Impediment to a Health Seeking Behaviour: an evaluation of Access to Reproductive Health Services for rural women in Matabeleland South

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Abstract: *The study sort to evaluate the barriers to access to reproductive health services for women in Matabeleland South. The study was premised on the Health Belief Model (HBM) formulated by Hochbaum, Kegees, Leventhal and Rosenstockof 1974 cited in Chiremba and Maunganidze (2004). They propound that the HBM has 3 main components, namely individual factors, modifying factors and likelihood of action. They infer that, an individual's attitude determines how she/he engages in certain behaviour. Conducted over 21 days, the study employed both qualitative and quantitative methodologies. The quantitative aspects included questionnaires that were administered to women of child-bearing age and adolescent girls, whilst the qualitative aspect involved secondary data review, facility assessment and focus group discussions. Purposive and random sampling techniques were used to identify the ideal participants for the survey. The key findings were that; Safe Motherhood was and is dependent on a lot of issues, some of which are, policies and systems, resources (financial, material and human), community/departmental structures, infrastructure and mostly the demography of the community including their attitudes, perceptions and beliefs. The study recommends removal of barriers to access to health through: Resuscitation of the country's strategy of having a health facility at every 10 kilometre radius; Regular mobile clinics especially for reproductive health services and baby clinics to resettlement areas that were pegged far from services; Resourcing of existing health facilities in terms of human, material and financial resources and most of all; Change of policies, perceptions and practises that hinder access to reproductive health services and attainment of basic health rights.*

Keyword: *Access, Barriers, Health seeking behaviour, Matabeleland South, Safe motherhood*

I.   Introduction

Reproductive health has ceased to be a health issue, not that schools of thought have managed to find where to premise it, but because it has progressed in a subtle manner and has become a developmental issue. Zimbabwe is not at war; actually the country has not had war in 3 decades. However, there are intense social and economic conflicts at this point in time which impact on development. Addressing health challenges therefore means addressing poverty, unemployment, policies and systems that govern allocation of resources and services. The right to access to health is a basic human right and a breach of such a right is a country's liability and it negates the country's progress towards fulfillment and achievements of its goals and/or declarations.The Government of Zimbabwe is a signatory to a number of important international legal instruments that bind states and governments to create an enabling environment for delivery of maternal, neonatal and child health services, which are: The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (2008); The Regional Child Survival Strategy for the African Region developed by WHO, UNICEF and the World Bank and adopted by the 56th Regional Committee of Health Ministers in August 2006; The Maputo Plan of Action (2006); The Millennium Declaration (2000); The Abuja Declaration (2000); The International Conference on Population and Development (ICPD) Programme of Action (1994); and The UN Convention for the Rights of the Child (1989). However, being a signatory of a legal framework is one thing and implementing it, is another.

Confronting policies and strategies that aim at ensuring the attainment of highest standards of human rights is maternal mortality rate which is the biggest threat to the stabilisation of a country's population as well as development. According to the United Nations Population Fund (UNFPA) (2010), the maternal mortality ratio in Zimbabwe has worsened significantly over the past 20 years. At least 8 women die every day while giving birth. This translates to a maternal mortality ratio of 960 per 100 000 according to Zimbabwe Demographic Health Survey (ZDHS) (2010/11) from 725 deaths per 100 000 live births, stated by Munjanja (2007). The statistics from National AIDS Council (NAC) (2011) indicate that Matabeleland South is leading in HIV and AIDS prevalence (rated at 18% in females and 12% in males). It is also indicated that reproductive health service is inaccessible with some women travelling as much as 40 kilometres for maternal health services.

1.2 Research Questions

- What causes pregnant women to delay to seek health care?
- Which factors contribute to the delay to reach proper medical services by pregnant women?
- Why are there delays in accessing quality care at a health care facility once arrived?

1.3 Limitations

Getting a clearance from the Ministry of Health and Child Welfare (Provincial Medical Director's office precisely) to assess the health departments was not possible hence the findings do not represent the information obtained from or available at the health facilities. Findings were therefore inferential, and were derived from the responses from other methods of data collection techniques and data sources.

