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Investigating Barriers Faced By Women In Accessing Maternal Services. A Case Study Of Goromonzi Ward 16

BY

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APPROVAL FORM

The undersigned certify that they have read the dissertation and have approved its submission for marking confirming that it conforms to the department requirements on research entitled **"INVESTIGATING THE BARRIERS FACED BY WOMEN IN ACCESSING MATERNAL SERVICE. A CASE STUDY OF GOROMONZI WARD 16"** submitted by **TADIWANASHE S CHORUMA** in partial fulfilment of Bachelors of Science Honours Degree in Development Studies

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DECLARATION

I **Tadiwanashe Shalome Choruma** confirm that this thesis is my original work.

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DEDICATION

This work is dedicated to my loving mother Fungai Chamburuka, my sister Tanaka, and my big brother Kudakwashe and little brother Kudzaishe as well as my friends and relatives for their love and support.

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ABSTRACT

Maternal healthcare encompasses all aspects of a woman's well-being during pregnancy, childbirth, and the postpartum period, including contraception, preconception care, and post-delivery treatments. However, in impoverished countries, complications during pregnancy and labour are major causes of maternal and infant mortality, as many women do not receive the necessary medical attention. The purpose of this study was to investigate barriers faced by women in accessing maternal service, using the case of Goromonzi Ward 16. The research objectives were to identify the obstacles women encounter when attempting to obtain service delivery, to assess the impact of barriers women face in receiving maternal health treatments, and to investigate the effectiveness of the measures implemented to improve maternity services. The interviews, questionnaires and focus group discussions were done to collect the data. From the research findings, results revealed that pandemics, delays at clinics, poor service delivery, poor referral systems, religious considerations and maltreatment by hospital workers are the barriers faced by women in accessing maternal service. The effects like poor health-seeking practices and diminished trust in the healthcare system were on the findings. The different effective measures put in place to help improve maternal service such as maternal education, provision of free health service, and development of healthcare infrastructure were also revealed in the findings. From these results, the researcher recommended that there is a need to train more staff in the health sector to meet the demands of maternal health care, hence reducing waiting time and increasing the number of expert staff which understands public relations. This might boost the confidence of women to visit clinics nearby. The churches and cultural leaders, women, and the community need to be sensitized on the effects of not using maternal services facilities and the dangers that happen to pregnant woman and their babies due to that.

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LIST OF ABBREVIATION

WHO	World Health Organisation
HBM	Health Belief Model
STIs	Sexually Transmitted Infections
STDs	Sexually Transmitted Diseases
ANC	Antenatal Care
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
PNC	Post Natal Care

Contents

CHAPTER ONE: INTRODUCTION

1.1Overview

This chapter serves as the introduction to the study by giving the background, justification of the study, problem statement, aims and study objectives, research questions, and definition of key terms, among other things. The research intends to conduct a detailed assessment of the barriers faced by women in accessing maternal services in Goromonzi Ward 16.

1.2 Background of the study

Maternal health encompasses the well-being of women during pregnancy, delivery, and after childbirth. It includes contraceptives, preconception, before delivery, and afterwards treatment to prevent the death and morbidity of mothers (WHO, 2012). Complications during gestation and labour are major reasons for maternal and infant mortality in impoverished countries like Zimbabwe, and deaths like this occur because the majority of pregnant women do not receive enough treatment. However, various regulations limit women's access to such treatments across the entire globe.

In various parts of the globe, women seeking maternal health services face considerable hurdles due to restricted access to transportation and remote healthcare facilities (Reddy, Pandey, Swain, & Goswami, 2020). In remote areas, a lack of qualified healthcare workers and medical supplies exacerbates the situation, making it harder for women to receive timely care (Kabiru, Izugbara, & Beguy, 2017). Poverty is a major obstacle to accessing maternal healthcare, with economically disadvantaged women unable to cover the costs of healthcare, transportation, and even hospital fees (Singh, Diamond-Smith, Carney, Kumar, & Speizer, 2016). Women's ability to look for healthcare services for mothers is hampered by economic burden as well as a lack of social support and financial autonomy (Hulton, Matthews, & Stones, 2000).

Women are frequently prevented from receiving maternal health care services because of deeply ingrained cultural practices and traditional beliefs (Muganyizi, Shao, & Grossman, 2015). This obstacle is exacerbated by factors such as women's desire for home delivery, fear

of cultural stigma, and restricted decision-making power. Gender imbalances persist, creating substantial limitations on accessing parental health care services. These include inadequate possibilities for women's empowerment and learning, gender-based violence, and discriminatory social norms (Beyene, 2018; Singh et al., 2016). Such disparities impede women's capacity to efficiently access and utilise maternal health treatments.

Inadequate health infrastructure, such as a lack of medical equipment, medications, and healthcare professionals, substantially restricts women's access to maternity care services (Gupta, Morgan, & Esber, 2017). Weak governance, corruption, and a lack of investment in healthcare systems compound this barrier (UN, 2021). Zimbabwe, a country beset by socioeconomic and political issues, confronts particular impediments to maternal health care services. Zimbabwean women confront additional obstacles as a result of the economic crisis, a shaky healthcare system, and gender inequities (Chodota, Kagurabadza, & Li Qin, 2019). Furthermore, societal views such as a preference for traditional delivery attendants and mistrust of healthcare professionals make it difficult for women to seek modern maternal health treatments (Munjanja, Lindmark, & Nystrom, 2003).

1.3 Statement of the problem

Despite the numerous studies conducted on pregnant women in Zimbabwe, a thorough understanding of the level of access to healthcare facilities remains a challenge in rural areas. Inter-collegial discussions with healthcare policymakers, planners, politicians, and patients revealed that healthcare access in Zimbabwe is a major concern. Inadequate and limited access to health care during pregnancy and childbirth raises maternal mortality rates in the population. The maternal death rate in Zimbabwe increased from 695 per 100,000 in 2008 to 960 per 100,000 in 2011 (ZNSA 2012b:278). This upward trend contradicts the Millennium Development Goals (MDG) targets of reducing child mortality by two-thirds and maternal mortality by three-quarters between 2000 and 2015 (Mathew and Waiswa 2012). Hence, due to this rise in Zimbabwe, the researcher therefore intends to examine if any barriers are being faced by women in accessing maternal services in Goromonzi Ward 16, a rural setting in Zimbabwe.

1.4 Justification of the Study

The enthusiasm for conducting this study stems from the scarcity of detailed literature specific to Zimbabwe on the barriers to proper maternal services for women in rural areas. Identifying barriers assists healthcare practitioners in tailoring interventions at the individual and community levels, enabling equitable access and use of maternal medical care. Researching barriers allows the development of methods that help women overcome obstacles and make educated decisions about their maternal health, thereby fostering autonomy and agency. In several parts of the world, women seeking maternal medical care face considerable hurdles due to restricted access to transportation and remote healthcare facilities (Reddy, Pandey, Swain, & Goswami, 2020). In remote areas, a lack of qualified healthcare workers and medical supplies exacerbates the situation, making it harder for women to receive timely care (Kabiru, Izugbara, & Beguy, 2017). As a result, the purpose of this research article is to create findings that will not only supplement existing literature, but will also assist policymakers, health workers, and the community in identifying methods to reduce barriers to quality maternity care in Zimbabwe.

1.5 Aim of the study

The study intends to investigate barriers faced by women in accessing maternal health services.

1.6 Research Objectives

- To identify the obstacles women encounter when attempting to obtain service delivery.
- To assess the effect of barriers women face in receiving maternal health treatments.
- To investigate the effectiveness of the measures implemented to improve maternity services.

1.7 Research Questions

- What obstacles do women encounter when attempting to obtain service delivery?
- What are the effects of barriers women face in receiving maternal health treatment?
- How effective are the measures implemented to improve maternity services?

1.8 Definition of Terms

Maternal Health Service: Maternal health services include a variety of healthcare interventions and assistance provided to women during pregnancy, delivery, and the postnatal period to ensure the health of both the mother and the newborn. These services include antenatal care, competent delivery attendance, postoperative care, family planning, and pregnancy-related problem management (World Health Organization 2018).

Barriers: Obstacles or factors hinder or prevent individuals from utilizing healthcare services. In the context of maternal health barriers may be related to financial constraints, healthcare infrastructure, religious considerations, or availability of skilled providers (Thaddeus and Maine, 1994).

1.9 Organization of Study

Chapter One; deals with introducing the research project. Chapter two will concentrate on reviewing related literature and how it applies to the Goromonzi Ward 16 setting. Chapter three deals with the methods used in collecting data and explain why these methods were used. Chapter four gives the research findings, and the data is processed into information and analysed to give meaning to the findings, while Chapter five (5) comprises discussion, conclusions, and suggestions based on the findings.

1.10 Conclusion

This chapter addressed the research problem, the background of the study, the research objectives and research questions, the study's justification, and essential term definitions. Chapter 2, which follows, examines the literature pertinent to this topic.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter looked at the literature review that guided the study. This chapter contains the texts and literature that are related to the barriers faced by women in accessing maternal services in a case study of Goromonzi Ward 16. In this chapter, the researcher discussed what other researchers have studied and said about the barriers faced by women in obtaining prenatal medical care.

