communication barriers • Preferential treatment of locals ahead of migrants • Blame/s accusations of depleting resources

	• Delays in the provision of care
Institutional constraints	• Inadequate human resources • Heavy work loads • Conflicting policy directives and professional norms &ethics • Deteriorating infrastructure

There are three main themes that emerged in the data analysis process of the data gathered through direct observations, key informant interviews with the maternal health care providers and in-depth semi-structured interviews with the migrant pregnant women seeking health care services at both Mt Selinda mission hospital and Chipinge district hospital. These are summarised in Table 3. The first theme identifies with the motivations behind Mozambican pregnant mothers` motivations to seek care in Zimbabwe and their preference of hospital facilities to attend. A set of sub themes that constantly emerged include distance and transport cost, availability of infrastructure, affordability of services, availability of quality services. Overly, these sub themes resonate well with the access to health care framework by (Thiede et al, 2007 and McIntyre, 2009).

Secondly, the research found out barriers to maternal health care access and sub themes under this included language barriers and discrimination in its various forms are well explored in the ensuing section. Subthemes such as negative nurse-patient interactions, language and cultural barriers, discrimination by fellow local pregnant women and deliberate delays in service provision constantly emerged in the interview transcriptions. Provider concerns and experiences in maternal health care service provision to migrant populations are also incorporated in the themes and sub-themes.

The last theme identified in this research was institutional constraints. It was informed by responses gained from the key informant interviews. Sub-themes that sufficiently informed this theme include inadequate human resources, heavy workloads, limited operational resource, deteriorating infrastructure and regulatory policies that conflicted with the professional norms or ethics of service providers. All these will be adequately discussed in this chapter.

The chapter shall also present a detailed discussion on the findings of the research in relation to migrants` interface with state and mission hospitals on maternal health care access in a

Zimbabwean borderland, including case studies from other countries as well. The themes outlined above are thus going to be sub-divided into sub themes and discussed in depth in the ensuing discussion. The discussion is also framed in relation to the research objectives and the conceptual frameworks guiding the study.

4.4 MOTIVATIONS AND PREFERENCE OF HOSPITAL FACILITY

In terms of migrants` interface with a mission and state hospital in Chipinge district, there were numerous motivations and factors that were cited as attracting a large contingent of migrants to seek not only maternal health care but also other health related needs. Even though Zimbabwe is a poor resource country that is struggling to maintain and sustain its service delivery to its population, migrants still value and hail the health delivery system. The main motivations for a continuous use of the Zimbabwean maternal health services revolves around the proximity to the health facilities, quality of service delivery, quality of infrastructure among others as shall be discussed in the ensuing discussion.

4.4.1: Distance to the hospital facility

Most of the participants mentioned facility accessibility as one of the most influencing factor in their choice of where to access maternal health care services. Even though there is a frontier border separating Zimbabwe and Mozambique, residents of the Espungabera, Maridheya and other parts of Mozambique mentioned that they prefer to access maternal care services at Mt Selinda hospital, a mission hospital to Chipinge District hospital. The preference is based on distance as the major influencing factor. In support of this, one respondent has this to say;

> *"I prefer coming to Mt Selinda hospital because it's very near to where I stay…. Espungabera Provincial hospital is far away from where I stay. For me to go there I need to pay much money which I also don't have. It is easier for me to walk from my home to Mt Selinda hospital. In less than an hour I will be here… Chipinge district hospital is very far away from my area. I can only go there if nurses at Mt Selinda cannot help me then refer me there*
>
> *(*Oppah, Mt Selinda hospital, 26 November 2018)

Oppah`s sentiments relate well with the availability component of the access to health care framework (Thiede et al 2007) in which availability implies the location of health services in the right place and to be found or reachable at the right time, when needed (Thiede et al., 2007). Access to health care therefore relates to one`s physical and financial feasibility to get health care services at a health facility (IOM, 2013; Makandwa, 2014). The distance to be travelled by a pregnant mother to a hospital facility is vital as it also influences her decision choice on whether to make use of the hospital facility services. Zakeyo (2016) cites distance to a hospital facility, the cost of transport as well as the cost of getting a service as very critical in women's preferences to attend and access maternal services. This was reflective in not only Oppah`s but also in other migrants responses on why they chose to seek maternal health care services at Mt Selinda and not at Chipinge hospital despite the fact that both facilities are in the same borderland community

The research found out that in terms of transport, Mt Selinda hospital had only one ambulance to service a greater patient constituency, a finding that is consistent with Zakie's argument that, "distances to health centres in developing countries are very long and there rarely is an ambulance available to transport the women, although geographical access to delivery care and level of care offered at a health facility are determinants of facility delivery" (Zakeyo, 2016; 16). Accessibility in this case is determined by the cost associated with getting the much-needed services and the transport fees involved in getting o the facility.

Participants indicated they preferred Mt Selinda to Chipinge hospital due to its proximity to their area of residence and this was vital in minimising transport costs as they could easily walk to the health care facility. The same also applies to other participants who decides to go to Chipinge District hospital directly due to its proximity to the places of residence.

Some respondents also mentioned that they were ferried from the surrounding satellite clinics to Chipinge hospital since it's the referral hospital or the secondary level health care provider. However, it was also noted that the whole district had 3 functional ambulances, a number that is not adequate to cater for all the emergency needs of the population. Lack of an efficient ambulance transport service impedes access to maternal health care services since there will be delays in the referral chain between smaller clinics and bigger public hospitals (Mutseyekwa, 2010). However, the ambulance crisis was navigated by many through using the public taxis which they do hire in their personal capacities to get to the hospital facility in the best time. One woman indicated that she always prefers going to Mt Selinda even

though she is close to Chipinge District hospital because of the service rendered to her at the very first time she visited the facility. The challenge only arises when one does not have the money to board taxis from one`s place to the facility.

4.4.2: Quality of services provided

Research participants also indicated their satisfaction with the quality of services they receive at both Mt Selinda and Chipinge district hospital during the ante-natal, delivery and post-natal periods. Both local and migrant women except for a few could not hide their joy over the good services they were receiving at both Mt Selinda and Chipinge district hospital. Upon being asked on what they perceive as good service, various responses were given of which most were related to safe delivery, good interpersonal relations between patients and providers among many others as depicted in the below excerpts;

> *"When I come for ANC services, I feel so happy and impressed by the nurses. Their conduct upon receiving us is very good. They also provide us with training sessions on important topics of reproductive health such as birth preparedness, importance of HIV test during pregnancy, breast feeding and how to make self-assessment and identify any pregnancy related complications and seek health care interventions immediately in a very social and interactive manner"*
>
> (Rudo, Mt Selinda hospital, 24 November 2018)

> *"I am very impressed by the ANC education that we receive here. As you see what is happening around here. The nurses are very happy people with us…they do their job very carefully. They make us laugh while they are doing their job like checking BP, recording temperatures, measuring height and weight as well as making malaria diagnosis*"
>
> (Spiwe, Mt Selinda hospital, 24 November 2018)

The above relates well with the researcher`s observations during the research period. The researcher sat in and attentively took note of the proceedings during morning ANC education sessions provided at the facility. The researcher was so much impressed by the manner in which such lessons were given in an interactive way that included role plays- the sessions

were mesmeric and conducted in a way that provided a classic 'edutainment' i.e. it provided both entertainment and useful knowledge to both the health care providers and all maternal patients. Singing and dancing was also part of the program and it provided a very good form of exercise for the pregnant mothers. Such activities attributed to the aspect of quality of care provision as the migrant women never felt excluded and left out.

The availability of such of such maternal care services to all mothers also attributes to the quality of care at these facilities. Service availability as a component of the access to health care framework entails a lot of issues. According to Zakeyo (2016), availability means the accessibility of prenatal services such as health promotion, education, "screening and interventions, detection of complications and, in the post-natal period, nutrition, family planning, and counselling. Lack of service availability on the other hand would imply a shortage of midwives, obstetricians, anaesthetists and absence of support and management staff" (Zakeyo, 2016). The existence and continual effective provision of such services thus attracts more migrant women to access services at the Mt Selinda hospital and Chipinge hospital. This was further supported by the claims of Theresa, a maternal health care provider at Mt Selinda hospital as shown in the below interview excerpt;

BV: *[…] what can you say regarding the size of your catchment area?*

Theresa: *we do service a huge catchment area, it covers the whole of Chipinge south wards 13, 16, 17 18 and 19 and a greater part of Mozambique. We also service a sizable number of Mozambican pregnant mothers of who some come on referrals and some coming on their own.*

BV*: how would you define migration in your opinion?*

Theresa: *In generic sense it means the movement of people from one place to another even across borders for different reasons like seeking for better employment opportunities, better education, better health services or even food supplies*

BV: *if I get you well earlier on, you mentioned that Mozambican pregnant mothers do come here to seek maternal healthcare service, what do you think are their motivations to cross the border to access services at this facility?*

> ***Theresa:*** *Well from my experience at this institution and interaction with them, they do mention distance as one of the motivating factors as they live in the nearby communities among the border, it's even cheaper for them to commute this side than going to their nearest health facility. Some of them are referred to us from our satellite clinics. They also mention the quality better standards of care we provide as best in comparison to what is offered on the other side of the border. One thing I also noted on my own is that the ration of a resident doctor per patient at the Espungabera district hospital is too high that it may take long for pregnant mothers to be assisted in time, as a result they prefer coming to Zimbabwe and stay in the accommodation shelters we have for pregnant mothers here.*

Theresa's sentiments on shortage of health care professionals on the Mozambican side is in congruence with literature that recognizes lack of skilled and quality service providers as one of the major causes of maternal mortality in Mozambique with statistics showing a low ratio of a doctor/patient ratio of 0, 03/ 1000 and a nurse-patient ratio of 0, 21/1000(WHO 2004, 11; WHO 2009, 4; Dengo 2012; 33; Dgedge et al., 2014; Firoz et al., 2016). Such shortages of health care providers have an impact on the quality and accessibility of maternal care provided to the population. Such challenges do put the life of pregnant mothers and new borns in jeopardy and results in high rates of maternal mortality and infant mortality rates. Improving the quality of access to maternal health care will thus work towards the realization of the WHO Sustainable Development Goal 3 which calls for the reduction neonatal mortality rate to as low as 12 per 1000 live births. Due to the lack of adequate professional medical personnel as evidenced by the doctor/ patient and nurse patient ratios above, Mozambican pregnant mothers continuously seek maternal health care services on the Zimbabwean side where they perceive there are adequate services they need and quality medical personnel to attend to them.

However, it is important to note that quality goes beyond the availability of qualified medical professionals. It also considers the interpersonal aspect of care. Turnçalp et al., (2012), mentions that interpersonal care aspects of care affect the effectiveness, equitability and the quality component of services provided by health care facilities. Zakeyo in her comparative work on the quality of health care provision in state and mission hospital identified and acknowledged interpersonal aspect of "care as the way people are treated when they reach the maternal facility as one of the factors affecting access to maternal health care"(Zakeyo,2016;19).

Similarly, this research has also found out the importance of this aspect as participants aired their views relating to the way they interacted with the health care providers during the times they are seeking care. Annezia, a migrant pregnant mother who was transferred to from Mt Selinda hospital to Chipinge District Hospital had this to say in relation to her experience in accessing maternal health care at both facilities,

> **BV:** […] *you mentioned that you previously sought for maternal health care services at Mt Selinda hospital, what then motivated you to come to Chipinge District hospital?*
>
> **Annezia***: I came here last week after I was transferred from Mt Selinda hospital. I was told by the nurses that we are transferring you to Chipinge because of your condition.*
>
> **BV***: "what can you say about the nature of care you got from nurses at Mt Selinda and the one you are getting here? Are there any differences?"*
>
> **Annezia***: "…yes, there is a difference. Nurses at Mt Selinda handle patients with care and dignity unlike here. Nurses here do their work slowly and take too much time to attend to pregnant mothers even when some are in pain. Sometimes they can just bypass you without even asking what assistance you need. There is nothing we can do about it because they are doing their work. At Mt Selinda, there is nothing like this! If I was not transferred, I would not have chosen to be here*."
>
> (Chipinge hospital, 6 December 2018)

Other participants lamented how the health care professionals at the public hospital gave them unwarranted attitudes in their times of need. It is thus evident from the above excerpt that the timeliness of care and the professionalism exhibited by health care givers at the mission hospital (Mt Selinda) attracts a huge contingent of migrant pregnant mothers to seek maternal health care services at this facility. Similar studies in West Africa also reveals the significance of prompt and timely provision of care in mission hospitals as well as the hospitality and attitudes of health care providers towards the patients in creating demand and improvement of maternal health outcomes (Onah et al., 2006). Contrary, health care providers in South east Nigeria in state run hospitals were cited as uncaring and lacking compassion towards ailing pregnant mothers and this resulted in delayed access to the much-needed maternal health care services such as ANC initiation and treatment of pregnancy

related ailments (ibid). This resulted in undesirable maternal health care outcomes i.e. high maternal mortality neo-natal deaths. Mission based hospitals were thus regarded and recognised as better service providers and attracting many pregnant mothers to seek services in these premises. Zakeyo (2016) also cited another anomaly in Bolivia in which migrant women seeking maternal health care services in public hospitals were discriminated by nurses who scorned and mocked them of their dressing and cries on labour pains. Such kind of treatment they were exposed to have a dreadful impact on their future decisions in seeking care at such facilities as such experiences would always haunt them. The way care is administered on migrant and other marginalised populations should always be inclusive and equitable since the right to life and dignity are universal rights of every individual.

There are a lot of perceived expectations that considerably varies from individual to individual as well as the context on how maternal care services are provided in hospitals. Evidence from a research on clients perceptions on the nature of maternal service provision in mission and state-run hospitals in Uganda revealed that clients regarded mission hospitals as the best providers citing the promptness of service delivery, the friendliness and responsiveness of the care givers to the maternal needs of the clients and availability of vast technical capacity to address maternal related problems (Parkhurst et al, 2012). The conduct of the health care professionals in mission hospitals was thus applauded and recommended by many maternal service users unlike their sentiments on the conduct of their counterparts in the state-run hospitals whom they described as lacking compassion, negligent and offensive in some instances (ibid). This relates well with some migrant pregnant mothers who described their interactions with some of maternal health care providers at the government hospital as unwelcoming and hostile to them. The clients` or the user perspective on the quality of maternal health care provision thus provide a favourable base upon which remedial strategies to improve access to maternal health care can be formulated.

A research by Turnçalp et al.,(2012) revealed women`s views on what they perceive as quality maternal health care provision at a health care facility as entailing the availability adequate doctors and nurses to attend to the needs of the clients, positive interaction between the provider and the client base in terms of communication, positive attitudes upon rendering a service as well as availability of good infrastructure to ensure that the lives of mothers and the new born babies are not endangered. Zakeyo (2016) also emphasised the significance of health care providers not only to embrace what is perceived as quality care by the clients but to go beyond that as that will assist in creating more demand for the utilisation of the bio-

medical maternal services in the future. This will immensely contribute towards the reduction of maternal and neo-natal mortalities as set in the sustainable development goals

The admission by migrant pregnant mothers that Mt Selinda hospital had a competitive urge over Chipinge district hospital in terms of maternal health care service provision dwells well with Zakeyo (2016) who views mission-run hospitals as the best maternal health care service provision in the country and in the region due to their social inclusiveness which is the core of their missionary work. She gives a typical example of Kenya where,

> *"90% of clients at private not-for-profit and mission hospitals in Kenya purported that the health services providers asked about client concerns, compared to 65% of public health care service providers who did this"* (Zakeyo,2016;21).