II. Literature Review

There are various models that have been developed and used in the years to assess and relate health seeking behaviour and its determinants, for example, Triandi's Theory of Risk Taking Behaviour (1977), Theory of Reasoned Action by Fishbein and Ajzen (1973) and Locus of Control Model by Rotter (1966) (Glanz, Rimer and Lewis, 2002). These theories suggest that the individual's ability and purpose for an action is innate. The reason an individual will seek health service is determined by his/her perception, reasoning, cost benefit analysis and will. Most studies seem to suggest that the populations determine the development and utilisation of the health systems rather than the health systems development influencing the behaviour and utilisation of services by populations (MacKian, 2003). However, the writer thinks health seeking behaviour as a theory or philosophy is incomplete if it does not integrate the determinants of such behaviour. Taking cognisance that a human being has internal and external factors that determine her/his attitude as motivation and the way s/he behaves (as a consequence), therefore behaviour is a consequence of many attributes (Adam, Beck and van Loon, 2000). The Health Belief Model (HBM) suggests that the likelihood and degree of susceptibility and severity of the consequences will influence the individual behaviour. In support of the HBM theories, the social cognitive models suggest that an individual is a purposive and rationale agent and has the control and mandate to decide his/her fate and suggest that factors that promote health seeking behaviour are tooted in individuals (Sheeran and Abraham, 1996).

In 1994, Thaddeus and Maine developed the 3 Delays Model that prevent access to care which are: The delay to seek care; The delay to reach proper medical services and; The delay in accessing quality care at a health care facility. They propound that, the outcomes of care are dependent on the consequences happening along the continuum of health care of pregnant women. They highlight that, the delay at one level determines the outcome at another. According to Thaddeus and Maine, the delays are caused by internal and external factors. At independence in 1980, Zimbabwe adopted the Primary Health Care (PHC) approach as the main strategy for delivering healthcare to the majority of the population, with a focus on increasing community access to health services. The initiatives to improve maternal, neonatal and child health within the PHC approach included: a comprehensive antenatal and postnatal care program, a well-supported Expanded Program on Immunization (EPI), and community level child monitoring and surveillance through Village Health Workers (VHWs). Health care services were provided through a "supermarket approach", where preventive and curative maternal, newborn and child health services were accessed at a single visit. Together, these initiatives resulted in a decline of early childhood mortality rates. This saw the period between 1983 to 1988 recording an under-5 mortality rate of 75 per 1 000 live births compared to the preceding period (1978-1982) with a rate of 104 per 1 000 live births. The infant mortality rate declined in the same periods, from 64 to 53 per 1 000 live births (Embassy of Zimbabwe, 2007). However, due to the resettlement from the Zimbabwe Land Reform Programme (2000), most communities migrated, with some moving to areas that were not initially designated as residential areas. The areas have no public services (health and schools). Therefore, utilisation of such services may not be influenced by the 'Risk Perception' or 'Health Seeking Behaviour' but merely the unavailability of them.

The Prevention of Mother to Child Transmission (PMTCT) statistics captured for Matabeleland south province between April and June 2011 by the Ministry of Health and Child Welfare (MoHCW) revealed the following figures; HIV positive pregnant women accounted for more than 70% of all booked cases, infants born to HIV positive mothers more than 60% and infants born to HIV positive women receiving prophylaxis for PMTCT more than 40%. In the same period it was reported that the HIV positivity rate was higher among females than males in the age groups 15-19 and 25-29 and of those who tested during the same period, women accounted for more than 55% of the STIs positivity rate. The report from United Nations, Department of Economic and Social Affairs (2006) on birth outcomes in urban areas versus rural areas in Zimbabwe indicates that, 71% of births occur in rural areas with only 29% occurring in urban areas. Of the births occurring in the rural areas, 41% happen outside the health facilities. Also, 75% of maternal deaths occur during delivery and the immediate post-partum period, 60% of deliveries are conducted by skilled birth attendants with 40% being attended by unskilled birth attendants. In view of neonatal deaths, 67% die within the first week of life and less

than 35% of neonates born during complicated deliveries are followed up. For countries with no vital registration data such as Zimbabwe, the estimates are produced by statistical modelling, which produces large confidence intervals. The writer thinks these figures cannot therefore, be used for monitoring trends or for comparison with other countries let alone within itself. It is also unfortunate that most studies that are stated as Zimbabwean studies are actually representing a small fraction of the population and have mainly been conducted in and around Harare (the capital city) which is demographically advantaged than other parts of the country (mostly rural provinces). All these factors contribute to the subjectivity of findings from such researches.