2.2 Theoretical framework

A theoretical framework provides structure to the research as well as lenses through which it can be examined. This study employs the Health Belief Model (HBM). The Health Belief Model is a popular theoretical framework for public health and healthcare research (Green and Murphy, 2014). It focuses on understanding people's views, beliefs, and behaviours about health-related decisions and activities. According to the model, people's behaviour is influenced by their estimations of the severity of a health issue, their vulnerability to illness, rewards of taking action, and perceived barriers or cues to action. The Health Belief Model can be used to investigate the hurdles that women confront while obtaining maternity services, providing insights into their decision-making processes and the factors that impact their use of such services. Here's an example of how to use the model's many components.

Perceived Susceptibility: This component describes a woman's impression of her vulnerability to complications or negative outcomes during pregnancy and childbirth. Understanding women's perceptions of the hazards they face can assist in identifying any misconceptions or information gaps that may be impeding access to maternity services.

Perceived Severity: This component refers to a woman's assessment of the gravity of the probable effects of insufficient prenatal care or limited access to maternity services. Assessing women's perceptions of the severity of pregnancy-related issues, as well as the impact on their own and their babies' health can shed light on the reasons for seeking proper care.

Perceived Benefits: This component discusses the perceived advantages or benefits of using maternity services. It includes things like access to prenatal care, trained healthcare providers,

proper medical interventions, and support for a safe and healthy birthing. Identifying women's opinions of the benefits of receiving maternity care might emphasize the positive features that may boost utilization.

Perceived impediments: This component includes the perceived difficulties or impediments that women have in getting maternity care. Financial restrictions, a lack of transportation, cultural or social conventions, language problems, geographical distance, or insufficient service availability are all potential barriers. Women's views of these barriers can assist in identifying specific issues that must be addressed to enhance access to maternity care.

Cues to Action: This component describes the extrinsic variables that lead or motivate women to seek maternity care. These cues may include guidance from family or friends, recommendations from healthcare experts, media campaigns, or community-based activities. Understanding the cues to action can aid in developing effective ways to motivate women to seek maternity care.

Researchers can acquire a full picture of the hurdles that women face when seeking maternity care by utilizing the Health Belief Model. This understanding can help to shape targeted interventions, policies, and programs that address these barriers and encourage better access to quality maternal healthcare.

2.3 Maternal Mortality

Women of childbearing age, between 15 and 44 years old, are at risk of experiencing maternal mortality due to problems that may arise during pregnancy and childbirth. According to Makura et al. (2018), Zimbabwe's maternal mortality ratio fell from 960 deaths per 100,000 live births in 1990 to 651 deaths per 100,000 live births in 2015, but it remains high in comparison to the global average of 211 deaths per 100,000 live births (WHO, 2022). In contrast, the United States of America has a maternal mortality rate of 8 fatalities for every 100,000 live births (UNDP, 2004). The primary causes of maternal mortality after delivery are bleeding, anaemia, and infection. High rates of maternal death and pregnancy complications are often linked to a lack of access to or utilization of appropriate care during pregnancy and after childbirth. Factors contributing to high maternal death rates include a lack of access to antibiotics, blood transfusions, and aseptic facilities. These problems are exacerbated when women deliver with the assistance of unskilled traditional birth attendants, such as village

midwives, rather than skilled healthcare professionals. 45% of mothers in evolving countries give birth to their children with unqualified traditional delivery attendants who are unable to handle or avoid possibly serious problems (UNDP 2004).

Maternal death risk can be reduced over a woman's lifetime by postponing her first pregnancy, lowering her fertility rate, delaying having children until later in life, protecting oneself from sexually transmitted infections (STIs), and avoiding late-life pregnancies. The use of contraceptive devices helps reduce unwanted pregnancies that may result in abortion, thus giving birth to healthier offspring. Kids born two years after their closest siblings have a significantly higher risk of death at the age of one year than kids born more than two years later. Pregnancies should be spaced out as evenly as possible to avoid low-birth-weight children. Extended breastfeeding lowers the incidence of infectious and diarrheal disorders, which lowers morbidity and mortality in children. This is especially relevant in underdeveloped nations where access to potable water may be limited. Children who are breastfed have better nutritional and immune outcomes. In Wolf (2003) Contraceptive use gives women more control over their health and fertility, which creates chances for education and employment that a woman may miss out on if she has a large number of children at home. A woman may be able to work and improve her family's standard of living if she has fewer children.

2.4 Fertility Rate and Access to Contraceptive Methods

The fertility rate, defined as the average number of children born to a woman throughout her lifetime, is an important demographic indicator that reflects a country's reproductive health and family planning landscape (World Bank, 2022a). Many developing nations continue to have high fertility rates due to a combination of socioeconomic, cultural, and structural factors that limit access to effective contraception methods (Cleland et al., 2006; Guttmacher Institute, 2017). Developing countries, particularly those in sub-Saharan Africa, tend to have higher fertility rates compared to developed nations. For instance, in 2020, the total fertility rate in sub-Saharan Africa was 4.6 births per woman, which is much higher than the global average of 2.5 births per woman (World Bank, 2022b). The persistently high fertility rates in developing countries, especially in sub-Saharan Africa, are indicative of the challenges these regions face in providing comprehensive reproductive healthcare and family planning services to their populations. Several factors contribute to increased fertility, including early marriage, low educational attainment, gender inequality, and restricted access to family planning services

(Bongaarts, 2017; Verma and Bhagat, 2020). Access and usage of contemporary contraception technologies a key factors influencing fertility rates in underdeveloped nations. However, many women in these locations experience significant challenges in getting contraception, including limited availability, affordability, and societal acceptability (Darroch et al., 2016; Guttmacher Institute, 2017). Furthermore, healthcare infrastructure, supply chain difficulties, and health worker knowledge and attitudes can impede contraceptive access (Cleland et al., 2006; Guttmacher Institute, 2017). Zimbabwe, a developing country in Southern Africa, has seen fertility rates gradually fall over the last few decades, from 5.5 births per woman in 1988 to 3.8 births per woman in 2019 (Zimbabwe National Statistics Agency and ICF, 2020). This decrease is related to increased contraceptive use, which rose from 53% of married women in 1988 to 67% in 2019 (Zimbabwe National Statistics Agency and ICF, 2020). However, discrepancies in contraceptive access and usage remain, particularly among rural, younger, and less educated women (Muhwava et al., 2016; Zimbabwe National Statistics Agency and ICF, 2020).

2.5 Aspects of Maternal Medical Facilities

2.5.1 Antenatal Care

Antenatal care (ANC) is an important component of medical care for expectant mothers, as it provides essential services to monitor the health of pregnant women and ensure the safety of both the mother and the developing baby (World Health Organisation, 2016). Access to adequate antenatal care is particularly crucial in developing countries, where maternal and infant mortality rates remain high (Bhutta et al., 2014; Alkema et al., 2016). Antenatal care is critical for diagnosing and managing pregnancy-related issues, encouraging healthy behaviours, and educating women about various aspects of maternal and child health (WHO, 2016). Numerous studies have shown that antenatal care improves maternal and newborn outcomes, such as reducing the incidence of preterm delivery, low birth weight, and maternal mortality (Villar et al., 2001; Dowswell et al., 2010; Lassi et al., 2015). Comprehensive antenatal care plays a vital role in supporting the health and well-being of pregnant women and their unborn children, particularly in developing regions where access to quality healthcare services may be limited. The availability and utilization of antenatal care services are crucial for improving maternal and infant health outcomes

2.5.2 Trained Birth Attendance

Trained birth attendants provide pregnant women with the care they require throughout labour, childbirth, and the early stages of postpartum. This procedure entails the employment of skilled staff in a healthy and safe environment to care for pregnant women. It also includes the availability of proper medications and equipment, as well as a good feedback mechanism and a reliable referral system. Pregnancy and delivery are handled by a qualified birth attendant.

2.5.3 Postnatal Care

Postnatal care (PNC) is an important component of child and maternal healthcare, providing necessary services to monitor the condition and well-being of women and children after childbirth (WHO, 2013). Access to appropriate postnatal care is especially crucial in developing countries where mother and infant death rates are still high (Alkema et al., 2016; WHO, 2019). Postnatal care is critical for diagnosing and controlling postpartum problems, encouraging healthy behaviours, and easing the transition to parenting (WHO, 2013). Postnatal care has been shown to improve mother and newborn outcomes, including lower rates of bleeding after delivery, sepsis, and neonatal mortality (Srivastava et al., 2014; Baqui et al., 2008; Duysburgh et al., 2015).