Furthermore, evidence from study done in West Africa and East Africa shows that maternal health service provision in mission hospitals is superior to that provided in most state-run public hospitals (Hutchinson et al., 2011). The superiority of mission hospitals according to the study is heavily associated with a greater confidentiality assurance and the urgency exhibited in addressing all maternal related issues in comparison to state-run health facilities (ibid). Mt Selinda hospital and other mission hospitals in Zimbabwe and elsewhere in Africa thus have desirable features that create more demand in the utilisation of their facility services by women compared to the utilisation of maternal health services in state-run hospital facilities. The flexibility of their institutional regulatory guidelines in terms of care provision as guided by humanitarian and non-discriminatory Christian principles-where documentation and nationality is not important as opposed to state-run health facilities where nationality and documentation is seen as essential before care is provided.

4.4.3 COST OF SERVICE

The costs associated with accessing maternal health care is another factor that normally impacts on refugee and migrants' utilisation of care. It is important to note that during the period in which this research was conducted, all maternal related costs and user fees were taken care of by the state. The government took responsibility for all maternal and infant health in a drive to reduce maternal and neo-natal mortalities in with the MDGs and the 2030 SDGs (Zakeyo, 2016). Currently all maternal costs are taken charge of by the government with the support of the Norwegian aid called the Result Based Fund which is a performance-

based funding to all hospitals in Zimbabwe. Below is an interview excerpt of the interview I had with the sister in charge of Mt Selinda hospital showing how the cost of service impacts on access to maternal health care services at Mission hospital;

BV: […] *what do you require from them before you render them a service?*

SC: *"well depending on the condition, for example if a patient is in critical condition on arrival, we assist with the much-needed service and then take all the biographical information later. If the situation is normal, we begin by taking all the biographical information that is the patient`s details from age, village of origin, spouse name etc. if the patient doesn't have I.D. card, we only take note of village of origin. Documentation is not much crucial in this border area, most pregnant mothers both Zimbabweans and Mozambicans do not have ID cards and that does not matter most when we provide services."*

BV: "*do you require any fee of payment from them before you render then a service?*

SC: *Prior to the year 2009, they used to pay fee but with the injection of the Health Transition Fund from the UN which made maternal healthcare free to all, maternal health services are free to all irrespective of nationality, race or origin."*

BV: *"how much was the fee for one to deliver here"*

SC: *"charges kept on fluctuating especially during the hyper inflationary period and I can't remember the exact amounts we were charging. Roughly I can say it was between US$10 and $15"*

BV: *"were the fees charged on migrant's uniform with those charged on Zimbabwean mothers?"*

SC: *"no they were not the same; we charged an extra US$5 fee to Mozambican mothers to supplement our supplies since we had limited resources."*

BV: *"if I may ask, were the fees charged here the same with charges at Chipinge District hospital?"*

SC: *"…well all I know is we (Mt Selinda) our charges were relatively lower than Chipinge District Hospital. As a mission hospital, we had the privilege of having*

funds and donations from our mother body other well-wishers from abroad. That enabled us to subsidize our fees to ensure health services are accessible by all. Saving humanity and lives is our number one priority as a mission hospital and many migrants prefer coming here because of this..."

(Sister in charge, Mt Selinda hospital, November 28, 2018)

It is quite clear form the above excerpt that user fees do have a huge impact on access to maternal health care by both local and migrant pregnant mothers. This finding is consistent with what was observed in in Ghana and Malawi where mission hospital was providing similar maternal health care services with the state-run facilities at a relatively lower cost (Widmer et al, 2011). However, on the contrary, the cost of accessing maternal health care services in Uganda was relatively higher compared to the government run ones due to their vast technical capacity to provide best services (Zakeyo, 2016).

One of the major cited reason why the cost of services in most church-run hospitals are low especially in Africa is their ability to retain the best of their health care personnel and the general work force through provision of lucrative remunerations and in some cases services are provided on a humanitarian and voluntary basis(Gill & Carlough, 2008). This is further confirmed by Zakeyo (2016) who mentions that some medical professional working in mission hospitals in Uganda were earning less wages compared to their counterparts in regional public health care facilities run by governments. This had much to do with the voluntarism and humanitarianism associated with the founding principles of their missionary work. The provision of health care at almost free of charge therefore attracts many women to find mission run hospitals more favourable since there is free access to the services, they need most.

Maternal service charges have been found to be one of the most constraining factors for most women in the access of maternal health services especially in most resource poor countries. Many women in Africa and in Zimbabwe, Malawi and Mozambique end up opting for home deliveries that are in most cases not safe because on high cost of accessing maternal health services. A study done in Ghana identified the expenses in getting a much-needed maternal service as a determinant factor in the accessibility of maternal health care services (Turnçalp, 2012). It is further noted that all maternal related services were not all covered by the

National Health Insurance, for instance additional payments were required for drugs since the insurance would only cover for delivery costs only(ibid).

In Zimbabwe, it was established that the cost of accessing maternal health care was relatively cheaper at mission hospitals. It is mentioned that, " the hospital per inpatient admission were 40%-50% lower at the church mission hospital than at government hospitals and the outpatient costs to the hospital per visit were up to four times more at the government hospital than at the mission hospitals" (Zakeyo, 2016;18). However on the contrary, the cost of accessing maternal health care in mission run hospitals in Ghana were found to be more compared to state run institutions due to the availability of high expertise and technical capacity that plays a key role in raising demand for such particular services(Levin et al, 2003).The service fees associated with obtaining a maternal health care thus is a key determinant factor in the women's` choices on the facility to seek care from between mission run and state run hospitals.

Findings of this research revealed that Mt Selinda church mission hospital was highly favoured by migrant pregnant women ahead of Chipinge District Hospital. This was attributed most to its reputation in providing health care services in an inclusive and much affordable way. It was also established in this research that there was almost uniformity in the cost of accessing maternal health care services among all who sought care at the facility whether the patient is a citizen or non-citizen. This was different to how services were provided at the Chipinge District Hospital, where there was non-uniformity in terms of cost of accessing a service between citizens and non-citizen. Lower costs of accessing maternal health care services at the mission hospital thus attracted a huge contingent of Mozambican migrant women to seek care at this facility. This also relates well to ma study done in the Tudor District of Tanzania where it was revealed that the higher costs of accessing maternal health services in state-run hospitals resulted in much lower statistics of women utilising services provided in those facilities irrespective of the fact that the nature and quality of service provision there was at par with the mission hospitals (Tabatabai, et al, 2014.)

Lower user and maternal fees thus attract many pregnant mothers to Church mission. The is exemplified by the findings of this research in which it was found out that prior to 2011, when the Health Transition Fund came in to finance all maternal related services in order to reduce maternal mortality rates in the country, user fees and maternal services fees at Mt Selinda was relatively lower than that at Chipinge district hospital. This was also confirmed

by the findings of Zakeyo (2016) in which maternal related fees at Karanda mission hospital were lower than those charged at Harare provincial hospital. The cost of accessing maternal health services in mission run facilities was reportedly quoted as much cheaper too compared to the government run ones in South-East Nigeria (Onah, Ikeako & Iloabachie, 2006). Resultantly, there was there was a higher rate of maternal health service utilisation in mission hospitals in this region. Such is the case with Mt Selinda mission hospital that draws not only many migrant maternal patients but also many local citizens who are in need of specialised medical services.

Commenting on why there is much demand for maternal health services and general health care in mission –run hospitals, it was mentioned that, "government hospitals suffer from scarce resources, limited government budgets, mal distribution of health centres, inadequate technical capacity and lack of transport (Zakeyo, 2016;19). This is far way in contrast to mission run hospitals that are in most cases characterised by good governance and efficient budget systems that are boosted by external capital injection from their international partner bodies. This is greatly part of the explanation on why the cost of accessing health services in mission hospitals are relatively cheaper compared to state-run health care provision systems.

4.4.4: QUALITY OF INFRASTRUCTURE

The research also identified the quality of infrastructure as one of the major factors attracting migrants to seek care in the hospitals in the Zimbabwean borderland. Participants mentioned how they were satisfied with the quality of infrastructure at both Mt Selinda mission hospital and Chipinge District hospital with an admission that Mt Selinda was a bit ahead in terms of infrastructure. This admission that Mt Selinda mission hospital was ahead of the state-run hospital in terms of infrastructure resonates well with literature that has shown that mission hospitals possess and run better infrastructure in comparison to their counterparts and this enables them to provide services in an effective and efficient manner. Widmer et al (2011) notes that hospitals run by faith-based organisations or missions provide state of the art infrastructure and they do provide efficient and equitable health services mostly in marginalised communities. Mt Selinda hospital, a mission run hospital is a typical example of a hospital facility situated a few kilometres away from the border that separates Zimbabwe and Mozambique to serve the marginalised border community residents.

Basic hospital infrastructure plays a significant role shaping and moulding the experiences of service users in these hospitals. Mt Selinda hospital in comparison to Chipinge district hospital was hugely applauded by migrants accessing maternal health care services there for its good and well-furnished maternity wards, maternity waiting homes as well as quality bedding materials among other things. Quality of maternal service provision at Mt Selinda hospital is boosted by the presence of the mid-wifery training school on its premises, a facility that is not available at Chipinge district hospital. This therefore means that the clinical instructors at the school, work hand in hand with junior staff in the maternal wards, supervising all procedures in both delivery and the immediate post –partum phase. The presence of such infrastructure breeds confidence in both local and migrant pregnant mothers fully utilise maternal services provided at the hospital facility.

The above is also in congruence with Widmer et al, (2011) who postulates that mission –run health facilities have better infrastructure in terms of buildings, equipment, drugs, ambulances and wards among many others compared to state run clinics and hospitals. It is noted that 40% of the health care infrastructure across the sub –Saharan Africa is run missions and faith-based organisations (Widmer, 2011; Wooden et al, 2015). It is thus beyond any reasonable doubt that these mission hospitals are better equipped with better and advanced infrastructure since they receive external donor aid and funds from their mother bodies. The general outlook of these hospital facilities on its own plays a significant role in attracting patients to access services there.

Availability of basic equipment in hospitals is also of great importance in as much as maternal health care access is concerned. Levin et al. (2003) is of the view that there are generally lesser disparities in terms of supply of equipment and medicines between mission and state-run institutions. This is contrary to the findings of this research where it was discovered that Mt Selinda hospital (a mission health facility) had better infrastructure in terms of equipment and the supply chain of drugs among, backup power supplies clean water supply than Chipinge hospital which is a state-run institution. In a similar research conducted in Zimbabwe by Zakeyo (2016), it was revealed that Karanda mission hospital had better medical equipment for medical procedures, better maternity and bedding facilities, better water and electricity supply compared to Parirenyatwa hospital which is the biggest hospital in the country. Another study done in Tanzania revealed that frequent power cuts and inadequate supply of electricity in state run public health care facilities in the rural areas incapacitated medical professionals to fully discharge their mandate in an effective and

efficient manner (Kahabuka et al., 2012). More so, it was revealed in a study conducted in Ghana that treatment and emergency surgeries for pregnant mothers at state-run public hospitals were delayed owing to high load of cases and inadequate equipment (Turnçalp et al., 2012). In Brazil as well, the rate of maternal and neo natal mortality at mission-run hospitals were much lower in comparison to state -run general hospitals, mainly due to the fact that mission-run hospitals had inadequate equipment for obstetric interventions (Simoes and Almeida, 2010). It is therefore clear that the shortage of basic infrastructure at hospital facilities has a deadly impact on maternal service delivery.

This was also well evidenced by a research by Otis & Brett, (2008) in Bolivia where shortage of infrastructure in terms medical equipment to do medical procedures, drugs, facilities to accommodate family members accompanying their loved ones and poor ambulance services in state run public health care institutions delayed and inconvenienced pregnant mothers in accessing maternal health care in time. In an extreme assessment of maternal health care service provision in Bolivia at that time, service provision was viewed as culturally inappropriate and not accommodating just because of resource inadequacy (ibid). Shortage of operational resources thus disempowers health care providers to efficiently and effectively discharge their mandate and endangers the lives of mothers and their newborn, resulting in increased maternal and neo-natal mortality rates.

The focal argument advanced here is that the availability of equipment and other basic infrastructure in maternal health care provision facilities is of great significance as it breeds the confidence in women to utilise the biomedical services provided in health care institutions especially in the era of medical pluralism. This is explicitly evidenced by a rapid increase in the number of women delivering in hospitals in rural Nigeria as a result of improved infrastructure in terms of availability of life saving and other medical equipment required to ensure safe deliveries compared to the past where hospitals had inadequate infrastructure and equipment required to guarantee safe deliveries (Onah et al., 2006). This paper therefore recommends and appeals to the government of Zimbabwe and regional governments as well to invest much in the health delivery system and to upgrade the state of infrastructure in public hospitals to meet the perceived expectations of maternity service users.

The inadequate supply of medical resources and infrastructure in most state –run public hospitals in Zimbabwe has a great impact on service provision and availability not only to the citizens but also the migrant communities that still retains high faith in the Zimbabwean

health delivery system. The poor state of health infrastructure has incapacitated the public health care work force to efficiently discharge their mandate. This further worsened by the government`s reluctance and failure to properly remunerate the doctors and nurses and this has forced many to quit the public sector, opting for greener pastures elsewhere around the globe (UNICEF, 2013; Zakeyo2016). Such massive brain in the medical profession further jeopardised accessibility of quality services in Zimbabwean hospitals (Gerein, Green & Pearson, 2006). As a result of these shortages, health workers could not cope with them and opted to go for greener pastures. This research also found out that some health care professionals as well had to quit in government to join non-governmental and church or mission based health care institutions not only for better remunerations but also because of the improved quality of infrastructure and equipment that would allow them to effectively and efficient discharge their mandate to the populations in need of service without endangering their lives. It is also mentioned that in 2008, health care providers resorted to an industrial action in a protest for improved working conditions and this resulted in a temporal closure of Harare provincial hospital and Parirenyatwa hospital as well of which these are the highest on the hospital referral chain in the country(Zakeyo 2016) the same situation repeatedly happen in the first quarter of the year (2018) with health care providers downing their tools because of poor working conditions and inadequate resources (Newsday, March 14, 2019). Such shortages of basic equipment have seen the head of the Paediatrics division at Parirenyatwa making an emotional plea that went viral on social media to the government to act set its priorities right and improving the conditions of service by providing the necessary equipment and materials required for mothers too have safe delivery(ibid).

A similar case was recorded in the findings of research that was done in South- west Nigeria, in which inadequate supplies of materials required medical caesarean procedures care jeopardised the health of mothers as medical professionals and mid wives were incapacitated to efficiently carry out basic and emergency procedures (Ijadunova et al., 2007).

Research participants also mentioned how their family members were asked to bring or buy materials such as cotton wool, methylated spirit among other things at Chipinge district hospital and other surrounding satellite state-run clinics to ensure safe delivery, something that is not requested at Mt Selinda hospital. The same is also recorded in Uganda, where due to limited resources in public hospitals, relatives of the pregnant mothers who would have to undergo caesarean procedure were tasked to buy some of the materials required for such operations to be carried out (Zakeyo, 2016). Such requests by public hospitals for clients to

bring own materials had a greater influence on the migrants` choice of maternity facility to attend and access services from. Thus, Mozambican migrant pregnant mothers find Mt Selinda most preferable to Chipinge district hospital mainly because there is better service provision since it's supported by external donors and its mother body in the United States.