In support of the debates related to maternal and reproductive care health, Osotimehin (2012) states that:

We know exactly what to do to prevent maternal and neonatal deaths: improve access to voluntary family planning, invest in health workers with midwifery skills, and ensure access to emergency obstetric care when complications arise. These interventions have proven to save lives and accelerate progress towards meeting the Millennium Development Goal 5.

The President of the International Federation of Obstetricians and Gynaecologist, Mahmoud Fathalla in Ganatra (2012) said:

Women are not dying because of diseases we can't treat. They are dying because societies have yet to decide that their lives are worth saving… States and governments should therefore recognise that, reducing maternal mortality is not an issue of development, but also an issue of human rights….

Having a health facility which is more than 20 kilometres from the communities may be interpreted as a breach or infringement of people's right to health. The writer thinks that, the government of Zimbabwe knows exactly what to do to improve access to reproductive health services, reduce maternal and neonatal deaths and prevent complications, what may lack is the commitment. Bennet and Brown (1999) state that a pregnant woman is monitored throughout the pregnancy so as to: observe for maternal health and freedom from infection and other systemic conditions; assess the foetal wellbeing; ascertain whether the foetus has adopted a lie, position and presentation that will allow normal vertex delivery to occur; ensure that the mother and family are confident to decide when to seek help if labour has commenced; offer an opportunity to express any fears or worries about labour and to ensure that the mother is psychologically and emotionally prepared for the birthing process. However, with the distances that women travel to health facilities, the monitoring processes is not consistent and the impediment to health seeking behaviour is inevitable.

III. Research Methodology

The survey employed both quantitative and qualitative research methodologies. The quantitative aspect involved a questionnaire that was administered to girls and women of child-bearing age (between the ages of 15 years to 49 years). The qualitative research involved use of in-depth interviews with key informants and Focus Group Discussions (FGDs) targeting younger women and older women. The facility assessment included analysing the infrastructure, the distance to health facility, the capacity of health facility, availability and mode of transport to the facility. Data analysis was an on-going process and used qualitative and quantitative methodologies.

3.1 Sampling Techniques

Purposive and Random Sampling techniques were employed. Purposive sampling was used for selecting the areas to be covered (which consisted rural homes, the peri-urban homes and the resettlement areas). It was also used for selecting FGDs' participants, key informants as well as selecting the health facilities to be assessed.

Random sampling technique was used to administer the questionnaire. In total a number of 174 respondents were reached out for the quantitative methodology.

3.2 Data Collection Techniques

4 Focus Group Discussions were held with older women and younger women. In each village, the participants were segmented into 2 segments according to their age-group. Each group had between 10-12 people. For the quantitative information, a simple random sampling technique was used to select the women of child bearing age and out of school youths. To ensure that all participants had an equal chance of being selected, women were identified from every other 5th homestead. Due to time factor and limited resources, 60 questionnaires per ward were distributed with an expected return rate of 85%, to which an impressive 96.66%

was achieved. A total number of 180 questionnaires were distributed (with 174 returned), 43 women were interviewed and 5 key informants were interviewed.

3.2 Data entry and analysis, report production

Data generated from the evaluation was analysed and segmented per district, category and data collecting technique. The quantitative data was entered and analysed using PASW 18 which elicited descriptive data of key variables and cross-varied data. Qualitative data was transcribed, coded and analysed using thematic content analysis. Report writing was ongoing and it started during data collection, entry and analysis

IV. Research Findings

4.1 The Demographic Data

The informative variables for analysis of demographic information were the age, marital status, age at first pregnancy and number of pregnancies and children. These variables were used as pointers to 'risks factors' that were likely to compromise maternal health. Therefore, these variables were considered for analysing the types of women that needed close monitoring during pregnancy, labour and/or immediate postnatal period. For the marital status and whom the respondent stayed with, these variables were not scored; however, they were used to elicit data that were relevant to the women's reproductive life, care and support. The researcher felt all the highlighted variables had the potential of eliciting data on the determinants of health seeking behaviour.