2.5.4 Access to Health Care

Access to quality healthcare is a fundamental determinant of maternal and child health outcomes, particularly in developing countries where maternal and infant mortality rates remain unacceptably high (Moller et al., 2019; World Health Organisation, 2019). Ensuring equitable access to maternal healthcare facilities is crucial for improving the health and well-being of women and their newborns. Access to maternal healthcare is frequently unequally distributed, with socioeconomically disadvantaged women, rural residents, and marginalized groups encountering disproportionate barriers to important services (Benova et al., 2015; Wilunda et al., 2015). These biases can exacerbate gaps in maternal and child health outcomes. The availability, distribution, and quality of maternal medical services, such as maternity clinics, delivery centres, and postpartum care units, are important factors influencing access to care (Benova et al., 2015; Wilunda et al., 2015). Inadequate access to these essential healthcare

resources can contribute to the persistently high maternal and infant mortality rates observed in many developing regions. Equitable access to quality maternal healthcare is a critical determinant of improved maternal and child health outcomes, but significant barriers and disparities in access continue to exist, particularly for socioeconomically disadvantaged and marginalized populations in developing countries.

2.6 Factors influencing the use of health services

The availability of healthcare facilities, clinicians, and vital drugs is a critical factor influencing health service consumption (Awoyemi et al., 2011; Sahn et al., 2003). Limited geographic distribution of clinics, shortages of competent healthcare personnel, and prescription shortages can all be substantial hurdles to getting care (Ricketts & Goldsmith, 2005; Kruk et al., 2009). The cost of medical services, including direct personal expenses and other expenses such as transportation, can have a major impact on an individual's decision to seek care (Ensor and Cooper, 2004; Lagarde and Palmer, 2008). Financial constraints, especially among low-income populations, might result in the underutilization of vital health treatments (Kruk et al., 2009; Yastes, 2009). Schoen et al. (2013) performed research that examined the influence of healthcare costs on access to care in eleven high-income nations, including the United States. The study discovered that greater healthcare expenses were connected with reduced healthcare usage, as people faced financial restrictions that prevented them from obtaining essential medical attention. The perceived quality of healthcare services, including clinician competency, availability of equipment and supplies, and overall patient experience, can have an impact on care-seeking behaviour (Andaleeb, 2001; Baltussen & Ye, 2006). Poor care quality can cause discontent and confidence in the healthcare system, resulting in reduced use (Kruk et al., 2009; Rao et al., 2006). Existing gender norms, power dynamics within the household, or traditional healing practices may discourage or delay individuals, particularly women, from receiving formal healthcare services (Mackian et al., 2004; Srivastava et al., 2015). Gender roles, family dynamics, and traditional healing methods can all influence whether or not people use modern medical facilities (Grossman-Kendall et al., 2001; Sipsma et al., 2013).

2.7 Barriers women encounter when attempting to obtain service delivery

Health system restrictions: A weak healthcare system can significantly limit women's access to maternity healthcare treatments. One major issue is uneven resource distribution, with rural and underdeveloped areas frequently missing basic healthcare infrastructure and personnel (Farr et al., 2017). As a result, women in these communities may have difficulty receiving critical services such as prenatal care, competent delivery attendance, and postnatal care. Limited healthcare resources also lead to overcrowding and long wait times in healthcare institutions, deterring women from seeking treatment (Qureshi et al., 2016). Another restriction in the health system is a shortage of competent healthcare providers, notably midwives and obstetricians, which results in limited service availability and decreased quality of care (Molina et al., 2020). This problem is compounded in low-income communities, where healthcare institutions are already overworked and understaffed. Furthermore, communication gaps between healthcare providers and patients, insufficient training, and inadequate oversight can all contribute to poor treatment quality and medical errors (Green & Murphy, 2014).

Financial Barriers: Women face severe financial barriers to getting vital maternal medical care, particularly in countries with low to middle incomes. The cost of healthcare services is a substantial financial barrier since many women must pay for, professional birth attendance, antenatal care, and postoperative care themselves (Molina et al., 2020). Furthermore, secondary costs such as transportation, lodging, and lost income can add to the financial strain on women and their families (Farr et al., 2017). These financial hurdles disproportionately affect women from low-income families and marginalized areas, who frequently struggle to afford healthcare services (Qureshi et al., 2016). Furthermore, a lack of cheap health insurance options and limited access to financial assistance programs may leave women with few options for paying for care (Green & Murphy, 2014).

Language and communication hurdles can make it hard for women to access maternal health services treatments, especially if they speak a minority language or have poor competency in the language spoken by clinicians. Miscommunication, misunderstandings, and a lack of trust between patients and clinicians are all possible outcomes of communication problems (Green & Murphy, 2014). Women may feel uncomfortable or embarrassed discussing sensitive health matters, such as sexual and reproductive health, which can result in insufficient information exchange and poor care. In some cases, healthcare workers may not be fluent in the local language or have cultural competence, which can exacerbate communication hurdles and result in lower-quality care (Molina et al., 2020). Furthermore, insufficient health literacy can make

it harder for women to grasp health information and make joint decisions with their doctors (Farr et al., 2017).

Stigma and discrimination can drastically reduce women's access to maternity healthcare treatments. In some cultures, women may suffer stigma when seeking treatment for sexual and reproductive health issues, such as family planning and pregnancy-related concerns (Green & Murphy, 2014). This stigma can be reinforced by society's views, cultural conventions, and religious beliefs, causing shame, embarrassment, and fear of judgment. As a consequence, women may neglect or postpone seeking medical assistance, which can have serious consequences for their health and well-being. Discrimination based on age, marital status, socioeconomic status, or other criteria can all limit access to maternal healthcare treatments. For example, unmarried or adolescent moms may encounter negative attitudes from healthcare providers or community members, resulting in insufficient care or complete avoidance of healthcare services (Molina et al., 2020).

Education and awareness gaps can significantly limit women's access to maternity healthcare treatments. Inadequate understanding regarding the need for antenatal care, skilled delivery attendance, and postoperative care might result in delayed or non-use of necessary services (Molina et al., 2020). Women may be unaware of the risks of pregnancy as well as delivery, the importance of seeking prompt care, or the availability of healthcare resources in their neighbourhood. Furthermore, low literacy skills might make it hard for women to understand and navigate the healthcare system, including obtaining health information and efficiently speaking with healthcare practitioners (Farr et al., 2017). Limited knowledge about maternal health entitlements, such as free or subsidized services for pregnant women, might also impede access to care (Qureshi et al., 2016).

Geographical limitations greatly limit women's utilisation of care during pregnancy, especially in rural and isolated locations. One major difficulty is the distance to healthcare facilities, since women may need to travel considerable distances to access maternity health services (Molina et al., 2020). This can be physically challenging and time-consuming, especially during pregnancy and labour. Furthermore, transportation issues such as poor infrastructure, bad road conditions, and a lack of dependable transportation options compound the geographical barrier (Farr et al., 2017). In certain circumstances, women must travel long distances or rely on expensive or unreliable modes of transportation, which can be especially difficult for those with limited financial resources (Qureshi et al., 2016).

Sociocultural factors play a significant role in shaping women's access to maternal healthcare services. Cultural norms, beliefs, and practices can influence how women make decisions and seek care throughout pregnancy and childbirth. For example, in some cultural contexts, women are expected to give birth at home assisted by traditional birth attendants, which may result in missed or delayed opportunities to receive competent professional care (Green & Murphy, 2014). Gender inequality and power dynamics within households and communities can also create barriers to maternal healthcare access. In some cases, women may require permission from their husbands or other family members before they can seek care, leading to delays or missed opportunities to access essential services (Molina et al., 2020). Furthermore, stigmatization and prejudice against specific groups of women, such as unmarried or adolescent mothers, can impede their access to maternal health services. The social marginalization and discrimination faced by these women can discourage them from seeking the care they need during pregnancy and childbirth (Qureshi et al., 2016).

Pandemics, such as COVID-19, have posed substantial impediments to women's access to maternal healthcare services. The disruption of healthcare systems, fear of infection, travel restrictions, and socioeconomic effects have all contributed to lower utilization of key maternal health services, potentially jeopardizing the health of mothers and newborns. Several studies have indicated a decrease in the utilization of prenatal care, skilled birth attendance, and postnatal care services during the COVID-19 pandemic due to these factors (Moyer, 2021; Feroz et al., 2020; Riley et al., 2020). The diversion of healthcare resources to manage the pandemic, as well as the implementation of lockdown measures, reduced women's physical access to healthcare facilities and crucial maternal health services.

2.8 Challenges Faced by Maternal Health Care Providers

The lack of resources is a key issue for maternity healthcare professionals in Zimbabwe. This involves a lack of medical supplies, equipment, and qualified healthcare workers. According to Chavula et al. (2019), insufficient healthcare funding has resulted in a shortage of medications, maternity kits, and critical equipment such as ultrasound machines and blood pressure monitors. As a result, healthcare practitioners struggle to deliver complete maternity care, resulting in poor outcomes for both mothers and their infants.

Maternal healthcare practitioners in Zimbabwe have inadequate infrastructure in addition to restricted resources. Many healthcare institutions lack the required equipment and facilities to provide safe and effective care. Pires et al. (2019) discovered that the majority of Zimbabwean health facilities lack running water and electricity, making it impossible for healthcare providers to maintain basic cleanliness standards and offer emergency obstetric treatment. This lack of infrastructure creates significant difficulties in providing a safe environment for childbirth and handling obstetric crises.