In a nutshell, infrastructure plays an important role in in ensuring accessibility of maternal health services by both local and the migrant population in the Chipinge borderland of Zimbabwe. Of equal importance as well are distance to the health care facility, availability of transport, affordability of and availability of services as well as the inter-personal aspect of care in the provider-client interactions as they all contribute and influence maternal outcomes. The motivations and migrants' interface with a state and a mission hospital on maternal health access in this Chipinge borderland are thus framed along the above-mentioned attributes. Long distance to maternity facilities, shortage of transport, overcrowded maternity wards, high cost of service, shortage of drugs and equipment as well as negative provider –client interactions thus are constraints to the accessibility of maternal health care services by the marginalised and migrant population. There must be thus a strong strategic bilateral agreement and commitment from both the Zimbabwean and Mozambican government to ensure equitable, efficient and effective health care provision to the residents of this borderland constituency. Governments must therefore recapitalise and empower and improve service accessibility by upgrading roads infrastructure, provide all the basic equipment required to ensure that the life of precious pregnant mothers and their new-born are not endangered. Service provision should also be culturally appropriate and accommodating to ensure maximum utilisation of maternal health care services by the diverse migrant and local population.

4.5 EXPERIENCES OF MOZAMBICAN AND OTHER MIGRANT WOMEN IN ACCESSING MATERNAL HEALTH CARE

Migrants are confronted by different situations when they access maternal health care services in hospitals in the Chipinge borderland of Zimbabwe. Their experiences significantly vary from one individual to another depending on their interactions with the service providers. Communication barriers and discrimination in various forms emerged to be the dominant barriers to effective access to maternal health care services. All their experiences, good or bad when summed up depicts a clear reflection of their interface with a mission and state –run public hospital in terms of maternal health care provision within the Zimbabwean borderland. The following sub sections are committed to express and reflect the migrants` experiences, views and opinions over the general maternal health care provision in the facilities understudy quality of maternal health care provision as well as the constraints they do face when accessing health care in a mission hospital and a state-run or government hospital.

4.5.1 LANGUAGE/ COMMUNICATION BARRIERS

Data collected from the sample revealed that communication was a major barrier for migrant patients to access maternal health care services within the Zimbabwean borderland. There were several occasions where migrant maternal patients indicated that they would spend more hours at Chipinge hospital because their mother tongue or native language was not being understood by those who are supposed to help them in the medical fraternity. Some Mozambican pregnant mothers and others from DRC (residing in Tongogara refugee camp) who were seeking maternal care services at Chipinge District hospital during the period of research thus cited language as one of the barriers to access to maternal health care. The following direct quotations give a glimpse in to the issue under discussion;

> *"… The major problem we have is talking to the nurses. I come from Maridheya in Mozambique; I know Shona a bit but if it is deep, I don't understand it. Here at the hospital Shona is the language they use and sometimes I have to ask other colleagues what the nurse was saying so that I can follow the things and instructions the nurses are giving us…."*
>
> *(*Francesco, Mozambican, November 26; 2018*)*

Another participant had this to say,

> *"…for me, I come from Congo DRC and I am staying in Tongogara refugee camp since 2011. Tongogara refugee clinic is small and the services given there are not big as here at Chipinge district hospital…I was referred here so that I may have a safe delivery. The problem I have here and some other pregnant mothers in the maternity home shelters is that we speak Swahili, French and a bit of English…. getting instructions in Shona, the local language is difficult, so we try to speak in English. Sometimes we get jumped in the queue because we did not understand what the nurse is saying…. sometimes we are served late because they will be waiting for an interpreter to come and translate English to French and then to Swahili."*
>
> *(Myambi*; DRC, November 28; 2018)

It is evident from the above quotations that communication is one of the greatest barriers to effective and efficient health care access my marginalised populations – migrants in this case. Even though most of the migrants could speak Shona, giving instructions in the local Ndau/Shona language was much beneficial to the local citizens who would seize the opportunity to jump queues at the expense of migrants who would have come earlier than them. Because Ndau/Shona language is not their mother and language, migrant pregnant mothers from deeper parts of Mozambique and those coming from the Tongogara refugee camp struggled to explain and express their inner most feelings pertaining their medical conditions very well. The language barrier also meant that they won't be able to ask questions to the medical and nursing practitioners.

This scenario is not only unique to Zimbabwe but also prevalent all around the globe. A typical example is that of Zimbabwean migrants seeking health care services in the neighbouring South Africa. Similar studies contacted in South Africa on the experiences of Zimbabwean migrants in accessing health care in South Africa found out that language is the greatest barrier to effective and efficient access to health care (Davies, 2010; Crush and Tawodzera 2011; Makandwa, 2014, Mafuwa, 2016; Vanyoro, 2017 and Saburi, 2017). In a research by Crush and Tawodzera (2011), it was noted that the Zimbabwean migrants` most common problem with the South African health delivery system is language related except for Ndebele and Venda which are also spoken in other parts of Zimbabwe. In public health care facilities where language of instruction is purely Zulu or isiXhosa, migrants found it difficult to fully express their feelings to the nurses and an attempt by other health care

providers to mix local language with English further confusing the immigrant patients more. The various communication barriers faced by migrants when seeking maternal health care has a greater bearing on the cultural and linguistical dissimilarities which makes it impossible for the migrants to comprehend the operations of the health care systems of the hosting country (Davies et al, 2010; Makandwa, 2014).

Communication is thus an important aspect that influences access to health services in the globe over. For health services to be rendered equitably, effectively and efficiently, health care professionals (the provider) and client (patients) need to understand each other. It is mentioned that in situations where such communication does not exist or is poor, there is danger that at the very least patients may be given inadequate attention or prescribed wrong treatment (Davies et al, 2010; Mafuwa 2016). In extreme cases, migrants end up defaulting on treatment and miss out on medical check-up dates owing to language barriers. Makandwa (2014) mentions that misunderstandings between the provider and the client may result in incorrect translations and this leads to delayed care, clinical errors and even death. Since not all Mozambicans and other migrant population groups from around the region residing at the Tongogara refugee camp did not understand Shona language just as other migrants in other countries do not understand the native languages of those particular countries, communication was a barrier that affected how they accessed health care. Makandwa (2014) and Mafuwa (2016) mention in their works how Zimbabwean migrants were ridiculed by local patients and health care providers for their terrible attempts to speak local South African languages. The same was reported at Chipinge district hospital where some health care providers and local pregnant mothers would laugh at the accent and tone of the Mozambican and Congolese pregnant mothers seeking care at the facility whenever they try to speak in in the native language.

It was also noted during the phase of research that communication wasn't only a barrier on the client`s side but also on the providers` side. The sister in charge at Chipinge has this to say on how language was a barrier to the effective and efficient discharge of their duties;

> *"…we do face a communication barrier when it comes to providing not only maternal services to Mozambican, Congolese and other migrants coming from the Tongogara camp….we even have nurses that are coming from other provinces and they have a challenge in understanding our local Ndau language for example, we have a nurse from Mt Darwin, deep Ndau language is problematic for her to understand ,it thus*

makes it difficult for her to discharge her duties without the assistance of other nurses to interpret for her..”

(Chihwa; Nurse, Chipinge, 2 December 2018).

“…our work is complicated especially when we are dealing with patients who neither speak Shona nor English…it is really hard to help because there is a communication breakdown. Some don’t even know the basics of English and that makes our work difficult. We are lucky that we now have French and Portuguese interpreters at our facilities that are doing their best to assist those who struggle with the common languages...”

(Susan; Nursing aid, Chipinge hospital, November 26, 2018)

“…I remember putting one pregnant mother on hold and allowed others to bypass her into the consultation room just because she didn’t want to talk to me… I told her to come back in the room when she will be ready to talk … little did I know that she was couldn’t speak Shona or English. I felt so bad when she came back with a Congolese colleague who spoke on her behalf….”

(Tafadzwa, Nurse, Chipinge hospital, November 28, 2018)

It is evident from the above excerpts that communication barriers between service providers and the clients have deadly impact on migrant and refugee access to healthcare. Crush and Tawodzera (2011), affirms that in cases where language becomes a barrier between the service provider and the cliental, the solution is to have an interpreter or the use of a common language, well understood by both parties. Lamb & Smith (2007) argue that it is not only the absence of interpreter services that creates a barrier to the provision of public health care service to immigrant populations but the effective use of it as well. A typical example given was that of the Dinka people from South Sudan who are a minority in Australia who have been victims of non-use of interpreter services. It was noted that, while a free telephone interpreter service exists for medical practitioners many doctors are reluctant to use it (ibid). This non-use of interpreter service created barriers of access to public health care to immigrant patients who needed it as a last resort so that they could be afforded effective public health care services.

The reluctance by the health care providers to immediately engage the services of an interpreter compromises the immigrant`s right to health (Lamb and Smith 2007; Mafuwa 2016). Basing on the provider`s discretion, she or he might delay serving the migrant thereby giving preference to those well versed with her or his language. The reluctance by health care providers to speak in a language that the migrant patient is well versed with results in immigrants experiencing challenges in accessing the much need services. This also shows how power dynamics between the provider and the client would work at the detriment of the client. Foucault (1998) in his theory of knowledge and power talked about knowledge being inextricably entwined with relations of power and advances in knowledge being associated with advances and developments in the exercising of power. Medical personnel employed the power that they had in addressing and talking to the immigrant patients in the languages of their choice, but the knowledge that immigrants have in terms of their access to public health care also produced power as indicated by most migrants who are aware of their right to basic health.

4.5.2 PREFERENTIAL TREATMENT OF LOCALS OVER IMMIGRANTS

Another interesting theme that emerged during data collection was preferential treatment of locals over immigrants. Respondents expressed varying feelings and emotions towards the manner in which maternal health services were provided to them. Some participants interviewed indicated and displayed their discontent with some medical personnel whom they allege were offering preferential treatment to citizens over non-citizens.

> *"…. the way services are given here at Chipinge hospital is not good. I came here in the morning before 7:00 am and I was number six on the queue but when the nurses started to serve us, they started serving according to villages of origin… some people who came later than us got served before us and its painful to see them being attended first when I arrived first. Us and Congolese are always served last because we do not belong to the villages mentioned…it's not fair* ***mukwasha…ndirwo rusaruraganda chairwo urwu*** *(in English translation it means this is pure discrimination) …"*
>
> (Gracia, Chipinge hospital, December 4, 2018).

Another participant emotionally explained how she lost her place in the queue;

> *"I came here very early and I was on a very good position… when the clinic opened, I did not hear what the nurse said, and I just saw people by passing me going into one room after the other… One fellow pregnant woman approached me after some time and asked me if I was served…she later explained to me what the nurse had said…. I wasted many hours sited on the outside bench because the announcement was made in local language which I did not understand. The language that was used to make the announcement only benefited the local women who came later than me…*"
>
> (Epiphania, Mt Selinda hospital, November 27, 2018)

The above sentiments in the participants` view shows some degree of unfairness in the provision of health care services at the two facilities understudy. This kind of discrimination is in contravention of the dictates of UN Committee on Economic, Social and Cultural Rights (CESCR) protocol emphasizes the need for states to recognize the right of migrants, asylum seekers and undocumented migrants clearly states that asylum seekers and undocumented migrants to equal treatment and dignity(HRW 2011). It also emphasizes the need to ensure availability and accessibility (affordability) of adequate health care services in an ethical and culturally appropriate manner (WHO, 2007; IOM, 2013; 18).

A similar case was also recorded by Mafuwa (2016) in which he mentions how South Africans in Cape Town benefited on preferential treatment over the non-nationals when those with South African identity cards were served first as well as instructions to go into certain rooms and to follow certain queues were given in Xhosa language which immigrants were not able to grasp. However, in this research, all the key informants interviewed indicated that they do not offer preferential treatment to locals over non-citizens and one had this to say;

> *"It is worth noting that as health care providers, we do have certain ways of conducting business in an orderly manner and in a manner that allows us to effectively and efficiently discharge their duties. We put procedures and systems in place, and they are supposed to be followed and everyone who wants to be served must follow our directives…"*
>
> *(*Rosey, Nurse Aid, Chipinge hospital, 4 December 2018)

Health care providers also retain the power to efficiently organise the way they want the business of the day to be conducted. All the health care providers interviewed refuted the claims by migrants that they do offer preferential treatment to, local over non- citizens. The matron at Mt Selinda hospital was quick to refer me to the mission statement of the maternity ward mission statement which read;

> *"…to provide quality care to all pregnant mothers during antenatal period, labour, delivery and post-natal periods in a non-discriminatory manner thereby reducing maternal and neonatal morbidity and mortality rate throughout 24 hours"*
>
> (Mission statement, MT Selinda maternity ward, 2018)

To further elaborate on the matter, below is an excerpt of the interview I had sister Sigauke, a senior clinical instructor at Mt Selinda hospital;

> **BV:** "*…as we have discussed earlier on, Mozambican migrant pregnant mothers do come here seeking for health care services, what are your views, perceptions or feelings towards them?"*
>
> ***SS: "****with my vast experience working at this institution, I don't have any negative feelings towards them, we just treat them normally and equally with everyone. Our mission as a hospital compels us to provide for all without discrimination on the basis of nationality, race, gender and origins. We don't deny a person a service just because she or he is not Zimbabwean. This is a border area and people travel as far as the far part of Espungabera and we don't deny anyone service here. We live like one huge community. Our people also go there to Mozambique seeking different services and that's how I see it".*
>
> (Sister Sigauke, Mt Selinda, November 27, 2018*)*

A similar response was also given by the sister in charge at Chipinge district hospital dismissing claims that there is preferential treatment on local over the non – nationals. She had this to say;

> *"We do provide a range of maternal health care services to all, regardless of race, nationality, citizenship and colour in accordance with the provision of the provisions of the national constitution. We don't segregate or discriminate anyone, but we treat*

> *everyone equally in our institutions in the district. As health professionals, we are mandated to provide services to all in a non- discriminatory manner…it's so unfortunate if such things are coming up and if it's true, an immediate action will be taken to ensure all our clients attain the best of service".*
>
> (Sister in charge, Chipinge hospital, 6 December 2018)

All these mixed responses from both the migrant women and the maternal health care providers can well be explained by Foucault's theory of power (1998) in which he argues that power acts as source of social discipline and conformity which the institutions encourage and has become more of a norm in modern society. This means that medical institutions can enforce rules that in the end offer what seems to be preferential treatment to locals over non-locals as they start by assisting those patients coming from the villages they call first, this deprives anyone who does fall into that category to get attended to first. Immigrants according to this theory are still active participants of power relations as they conform to the requirements, they possess power to conform. Evidence gathered through direct observations indicated that this format was not a daily routine; everything was subject change in order to make sure there is fairness equity in the distribution in the provision of maternal care.

A point of interest also arose from sister Sigauke`s response where she mentions that,

> "…*We live like one huge community. Our people also go there to Mozambique seeking different services and that's how I see it"*
>
> (Sister Sigauke, 2018*).*

The acknowledgement relates well to the works of Pophiwa (2010) and Diamon (2012) where it is revealed that there are greater kinship ties between the Ndau speaking people of Chipinge and those in the Manica province of Mozambique and as commuter migration across the Mt Selinda border post is highly prevalent on daily basis, with residents from both sides seeking social and economic benefits such as health, education, employment and affordable goods and services on either side. Such interactions and close socio-economic ties between the two communities makes the border appear more like an artificial boundary as many even cross it through undesignated entry points as revealed by other participants who mentioned that they find their way to Mt Selinda and Chipinge hospital through short cuts to access maternal health services there. Zimbabweans also find their way to Mozambique by

either designated or undesignated entry points in pursuit of both economic livelihood and health related services as revealed in the above excerpt.