Of the women who responded to the questionnaire (174 out of 180), 31% were aged between 19-29 years, 43.1% were between the ages 30-39 years and 25.9% were aged between the ages of 40 and 49 years. 70.7% of the women had their babies when they were 19 years or younger with 29.3% having their babies when they were above 20 years (Table 1). On assessment of the number of children women had, 55.2% had between 1-3 children (which could be attributed to good family planning knowledge and/or usage). About 39.7% had between 4-5 children. On cross varied data 5.1% had more than 6 children and most mothers who had more than 6 children had low levels of education (gone up to grade 7 only).

Table 1: Age at first pregnancy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Below 14 years	3	1.7	5.2	5.2
	Between 15-16 years	24	13.8	10.3	15.5
	Between 17- 19 years	96	55.2	55.2	70.7
	Above 20 years	51	29.3	29.3	100.0
	Total	174	100.0	100.0	

In terms of level of education, 51.7% women went up to primary schools, with 46.6% completing O' level and 1.7% going up to tertiary education. For the assessment of marital statuses, 77.6% women were married though they were not staying with their partners (partners were out of the country, in the city or neighbouring towns), with 5.2% single, 6.9% divorced and 10.3% were widowed, making a combined total of women without partners, 22.4%. These findings also assisted in giving credence to the information on support systems and/or lack of them, especially those women who could not book their pregnancy on time.
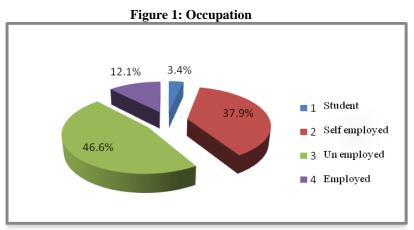
Figure 1: Occupation

Figure 1, displays data on the employment statuses of the women which reflects that 46.6% were not employed. The assumption is that, these women were dependent on their significant others, depending on their marital statuses and/or whom the respondents stayed with.

37.7% were self employed and 12.1% were employed. 3.4% were students at various institutions and all of them were lactating mothers.

4.2 Key Findings
The questionnaire adopted the 3-D model, to which the 3Ds represent:
- Delay in recognising the problem and deciding to seek care;
- Delay in reaching a facility once a decision has been made to seek care; and
- Delay in getting appropriate treatment once a facility has been reached.

The researcher therefore tailor-made the model to the delays that confront the women of the Matabeleland communities based on the knowledge of the demography of the region. The 3Ds were therefore interpreted as: **D**elay in seeking appropriate medical help for reasons of cost, lack of recognition of an emergency, poor education, lack of access to information and gender inequality; **D**elay in reaching an appropriate facility for reasons of distance, infrastructure and transport; and **D**elay in receiving adequate care when a facility is reached because there are shortages in staff, or because of electricity, water, drugs or medical supplies are not available. Hence the findings are expressed in alignment to each delay as was seen to be prevalent in the community.

4.2.1   Delay in seeking appropriate medical help for reasons of cost, lack of recognition of an emergency, poor education, lack of access to information and gender inequality.
Women in the 2 districts suffered from a lot of constraints among them: Lack of financial independence, lack of psychological independence and they had been so conditioned to think that they could not escape the boundaries created by their spouses and/or the environment they were living in. There was a significant percentage of women who were illiterate, which limited their understanding of the magnitude of maternal health problems. Culture to some extent had infringed in the rights of women by acknowledging and accepting little girls to be married and/or given away to men whichever was the first to occur. Most women (55.2%) had their first babies at the age of between 15-19 years, 15.5% had their first babies before the age of 14 years. Anatomically and/or biologically, below 13 years, a girl/woman is still a child and her reproductive system is not fully developed (Fraser & Cooper, 2009). On the contrary in medical practise a 14 year old pregnant child is an adult/parent and she is made to sign her own consent in case of an operation and these little pregnant girls are called mothers.