Also, the burden of transmissible diseases, especially malaria and HIV/AIDS, has an impact on maternal healthcare delivery in Zimbabwe. Zimbabwe has one of the highest HIV/AIDS prevalence rates in the word, with around 14.6% of pregnant women infected (UNAIDS, 2021). This poses challenges in terms of antenatal care, preventing transmission from mother to child, and managing HIV/AIDS complications throughout pregnancy. Malaria is also endemic in many parts of Zimbabwe, with pregnant women being especially vulnerable to severe consequences. This poses an added burden on maternal healthcare practitioners, who must manage these infectious disorders alongside standard prenatal care (WHO, 2021).

2.9 The effect of barriers women face in receiving maternal health treatments.

Maternal mortality is a major public health concern, with barriers to accessing maternal healthcare services contributing significantly to avoidable deaths. In low-income countries, a shortage of competent birth attendants and emergency obstetric treatment has been associated with high maternal death rates (Samaha et al., 2019). In conflict-affected areas, interruptions in health systems and limited resources compound these issues, increasing the risk of maternal mortality (Bohren et al., 2017). Furthermore, limited access to family planning services can result in unwanted pregnancies, unsafe abortions, and other issues that contribute to maternal mortality (Campbell et al., 2017). Furthermore, underlying social determinants such as poverty and gender inequality can exacerbate these issues, with women from marginalised communities frequently facing the most significant barriers to care (Abbas & Karmaliani, 2020).

Poverty has a considerable impact on women's utilisation of maternity healthcare services, eventually contributing to poor maternal medical results. In low-income areas, healthcare services costs can discourage women from seeking care, resulting in complications and unnecessary maternal fatalities (Samaha et al., 2019). For example, in some cases, out-of-

pocket costs for treatments like prenatal care and skilled birth attendance can be significant hurdles to access, especially for low-income women (Abbas & Karmaliani, 2020). Furthermore, poverty is linked to other socioeconomic variables such as low education and gender inequality, aggravating women's access to care (Kalogirou et al., 2020). Women in underprivileged areas may have limited decision-making power in their households, making it harder for women to prioritise their health requirements (Campbell et al., 2017).

Women's barriers to receiving maternal health treatments can lead to long-term health problems, hurting their general well-being and quality of life. Inadequate prenatal care can have significant consequences for women's health during pregnancy and childbirth. For instance, the lack of proper prenatal care can contribute to the development of complications such as pre-eclampsia and obstetric fistula. These complications can have long-term detrimental effects on women's physical and mental well-being (Campbell et al., 2017). Furthermore, inadequate postnatal care can lead to untreated infections, chronic discomfort, and other health problems that last long after the pregnancy (Kalogirou et al., 2020). For example, women who suffer severe perineal trauma following childbirth may develop long-term consequences such as urine incontinence and sexual dysfunction (Abbas & Karmaliani, 2020). Furthermore, limited access to family planning services might lead to repeated, narrowly spaced pregnancies, which can have long-term detrimental consequences for women's health (Samaha et al., 2019).

Gender inequality is both a cause and a result of women's difficulties in getting maternal healthcare services. Many societies discriminate against women based on their gender, limiting their access to education, economic prospects, and decision-making power within their households and communities. These disparities might create barriers to maternal healthcare services because women may lack the means, autonomy, or knowledge required to seek treatment. Furthermore, low access to maternity healthcare services might exacerbate gender disparities by resulting in poor health outcomes and greater vulnerability for women (Kalogirou et al., 2020). Women who have problems during pregnancy or childbirth, for example, may face stigma or exclusion from social and economic activities, aggravating their marginalisation (Campbell et al., 2017). Furthermore, the financial burden of maternal healthcare services can disproportionately affect women, perpetuating a cycle of poverty and poor health outcomes that exacerbate gender disparities (Abbas & Karmaliani, 2020).

Women's challenges in receiving maternal healthcare treatments can contribute to poor mental health outcomes. Inadequate prenatal and postnatal care can lead to anxiety, depression, and

other mental health problems that can last well after pregnancy and childbirth (Molina et al., 2020). For example, women who have challenges during pregnancy or childbirth may develop post-traumatic stress disorder or other trauma-related mental health issues (Bohren et al., 2017). Furthermore, the stigma and prejudice associated with maternal health difficulties can exacerbate mental health challenges by making women feel alone, ashamed, or unable to seek help (Qureshi et al., 2016). Furthermore, the financial burden of maternal healthcare services might increase stress and anxiety, especially among low-income women (Riley et al., 2020).

Women's difficulty in receiving maternal healthcare services might have a substantial economic impact. Poor maternal health outcomes, such as maternal mortality and long-term health problems, can lead to reduced productivity and higher healthcare expenses (Kalogirou et al., 2020). For example, in some low-income countries, maternal mortality accounts for a large proportion of fatalities among women of reproductive age, resulting in a loss of human capital and potential economic growth (Campbell et al. 2017). Furthermore, insufficient access to family planning services can result in high fertility rates and population expansion, putting additional demand on already scarce resources and infrastructure (Samaha et al., 2019). Furthermore, the cost burden of maternal healthcare services might push households into poverty, worsening economic disparities and perpetuating the cycle of poverty (Farr et al., 2017).

Women's barriers to receiving maternity healthcare services may have long-term consequences for future generations. Poor maternal health outcomes, such as early births, low birth weight, and birth abnormalities, might increase infant and child morbidity and death (Abbas & Karmaliani, 2020). These children may experience developmental delays and learning issues, which can have long-term effects on their health, education, and future chances (Kalogirou et al., 2020). Furthermore, insufficient access to family planning services can lead to unintended pregnancies and closely spaced deliveries, which contribute to high fertility rates and population growth (Campbell et al. 2017). This can put further demand on already limited resources such as education and healthcare systems, perpetuating the cycle of poverty for future generations (Samaha et al., 2019).

The barriers that women face in accessing maternity healthcare services can have long-term consequences that extend beyond the individual and impact future generations as well. Poor maternal health outcomes, such as preterm births, low birth weight, and congenital abnormalities, can increase the risk of infant and child morbidity and mortality (Abbas &

Karmaliani, 2020). These children who are affected by suboptimal maternal health may experience developmental delays and learning difficulties, which can have far-reaching implications for their health, education, and future opportunities throughout their lives (Kalogirou et al., 2020). Additionally, limited access to family planning services can lead to unintended pregnancies and closely spaced births, contributing to high fertility rates and population growth (Campbell et al., 2017). This cycle of inadequate maternal healthcare access and poor reproductive health outcomes can put further strain on already limited resources, such as education and healthcare systems, perpetuating the intergenerational cycle of poverty (Samaha et al., 2019).

Women's difficulty in accessing maternity healthcare services might have an indirect impact on the environment, particularly in terms of population growth and resource use. Inadequate access to family planning services can lead to high fertility rates and rapid population growth, putting a strain on natural resources and increasing environmental issues including deforestation, water scarcity, and climate change (Farr et al., 2017). For example, in areas where women experience major impediments to maternal healthcare services, high fertility rates might increase the demand for agricultural land to feed rising populations, resulting in deforestation and habitat destruction (Kalogirou et al., 2020). Furthermore, increased resource use caused by rapid population growth can contribute to pollution, waste, and greenhouse gas emissions (Abbas & Karmaliani, 2020).

2.10 How Quality of Healthcare Reduces Maternal Mortality

The quality of healthcare services is a significant predictor of maternal death rates. Research has demonstrated that increasing maternal and obstetric care can greatly reduce the risk of maternal death (Koblinsky et al., 2016; Tunc et al., 2019). Healthcare practitioners' knowledge and abilities are an important element of providing great care. Inadequately trained or supervised healthcare staff, particularly in emergency obstetric treatment, can lead to poor maternal outcomes (Ameh et al., 2019; Mgawadere et al., 2017). Proper training, ongoing education, and adequate supervision for healthcare providers have been linked to lower mortality (Koblinsky et al., 2016; Tunc et al., 2019).

The availability and functionality of important medical equipment and supplies are also critical for providing high-quality maternity care. According to Ameh et al. (2019) and Mgawedere et

al. (2017), shortages or faults in equipment such as blood banks, oxygen supply, and vital pharmaceuticals can dramatically impair healthcare institutions' ability to address obstetric emergencies, causing unnecessary maternal death. Furthermore, the organisation and administration of healthcare institutions have a considerable impact on providing quality care. Research has shown that effective referral systems, efficient patient flow, and comprehensive monitoring and evaluation procedures can improve maternal healthcare quality and minimise maternal mortality (Koblinsky et al., 2016; Tunc et al., 2019). Importantly, while addressing the quality of treatment, the patient experience and satisfaction must be considered. Respectful and dignified treatment, good communication, and responsive interactions between patients and providers can all affect the use of maternal healthcare services, resulting in better maternal outcomes (Afulani et al., 2019; Srivastava et al., 2015).