4.5.3 MIGRANTS BLAMED FOR DEPLETING LIMITED AVAILABLE RESOURCES

Participants also indicated that they were in most instances accused of putting too much pressure on the limited available resources at the disposal of the health care facilities understudy. The Zimbabwean ailing economy and the ongoing political crisis makes it difficult for the country`s health delivery system to deliver at optimal level. One participant had this to say relating to the accusations of draining resources;

> *"…one nurse asked me why I came all the way from Maridheya, she continued saying there are hospitals in Mozambique with better infrastructure and medicines there. She continued… We don't have medicines here, but you continue coming here…what do you want us to give to our people who have the basic right to enjoy the health benefits provided to them by the government? At one point I only got a prescription and was asked to go and buy or to visit a clinic in Mozambique to get it…"*
>
> (Oppah, Mt Selinda, 27 November 2018).

The researcher also inquired to know if migration was having an impact on the provision of health acre within Zimbabwean health care centres in the borderland. The administrator of Mt Selinda hospital had this to say;

> *"Well, the truth of the matter is migration does impact hugely on us. Given the fact that our economy is not doing well, the limited resources that the government is providing to us is meant for benefit of our population, but we can't turn away foreign nationals who need care. They do come here in large numbers because maternal services are given free of charge. As a result, there is pressure on infrastructure and the available resources depletes fast. We try to ration whatever resources available in order to make sure health services are available to all pregnant mothers. Sometimes we are forced to refer them further if we run out of required materials for certain procedures..."*

Similar sentiments were also shared by another nurse working in the maternity ward. When asked whether migrants were posing a threat on available resources, she had this to say;

> *"…one of the major challenges we face here in terms of maternal health care provision to these Mozambican pregnant mothers is around resources. The government is struggling to provide the necessary medical equipment, drugs and other maternal related resources required and the little we are allocated is not even enough to provide for our own patients. The situation is worsened by the fact that the government policy says all maternal related services are free of charge…and as a result we can't deny them the services they require. This has a serious impact on our resources".*
>
> (Hlatshayo, Chipinge district hospital, 5 December 2018)

Participants also indicated instances where they would hear fellow pregnant mothers (local) saying the same sentiments that migrants were putting too much pressure on the available resources at the healthcare facilities. Local mothers are cited as complaining that food rationing and space allocation in the hospital maternity home facilities is no longer favourable due to increase in population of pregnant mothers. One participant mentioned that she was at one point barred to charge her cell phone ahead of the locals,

> *"…they told me you can only charge your phone when we are all done…this is our electricity and you must know that you are not in your country. It is our government paying for this electricity. You must wait for our phones to be full then you will charge yours..."*
>
> (Philda, Chipinge hospital, 4 December 2018)

Such accusations on migrants as mounting intense pressure on resources are a sign of rising intolerance of the host population on the migrants who seeking and utilising maternal health care services provided at Mt Selinda hospital and Chipinge district hospital. Situations like these are not only limited to Zimbabwe. Intolerances on migrant populations has thus become too pervasive and heavily entrenched in societies everywhere around the globe. In both the global south and the global north, immigrants (both legal and illegal) are mostly viewed as causing extra burden to the already overburdened public health care sector (Evans, 2005). Examples include the stereotyping of immigrants coming to United States to use up social services at the expense of the taxpayers (Moss, 1996). In South Africa, immigrants in general

including Zimbabweans are blamed for draining local resources meant for the benefit of local citizens and shortages of these resources is believed to be attributed to intensive use by many marginalised citizens (Evans, 2005; Mafuwa, 2015; Makandwa, 2014 and Saburi, 2017). These conventional discourses are not only prevalent in the general public domain but are also sentiments shared and hyped by media, politicians and health care professionals who perceive migrants as negatively impacting on the health and welfare of the society (Evans, 2005 and Mafuwa, 2015). A typical case within the south African context is the recent sentiments by the Gauteng premier who threatened to force Southern African countries to pay for their citizens` access to health care services citing that the Gauteng government has been forced to increase its budget by billions of Rands due to millions of people flocking into the province, stretching the services and place enormous pressure on the local hospitals (Siziba, 2019). Such statements have been described by the Consortium for Refugees and Migrants in South Africa(CORMSA) director as purely discriminatory and xenophobic in nature as such utterances by public officials tantamount to the violation of the south African constitution`s provision that guarantees everyone the basic right to access basic health care (The Sunday Times, 2019).

The assumption that migrants overwhelm the local public health sector (Gushulak 2009) in its much-hyped fashion is associated with the popular yet untested narratives which negatively associate migrants with diseases. Participants mentioned that there are sometimes accused of bringing "chiabvu"- a deadly kind of cerebral malaria common in Mozambique and as a result statements like ***"munotitapurira matariya enyu muno"*** (you will pass on your malaria on us) becomes common in the maternity home shelters. In this way, cross border migrants not only in Zimbabwe the world around continue to be portrayed as 'disease carriers' and viewed as placing an unnecessary burden on all social services in general and public health care systems (Worth, 2006). This therefore leads to attachment of labels and marginalization of non-citizen groups. This has led to public health care becoming welded with 'politics of citizenship' in many cases, leading to the denial of health care to non-citizens (Grove &Zwi, 2006, Harper & Raman 2008). The use of this very language becomes the fuel that ignites anti-migrant sentiments within all levels of the society. For instance, in South Africa migrants are thus treated with contempt and become victims of xenophobia both in public health care institutions and society (Makandwa, 2014; Saburi, 2017 and Mafuwa 2016).

This very language used in assuming that migrants are many and overwhelm the local public health sector has so many implications (Gushulak 2009). How people respond to perceived threat or challenge is directly linked to how that 'challenge' is phrased linguistically. David Turton (Turton 2003) refers to '*Metaphors we Live By* ` by Lakoff and Johnson (1980). He draws on the linguist and philosopher respectively to explain how substance (liquid) metaphors used in conceptualising forced migration inform how host communities respond to the so called 'migrant threat". Metaphors such as 'waves' 'trickles' and 'flows' of migrants speculates migrants as a threat deserving to be 'dammed' and barred. Turton ultimately conclude that the use of these metaphors makes it easier to see the strangers as a threat for symbolic language that dehumanises and depersonalises the migrant.

This concurs with the 'othering' theory discussed by Grove and Zwi (2006) who argue that othering i.e. the process of marking and naming those perceived to be different from oneself (Weis, 1995) make the person being 'othered' experience marginalisation, disempowerment and social exclusion. This ultimately leads to hampered access to health care by migrants since a boundary would have been effectively created between 'us' the health care providers and 'them' the strangers. Furthermore, othering basing on citizenship, gender and ethnicity impedes migrants from fully accessing the much-needed health services (Groove and Zwi, 2006; Makandwa, 2015). Willen (2012) cited in (Makandwa, 2015) explored the concept of othering and observed it as a, "deadly impediment to the accessibility of health care services in South Africa, whose negative representations of undocumented migrants influence both the disposition of biomedical practitioners towards their undocumented migrant patients and the practitioner's clinical conduct, all exposing migrants to ill treatment and abuse" (Makandwa, 2014; 28). In such situations, migrant mothers also become victims since they are not immune to the predicaments faced by the larger part of the patient constituency seeking medical care in the public health care centres. Thus, the implication of the language used to phrase the assumptions is either denied or delayed health care access for the migrant who will have to navigate and negotiate the 'othering' frontier. This is true of some Mozambican migrants who then doesn't produce any form of identification and claim they are local citizens. They would claim that are coming from the nearby villages and as a result they get the services they want just like the local pregnant mothers.

It is also important to note that the denial or delayed health care seeking by migrants because of the exclusion through othering has a dreadful impact on the host community as it exposes the host community to ill-health. Landau and Wa Kabwe Segatti (2009) propounds that while

the health care system might be discriminatory, diseases are more generous to give both the migrant and the 'local' a fair share of ill-health. Migrants live in proximity with the local, hence the locals have no immunity to what the migrant suffers from. Many then expand on these observations and state that denied or delayed access to health care is more expensive than allowing ease of access (Grove & Zwi 2006; Amon & Todrys 2008; Vearey 2014). Delayed or denied access places a greater burden on the health system that such delaying and denying was attempting to avoid in the first place. The public health care system thus has to bear costs associated with delayed healthcare seeking (Grove & Zwi 2006; Amon & Todrys 2008; Vearey 2014). After all, the costs in providing services to migrants in the Zimbabwean borderland are statistically insignificant as the migrants themselves bring on their materials for usage during the waiting and delivery period. It is quite clear that migrants make little use of health care services in host community since in most cases, they only get prescriptions and they do buy the required medication on their own. Globally, cross border migrants constitute 3% and in South Africa, cross border migrants constitute 3.3 % (Vearey 2014). Cross border migrants therefore do not overwhelm health care systems of host communities since they make little use of it compared to the host populations.

In this regard, a multi-sectoral or multiple stake holder participation complemented by research informed health programmatic interventions should be adopted to ensure equitable health care access by all as advocated in national constitutions. Public officials and health care providers should thus desist from the above mentioned unfounded and untested conventional discourses. The human rights and social equity perspective clearly lay an explicit model of a good health delivery system that is aware and cognisant of migration as well as ensuring equitable distribution of healthcare services to all irrespective of immigration status. It is also in compliance with the World Health Assembly resolutions of 2008 which calls for universal access to healthcare by all.

4.6 INSTITUTIONAL CONSTRAINTS

Both Mt Selinda and Chipinge district hospital are facing numerous challenges that are hindering the two facilities to efficiently and effectively deliver the best services to their patient constituencies. However, it is worth noting that these constrain are not induced or precipitated by migration but have much to do with the economy of the country. The economic and political crisis that has rocked the country for over two decades now has

negatively impacted on the health delivery system of the country which was once celebrated as one of the best in the region. These constrains are as follows;

4.6.1 SHORTAGE OF HUMAN RESOURCES

The research has found out that inadequate human resources is one of the major constrains faced in both state-run and private health care centres country wide. When quizzed on the challenges the Chipinge district was facing in providing maternal health care services to both local and migrant women in this borderland, the Hospital administrator of Mt Selinda hospital had this to say;

> *"…the greatest challenge we have is shortage of human resources not only in the maternal health care service department but in all departments in general. We do have a limited number of midwives to attend to the patients considering the fact that our maternal patients also include some from Mozambique and those patients with maternal complications from the surrounding satellite clinics…as a result there will be too much work load on the limited available midwives, nurses and doctors we have as they are required to work for more hours. We are privileged a bit in that we have a mid-wifery school here, so the students also come in and help when the pressure is immense".*
>
> (Mr Madzaridzari, Administrator, Mt Selinda, 28 November 2018).

More so, the District Medical Officer for Chipinge district has this to say;

> *"…shortage of skilled manpower is the most challenge we have now not only in this district but across the whole country. This can be traced back to the 2008 hyper-inflationary era leading to the government`s failure to provide attractive remunerations to the qualified personnel and the working conditions were not conducive enough to retain these medical professionals. As a result, there was massive brain drain in the medical fraternity as many opted to leave the country for greener pastures. Some other professionals opt leaving the public sector for the private and non-governmental organisations that do give attractive remunerations and better working conditions. This had a huge impact on the country`s health*

> *deliverable outcomes. Currently the government is in an economic crisis and cannot hire more professionals. We have no other option except to work with the minimum workforce at our disposal".*
>
> (The DMO, Chipinge district, 6 December 2018)

From the above sentiments, it is clearly depicted that the shortage of qualified personnel in both the public and private health care institutions is a matter of concern that need an immediate intervention. Despite the Maternal and Neonatal Health roadmap (2015) whose primary goal was to safeguard and ensuring safe deliveries by making sure that all maternal related services such as ANC, delivery and post-partum care is administered by skilled provision of skilled professionals being in place, the government still failed to fulfil its commitment of providing adequate skilled medical practitioners to both state-run and church mission hospitals. This well confirms the deterioration of standards in terms of quality of maternal health care in most African countries due to the incapacitation of the governments to adequately deploy and retain a competent workforce in public health care institutions (Stekelenburg et al., 2004; Zakeyo, 2016). Gerein et al., (2006) echoed the same, advocating for the recruitment of over a million skilled maternal health care providers in Sothern Africa in order to improve maternal health outcomes as well as realising the 20130 Sustainable Development Goals. This therefore means that there is a greater need for governments in Africa and Zimbabwe to increase the number of skilled birth attendants in order to improve and achieve the most desired maternal health outcomes (Gill and Carlough, 2008). A good example is that of Srilanka and Malaysia which were able to reduce maternal deaths through the increased use of skilled midwives, and a series of awareness campaigns on female education as well as expanded treatment programs on all maternal related ailments in all health care facilities including those in the remote settings (Parkhurst et al., 2005).

One of the greatest implications of inadequate human resources is that it makes maternal health care services inaccessible and unavailable to those in need of them especially in marginalised communities. This is also evidenced by a study done in Madagascar in which it was found out that access to maternal health services was impeded by disparities in the distribution of human resources between urban and rural areas (Honda et al., 2011). This was further worsened by inadequate supply of essential equipment and materials to facilitate diagnosis and obstetric treatment (ibid). In a similar study conducted in Uganda, the shortage of skilled care givers resulted in other maternal patients on referral to other facilities go

unaccompanied (Kahabuka, 2012). The marginalised communities are the ones on the receiving end of these shortages and inequitable distribution of skilled health care professionals. That's the reason why maternal and neo-natal deaths are high in the rural areas and the most marginalised communities. It is therefore of great importance that Zimbabwe and Mozambique should engage in a bilateral agreement that would see both states contributing and playing a vital role in improving the availability and accessibility of maternal health care services in the Chipinge borderland as this will bring mutual benefits to all who resides in it.

Another notable issue of importance that emerged in relation to shortage of skilled personnel was absence of skilled interpreters to assist health care providers in navigating the communication barrier. Given the fact that the Tongogara Refugee Camp which hosts a huge number of refugees from DRC, Burundi and Somalia among many other African countries is situated in this Chipinge district, child birthing has no boundaries hence women from these nationalities do come and access maternal health care services in health care facilities in this borderland. Maternity health care providers mainly those at Chipinge district hospital and those migrant women seeking care their highlighted language as a barrier to effective maternal health care accessibility. When asked about how the Chipinge district hospital health care providers were dealing with the language barrier, sister Hlatshwayo, had this to say;

> *"…to overcome the communication barrier between us and the Congolese who are not able to speak in English, the hospital has engaged the services of an interpreter who is eloquent in both Swahili and French. She does have an office here but the challenge we face is that she is not always available on daily basis. We also have junior nurses that are taking French lessons and we are hoping this will go a long way in improving the quality of our services"*
>
> (Hlatshwayo, Assistant Sister in Charge, Chipinge hospital, 6 December 2018)

It is clear from the above sentiments that overcoming communication barrier is a matter of great concern. In as much as we may applaud the institution for taking such a great initiative of engaging the services of an interpreter as well as ensuring the enrolment of other maternal care providers in French lessons, more is still to be offered especially when one regards how important communication is when providing or receiving health care. Communication is thus an important aspect of access to health services in the globe over. For health services to be

rendered equitably, effectively and efficiently, health care professionals (the provider) and client (patients) need to understand each other. Where such communication does not exist or is poor, there is danger that at the very least patients may be given inadequate attention or prescribed wrong treatment, clinical errors as well as delayed care (Davies et al, 2010; Makandwa, 2014 and Mafuwa 2016). Studies done in south Africa revealed language as the greatest barrier to effective and efficient access to health care (Davies, 2010; Crush and Tawodzera 2011; Makandwa, 2014, Mafuwa, 2016; Vanyoro 2017 and Saburi, 2017). Shortage of interpreting services thus has a huge negative impact on accessibility of maternal care services. This goes well with Lamb & Smith (2007) who revealed that it is not only the absence of interpreter services that creates a barrier to the provision of public health care service to immigrant populations but the effective use of it as well as exemplified by the migrants of Sudanese origin leaving in Australia who became victims of the non - use of interpreting services in public hospitals. It is therefore recommended that the number of skilled interpreters in this borderland be expanded to make sure the communication barrier is well ameliorated. This will make maternal and other related services more accessible by all.