A child/girl/little mother at 14 years may not understand the urgency, severity or magnitude of their complications even when they occur. In total; 70.7% of women had their first children below the age of 19. With 46.6% of women unemployed; it was assumed that they relied on their spouses for financial support (in this case, transport money and layette) which also determined when they booked, if they booked, where they booked and where they delivered. Medical information in most cases is obtained from health facilities, which means the issue of women travelling for such a long distance to access information also determined how often they sought information, which information they sought and how much information they had, which translates to the second D. However, 55.2% women had between 1-3 children, with 50% having their children within an interval of 3-4 years and 15.5% with an interval of 5-8 years. This showed good family planning information and autonomy including the women's ability to reason on when to have children.

A significant number of women (67.3%) indicated that their spouses determined where they delivered their babies, with 11% stating that they mothers in-law had a stake in decision making. However, all women indicated that maternal health is free; the cost is in the travelling. They indicated that a donkey cart hire to a health facility is equivalent to a goat or alternatively $ 20 which all of them could not afford. Asked if the value of a goat was $ 20, they indicated that the goats are difficult to sell locally, therefore the hirers try to mitigate the loss of keeping many goats without buyers. For those who delivered at home, they indicated that they pay the traditional birth attendants (TBAs) in kind (a hen, a bucket of maize or give away an old maternity dress).

However they indicated that of late, the TBAs had been banned by the Ministry of health citing reasons of compromising the Prevention of Mother to Child transmission of HIV (PMTCT)'s strategy. The Ministry of Health was said to be purporting that TBAs are not technically competent to handle PMTCT cases.

4.2.2   Delay in reaching an appropriate facility for reasons of distance, infrastructure and transport

The average estimated distance pregnant women walked was 13 kilometres, with the shortest distance being 2 kilometres or less and the longest being 26 kilometres. Women in some villages walked as far as 15 kilometres to access health services. Regardless of their conditions, state of their pregnancies or

> *You arrive at the clinic with a baby in one hand and a placenta with sand on the other... that is if you don't leave it in the bush for the jackals*

the gestational ages, some women travelled by scotch carts, a few privileged ones cycled (6.32%), 1.72% had their partners hire a car for them with the rest walking all the way. The women had limited choices.

However, from a medical point of view cycling may not be convenient also considering the number of those who had miscarriages (17.2%). This impacted on the quality of services accessed as well as the health seeking behaviour metaphor. Inasmuch as women sought health, health was not found.

Figure 2 illustrates the distance women travelled to health facilities (to ensure a health seeking behaviour). There was a positive correlation between the distance travelled and the place of delivery; with 34.4% of women delivering at home against 29.31% who travelled above 11 kilometres to a health facility.
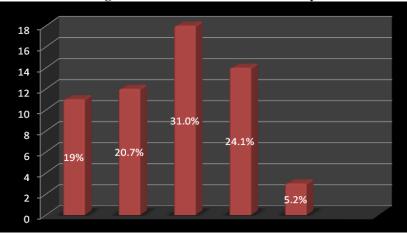
Figure 2:   Distance to a health facility

2km or less   3-5km   6-10km   11-20km   21km

In general, a combination of level of education, employment status, age at first pregnancy, distance travelled to access reproductive health services, mode of delivery and the types of services women accessed were determinants or components of a health seeking behaviour the study was concerned with. Women who travelled more than 11 km were the residents from resettlement areas. Among other things that were inaccessible in the resettlements area were the schools, water source, transport, police services and commodity supplies.

Table 2. Place of Delivery

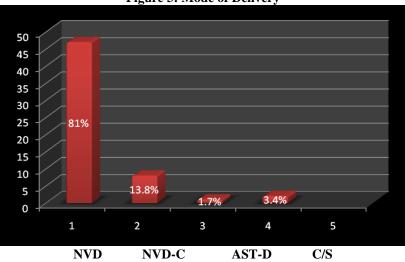|		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	At home without assistance	30	17.2	17.2	17.2
	At home with assistance from relative/friend	6	3.4	3.4	20.7
	At home with assistance from TBA	24	13.8	13.8	34.5
	At a health facility	111	63.8	63.8	98.3
	Waiting Shelter	1	1.7	1.7	100.0
	Total	174	100.0	100.0	

Regardless of the distance travelled to health facilities, 93.1% of women booked all their pregnancies and they had between 3-5 visits before delivery; however the last fewer months (when their pregnancies were advanced) the mothers could not travel. These were some of the pregnant mothers that delivered at their homes. Of those who did not book they cited the following reasons; distance, lack of finance, concealed pregnancies for teenage mothers, in laws determined where the baby had to be born, *inter alia*.