2.11 Effective measures put in place to help improve maternal services

Providing free health services has been recognised as a potential strategy for improving maternal healthcare, particularly in low-income communities. According to research, reducing user fees and other financial barriers can boost maternity healthcare access and improve women's health outcomes (Molina et al., 2020). For example, in a study of prenatal care in a US-Mexico border city, free or low-cost services were found to be an essential determinant in increasing access to treatment for women from underprivileged populations (Qureshi et al., 2016). Furthermore, offering free health services can help diminish socioeconomic disparities in maternal healthcare access and outcomes (Kalogirou et al., 2020). For example, a study of prenatal care in rural Tanzania discovered that offering free treatments improved attendance among women from poorer socioeconomic backgrounds (Farr et al., 2017).

Maternal education has been recognized as an effective strategy for improving maternal health outcomes. Educating women on pregnancy, labour, and postnatal care can boost their knowledge and confidence in accessing and using healthcare services (Bohren et al., 2017). For example, research has indicated that women who get prenatal education are more likely to attend antenatal care appointments and seek medical attention for difficulties during pregnancy or childbirth (Cilliers et al., 2019). Furthermore, maternal education can assist in minimising stigma and discrimination surrounding maternal health difficulties, thereby boosting women's general well-being and social inclusion (Riley et al., 2020). For example, teaching women

about their rights and the value of maternity healthcare can enable them to advocate for their health and oppose detrimental social norms (Kruk et al., 2019).

The development of healthcare infrastructure is critical for improving maternal health outcomes, especially in low-resource settings. Building and equipping healthcare facilities, training healthcare professionals, and strengthening health systems can all help to expand access to high-quality maternal healthcare services while decreasing maternal mortality and morbidity (Riley et al., 2020). For example, studies have shown that increasing the number of trained birth attendants and enhancing emergency obstetric care can considerably reduce maternal mortality (Bohren et al., 2017). Furthermore, investments in healthcare infrastructure can assist in addressing other variables that contribute to poor maternal health outcomes, such as poverty, gender inequality, and restricted educational opportunities (Kruk et al., 2019). Building health clinics in remote or underprivileged regions, for example, can increase healthcare access for women who might otherwise face major challenges (Cilliers et al., 2019).

Promoting women's rights and gender equality is an important step towards improving maternal health outcomes. Addressing gender discrimination and empowering women to make informed health decisions might boost maternal healthcare access and improve health outcomes for both women and their children (Cilliers et al., 2019). Interventions that strengthen women's decision-making authority in homes and communities, for example, have been proven to increase antenatal care and skilled birth attendance (Bohren et al., 2017). Furthermore, advocating for women's rights and gender equality can help to remove social and cultural barriers to maternal healthcare access, such as negative gender norms and behaviours (Kruk et al., 2019). For example, activities that involve both men and boys in promoting gender equality and women's health can lead to more equitable gender relations and better maternal health outcomes (Riley et al., 2020).

Improving the availability of vital medicines and supplies is a critical step towards improving maternal healthcare services and outcomes. Ensuring constant access to maternal healthcare drugs, equipment, and other resources can help mothers and their children use services more effectively and achieve better health outcomes (Kruk et al., 2019). For example, studies have shown that a lack of key drugs and supplies in healthcare facilities can cause delays in care and lower maternal health outcomes (Riley et al., 2020). Furthermore, enhancing the supply chain management of important medicines and supplies can assist in reducing health disparities and increasing access to healthcare for vulnerable populations (Cilliers et al., 2019). Implementing

new techniques for inventory management and distribution, for example, can boost drug and supply availability in rural or underprivileged communities, hence eliminating inequities in maternal healthcare access (Bohren et al., 2017).

2.12 Chapter Summary

This chapter laid the groundwork by reviewing the existing literature and theoretical underpinnings related to the topic of maternal healthcare access and barriers. The following chapter will delve into the practical aspects of how the research was conducted and how the data was collected to address the study's objectives.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter covers study design, the population of interest, sampling strategies, data collection techniques, ethical issues, data presentation and analysis, and justification for employing various methodologies and concepts in the research.

3.2 Research Design

The research design for his study was a descriptive survey. According to Bell (1993), a survey will seek information from a representative sample of the population, and the findings will subsequently be presented as typical of the community as a whole. According to Best and Khan (1993), surveys can provide reliable assessments of a field or event during a given period. It is contended that representatives of a large population can provide a wealth of information that is reliable within the sampling error ranges. Furthermore, successive surveys of the same

population or issue can reveal trends over time and aid in identifying gaps, where forms of research are frequently required, by recommending paths of inquiry.

The strategy was chosen since the data gathered is not static; how the environment reacts to the barriers, strategies, and treatments may change in the future. Descriptive research allowed for the gathering of qualitative as well as quantitative information; therefore, some statistical techniques were utilised to summarise the findings. Descriptive research also allowed the researcher to use data from both sources, which would not have been possible with exploratory research.

3.3 Study Setting

The study was carried out at Goromonzi Ward 16 and it was purposively chosen because it is served by a single public healthcare clinic that provides basic maternal healthcare services. The clinic's capacity, resources, and referral linkages to higher-level facilities may contribute to the challenges faced by women in accessing comprehensive maternal care.

3.4 Target Population

Is the entire population from which a sample of data is drawn (Momoh, 2020). The population is any entire group that shares at least one trait (Creswell, 2013). The target population was made up of all stakeholders in Goromonzi Ward 16, which are all local public clinic staff, local women of childbearing age, and the religious denomination Johwani Marange. 800 people were the key targets of the research.

3.5 Sample Size

It is not possible to obtain data from every respondent relevant to our study but only from a subset of the respondents; this process is known as sampling (David, 2013). As Fox (2012) mentions, sample design' refers to the joint method of selection and estimation; sampling should be designed in such a way that it is feasible to obtain data from each respondent relevant to our study. In this research, the sample size consists of 80 people which was ten per cent of the target population. This sample size was chosen because it affects the statistical power of

the analysis. Adequate statistical power increases the chances of identifying meaningful relationships or differences, if they are present, and supports the generalizability of the study findings to the larger population of interest.

3.5.1 Sampling Method

The researcher used a non-probability sampling strategy in which participants are chosen based on the researcher's subjective assessment rather than selection at random (QuestionPro, 2022). According to Nicolas (2021), the researcher chose participants based on their level of understanding of the subject.

3.5.2 Sampling Technique

The researcher employed convenient sampling because it allows for a prompt response. Frost (2022) defines convenient sampling as a non-probability sampling strategy in which researchers use participants who are easy to locate and engage in their research. This method involves taking samples from the crowd close to the hand, which is simple to obtain and practical, where units in a sample are to be chosen based on personal convenience. This method was employed because the potential respondents were those who could be reached and were available due to proximity and contact ability.

3.6 Data Sources

The investigation used primary as well as secondary sources of data.

- **Secondary data**

Most data was collected from the local clinic's past and current records which were used for patients who were helped to deliver their babies.

- **Primary data**

It was gathered using questionnaires and extensive face-to-face interviews. Clinic workers, as well as members of the community and religious groups, provide information. It was chosen because it is more dependable, accurate, and up-to-date. It may also be utilised for validating secondary information in the form of theories, viewpoints, and concepts and was chosen for its relevance to reality.

3.7 Data Collection and Instruments

Creswell (2014) defines a research instrument as "a tool for measuring, observing, or documenting quantitative data." It is a specific mechanism or instrument for collecting data, such as a paper-and-pencil questionnaire, a computer-assisted interview, a clinical measurement gadget, or an observation procedure. In this study, data was collected through face-to-face questionnaire interviews and telephone calls with individuals who were not physically available.

3.7.1 Pilot Study

According to Teijlingen and Hundley (2001), a pilot study is a small-scale, preliminary version of a larger, full-scale research study. It is also referred to as a 'feasibility' study, as it helps determine the viability and practicality of the planned research approach. It involves the specific pre-testing of a particular research instrument, such as a questionnaire or interview schedule, before implementing it in the main study. They emphasise the importance of pilot studies in excellent study design, as they can provide significant insights that can be used to inform the planning and execution of the larger research effort. The researcher sent three questionnaires to local women of bearing age and clinic workers as part of a pilot study.

3.7.2 Instruments

Interview Method

In this study, the researcher used key informants for interviews with healthcare workers such as nurses and church midwives. The purpose of these interviews was to investigate the hurdles that women have in accessing maternity healthcare services, their impact, and the effectiveness of alternative solutions. The interviews took place during the first phase of the study project, as part of a complete assessment of the barriers to maternal healthcare access. The key informants were chosen using convenient sampling because it allowed the researchers to choose key informants who were easily accessible, eager to participate and live in the study area. The interview method was chosen because it provides for a thorough examination of the barriers that women experience, as well as the underlying reasons and contextual nuances that

may be difficult to capture using other data collection methods. The interviews were performed utilising a semi-structured interview guide, which give a framework for the discussion while still allowing the key informants to convey their unique experiences and viewpoints.