4.6.2 INADEQUATE INFRASTRUCTURE

The research found out that both Mt Selinda mission hospital and Chipinge district hospital are suffering from an immense shortage of infrastructure in terms of drugs, electricity power cuts, bedding materials among other necessary materials required to properly and efficiently deliver effective maternal healthcare services to both local and migrant women in this Chipinge borderland. The matron of Chipinge district hospital mentioned that, the hospital was in short supply of antibiotics, uterotonic drugs, anticonvulsants and oxytocin that would ensure comprehensive obstetric and new-born care. The shortage of drugs and other required materials thus makes it difficult for the health care practitioners to effectively and efficiently discharge their duties. However, with such limited resources, the matron mentioned that his team is capable to ensure safe deliveries even in emergency situations as well as administering safe blood transfusions and care to premature babies.

The sister in charge at Chipinge district hospital maternity ward had the following to say upon quizzed on the challenges relating to infrastructure the department and hospital was facing in providing maternal health care services to its constituency,

> *"…indeed, we are facing numerous infrastructural constraints and this complicates our work as maternal health care providers. The first one has to do with our housing facilities for the mothers in waiting, their state is not that much pleasing and there are also times when our maternity wards are full since we receive many patients on referals from the clinics as far as Tamandayi, Kopera, Paidamoyo, Hwakwata, Jersey, St Peters and Mutsvangwa in Chimanimani among many others. In some cases, we receive patients from Mozambican clinics in critical maternal conditions that require us to provide emergency services. As a result, there is overcrowding in the maternity homes and in maternity wards leading to shortage of even bedding materials. Furthermore, we have only two ambulances fully functional at the moment and this affects the transportation of our patients from different zones surrounding us here. This normally causes some delays in the provision of care to mothers who need emergency services".*
>
> (The matron, Chipinge District Hospital, 3 December 2018)

Similar sentiments were also echoed by the Sister in charge at Mt Selinda mission hospital who had this to say;

> *"…our infrastructure at the present time is not sustainable enough. Our maternity shelters for the pregnant mothers in waiting needs refurbishment, the bedding materials in our wards is old and needs to be replaced. We also have a problem of power cuts here and currently our generator which is our back up alternative source of power is not working, and this complicates the running of the whole hospital systems. This coupled with other constraints such as shortage of necessary materials required to ensure safe deliveries such as oxygen, intravenous fluids and lifesaving materials impacts hugely on our annual maternal health delivery outcomes"*.
>
> (Sigauke, Sister in charge, Mt Selinda, 24 November 2018)

It is quite clear from the above, that the shortage of infrastructure in both facilities has a huge impact maternal health care provision in this borderland zone. It also plays a significant role in in shaping and framing the migrants` interface with a state-run hospital and a mission hospital facility. Mt Selinda is though considered a better service provider not only by many migrant women but also locals who prefer getting services there as has been noted in this research. Despite enjoying the benefit of funding from funding from its mother body and

other donor aid organisations, it is not immune to these infrastructural constrains that any other hospital facility is succumbing to in the country.

The shortage of adequate infrastructure in both state-run and mission hospital facility has a detrimental effect of placing the lives of mothers and the new-born at risk of maternal death. Zakeyo, (2016) mentions that maternal mortalities were relatively high in Zimbabwe prior to 2012 owing to the shortage of essential obstetric drugs, shortage of blood and blood products to administer post-partum haemorrhage as well as patients` inability to purchase some units of blood required for transfusion. It is further noted that high maternal mortality rates are also attributed to the government`s inability to finance the health sector resulting in hospital operating below optimal standards (ibid; 78). However, the Health Transition Fund availed by UNICEF to the government for the period 2011-2015 was key in the resuscitation and stabilisation of the health delivery system in the country by providing funds, medical equipment as well as incentives for midwives and medical practitioners. This was significant as it resulted in a great improvement on the reduction of maternal mortality rates.

Currently the Zimbabwean health delivery system is not operating at optimal level owing to a continued economic meltdown, a situation that resembles and relates to that of the 2007-2008 era where hospital facilities became dysfunctional and unable to sufficiently provide health care services due to incapacitation. This resulted in a massive brain drain of health professionals that left for greener pastures in Europe and other parts of the continent (Zakeyo, 2016; UNICEF, 2013). Mission hospitals like Mt Selinda, Karanda, Bonda among are remains the best maternal health care provision centres in the country owing to their strong back up and relationship with their mother bodies abroad who continue to support their mission work both financially and materially. This relates well to the work of Widmer *et al.* (2011) which revealed that mission-run hospitals perform much better compared to state- run public hospitals due to the support they enjoy from their external partners.

In terms of migrants` interface with these two institutions when it comes to provision of maternal health care services, it has emerged that migrant women do prefer accessing services at Mt Selinda to Chipinge District hospital. It has also emerged in the research that migrant women bypassed several state –run clinics and Chipinge district hospital in favour of the mission hospital because of its better infrastructure and service provision when compared to Chipinge district hospital. This relates well with literature that reveals that mission hospitals are highly favoured and regarded as the best providers of quality health care

services due to their capacity to have the state of art medical equipment and best facility structures (Kahabuka *et al,* 2012; Widmer *et al,* 2011).

5 CHAPTER 5: LEGAL AND POLICY INSTRUMENTS GUIDING MATERNAL HEALTH CARE PROVISION IN ZIMBABWE.

5.1 INTRODUCTION

This section is committed to reflect on the legal and policy instruments that guide and regulates the provision of maternal health care services within the Zimbabwean Health Delivery System. All the policies in place to guide maternal health care provision are informed by both international and regional policy instruments whose primary motive and objective is the improvement of maternal and new-born health, reduction of maternal mortality rates, reduction of maternal morbidity and deaths among many others. This section shall also discuss the extent to which these policies influences and shapes the experiences of migrant women in accessing maternal health care services in Zimbabwe. These regional and international legal and policy instruments are also in line with the Millennium Development Goals of the year 2000 as well as the 2030 Sustainable Development goals (SDGs). These are as follows;

5.2 INTERNATIONAL LEVEL

5.2.1 International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR)

This convention policy document is fundamental in most policies regulating and guaranteeing access to health care. Under article 12 of this convention, the need and the right of individuals to the attainment of the highest standard of health is well articulated. Zimbabwe as a member state has well embraced the right for individuals to health care including maternal health care through the promulgation of section 76 of the constitution as well as the adoption of other numerous pieces of legislation aimed at safeguarding the right of women in access to health care. For instance, Section 76 (1) and Section 76 (3) of the constitution states that,

> "Every *Citizen and Permanent Resident of Zimbabwe has the right to access basic health-care services, which include reproductive health- care services" and "No person may be refused emergency medical treatment in any healthcare institution"*
>
> (GoZ, 2013)

However, what is obscure in this provision is that it doesn't provide for non-citizens hence it might be lacking on international standards and call for states to provide care for all irrespective of nationality and race.

5.2.2 Convention on the Elimination of all forms of Discrimination against Women

Zimbabwe is also a member state to this Convention, and it is entrusted with the responsibility to respect, protect and promote the fulfilment of the health right of all (Human Rights Bulletin, 2009). The convention provides for sweeping rights to women and among such right enshrined therein is the right to the provision of adequate and quality maternal health services (Mwonzora, 2019). Article 12 of the convention compels governments and all its related organs to desist from carrying any form of discriminatory and retrogressive practices as well as tolerating any practices or policy violating the rights women in accessing health care services. Efforts by the Zimbabwean government to ensure equal access to health by all are indicated by section 76 of the constitution though the provisions enshrined therein have got some loopholes. In relation to maternal health care access, rights of women are well guaranteed as guided by the family planning act as well as the PMCTs. At grassroots level, mission statements of hospitals and clinics are clear on the protection of women against discrimination of women on access to health care. A clear example is of the mission statement for MT Selinda hospital which reads as;

> *"…to provide quality care to all pregnant mothers during antenatal period, labour, delivery and post-natal periods in a non-discriminatory manner thereby reducing maternal and neonatal morbidity and mortality rate throughout 24 hours"*
>
> (Mt Selinda Hospital; 2018)

However, laws relating to this convention protocol are not well known by women mainly in rural areas and this makes it difficult for these women to claim their rights (Zimbabwe, 2000:4). The situation is worse to the migrant women who also have lack of access to health

information especially when it's disseminated via print media. Their access to maternal health care services is also impeded by the government`s inability to sustain the health service delivery system which has been under collapse in the recent years. Hospital and clinic facilities have undergone, massive shortages of medical utensils including the simplest ones like bandages, syringes, gloves and needles among others (ZimFACT, 2018; Mwonzora, 2019). This is also attributed to the government`s error in misplacing its priorities. For instance the budget allocation for the ministry of health in most cases is far below that of the security and defense ministry and other non-essential ministries, a situation that opposes the Abuja Declaration which compels African states to allocate at least 15 percent of the national budget to the heath sector (Mwonzora, 2019). This shows lack of commitment on the government `s part to prioritize the health and maternal needs of women. This therefore impact heavily on the maternal needs of those migrant women seeking care on the Zimbabwean borderland side as well.

5.2.3 Millennium Development Goals 2015

Zimbabwe as a member state of the United Nations adopted the Millennium Development Goals (MDG) agreed upon at the 2000 UN development summit. The MDGs thus forms the base of all health programmatic interventions in the country. Examples include the Maternal and Neo Natal Health Road map (2015) and the PMCTs. In terms of maternal health care provision, the Millennium Development Goal # 5 was instrumental in all government`s efforts to reduce maternal mortality ratio from 960 deaths out of 100 000 live births in 2011 to 614 out of 100 000 live births in 2014(ZimFACT, 2018; 20) with the support of the Health Transition Fund from the international community.

5.2.4 The Protocol to the African Charter on Human and People's Rights on the Rights of Women 2005

Under this protocol, governments have the responsibility to protect and guarantee the rights of women regarding their fertility as well as their choices to contraception, family planning or even terminate pregnancy as enshrined in Article 14 of the protocol (Zakeyo, 2016). The government thus fulfilled its obligation to this protocol by enacting the National Planning Act, the Sexual Offences Act, the Domestic Violence Act and the Criminal Codification Act

in order to address the challenges that puts the lives of women at risk (ibid; 42). The protocol thus protects women from violent sexual offences and domestic violence that may lead to maternal morbidity which eventually leads to maternal mortalities. However, regarding migrants' women`s health, it is difficult to enforce as these women only visit the health care centers on the Zimbabwean side when they need maternal health services. There is nothing much that can be done on the matter as the legislation is only enforceable within the territorial boundary of Zimbabwe.

5.2.5 Campaign on the Acceleration in Reduction of Maternal Mortality in Africa (CARMMA)

In response to the regional Call on the reduction of maternal mortality in Africa, the Zimbabwean government through the ministry of Health and Child Welfare in 2012 launched A campaign themed,' "Zimbabwe Cares, no woman should die giving birth"(Zakeyo, 2016;43, GoZ,2012). This initiative was in line with the Maputo Declaration of 2008, a regional block summit in which the reduction of maternal mortality and improvement of women health through the integration of sexual and reproductive health into Public Health care, development and promotion of youth friendly services, safe abortion and safe motherhood among other action plans which were seen as key towards the realization of MDGs and SDGs (ibid). Under this campaign, the government redoubled its efforts towards the reduction of maternal mortality rates through the expansion of service availability and promotion of universal accessibility of quality sexual and reproductive health services throughout the country (UN, 2013). This was achieved with the assistance of the Health Transition Fund, a multi-donor fund that facilitated the revitalization of the Zimbabwean health sector (Zakeyo, 2016). As a result, there was massive upgrades on maternity wars and waiting homes, capacitation of the medical human resources and infrastructure among many other positives that significantly impacted on the improvement of maternal health care access by many in the country including both internal and cross border migrants.

More so, one of the positives scored under this campaign was an improvement in the utilization of antenatal and post-natal maternal health care services at clinics and hospitals compared to the past seasons. It was noted that many women both local and migrant pregnant mothers registered their pregnancies within 16 weeks after conception and kept on consulting with the health care providers at post-natal phase unlike in the past where pregnant mothers

fail to register their pregnancies and in most cases opt for home deliveries owing to higher maternal user fees (Zakeyo, 2016). Higher user fees were thus an impediment to the accessibility of quality maternal health services by all and this was indeed a gross violation of the Maputo Protocol that had called for the provision of services to women in an accessible and affordable manner. The removal of user fees on all maternal related services such as morbidity, delivery and post-natal services thus enhanced the accessibility of maternal health much to the delight of the service utilizers who includes migrant nationals from the neighboring Mozambique who access maternal health care services within the Zimbabwean borderland.

5.3 NATIONAL LEVEL

5.3.1.1 The constitution

The Zimbabwean constitution which is the supreme law of the land provides for the right to health. The right to health is defined in the constitution as "the right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health" (Government of Zimbabwe, 2013). The right to health care is thus essential for everyone and the health care itself must be accessible, available, acceptable and of good quality. Key components of the right to health include timely and appropriate health care; adequate supply of safe water, basic sanitation, nutrition and housing; maternal, child and reproductive health; participation in health-related decision making and access to health related information (Human Rights Bulletin, 2009, Government of Zimbabwe, 2013). The government has thus proved its commitment in fulfilling the right to health including maternal and reproductive health through the enactment of several pieces of legislation and policies that are in line with different regional and international treaties addressing the right of every individual to health as shall be discussed in the ensuing discussion.

To begin with, section 76 of the Zimbabwean constitution provides that,

> *"Every Citizen and Permanent Resident of Zimbabwe has the right to access basic health-care services, which include reproductive health- care service….and that no person may be refused emergency medical treatment in any healthcare institution"*
>
> (GoZ, 2013)

This is indeed a progressive vow to ensure and guarantee the rights of individuals to health care. However, I view this provision as exclusionary especially with regards to Article 12 of the International Covenant on Economic Cultural and Social Rights of 1966(of which Zimbabwe accedes to) which compels member states to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Under the obligations of this convention and the African Charter on Human Rights, Zimbabwe like any other member state is obliged to respect, protect, promote and fulfill the enjoyment of the right to health by all those under its jurisdiction as well as guaranteeing the availability, accessibility and acceptability of health services. Section 76 of the constitution thus narrows it down from everyone to only citizens and permanent residents and this reflects an exclusionary tendency when it comes to health care access by migrants especially those undocumented. Implementation of this provision against the health needs of non-citizens makes it difficult for them to access services. This impedes the accessibility of maternal health care services by most Mozambican migrant women cross the border in search of better health services via both designated and undesignated entry points. This was noted during the data collection process where participants of this research reported that there were some elements of discrimination in the way maternal health care services were rendered to them in state-run hospital. The migrant women were thus susceptible to discriminatory tendencies which I find rooted in this constitutional provision.