4.2.3   Delay in receiving adequate care when a facility is reached because there are shortages in staff, or because electricity, water or drugs and medical supplies are not available.

The capacity of rural district health centres were such that there were certain conditions that the facilities could not manage, regardless of the skill or resources. The facilities under survey were not able to cater for severe cases to which they transferred them to referral centres which were between 45 to 96 kilometres. The last D is normally dependent on the other 2. Depending on what time the woman finally arrives at facility, a lot of factors determine her condition and prognosis. The outcome of the mother's condition therefore depends on the ability of the health personnel to make prompt diagnosis and decisions, availability of transport to the referral centre, the availability of extra staff to escort the patient, availability of fuel, availability of other essential drugs to stabilise the patient on transit. In the absence of data from these facilities, conditions that were thought these facilities could not manage to stabilise were Ante partum haemorrhage; Post-partum haemorrhage;

Placenta Abruptio/Previa; 2nd and 3rd degree tears; Obstructed labour; Cord prolapse; Caesarean Section; *inter alia*. Therefore, the 3rd D was thought to be inevitable due to the capacity of these facilities.

Taking cognisance of the mode of delivery for some women, those with assisted deliveries (AST-D) did not deliver at these centres, so were women with Caesarean Sections (C/S). This meant that, the women were transferred during the booking visits or during labour, to which this would have been made possible by competent staff that are able to diagnose and refer on time as well as availability of resources to transfer the patients. The ability of the medical staff to transfer the patient on time is also dependant on the time the woman arrives at the health facility which is also determined by her ability to understand the need for her to seek medical care as well as her ability to afford to seek care and find it as well as the distance she has to travel.

Figure 3: Mode of Delivery

On assessment of the mode of delivery, 81% delivered their babies normally (NVD) without any complications, whilst 29% had various complications during pregnancy and delivery (NVD-C). Of note, most women (86.2%) were offered PMTCT services with the same figure being tested. That figure means that, there is 13.8 % of women out there who had no idea what their statuses were, it is however unknown if these contribute to the percentage of women who delivered at their homes and that is if, they did not book. What was more appalling was that, of the 86.2% women who were tested, only 50% of the partners were tested which translated to 43.1% partners that did not test as well as the 13.8% of the untested women's partners summing up to 56.9% untested partners.

Table 3. Tested with partner

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	75	50.0	50.0	50.0
	No	75	50.0	50.0	100.0
	Total	150	100.0	100.0	

The aforementioned data reveals that the statistics from the previous writers/researchers (MoHCW, 2011 and NAC, 2011) showing a higher positivity rate in women than that of men could be justified by the percentage of men who do not test for HIV with their wives/partners or by themselves or escorted by their parents. Therefore the researcher thinks the discrepancies of the male and female statistics hold true.

4.3 Facility Assessment

Among other variables, the assessment included evaluating if the facilities provided necessary level of obstetric care, if the facilities provided essential and most emergency obstetric care, if the facilities had skilled staff in place that could perform invasive procedures. This also included an assessing if there was means of transportation to quickly move a woman with any complications to a referral centre.

There were very few health facilities in the two districts and these were quite ill equipped in terms of human, financial and material resources as analysed from the information from the questionnaire. More so the 10 kilometre radius which was attributed to in the 1980's Country's Health Strategic Plan had been affected by the resettlements (newly occupied villages). Some women travelled more than 20 kilometres to a maternity centre using various mode of transport or walking regardless of the condition of the woman and or baby in *utero*. More than 85% of women who delivered their children had never had a scan, with about 20 % delivering

at home with the assistance of non trained birth attendants, which to some extent increases the chance of positive mothers passing HIV to the babies significantly.