Questionnaire Method

Haralambos and Holborn (1995) define a well-designed questionnaire as having the ability to deliver the information sought and being acceptable to the responders. The questionnaires were designed to collect quantitative data on the hurdles women face when accessing maternal healthcare services in Goromonzi Ward 16. The questionnaire's target respondents were women of reproductive age (15-49 years) who lived in Goromonzi Ward 16. The questionnaires were distributed throughout the research project's data-gathering phase after the key informant interviews were completed. This timing enabled the researchers to include any pertinent findings from the interviews into the questionnaire design. To guarantee accessibility and coverage, the questionnaires were distributed across the Goromonzi Ward 16 neighbourhood, and data was collected in a variety of contexts such as healthcare facilities, community centres, and houses. The questionnaire method was chosen to supplement the qualitative data collected through key informant interviews.

Focus Group Discussion Method

The focus group talks were utilised to investigate the challenges women encounter when obtaining maternal healthcare services in Goromonzi Ward 16. The focus group talks were held with women of reproductive age (15-49 years) who live in Goromonzi Ward 16. To allow for active interaction and conversation, group sizes were typically between 6 and 10 participants. The focus group discussions took place during the study project's data collection phase after the key informant interviews and questionnaire administration had been completed. This timing enabled the researchers to include findings from previous data collection methods in the focus group discussion guide. The focus group talks take place in a neutral, pleasant, and easily accessible site within the Goromonzi Ward 16 community, such as a community centre or a nearby healthcare facility. Focus group talks were chosen as a supplement to individual key informant interviews and structured questionnaires.

3.8 Data Analysis and Presentation

Data organisation and display in a meaningful and understandable manner are referred to as data presentation (Metway, 2012). This involves presenting the data in a way that is easy to understand and interpret, utilising a variety of tools and strategies. The purpose of data presentation is to convey the findings to the target audience and offer insights into the data. The process of looking at and understanding data using statistical and analytical methods is known as data analysis and contrast (Creswell, 2013). Finding patterns, connections, and trends in the data that can be used to understand the research issue is the goal of data analysis. The results were then subjected to statistical and analytical analysis. The information was then shown using visualisations, including tables. These visuals might assist in conveying the analysis's conclusions succinctly and clearly. Finally, inferences about the challenges women encounter in getting maternity services were made using the data analysis and presentation. These findings should be supported by the data as evidence and presented in a style that is clear to the target audience.

3.9 Ethical Considerations

According to Singh (2019), research ethics refers to the moral principles and guidelines that researchers must adhere to when conducting and disseminating their research. These ethical standards are in place to ensure that the research process does not involve any deception and that there is no conscious or unintentional intention to harm the study participants or the broader society. In the specific context of this study, the researcher took several measures to uphold ethical considerations. Respondents were instructed not to write their names on the research form, thereby protecting their anonymity. Additionally, before starting the research, the researcher sought permission from the community leader or overseers, demonstrating respect for the local context and authority. The researcher made efforts to safeguard the privacy and confidentiality of the respondents by asking them not to include any personal information on the questionnaire. This was likely done to ensure that the data collected would not be linked back to the individual participants, thereby preserving their right to privacy and autonomy.

3.10 Chapter Summary

This chapter provided a concise explanation outlining how the study was carried out, as well as all of the actions and processes that the researcher completed during the research process. Various procedures and techniques were employed throughout the study to improve the validity and reliability of the obtained data. The sampling strategies used provided a representation of the entire population under study. All essential steps were taken to mitigate the issues connected with the chosen approaches. The researcher's primary concern was the confidentiality and privacy of the information acquired, and considerable care was taken to prevent disclosing the data. The following chapter focuses on data presentation, analysis, and discussion.

CHAPTER FOUR: RESEARCH FINDINGS

4.1 Introduction

This chapter includes an analysis of a mixed methods study to study the hurdles that women face when receiving maternal services. The chapter is organised as follows: the first section focuses on the challenges that women face when attempting to receive maternal service delivery. The second examines the consequences of women's barriers to receiving maternal health services, and the final examines the efficacy of the policies put in place to help improve maternity services. As stated in the preceding chapter, the responses of the respondents will be coded for confidentiality.

4.2 The obstacles women encounter when attempting to obtain maternal service delivery.

4.2.1 Pandemics

Accessing maternal care can be difficult for women due to a variety of issues, such as pandemics. Given the circumstances at the time, COVID-19 was identified as one of the barriers to getting maternal health treatments. Many of those interviewed wished it would never come back. Respondents 1, 3, and 6 agreed with the following:

"The COVID-19 pandemic and associated prevention and control measures have had a substantial influence on mother and child health (MCH) services. During the lockout, patients had difficulty accessing MCH services, and healthcare providers struggled to administer those treatments. Take notice that people were urged to stay at home for their protection, but no medical services arrived at your location. Patients had to stay at home to comply with restriction orders, yet they were disadvantaged in terms of maternity services."

4.2.2 Delays at Clinics

During one of the focus group sessions, it was determined that clinic delays limit women's access to maternal health care. 10% of the participants agreed with this viewpoint, and two of them stated the following:

"I arrived at the clinic at night wanting help, and I was about to give birth, but the nurses were delaying helping me because they were busy with other things. They later started to help me after they saw that the baby was about to come out, and I almost gave birth in the car. If it were someone else, a complication could have happened, and hopefully, they will change how they operate."

In the same vein, another respondent stated: "*We go to clinics, and they do not give you the necessary drugs or services. You're informed they don't have anything available, not even something as simple as paracetamol, which is disheartening and leads many people to avoid clinics. They do not reply to expecting mothers unless they are paid a tiny remuneration, which is completely unfair."*

Shortages of resources, which include qualified staff, drugs, and vital equipment, were identified as reasons why pregnant women did not perceive the need to seek healthcare services, which frequently contributed to the delays they were experiencing.

Another explanation could be that you arrive when the person assigned to assist is not accessible.

Another respondent added, *"What happens to nurses is that there will only be one nurse present throughout the night. As a result, weariness prevents them from attending to patients. There should be two or three nurses, so they can take turns resting."*

4.2.3 Poor Service Delivery

Despite significant advances, maternal mortality during and after pregnancy and childbirth remains unacceptably high. *According to the researcher's key informants 5 and 6, "most maternal deaths can be avoided with timely management by skilled health professionals in a supportive environment." The most prevalent direct causes of maternal injury and death include severe blood loss, infection, high blood pressure, botched abortion, and obstructed labour."*

4.2.4 Poor Referral Systems

According to one of the main informants, inadequate referral systems can prevent women from accessing timely and effective maternal care. *"Poor referral systems contribute to delays in receiving proper care, higher financial burdens on patients, and general dissatisfaction with the healthcare experience. It can also result in revenue leakage for healthcare providers, limiting their ability to deliver quality care."*

4.2.5 Religious Considerations

People from numerous apostolic sects live in the research area, and it has been determined that this has contributed to hurdles to women's access to maternity health treatments. This idea was confirmed by 15% of respondents. One was Grace, who stated, *"My husband attends an apostolic church (name omitted), and he always refuses to let me visit the clinic. He is very trusting in his church and its doctrine. The first time I went to the clinic, it was for something else at home, which I remedied by not going. However, you can tell sometimes that you require those maternal services."*

In keeping with similar ideals, Tino stated, *"My auntie was an herbalist who didn't want to hear about clinics and such. Unfortunately, she died from a condition that may have been treated at the clinic.*

4.2.6 Mistreatment by Clinic Workers

Mistreatment by staff was indicated as a barrier to using facility delivery services. The participants stated that the majority of government facility staff, including medical and administrative personnel, mistreated patients.

"I didn't appreciate how they constantly shouted at individuals. You are aware that the clinic will have patients with a variety of conditions. A medium noise may be uncomfortable for the sufferer since it feels so loud. They do not speak in a regular tone or are concerned about the patient's discomfort."

Other individuals had witnessed cruelty when visiting healthcare facilities with other patients or had heard about it from relatives or neighbours. One respondent had witnessed workers, including Indigenous staff, lecturing and shouting at pregnant women and their families during a previous visit to the health centre.

"They scolded and shouted at us frequently! That is what I find so awful: "Both the nurse and the cleaners mistreated us."

4.3 Effects of barriers women face in receiving maternal health treatments.

4.3.1 Loss of Life

One of the main issues or consequences of the impediments to maternal services for women in Goromonzi has been recognised as the loss of life. The researcher saw that sometimes people were dying as a result of not arriving at the hospital in time. Stacy stated,

"We took public transportation to get to the hospital, but when we got to the local clinic, there was no ambulance to do that for us. I had a sister who needed to be transferred to the general hospital. To aid my sister and myself, I had to rent a different car and hike on the main road.

It's regrettable that, despite clinical recommendations, she passed away before we could get to the hospital. The car took longer to arrive, and we let my sister down."