These discriminatory tendencies relates to non- uniformity in the charges of maternity fees between local and migrants women as well as preferential treatment of locals over migrants and the casting of aspersions on migrants as depleting resources as has been indicated in chapter 4. This has a dreadful impact on the experiences of migrant women in accessing maternal health care in the Zimbabwean borderland of Chipinge. As a result of the state-run health care centers adherence to policies and regulations, they were viewed as hostile to the migrant community health needs, a situation that was seen as adverse to that in mission run hospitals whose services were viewed as available, accessible, acceptable and of good quality.

According the Human Rights Bulletin (2009), the government of Zimbabwe(and all its organs) as a member of the ICESCR is compelled to desist from all forms of discriminatory and retrogressive practices and policies violating the right of individuals to health including the sending away patients from health care facilities on the basis of their political affiliations, gender or citizenship. In the case of Mozambican migrant women experiences in accessing

maternal health care, the mission hospital was viewed as having desirable attributes of social inclusion and good interpersonal aspect of care in comparison to the state-run hospital. This was vital in positively shaping their experiences as well as contributing to the desired maternal outcomes in relation to the SDG 3 that calls states to ensure healthy lives and promote wellbeing for all at all stages.

5.3.2 Maternal and Neonatal Health Road Map 2015

The Maternal and Neo Natal Health Road map (2015) was proactively launched by the government in response to the call to all member states that accedes to the Millennium Development Summit of 2000 to improve efforts if reducing maternal and neonatal deaths (MDG 5). The road map was guided by the need to, "provide skilled attendance during pregnancy, child birth and the post-natal period and to strengthen the capacity of individuals, families, communities and civil society organizations to improve maternal and new-born health"(Zakeyo, 201; 24). Underpinning this policy instrument were three fundamental pillars namely, are family planning, antenatal Care, clean and safe delivery for the mother and the new-born (ibid).

This initiative was so vital in showing government`s commitment towards the reduction of maternal and neonatal mortality rates. The policy precipitated a massive expansion on midwives training programs countrywide and this resulted in all health care centers both rural and urban having more skilled personnel to attend to the maternal health needs of the population. Vital maternal health services such as antenatal services as well as prevention from mother to child; and nutrition were made available to all pregnant mothers. The provision of skilled attendance during pregnancy and childbirth in all major health care centers across the country resulted in the once marginalized communities benefiting more from the provision of quality maternal health care services. Such marginalized communities include remote areas and those communities along borderlines separating the country with Mozambique. This saw migrant pregnant mothers from the other side of the Zimbabwe-Mozambique border attaining the best of quality maternal health care in the health facilities such as Mt Selinda, Chipinge hospital and other satellite clinics with in the Chipinge borderland.

The provision of such services and incentives to both local and migrant pregnant mothers in health care facilities was thus significant in ensuring and guaranteeing the rights of individuals to health care as enshrined in the International Covenant on Economic Cultural and Social Rights. The government thus took the responsibility to ensure that maternal health care services were made accessible, acceptable and available in good quality. The Legal Rights Bulletin (2000) emphasized that the government of Zimbabwe had the responsibility to ensure that all public health care facilities have adequate goods and services such as water, electricity and trained medical professionals to ensure full access by the patient constituency.

However, it is sad to note that the deteriorating standards within the Zimbabwean health service delivery system in the recent years owing to the ongoing political and socio-economic crisis has left many health care centers and facilities incapacitated to fulfil their mandate. This has resulted in few doctors remaining to man government hospitals and clinics and this negatively impacts on the accessibility of maternal health care services as evidenced by the high patient-doctor ratio (Mwonzora, 2019). This therefore means only a few patients have access to see a doctor. This place the lives of pregnant mothers and the new-born babies in jeopardy thereby contributing to undesired maternal health outcomes.

5.3.3 Zimbabwe National Family Planning Act

The act is a product of government`s response to international and regional treaties calling for states to uphold the rights of women when it comes to health care access. Guided by the Alma Alta Declaration of 1978 which called governments to embrace the significance of primary health care, and the Protocol to the African Chatter on Human Rights and the rights of Women (2005) which provides women with the sole right to control their fertility as well as contraception method to use, the Government of Zimbabwe enacted the Zimbabwe National Family Planning Act (Zakeyo, 2016). This act provides for the provision of fertility and child spacing services as well as the promotion and implementation of primary health care services and other community –based development programs relating to family health(ibid;44). This is facilitated through the assistance of the Community Based Distributors whose functions include the promotion, education, distribution and provision of family planning services through the supply and re-supply of contraceptives to eligible clients (ZimFACT, 2018). Through this policy, the government should be applauded for bringing the

much-needed services much closer to the patient constituency as they are readily made available even in their doorsteps.

This is very vital as it positively contributes to the realization of the desired maternal health outcomes and it is indeed in line United Nations Human Rights Watch Committee recommendations on the ways of reducing maternal mortalities that says;

> "*where there is a high maternal mortality, in order to protect the right to life, the state should "[ensure] the accessibility of health services including emergency obstetric care … ensure that its health workers receive adequate training … [and] help women avoid unwanted* pregnancies *… by strengthening its family planning and sex education programs."*
>
> (Makandwa, 2015; 23*)*

Birth control contraceptives and other family planning related services are thus provided for free in every health care center across the country. These services are fully utilized and equally accessed by all in the borderland community of Zimbabwe and Mozambique and equitably.

The Zimbabwe Family Planning Act is also guided by the Maputo Declaration (2005) a regional campaign by African states to accelerate efforts in reducing maternal and neonatal mortality rates in the region (Zakeyo, 2016). The tenets of this regional treaty were well incorporated into this Act i.e.

> "the *integration of sexual and reproductive health services into the public health care, the repositioning of family planning, development of youth friendly services, unsafe abortion; quality safe motherhood; resource mobilization; commodity security; and monitoring and evaluation*"
>
> (Zakeyo, 2016; 43)

Maternal health services are thus made available and accessible in enough quantities to both local and migrant pregnant and potential mothers. This will therefore contribute positively to the reduction of maternal mortality rates since mothers and women have the power and right to control their fertility.

5.3.4 Prevention from Parent to Child Transmission Programs (PMCT)

In attempts to reduce maternal and neonatal mortality rates, the government also instituted PMCT programs. These are framed and guided by need to avert violent and sexually related offenses that may put the lives of women at risk hence the establishment and enactment of the sexual offences Act, the National AIDS strategic plan and the National Aids policy (Zakeyo, 2016).Pursued in these instruments as well is the reduction of HIV infection rates so as to reduce maternal mortality. Of great importance in this policy instrument is the sensitization of women belonging to numerous religious sects which normally refrain from using health facilities to make utilization of contraception and STIs and AIDS prevention services provided at health care centers

5.4 CHAPTER SUMMARY

The above chapter reflected on the legal and policy frameworks that guides the provision of maternal health care services in Zimbabwe. It has been noted that all the frameworks are in line with both regional and international statutes that binds and obliges all states to work towards the same values of improving and achieving the world set sustainable and development goals. The constitution of Zimbabwe thus provides and ensures the provision of health care to all in a non-discriminatory matter. The policy and legal instruments in place universally bind private, mission and state-run hospitals in their provision of care. Their implementation at facility level significantly varies as has been attested in the research findings. In principle, these policies are regarded universally applicable to all mothers accessing maternal care services in Zimbabwe, including those in the borderline community.

6 CHAPETR 6: CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This is a detailed research report on refugee and migrant women`s access to maternal health care services in a mission and a state-run hospital in Chipinge District, a borderland community close to the frontier boundary that separates Zimbabwe and Mozambique. This chapter is aimed at providing a comprehensive summary and discussion of the major findings of this research, the conclusions that were drawn from them. The findings and conclusions of this research report were arrived at basing on the research question; (In what ways does the access to health care framework and the maternal health delivery framework aid the understanding of refugee and Mozambican migrant women`s experiences in accessing maternal health care at a mission and state hospital in Chipinge district, Zimbabwe?) as well as themes that emerged during data collection and analysis as discussed in the ensuing sections. The chapter shall conclude by providing a set of recommendations based on the findings and conclusions of this research.

6.2 SUMMARY OF THE MAJOR FINDINGS

Numerous issues relating to migrants` interface with a mission and state-run hospital on maternal health care provision in the Zimbabwean borderland of Chipinge emerged during data collection and analysis process. Basing on the research question and the objectives together with the aid of the conceptual frameworks (access to health care framework-McIntyre et al 2009 and the maternal health delivery service framework -Zakeyo, 2016), three main themes emerged from the participants' narratives. The themes revolve around motivations of migrant pregnant mothers in seeking care on the Zimbabwean side and the barriers they face in accessing maternal health care services. The third one was mainly from a provider perspective. All the above themes had subthemes under which much was discussed as shown in Tab 4.

It is evident from the findings that migrants` are attracted to seek maternal health care services on the Zimbabwean side because of their proximity to the health care facilities, cost of service, their perceptions on the quality of care provided as well as better infrastructure.

These factors were also instrumental in shaping migrants` choices on whether to seek care from a mission or a state-run hospital in this borderland zone. However, in terms of their interface with a mission and a state-run hospital, it has emerged that that the mission hospital had a better service provision compare to the state-run facility. This was highly attributed to the availability and acceptability of service. The mission hospital was highly applauded for its inclusionary and non-discriminatory tendencies toward the migrant community, all this resonating well with the acceptability component of the access to health care framework. Cost of service was also a decisive factor on the migrants` choices on facilities to which they would seek the much-needed services. The access triangle (McIntyre et al 2009) thus provided a solid base upon which the understanding of the service provider and client relationships and interactions during time of access can be evaluated.

Other issues on why the mission was much favorable to the migrant community in terms of service provision includes its better infrastructure, adequate skilled personnel, positive provider-client interactions and inclusionary policies. All these fits well in the maternal healthcare delivery service framework that emphasizes the above mentioned as pivotal in enhancing the attainment of maternal care delivery outcomes. The access to healthcare framework and the maternal healthcare service delivery framework were thus instrumental in modelling, guiding and broadening the understanding of the migrants` interface with sate-run and mission hospitals on maternal health care provision in the Zimbabwean borderland. The two frameworks successfully informed the researcher to effortlessly unearth and prove how the aspects of power, type of staff and professionalism are critical in shaping the provider-client interactions within the health care system and inform the migrants` experiences in accessing health care in Zimbabwe. This thus gives a balanced provider-client perspective on maternal health care delivery in the borderland community.

Regarding the challenges migrant women face in accessing maternal health care services in the state-run and mission hospital, it emerged that communication was one of the greatest barriers especially to the Congolese (residing at Tongogara Refugee Camp) and some Mozambican who were not so much familiar with the deep chiNdau language. It was not only a challenge to the clients but to some of the staff too especially those who come from other provinces where chiNdau language is not common. English also proved to be problematic to most service users and this led to the employment of interpreting services of which they were always not fully available. This has resulted in delay and to some extent denial of the much-needed services by the migrant population.

Discrimination by both local women and health care providers was also reported to be inherent in the day to day operations of the system especially regarding health care access at the state-run institution. Discrimination was thus reported to have manifested in numerous ways including preferential treatment with services being rendered to locals first, harassment and accusations on bringing in diseases and putting too much pressure on the locally-already limited resources. Such discriminatory tendencies and casting of labels on the migrant community relates well to literature that speaks about the theory of "othering" (Groove and Zwi, 2006; Harper & Raman 2008; Siziba, 2013) as having a deadly impact on their access to maternal health care services. One of such deadly impacts of viewing immigrants as disease carriers is that it leads to anti-foreigner sentiments that are usually hyped by politicians and the media which further marginalises non- citizens hence denying them of the much-needed health services.

It also emerged in the research that provision of maternal health care services to migrant populations in the Chipinge borderland is hampered by institutional constraints. Both the mission and state-run hospital facilities were seen to be experiencing serious challenges in their effort to serve their patient constituency. The institutional challenges faced by these two facilities significantly varied depending on the institutional contexts. Inadequate infrastructure and inadequate medical human resources within the facilities poses a great threat to the accessibility of maternal health care services. Lack of equipment such as drugs and machinery as well as inadequate transportation services in most state-run hospital institutions proved detrimental. Much of these constraints are mostly connected to the government`s inability to retain the best medical professionals, provide adequate state of art infrastructure and to finance the general health delivery system. However, to the relief of most migrant women seeking maternal care in Zimbabwe, Mt Selinda hospital because of its ability to secure, maintain and sustain its infrastructure through external injection of funds from its mother board abroad and other voluntary non-governmental organisations is still able to provide better services to all in an inclusionary and non-discriminatory manner. Through its missionary work and ability to retain the best of its workforce as well as the presence of the mid-wifery school in its premises help to boost the confidence of the maternal patients of both local and foreign origin to continue utilising the available maternal health care services.

In summation, in terms of migrants` interface with a mission and state-run hospital on maternal health care provision, Mt Selinda hospital is reported to be providing better services compared to its counterpart irrespective of the fact that are both operating in a resource

constrained environment. Because of its missionary work and inclusionary policies, it is highly regarded as one of the best health care service provider in the region and migrants lamented the fact that the attitudes, perceptions and form of interaction of the health care providers and the clients is positive and highly welcoming. Migrant pregnant mothers thus expressed their desire to continue utilise the services provided at the mission hospital. However, it is worth noting that these two facilities are not competitors but partners with a well functional referral system that work perfectly to improve accessibility of maternal health care services to all. Their referral systems work perfectly, and in most cases, they do share resources in serving their patient constituency.

6.3 RECCOMENDATIONS

- To deal with inadequacy of infrastructure and human resources constrains, the researcher suggest that the government create an economically and politically conducive environment that would create conditions favourable for external parties and donor organisations to partner with the government in financing health infrastructure and improve the working conditions of medical practioners by increasing their remunerations. A clear example is of the 2009-2013 where the economy was stabilised by the government of national unity, an environment that ushered external funding of the health delivery system of the country.

- Secondly, there must be a partnership at government level between the Zimbabwean and Mozambican health ministries, to mutually work together in addressing the challenges that these health facilities in the borderland zone are facing in discharging their mandate to their patient constituency. Social and health linkages between health officials in both countries should be in place to ensure that health care services are universally accessible to all in this borderland community.

- There is a greater need for political will on the part of the Zimbabwean government to invest in the health delivery system of the country. Lack of political will is seen in the government`s misplaced priorities on the national budget where line ministries such as the defence and security are allocated very high ministerial votes at the expense of

the health sector. The lack of political will to adequately finance the health sector is also typified by the routine medical check-ups of the political elites in South Africa and other countries which is a clear indication of their lack of trust and faith in the local medical fraternity. If governments priorities are not misplaced, the country`s health delivery system of the country will be sustainable.

- In terms of language as a barrier to effective and efficient access to maternal health care services, this research applauds the health care facilities for engaging the services of interpreters but there is still more to be desired. The government should unroll and sponsor some health care practitioners to undergo a course training in French and Portuguese language to ensure that the migrant's health needs are addressed without delay.

- There should also be regular health staff training workshops on immigrant rights to minimise situations where one is denied service just because of being an immigrant. Health care workers should always be conscientized and reminded of the health care policy, code of medical ethics and international conventions that protect immigrants' rights.