Table 4: Scanned during pregnancy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	8	13.8	13.8	13.8
	No	50	86.2	86.2	100.0
	Total	58	100.0	100.0	

Most women did not have helpers soon after delivery; however they had a relative who stayed with them for 2 weeks at most, to which after that they were expected to do the entire house hold chores including looking after the baby and other children. Hence, the environment was not conducive for them to recuperate properly.

V. Key Findings
5.1 Delay in recognising the problem and deciding to seek care;
- Women had their first babies at a tender age, which may have influenced their ability to make reasonable judgement and understanding of their reproductive/maternal health needs.
- There was low adult literacy level which affected the knowledge and understanding of severity of their conditions as well as their ability to make informed decisions.
- There was high unemployment rate, which subjected them to dependency to their spouses and significant others. This in turn determined if they booked, when they booked and where they booked for maternal care.
- Women lacked financial, economical, social and psychological independence due to poverty and gender imbalances; hence even if they recognised the problem, they still had to get permission from their support systems on their choice of health care service. However, there was good use of family planning.
- The culture to some extent influenced the decision making autonomy, with mothers in law having a stake on the wellbeing and outcome of the women's maternal health, hence if the mother in law thought the problem was not worth seeking medical care, to some extent that was not sought.

5.1.2 Delay in reaching a facility once a decision has been made to seek care;
- The distance some women travelled to health facilities was extreme with some travelling up to 26 kilometres one way to ensure a Health Seeking Behaviour.
- There was a positive correlation between distance to the health facility and place of delivery, with those whose distance was more than 11kms delivering at home.
- Pregnant women used donkey drawn carts, bicycles or walked all the way to the health facilities. There were a few that hired cars in cases of emergencies which were quite expensive.
- The distances to health facilities also determined the number of visits the women had during pregnancy and where they delivered.

5.1.3 Delay in getting appropriate treatment once a facility has been reached
- There were very few health facilities in the two districts which were quite ill equipped with human, financial and material resources as analysed from the information from the questionnaire.
- These facilities had limited capacity to deliver maximum and essential medical and maternal health medical care.
- In cases of complications, pregnant mothers were transferred to referral centres and this was also dependent on the ability to diagnosis promptly, stabilise clients, availability of an ambulance to transport the pregnant mother and whether the receiving hospital was ready for the referred mother.
- There were pregnant mothers that died along the way to the hospital, some with babies in *utero* and some leaving behind babies.

VI. Conclusion and Recommendations
According to the findings, health seeking behaviour is not necessarily dependant on the individual's risk perception, ability to reason, choices or influence. In the community under study, it was largely influenced by the health systems' availability/accessibility and/or lack of them. Determiners of health seeking behaviour are multi-faceted and have evolved over the course of time. As much as social and psychological determinants matter, there are economical and structural barriers to health and some of which are caused or fuelled by

political determinants. Therefore, researchers need to understand the demography of the country and/or communities, its health care systems strategies as well as social and economic issues. This will help in understanding why communities utilise or do not utilise health care services. There was poor male involvement in this community as evidenced by 50% men that did not accompany their partners for maternal health care. Infact, more than 50% of married women were not staying with their spouses (spouses were in the city, neighbouring countries or in the bush gold panning). Therefore, the discrepancies in the statistics of male to female HIV positivity rate as highlighted by previous writers may be justified by these facts. The level of awareness of sexual reproductive health and rights was very low; women were not aware of their entitlements and service provider obligations. Access to services was determined by a lot of confounders such as social statuses, distance, availability of services, capacity of facility, resources and culture *inter alia*.

Therefore the survey recommended the following:

Policies
- Reproductive, maternal and child health is a right issue hence the government and its stakeholders should understand that prioritising it is a mandate not an option. The government of Zimbabwe is a signatory to a number of conventions, declarations and protocols; therefore it is imperative that the commitment to statutes equals to the implementation processes.
- The government and its stakeholders should ensure that maternal health services are available, accessible and affordable, either by having a well equipped health facility within a 10 km radius or by having a mobile clinic coming within reach of every woman who needs it.
- The availability of health oriented non-government organisations should surely complement the government's ability to providing health services and care.
- The government should increase the capacity of rural heal facilities in terms of human, material and financial resources

Community level Interventions
- In view of the adult literacy rate, there is need for adult education programmes by the government as well as non-governmental organisations.
- Community sensitization and education on sexual reproductive health services and rights is key.
- Education of youth on sexual and reproductive health and rights issues which will ensure they delay onset of parenting.
- Income generating projects for women to boast autonomy and financial independence
- Implementers have to work towards addressing barriers that interfere with access and promotion of sexual reproductive health services and care and have to ensure community education and involvement.