This demonstrates how accessing prenatal services on time for women is hampered or impossible by transportation issues. One of the women said, as a result,

"The clinic is not as near to everyone here. Vamwe vedu vanobva nekugomo ramukuona iro kusina kana nzira inofamba mota yakanaka iro. Tinofamba kubva ikoko netsoka kusvika kuno zvinova zvinokonzera kuti dzimwe dzenguva tirasikirwe nevanhu vakawanda mushure mekunge vanonokerwa kuonekwa navana chiremba paclinic. Dai tagadzirirwawo road iyoyo kuita kuti mota dzisvikewo tiwane maambulance kwedu uko....."

4.3.2 Poor health-seeking Practices

Many factors, such as a lack of knowledge about health issues, poor access to healthcare facilities, fear of medical treatments, cultural beliefs, and cost-related hurdles, can be blamed for the poor health-seeking habits of people living in rural areas. Serious health effects could result from this, such as longer sickness times, missed diagnoses, and higher death rates.

"We know we have to visit the doctor but think of it: they don't have painkillers, we don't have transportation to go there, and the hospital there offers poor services," said one additional respondent. I'd rather stay at home than go to the clinic. Toshanda nezviripo izvozvo.

One of the respondents stated, *"We are Africans, and it is not in us to visit the doctor anytime without cause," stated one of the study participants. When we experience pain or feel unwell, we visit the doctor. At the same time, if you truly want to get treated these days, visiting the hospital will cost you a significant sum of money. Therefore, I don't need to go to the doctor when I don't have the money, and I feel rather well so as not to waste it all on anything else."*

Therefore, one can be persuaded that the inadequate care given by rural hospitals and clinics has led to rural residents' poor health-seeking behaviours, exposing them to infections and diseases that are treatable.

4.3.3 Diminished trust in the healthcare system

The last shred of trust that the public had in the neighbourhood health services has been destroyed by poor service performance. *"Isu takatongoona kuti kuenda kwana mbuya nyamukuta mumana medu umu kurinani. Vanokubatsira nguva nenguva neruzivo rwavo rwechikuru kubva pakutanga kuzvitakura kusvika pakunobatsirwa. Zvekuno kuchipatara izvi ukanzi akuna maparacetamol, akuna ambulance mukuda kuendeswa kuhospital, mishonga yapera takamirira paichazouya atizivi kuti rini, kana kunzi chimbomirai tichazokuonai tadzoka pane patikumbosvika."* These folks don't even consider you when you come in for a check-up if you don't pay them more. That undermines our self-assurance.

4.4 The effectiveness of the measures put in place to help to improve maternal services.

Table 1: 4.1 Intervention methods put in place to reduce the barriers women face when accessing maternal services

Variable	Description	Frequency	Percent (%)
Building health infrastructures nearer to residents reduces the barriers women are facing	Strongly agree Disagree Not sure Disagree Strongly disagree **Total**	30 17 3 20 8 **80**	40.0 21.2 3.8 25.0 10.0 **100**
Increasing the health workforce reduces the obstacles you face when accessing maternal services	Strongly agree Disagree Not sure Disagree Strongly disagree **Total**	30 20 3 17 10 **80**	40.0 21.2 3.8 21.2 12.5 **100**

The provision of free health services reduces the barriers you face when accessing maternal services	Strongly agree Disagree Not sure Disagree Strongly disagree **Total**	28 20 5 20 7 **80**	35.0 25.0 6.3 25.0 8.7 **100**
The provision of adequate material resources reduces	Strongly agree Disagree Not sure Disagree Strongly disagree **Total**	30 20 - 22 8 **80**	37.5 25.0 - 27.5 10.0 **100**

Source: Questionnaire, 2024

The above table 4.1 shows the distribution of responses from the questionnaires in percentages. The majority of the responses were laid in agree and strongly agree on boxes. This led to the averages being skewed towards agree and strongly agree, giving an overall lean on the existence of a strong positive impact of the intervention methods put in place to overcome the barriers faced by women. As shown in Table 4.4.1 above, the invention methods are very effective and acceptable. This is confirmed by the bulk of respondents (n = 49, 61,2%), who pointed out that building health infrastructure nearer to residents reduces the barriers women face, emphasising that the government of Zimbabwe considers building health infrastructure seriously as a way of addressing the barriers pregnant women are facing. Only a sizeable figure of n = 26, 18, and 7% do not agree, while n = 5, equivalent to 16, and 7% of the target population were not sure about this idea.

Furthermore, table 4.4.1 above reveals that increasing the health workforce reduces the obstacles. This is acknowledged by the majority of the respondents (n = 50, 62, 5%), who pointed out that increasing the health workforce reduces the obstacles faced when accessing maternal services. A less disturbing number n = 27, worth 33, 7% do not agree, while a paltry n = 3, worth 3, 8% are not sure.

The researcher also conducted three focus group discussions aimed at investigating the effectiveness of measures put in place to improve barriers to better maternal services. Women were aware of their well-being challenges due to poor health infrastructure and cultural and religious norms and beliefs when it comes to maternal care and services. Most of the respondents confirmed the following strategies are effectively overcoming the barriers at hand:

(1) developing health infrastructure nearer to residents; (2) developing and retaining health workers; (3) addressing the shortage of workforce; (4) providing adequate material resources; and (5) providing free health services for all.

Provision of free health service

Provision for free health services is a measure that is put in place to help improve maternal service in Zimbabwe, and this measure is effective. One of the respondents stated that

"There are a lot of things that our community is getting; for instance, pregnant women are getting free services when delivering. So far, things are better. Health workers are disseminating information on children's vaccination dates; some people do not have radios, but the information is getting to people. The number of women delivering at home has declined."

Development of healthcare infrastructure

Developing the healthcare infrastructure is a measure being put in place by the government to improve women's access to maternal health services. One of the key informants responded by saying that

"*The government had done a lot to develop the health care infrastructure in this ward, and now we have more labour rooms and also waiting rooms that pregnant mothers can occupy when they are about to give birth, and this gave us room to monitor our patients and reduce complications during birth.".*

Maternal Education

Maternal education is one of the measures being used by the government, and this measure includes the introduction of village health workers that would help and educate the people within the village. The respondent, named Tanei, said that

"*Through the village health worker, I was educated on the importance of access to the maternal health service, and this encouraged me to go to the clinic when I was pregnant with my second child, and I gave birth without any complications*."

4.5 Chapter Summary

This chapter focused on bringing forward the data found in the study. The data from the case study was analysed through descriptive statistics. The findings were presented as frequencies, tables, and figures. A narrative discussion was done to explain the findings of the study. In the following chapter, V will present a discussion of the research findings, conclusions, and recommendations and spell out an intended area of further research.

CHAPTER FIVE: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses the key research findings about barriers faced by women in assessing maternal services, conclusions and recommendations and areas of further study of the results have been explained.

5.2 Discussions

Cues to action are external elements that motivate or inspire women to take action and seek maternity care. These cues could include guidance from family or friends, suggestions from healthcare providers, media campaigns, community-based activities, and potential risks. For example, research has shown that barriers to maternal healthcare access may result in death or future difficulties, motivating women to seek maternal care as soon as possible. Memory, a young lady who unfortunately died during childbirth, exemplifies the critical need for timely

maternal treatment. Women who interact with others frequently benefit from peer support, which includes encouragement to prioritise maternal health treatments as appropriate. Similarly, the potential benefits of maternity services serve as a call to action for women, especially those who are empowered. Understanding how maternal services can help reduce difficulties can encourage women to seek maternal care.

According to this study, impediments to accessing maternal services can cause women to lose faith in the local healthcare system and inhibit health-seeking behaviours. According to the study's theory, this considerably adds to women's negative impressions of obtaining maternal assistance. It is not necessarily due to a lack of resources at the clinic, as proven in this study, but rather to a sense of drug scarcity or concerns about the behaviour of healthcare workers.

To understand the barriers pregnant women face in attempting to get maternal service, the study first sought to understand how pregnant women felt when it came to obtaining service. From the data presented in Chapter 4, the researcher found out that women in Ward 16 Goromonzi face serious challenges in obtaining maternal service. Thus, women revealed that a pandemic such as COVID-19 has acted as a barrier for women seeking maternal care. People dreaded the pandemic so much that they felt threatened if they ventured out to seek maternal care during this time. It also raises the question of perceived susceptibility, as discussed in the theoretical framework. The issue at hand concerns the individual's subjective impression of the danger of contracting an infection or sickness. Women's fears of contracting an infection led to many of them not seeking maternal care before, during, and after pregnancy, which contributes to the ever-changing number of women dying from treatable conditions (Dzinamarira et al., 2022). The coronavirus pandemic resulted in an intensified burden on medical care, with pregnant ladies facing the most difficult circumstances. The methods implemented to minimise viral transmission, such as lockdowns and keeping social distance, hurt the provision of maternal health services, such as prenatal, post-delivery, and infant care (Chitungo et al., 2022). Pregnant women struggled to get to healthcare institutions using public transportation. Furthermore, healthcare staff prioritised coronavirus pandemic patients over other medical disorders (Kc et al. 2020; Pant et al. 2020). The results revealed that some pregnant moms received less support from health providers due to the coronavirus restrictions.