- There should be coordinated efforts and attempts by civic and other non-governmental groups to engage both the health care providers, migrants and local citizens in order to raise awareness on the need to respect immigrant rights and their dignity

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APPENDICES

Appendix A: Key informants Participant Information sheet

Good day,

My name is Bothwell Vumai and I am a master's student in Migration and Displacement at Wits University in Johannesburg. As part of the requirements for the degree, I am undertaking a research entitled, "Migrants' Access to health: Exploring the migrants' interface with a mission and a State Hospital on maternal health care provision in a Zimbabwean borderland". The aim of the research is to investigate the experiences of Mozambican migrant pregnant women in accessing maternal health care at a mission and state hospital in Zimbabwe (Mt Selinda and Chipinge district hospital), to investigate how the services provided relate with the migrants` understanding of health care and probe whether/how this influence the relationship between the health care providers and the migrant patients, to explore the health care professionals` perceptions and understanding of borders, citizenship and access to healthcare as well as to understand migrants interface with a Mission and a State hospitals in in the provision of maternal health care in a resource poor environment, humanitarian crisis, migration and international context. As part of this project I would like to invite you to take part in an interview. This activity will involve answering a set of questions in a single interview session that will take at most 30 minutes. With your permission, I would also like to record the interview using a digital device.

There are no direct benefits associated with participation in this study, and there are no disadvantages or penalties for not participating. You may withdraw at any time or not answer any question if you do not want to. The interview will be completely confidential and anonymous as I will not be asking for your name or any identifying information, and the information you give to me will be held securely and not disclosed to anyone else. I will be using a pseudonym (false name) to represent your participation, in my final research report.

This study will be written up as a research report which will be available online through the university library website. If you wish to receive a summary of this report, I will be happy to send it to you upon request (optional). If you have any queries, concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (non-medical), telephone + 27(0)11 717 1408, email hrec-medical.researchoffice@wits.ac.za/ Shaun.Schoeman@wits.ac.za

Yours sincerely,

Bothwell Vumai. Email: bothyvee@gmail.com. Cell: +27 624 040 452

Supervisor name: Professor Jo, Vearey. Email: jovearey@gmail.com. phone number: +27 723 927 034

Appendix B: Participant Information sheet (pregnant women)

Good day,

My name is Bothwell Vumai and I am a master's student in Migration and Displacement at Wits University in Johannesburg. As part of the requirements for the degree, I am undertaking a research entitled, "Migrants' Access to health: Exploring the migrants' interface with a mission and a State Hospital on maternal health care provision in a Zimbabwean borderland". The aim of the research is to investigate the experiences of Mozambican migrant pregnant women in accessing maternal health care at a mission and state hospital in Zimbabwe (Mt Selinda and Chipinge district hospital), to investigate how the services provided relate with the migrants` understanding of health care and probe whether/how this influence the relationship between the health care providers and the migrant patients, to explore the health care professionals` perceptions and understanding of borders, citizenship and access to healthcare as well as to understand the roles and interface between Mission and State hospitals in access to health care in a resource poor environment, humanitarian crisis, migration and international context.

As part of this project I would like to invite you to take part in an interview. This activity will involve answering a set of questions in a single interview session that will take at most 30 minutes. With your permission, I would also like to record the interview using a digital device.

There are no direct benefits associated with participation in this study, and there are no disadvantages or penalties for not participating. You may withdraw at any time or not answer any question if you do not want to. The interview will be completely confidential and anonymous as I will not be asking for your name or any identifying information, and the information you give to me will be held securely and not disclosed to anyone else. I will be using a pseudonym (false name) to represent your participation, in my final research report. In the case that you are distressed following your participation in this interview, I will personally organize a counselor to assist you in the best possible way at no cost.

This study will be written up as a research report which will be available online through the university library website. If you wish to receive a summary of this report, I will be happy to send it to you upon request (optional). If you have any queries, concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (non-medical), telephone + 27(0)11 717 1408, email hrec-medical.researchoffice@wits.ac.za/ Shaun.Schoeman@wits.ac.za

Yours sincerely,

Bothwell Vumai. Email: bothyvee@gmail.com. Cell: +27 624 040 452

Supervisor name: Professor Jo, Vearey. Email: jovearey@gmail.com. phone number: +27 723 927 034

Appendix C: Participant information sheet in Portuguese



Dia bom

Meu nome é Bothwell Vumai e sou estudante de Mestrado em Migração e Deslocamento na Wits University em Joanesburgo. Como parte dos requisitos para a licenciatura, estou a realizar uma pesquisa intitulada "Acesso de migrantes a cuidados de saúde: a interface entre a missão e os hospitais estatais sobre a prestação de cuidados de saúde materna numa zona fronteiriça do Zimbabué". O objetivo da pesquisa é investigar as experiências de mulheres migrantes moçambicanas no acesso aos cuidados de saúde materna em uma missão e hospital estadual no Zimbábue (Mt Selinda e Hospital Distrital de Chipinge), os fatores que os atraem para essas instalações e os profissionais de saúde `percepções e compreensão das fronteiras, cidadania e acesso aos cuidados de saúde.

Como parte deste projeto, gostaria de convidá-lo a participar de uma entrevista. Esta atividade envolverá responder a um conjunto de perguntas em uma única sessão de entrevista que levará no máximo 30 minutos. Com sua permissão, eu também gostaria de gravar a entrevista usando um dispositivo digital.

Não há benefícios diretos associados à participação neste estudo, e não há desvantagens ou penalidades por não participar. Você pode desistir a qualquer momento ou não responder a qualquer pergunta, se você não quiser. A entrevista será completamente confidencial e anônima, pois eu não pedirei seu nome nem nenhuma informação de identificação, e as informações que você me fornecer serão mantidas com segurança e não serão reveladas a ninguém. Eu usarei um pseudônimo (nome falso) para representar sua participação no meu relatório de pesquisa final. Se você sentir qualquer desconforto ou desconforto, interromperemos a entrevista ou retomaremos outro horário. Se você precisar de qualquer suporte ou serviços de aconselhamento após a entrevista, eu organizarei esses serviços gratuitamente ou a um custo mínimo no Hospital de Mt Selinda Serviços de Aconselhamento, Private Bag 509 Chipinge Tel +263 227 204 3228 e Hospital Distrital de Chipinge PO Caixa 200, Chipinge, Tell +263 227204 2424.

Se você tiver alguma dúvida sobre esta pesquisa, sinta-se à vontade para entrar em contato comigo nos detalhes listados abaixo. Este estudo será escrito como um relatório de pesquisa que estará disponível on-line através do site da biblioteca da universidade. Se você deseja receber um resumo deste relatório, terei prazer em enviá-lo a você mediante solicitação (opcional). Se tiver dúvidas, preocupações ou reclamações sobre os procedimentos éticos deste estudo, entre em contato com o Comitê de Ética em Pesquisa com Seres Humanos da Universidade (não médico), telefone + 27 (0) 11 717 1408, email hrec-medical.researchoffice @ wits.ac.za / Shaun.Schoeman@wits.ac.za

Com os melhores cumprimentos,

Bothwell Vumai. Email: bothyvee@gmail.com. Célula: +27 624 040 452

Nome do supervisor: Professor Jo, Vearey. Email: jovearey@gmail.com.

número de telefone: +27 723 927 034

Appendix D: Participant information sheet (ChiNdau/chi Shona) version

Ziviso pamusoro petsvagurudzo

Makadii

Zita rangu ndinonzi Bothwell Vumai uye ndirikuita zvidzidzo zveMasters in Migration and Displacement paWits University muSouth Africa. Mukuzadzikisa zvidzidzo zvangu, ini ndiri kuita tsvakurudazo pamusoro pekudyidzana kuripo pakati pezvipatara zvamamishini nezvehurumemde mukuwaniswa kweutano hwamadzimai vakazvitakura/ vane mimba vouZimbabwe nevekuMozambique munzvimbo yemuganhu wenyika. Ongororo iyi irukuita nemadzimai vakazvitakura vanotsvaga rubrtsero pachipatara che Mt Selinda icho chinova chipatar chemishini neChipinge District Hospital chinovova chiri chehurumendende.

Chinagwa cheongororo iyi ndechekutsvaga pfungwa, maonero nemanzwisisiro anoita madzimai vakazvitakura mabatirwo avanoitwa muzvipatara zvemamishini nezvehurumende, musiyano uripo, zvimhingamupinyi zvanosngana nazvo mukutsvaga rubetsero, zvingaitwe kuderedza matambudziko iwayo uye mafungiro avo pamusoro pekuwaniswa kweutano hwevakazvitakura vanobva kudzimwe nyika.

Panguva ino ndinoda kukukokai kuti muite rupande rwenyu muchikamu chehurukuro ino. Ichi chiitiko chinosanganisira kupindura mibvunzo yandinayo munguva isingadarike maminitsi makumi matatu. Nekutendera kwenyu, ndinodawo kunyora pasi uye kurekodha hurukuro yatichaita. Ndinovimbisa kuti kukururukura kwatichaita uku hakuzovi kwekumanikidza. Unogona kurega chero nguva yavwada kana kuramba kupindura mubvunzo kana yaunenge usingachadi. Nhaurirano iyi uye ruzivo rwauchandipa zvichave zvaakavanzika nekuchengeteka zvakakwana. Ini ndichave ndichishandisa pseudonym (zita renhema) mukunyora rugwaro rwangu rwekupedzisira kuitira kuchengetedz ubju hwako.

Kana iwe uchinge wonetseka chero kushungurudzika zvichitevera hurukuro iyi, ini ndichamisa mubvunzurudzo kana kuti tadzokerezve imwe nguva. Kana uchida chero rubatsiro kana mazano ekupa mazano mushure mekubvunzurudzwa, rubetero rwe counselling ruchavapo kwauri pachena paMat Selinda Hospital Counseling Services, Private Bag 509 Chipinge Tel +263 227 204 3228 uye Chipinge District Hospital PO Bhokisi re 200, Chipinge, Taura +263 227204 2424.

Kana uine mibvunzo mushure mekutsvakurudza uku, inzwa wakasununguka kutaura neni pamusoro pemashoko akanyorwa pasi apa. Ichi chidzidzo chichanyorwa sezveshumo rekutsvakurudza iro richave riripo paIndaneti kuburikidza neyunivhesiti yeyunivhesiti yewebhu Kana uchida kugamuchira chidimbu chemugumo uyu, ndichafara kukutumira kwauri pakukumbira (kusarudza).

Kana uine chero mibvunzo, zvinonetsa kana kuti kunyunyuta pamusoro pemitemo yezvidzidzo zvekudzidza uku, unogamuchirwa kutaura neYunivesiti Human Research Ethics Committee (kwete yezvokurapa), nhare + 27 (0) 11 717 1408, email hrec-medical.researchoffice @ wits.ac.za / Shaun.Schoeman@wits.ac.za

Wenyu akatendeka,

Bothwell Vumai. Imeyili: bothyvee@gmail.com. Cell: +27 624 040 452

Murairidzi: Purofesa Jo, Vearey. Imeyili: jovearey@gmail.com. nhamba yefoni: +27 723 927 034

Appendix E: Informed Consent form

Title of project **:** "Migrants access to healthcare: Exploring the migrants` interface with a mission and a state hospital on maternal health care provision in a Zimbabwean borderland".

Name of researcher: Bothwell Vumai

Student email: **1504657@students.wits.ac.za**

Student contact: **0624040452**

I …….. agree to participate in this research project. The research has fully been explained to me and I understand what my participation will involve. I understand that my participation is voluntary and that I may refuse to answer any items or withdraw from the study at any time without any negative consequences.

I agree that my participation will remain anonymous YES NO (please circle)

I agree that the researcher may use anonymous quotes

in his research report YES NO

I agree that the interview may be audio recorded YES NO

I agree that the researcher may take photos of me YES NO

(But not my face)

I agree that the information I provide may be used YES NO

anonymously by other researchers following this study

Signature ……

Name of participant ……

Date ……

Appendix F: consent form in Portuguese

Título do projeto: "Acesso dos migrantes aos cuidados de saúde: a interface entre a missão e o hospital estatal sobre a prestação de cuidados de saúde materna numa zona fronteiriça do Zimbabué".

Nome do pesquisador: Bothwell Vumai

E-mail do aluno: 1504657@students.wits.ac.za

Contato do estudante: 0624040452

Eu …… ... concordo em participar deste projeto de pesquisa. A pesquisa foi totalmente explicada para mim e eu entendo o que minha participação envolverá. Entendo que minha participação é voluntária e que posso me recusar a responder quaisquer itens em particular ou retirar-me do estudo a qualquer momento, sem quaisquer consequências negativas.

Concordo que minha participação permanecerá anônima	SIM	NÃO (por favor, circule)
Eu concordo que o pesquisador pode usar citações anônimas		
em seu relatório de pesquisa	SIM	NÃO
Concordo que a entrevista pode ser gravada em áudio	SIM	NÃO
Eu concordo que o pesquisador pode tirar fotos de mim	SIM	NÃO
(mas não meu rosto)		
Concordo que as informações fornecidas podem ser usadas	SIM	NÃO
anonimamente por outros pesquisadores seguindo este estudo		

Assinatura ……

Nome do participante ……

Encontro ……

Appendix G: Consent Form-Shona version

Musoro weprojekiti: "Migrants' Access to Health: Exploring the Migrants' Interface with a Mission and a State Hospital on maternal health care provision in a Zimbabwean borderland"

Zita remutsvagurudzi: Bothwell Vumai

Imeyiri yemutsvagurudzi: 1504657@students.wits.ac.za

nhamba dzemutsvagurudzi: 0624040452

Ini .... ndinobvumirana kubatanidzwa muchirongwa ichi chokutsvakurudza. chinangwa chetsvaguurudzo chanyatsotsanangurwa kwandiri zvivere uye ndinonzwisisa kuti rupande rwangu runobatanidza chii. Ndinonzwisisa kuti kubatanidzwa kwangu muchirongwa ichi kuzvipira kwagu uye kuti ndinogona ndinoramba kupindura chero chinhu chipi zvacho kana kuti kubvisa pane zvidzidzo panguva ipi zvayo pasina migumisiro yakaipa.

Ndinobvuma kuti kusarudzwa kwangu muhurukuro iyi kunoramba kusingazivikanwi

Hongu **Kwete (**ndapo**ta** shandisai denderedzwa)

Ndinobvumirana kuti muongorori anogona kushandisa mazita asina kutaurwa

mubhuku rake rekutsvakurudza. **Hongu** **Kwete**

Ndinobvumira muongorori kuti arekodhe kand kunyora pasi zvatichakurukura,

Hongu **Kwete**

Ndinobvuma kuti muongorori anogona kutora mifananidzo yangu. **Hongu** **Kwete**

(asi kwete chiso changu)

Ndinobvuma kuti ruzivo rwandinopa runogona kushandiswa nevamwe vadzidzi

nevamwe vanotsvakurudza mushure mekudzidza uku. **Hongu** **Kwete**

Chiratidzo .....

Zita rokubatanidzwa .....

Zuva .....

Appendix H: Key informant interview guide

Tittle of research project: "Migrant access to health: Exploring the migrants` interface with a mission and a state hospital on maternal health care provision in a Zimbabwean borderland"

Hello,

My name is Bothwell Vumai, I am a student at the University of Witwatersrand studying MA in Migration and Displacement. Firstly, and foremost, I would like to thank you for agreeing to take part in this research which is concerned with migrants` access to healthcare: the interface between a mission and state hospital on maternal healthcare provision in a Zimbabwean borderland"

Questions

1. How long have you worked at this facility/department/institution?
2. Have you worked in other health institutions before?
3. What does your work entail? Brief description
4. In terms of maternal health care service provision at this facility, how big is the catchment area?
5. What do you understand the term migration?
6. I understand you do provide maternal healthcare services to migrant women from Mozambique, what do you think are the reasons why they choose to seek care at this facility?
7. What sort of services do you provide?
8. If you to g give an estimate of migrants who come to seek maternal health care at this facility, how many would you say come in a week? (Probe week, month, year)
9. What do you require from the migrant women before you render them a service?
10. Are there charges for the maternal healthcare services you provide to these migrant women?
11. Are the charges uniform with those charged on locals?
12. How do you interact with them?