Advocacy
- Communities should ensure that government is delivering what it purports, with partners complementing the effort.
- Some of the programmes are parallel to the community needs, therefore, there is need to align health objectives and activities that address the community gaps and ultimately communities should access the basic requirements in reproductive health care which is not a favour but a right.
- There is urgent need of synchronizing programmes from the government, private sector and civil society and these should be rights based and should be determined by the demography of individual community.

6.1 Strategic interventions
- An overhaul of some policies, strategies and linkages that do not serve their purpose.
- Development of strategies and programme packages that promote male involvement and their meaningful participation.
- Collaboration between stakeholders so as to avoid omission, duplication and double dipping of community programmes.

References

[1]. Chiremba, W. and Maunganidze, L. (2004). Health Behaviour. Harare: Zimbabwe Open
[2]. University
[3]. World Health Organisation, UNICEF, UNFPA and The World Blank, (2010)Trends in the Maternal Mortality 1990-2010. Available from: http://www.unfpa.org/webdav/site/global/shared/documents/publications /2012/Trends_in_maternal_mortality_A4-1.pdf. (Accessed on the 17 July 2012).

[4]. Zimbabwe Demographic and Health Survey 2010-11. http://countryoffice.unfpa.org/zimbabwe/drive/2010-11ZDHSPreliminaryReport-FINAL.pdf. (Accessed 23 May 2012).

[5]. Munjanja, S. P. (2007). Maternal and Perinatal Mortality Study. Available from: http://www.unicef.org/zimbabwe/ZMPMS_report.pdf . (Accessed 5 April 2012).

[6]. Glanz, K., Rimer, B. K. and Lewis, F. M. (2002). Health Behaviour and Health Education. Theory, Research and Practise. San Fransisco: Wiley and Sons

[7]. MacKian, S. (2003) A review of health seeking behaviour: problems and prospects. Available from: http://r4d.dfid.gov.uk/PDF/Outputs/HealthSysDev_KP/05-03_health_seeking_behaviour.pdf. (Accessed 2 April 2013)

[8]. Adam, B., Beck, U., and van Loon, J. Eds, (2000). The Risk Society and Beyond the Critical Issues for Social Theory. Sage: London

[9]. Sheeran, P. and Abraham, C. (1996). The Health Belief Model in Corner, M. and Norman, P. (eds). Predicting Health Behaviours: Research and Practise with Social Cognitive Models. Open University Press, Buckingham (23-61).

[10]. Embassy of Zimbabwe, (2007). Health and Education. Available from: http://www.zimembassy.se/health.html. (Accessed 13 February 2013)

[11]. Osotimehin, B. (2012). Maternal Deaths Halved in 20 Years, but Faster Progress Needed. Available from: http://www.unfpa.org/public/home/news/pid/10730. (Accessed 7 February 2013)

[12]. Ganatra, B. (2012). Update on Safe Abortion Guidelines and the context of Unsafe abortion Available from: http://www.acaive.com/pdf/Ponencia%20Bela%20Ganatra%20-%20update%20 of%20safe%20abortion%20 Guidelines%20and%20the%20context%20of%20un safe%_20abortion.pdf. (Accessed 29 December 2012)

[13]. Bennet, V. R. and Brown, L. K. (1999). Myles Textbooks For Midwifes. Edinburg: Churchill, Livingstone.

[14]. Fraser, D. M. & Cooper, M. A. (2009). Myles Textbooks for Midwives (15thEdn). Churchill

[15]. Livingstone: Elsevier Limited. Hunt, P. & Bueno M. J. (2010). The contribution of the right to the highest attainable standard of Health. Available from: http://www.unfpa.org/public/publications/pid/4968. (Accessed 5 May 2012)