According to this study on the results in Chapter 4, mistreatment by healthcare providers is a significant barrier that prevents women from seeking and using maternal health services. This mistreatment can take many forms such as verbal and physical abuse, neglect, prejudice, and a

lack of informed consent. Such experiences can reduce women's trust in healthcare institutions and physicians, influencing their decision to seek treatment. Bohren et al. (2019) conducted a comprehensive study of the global prevalence of mistreatment during childbirth, which included allegations of physical violence, verbal abuse, stigma, and discrimination. Furthermore, a study conducted in Nigeria by Sando et al. (2020) found that women who had been mistreated were less likely to use antenatal care services following pregnancy.

According to this study in Chapter 4, strengthening healthcare infrastructure is an important step towards overcoming barriers to maternal healthcare access because it ensures the availability, accessibility, and quality of crucial services for women. This concurs with Renfrew et al. (2014), who conducted a systematic review that showed the importance of both physical and human resources in enhancing mother and infant health outcomes. The review emphasised the need for suitable infrastructure, including healthcare facilities, competent healthcare personnel, and necessary equipment, to improve the quality and safety of maternal healthcare services. Singh et al. (2020) observed that implementing a maternity waiting home strategy in rural Zambia increased facility-based deliveries and competent birth attendance, which contributed to lower maternal and newborn mortality rates. This emphasises the significance of investing in local healthcare facilities to overcome geographic obstacles to care.

A study by Kyei-Nimakoh et al. (2020) in Ghana found that higher levels of maternal education were associated with increased use of prenatal care, skilled birth attendance, and postnatal care services. This underscores the importance of investing in girls' education as a means of enhancing the uptake of essential maternal healthcare. Similarly, a comprehensive review by Cui et al. (2019) also demonstrated that increased maternal education levels were correlated with greater utilization of skilled birth attendance, prenatal care, and facility-based delivery services. This emphasizes the need to prioritize girls' education as a strategy to improve maternal and child health outcomes. The researcher in Chapter 4 also observed that maternal education enabled the protagonist to deliver her second child at a healthcare facility without complications, further substantiating the positive link between maternal education and access to quality maternal care. Additionally, Chiwaula et al. (2019) investigated the effect of maternal education on healthcare-seeking behaviours in Zambia and found that educated women were more likely to seek antenatal care, deliver in a healthcare facility, and receive postnatal care. This suggests that improving maternal education can help remove barriers to accessing essential maternal health services.

5.3 Conclusion

The constraints that women confront in accessing maternity health treatments have far-reaching consequences for women, contributing to higher maternal mortality rates and poor maternal health outcomes. The diverse nature of these impediments, which include financial limits, a lack of transportation, cultural beliefs, and poor infrastructure, emphasises the issue's complexity. Various measures have been put in place to help improve maternal health services, including the implementation of government policies to provide free or subsidised maternal healthcare, the establishment of community health programmes to increase awareness and access to services, the training of more skilled birth attendants, and infrastructure improvements such as the construction of maternal health clinics. While progress has been made, much more needs to be done to guarantee that all women have equal access to high-quality maternal health care. It is critical to continue working for the removal of these barriers and the implementation of effective initiatives to improve maternal health services worldwide. By addressing these issues and working towards long-term solutions, we may move towards a future in which every woman has access to the maternal health services she requires, resulting in better health outcomes for both mothers and their newborns.

5.4 Recommendations

Based on the findings of the investigation, the following recommendations were made:

- There is a need to train more staff in the health sector to meet the demands of maternal health care, thereby reducing waiting times and increasing the number of skilled staff who understand public relations. This might boost the confidence of women to visit clinics nearby.
- The churches, cultural leaders, women, and community need to be sensitised on the effects of not using maternal services facilities and the dangers that happen to pregnant women and their babies due to that.

- Launch focused community outreach programmes to raise knowledge about maternal health, accessible resources, and the value of expert care during pregnancy and childbirth.

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APPENDIX 1: FOCUS GROUP DISCUSSION GUIDE

Dear Respondent

My name is Tadiwanashe Choruma, and I am taking an undergraduate degree in Development Studies at Bindura University of Science Education. I am conducting a study titled "Investigating Barriers Faced by Women in Accessing Maternal Services in the Case of Goromonzi Ward 16."

You are cordially requested to answer the question. All information on this will be kept strictly confidential and used only for academic purposes. There is no need to undersign your name, thus your identity will remain secret. I would be grateful for your participation in finishing this research.

Yours sincerely

T. Choruma

1. What barriers have you faced when trying to access maternal health services?
2. Can you describe any difficulties you have encountered in reaching maternal health services?
3. How have language barriers affected your ability to access maternal health services?

4. Can you share any experiences of discrimination or stigma when seeking maternal health services?

5. What financial challenges have you experienced when trying to access maternal health services?

6. How have long wait times or limited availability of appointments impacted your access to maternal health services?

7. What specific supplies or resources have you struggled to access for maternal health services?

8. Are there any transportation challenges that have made it difficult for you to access maternal health services?

9. How has the lack of breastfeeding support or resources affected you after giving birth?

10. What difficulties have you encountered in accessing postpartum care and support for recovery after giving birth?

APPENDIX 2: QUESTIONNAIRE GUIDE

Dear Respondent

My name is Tadiwanashe Choruma and I am pursuing an undergraduate degree in Development Studies at Bindura University of Science Education. I am carrying out a study on; "Investigating barriers faced by women in accessing maternal services in the Case of Goromonzi ward 16.

You are kindly requested to respond to the question on this form. All the information on this questionnaire will be kept confidential and will not be used for any other purpose outside of academics. Your identity will be kept anonymous since there is no need to undersign your name. I would appreciate your participation in completing this research

Yours sincerely

T. Choruma

DEMOGRAPHIC INFORMATION

Tick the appropriate box or fill in the space provided

1. Age group (years)

<18	18-24	25-30	31-39	Above 40

[ ] [ ] [ ] [ ] [ ]

2. Your highest academic qualifications

O' level A' level Certificate Diploma Degree Post Graduate

[ ] [ ] [ ] [ ] [ ] [ ]

3. Marital status

Never Married Married Divorced Widowed

[ ] [ ] [ ] [ ]

WHAT IS THE OBSTICALS WOMEN ENCOUNTER WHEN ATTEMPTING TO OBTAIN SERVICE DELIVERY?

1. Do you have difficulty getting to the healthcare facility?

   Yes [ ] No [ ]

2. Do you have to wait a long time to see a healthcare provider?

   Yes [ ] No [ ]

3. Do you feel safe when you visit the healthcare facility?

   Yes [ ] No [ ]

4. Do you feel like the healthcare providers treat you with respect?

   Yes [ ] No [ ]

5. Are the costs of healthcare services affordable?

   Yes [ ] No [ ]

6. Are you able to understand the healthcare providers when they explain things to you?

   Yes [ ] No [ ]

7. What is your biggest challenge when it comes to getting the healthcare you need?.....
.....

8. What could be done to improve your experience with the healthcare system?.....
.....

9. How would you describe the quality of the healthcare services you have received?.....
.....

10. If you could change one thing about the healthcare system, what would it be?.....
.....

11. How would you rate your overall satisfaction with the healthcare system?.....
.....

12. Give different effects of the challenges faced in accessing maternal health service ……
……

- **Please check the appropriate box to indicate your choice of response**

Effective measures put in place to help in accessing maternal services include the following:

Measure	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
Building health infrastructures nearer to residents reduces the barriers women are facing					
Increasing the health workforce reduces the obstacles you face when accessing maternal services					

The provision of free health services reduces the barriers you face when accessing maternal services					
The provision of adequate material resources reduces					

THE END

Thank you for participating in this study

APPENDIX 3: KEY INFORMANT INTERVIEW GUIDE

Dear Respondent

My name is Tadiwanashe Choruma, and I am taking an undergraduate degree in Development Studies at Bindura University of Science Education. I am conducting a study titled "Investigating Barriers Faced by Women in Accessing Maternal Services in the Case of Goromonzi Ward 16."

You are cordially requested to answer the question. All information on this will be kept strictly confidential and used only for academic purposes. There is no need to undersign your name, thus your identity will remain secret. I would be grateful for your participation in finishing this research.

Yours sincerely

T. Choruma

1. Could you tell me about the main obstacles that women in your community encounter when trying to access maternal health services?
2. What do you think are the main factors contributing to these barriers?
3. How do these barriers affect women's health and well-being?

4. Do you think any existing interventions are effective in addressing these barriers? If so, what are they?
5. What are your recommendations for improving women's access to maternal health services?
6. Are there any cultural or societal norms that you think contribute to these barriers? If so, can you give examples?
7. What role do men and other family members play in women's access to maternal health services?
8. How do you think the current healthcare infrastructure in your community impacts women's access to maternal health services?
9. Do you think women in your community are adequately educated about their reproductive health and available services? If not, what interventions could be implemented to improve this?

Tadiwanashe_S_Choruma_B200894B_Research_project_FIN... MAY 28...docx

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