13. How would you compare your interaction with migrants and your interaction with the locals in accessing maternal health care?
14. Are there policies in place that regulates and governs the provision of care to migrants?
15. In cases of emergencies or critical medical conditions that might require caesarean procedures, how do you deal with such cases especially when dealing with migrant women?
16. What do you think are some of the maternal healthcare challenges you are facing at this facility?
17. Anything you feel that it must be done to ease such challenges.
18. Do you think migration is impacting on the health system in Zimbabwe in terms of access? If yes- please explain!
19. Do you have networks with health professionals in the Mozambican health delivery system?
20. How is the relationship working?

Appendix I: Interview guide for migrant women

Tittle of research project: "Migrants` access to health: Exploring migrants` interface with a mission and state hospital on maternal health care provision in a Zimbabwean borderland"

Hello,

My name is Bothwell Vumai, I am a student at the University of Witwatersrand studying Masters in Migration and Displacement. Firstly, and foremost, I would like to thank you for agreeing to take part in this research which is concerned with migrants` access to healthcare: the interface between a mission and state hospital on maternal healthcare provision in a Zimbabwean borderland"

Questions

Can you please tell me your age and where are you from?

What`s the name of the closest hospital to you?

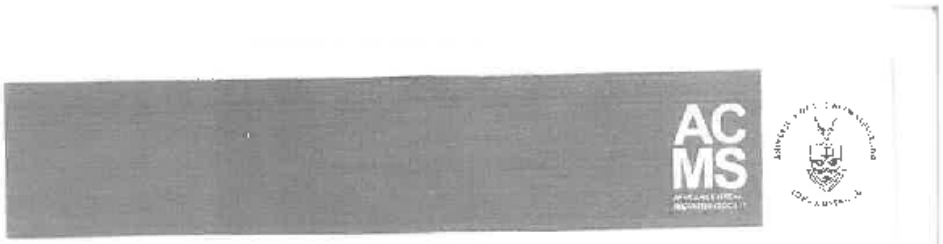
How long have you travelled from your home area to reach this hospital facility?

Can you please take me through your journey from the Mozambican side to this health facility?

1. Is it your first time coming to seek maternal care here at this facility?
2. What influenced you to come all the way from Mozambique to seek care at this facility on the other side of the border?
3. Is it your first pregnancy?
4. Do you often go for antenatal care or you just visit a hospital for delivery purposes?
5. In terms of your engagement and interaction with the nurses here, what is your experience regarding accessibility to maternal healthcare-are the nurses friendly to you,
6. Have you ever given birth here before?
7. Have you ever sought maternal care services on Mozambican hospital before?
8. What was the experience and how do you compare it with your experience here?

9. Are there any challenges that you are facing when seeking maternal care from this hospital? (Social and economic).
10. In terms of communication with the nurses, do you have any challenges?
11. How are these challenges addressed?
12. - are there any support structures in place to help you navigate all the barriers
13. Are there any recommendations you would like to make in terms of accessing maternal heath cares services?

Appendix J: Chipinge District hospital approval letters



MINISTRY OF HEALTH& CHILD CARE
CHIPINGE DISTRICT HOSPITAL
DISTRICT MEDICAL OFFICER
0 6 MAY 2018
P.O. BOX 200, CHIPINGE
ZIMBABWE

26th April 2018

To whom it may concern

Re: Bothwell Vumai MA Research in Migration & Displacement

I would like to confirm that Bothwell Vumai is a registered, full-time student at the African Centre for Migration & Society (ACMS) at the University of the Witwatersrand. Bothwell is undertaking an MA by research and is in the process of finalising his research proposal.

Given the importance of gaining insight into the relationships between migration and health, Bothwell would like to undertake research along the Zimbabwe-Mozambique border.

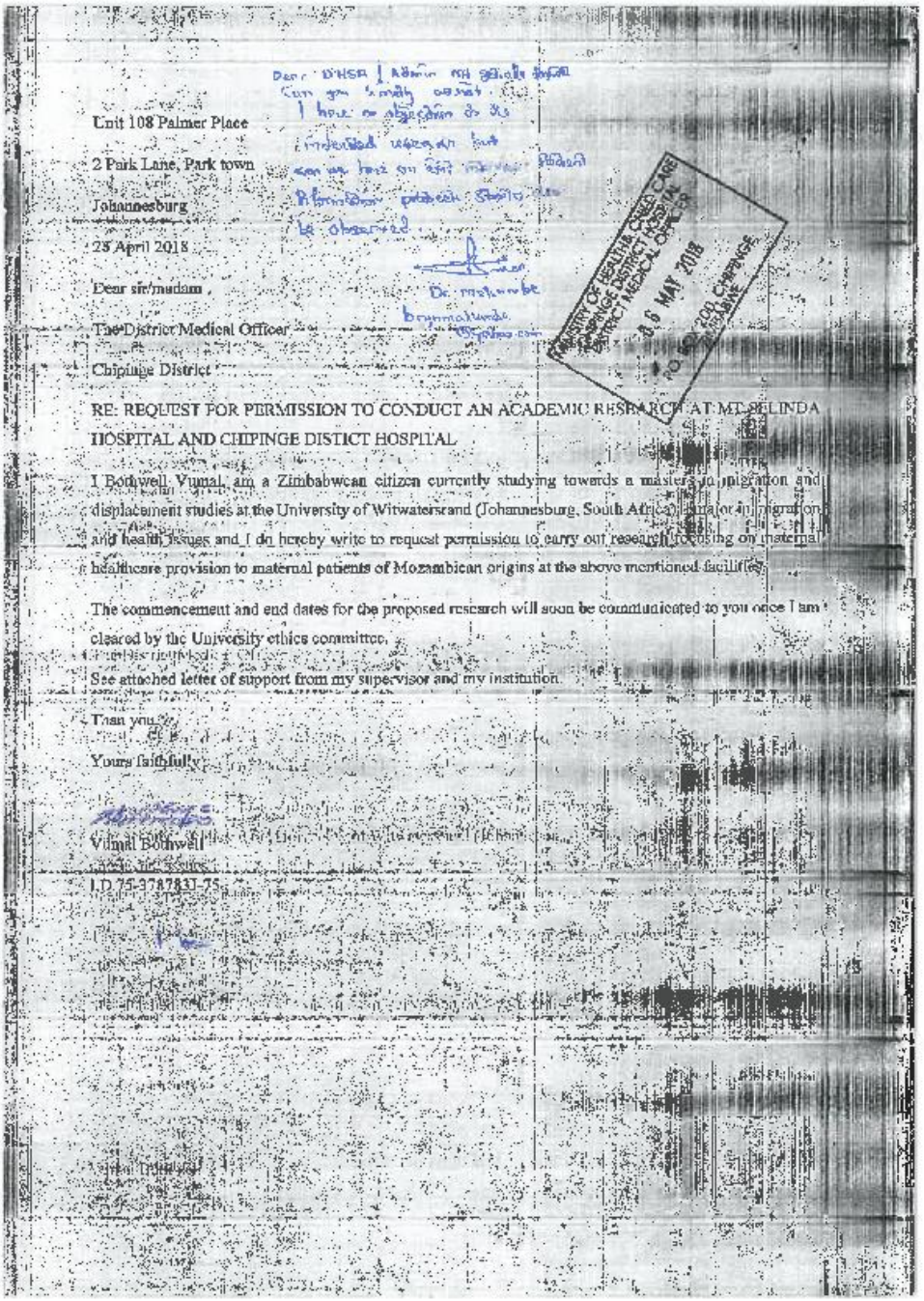
To this end, I support Bothwell's request for permission to undertake research at Mount Selinda Hospital. Should you be willing to agree, please could you provide a letter of support that Bothwell can include in his application for Research Ethics Clearance at WITS University. Bothwell will of course provide a copy of his final research report should that be of interest. We can also arrange for Bothwell to come and discuss the research findings with you.

Thank you in advance; please do not hesitate to contact me should you require additional information.

Sincerely

Jo Vearey, PhD
Associate Professor and Acting Co-Director
jo.vearey@wits.ac.za

African Centre for Migration & Society (ACMS), School of Social Sciences, University of the Witwatersrand, P.O. Box 76, Wits 2050, South Africa
T: +27 11 717 8558 F: +27 11 717 4001 www.migration.org.za



Unit 108 Palmer Place

2 Park Lane, Park town

Johannesburg

25 April 2018

Dear sir/madam ,

The District Medical Officer

Chipinge District

RE: REQUEST FOR PERMISSION TO CONDUCT AN ACADEMIC RESEARCH AT MT.MELINDA HOSPITAL AND CHIPINGE DISTICT HOSPITAL

I Bothwell Vumai, am a Zimbabwean citizen currently studying towards a masters in migration and displacement studies at the University of Witwatersrand (Johannesburg, South Africa), a major in migration and health issues and I do hereby write to request permission to carry out research focusing on maternal healthcare provision to maternal patients of Mozambican origins at the above mentioned facilities.

The commencement and end dates for the proposed research will soon be communicated to you once I am cleared by the University ethics committee.

See attached letter of support from my supervisor and my institution.

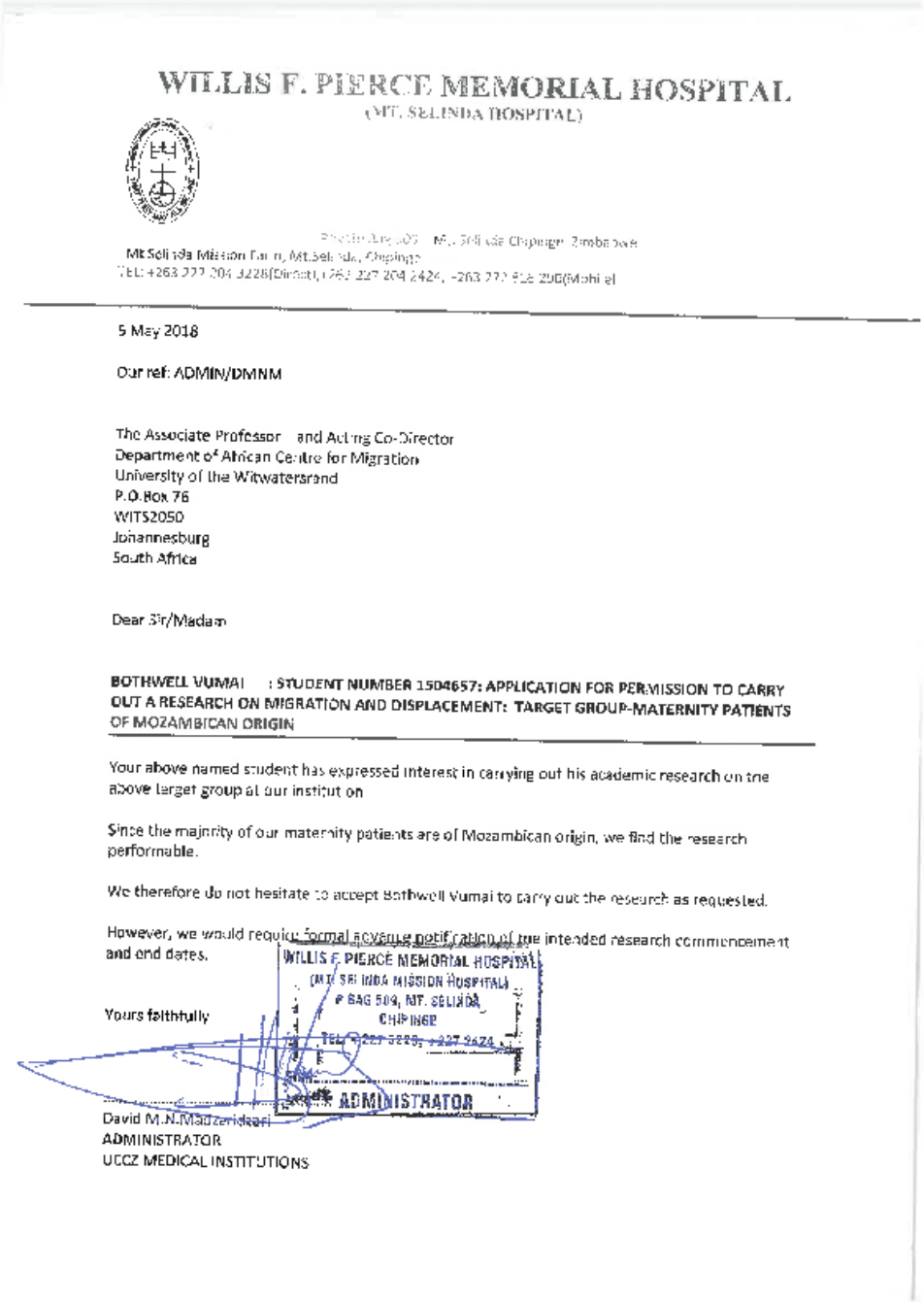
Than you.

Yours faithfully

Vumai Bothwell

I.D 75-378783T-75

Appendix K: Mt Selinda hospital approval letter



WILLIS F. PIERCE MEMORIAL HOSPITAL
(MT. SELINDA HOSPITAL)

Mt Selinda Mission Farm, Mt.Selinda, Chipinge
TEL: +263 227 204 3228(Direct), +263 227 204 2424, +263 772 [illegible] 206(Mobile)

5 May 2018

Our ref: ADMIN/DMNM

The Associate Professor and Acting Co-Director
Department of African Centre for Migration
University of the Witwatersrand
P.O.Box 76
WITS2050
Johannesburg
South Africa

Dear Sir/Madam

BOTHWELL VUMAI : STUDENT NUMBER 1504657: APPLICATION FOR PERMISSION TO CARRY OUT A RESEARCH ON MIGRATION AND DISPLACEMENT: TARGET GROUP-MATERNITY PATIENTS OF MOZAMBICAN ORIGIN

Your above named student has expressed interest in carrying out his academic research on the above target group at our institut on

Since the majority of our maternity patients are of Mozambican origin, we find the research performable.

We therefore do not hesitate to accept Bothwell Vumai to carry out the research as requested.

However, we would require formal advance notification of the intended research commencement and end dates.

Yours faithfully

WILLIS F. PIERCE MEMORIAL HOSPITAL
(MT SELINDA MISSION HOSPITAL)
P BAG 504, MT. SELINDA
CHIPINGE
TEL [illegible]
ADMINISTRATOR

David M.N.Mudzeridzeri
ADMINISTRATOR
UCCZ MEDICAL INSTITUTIONS

Appendix L: Wits Ethics clearance

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Vumai

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H18/09/32**
PROJECT TITLE	Migrants access to healthcare: Exploring the migrants interface with a mission and a state hospitals on meternal healthcare provision in a Zimbabwean Borderland
INVESTIGATOR(S)	Mr B Vumai
SCHOOL/DEPARTMENT	Social Sciences/
DATE CONSIDERED	14 September 2018
DECISION OF THE COMMITTEE	Approved
EXPIRY DATE	23 October 2021

DATE 24 October 2018 **CHAIRPERSON** (Professor J Knight)

cc: Supervisor : Prof J Vearey and Dr S Mahati

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES