

Health Provision in Tshitshi, Zimbabwe: A Focus on Sexual and Reproductive Health

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COMPULSORY DECLARATION

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Abstract

Political conflict in Zimbabwe led to a series of crises that has negatively affected the nation's socio-economic status for over a decade now. The public sector's ability to provide basic services has been affected by a dead economy: the scarcity of resources such as money, water, energy, food, and medical care has meant that a once-desirable system has become dysfunctional and is too incapacitated to meet the needs of the public. The population has been reduced to paupers and forced to adopt informal survival strategies to access services that in a functional economy would have been provided by the government. Little is known about how services that cannot be forfeited, in particular sexual and reproductive health (SRH) services, are accessed by the most severely disadvantaged segment of the population: people living in rural areas. This study explores how the economic crisis shapes Tshitshi women's access to and use of SRH services. Specifically, it maps out Tshitshi women's experiences in accessing SRH services, the coping mechanisms, and the non-biomedical alternatives within the socio-economic deprivation they encounter. Data was collected in Tshitshi village located in Matabeleland South province of Zimbabwe using qualitative methods through focus group discussions and in-depth interviews. In analysing data, I used thematic analysis with the help of NVivo version 12 to identify and sort themes. The study adopted the transnational care framework which was informed by the findings of the research, where I identified transnational medical resources and care as the overarching theme. Findings show that Tshitshi women's access to and use of SRH services is mostly influenced by transnational care resources which is how they improvise and manage the healthcare genocide. To cope with the lack of biomedical services, Tshitshi women improvise and access non-biomedical services which present convenience in availability, affordability, and acceptability. The study results elicited recommending outsourcing of medical supplies as an acceptable measure provided the state can be trusted to commit to meeting the needs of the people in positive sustainable ways.

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Chapter 1 Introduction

1.1 Introduction

Issues such as gender and sexuality are commonly discussed in silos and not in conjunction with economic development indices. More particularly, topics of sexual and reproductive health (SRH) are often thought of as distinct from discourses on poverty or economic crises. However, in countries that have economic crises, patterns that indicate the utmost link between poverty and reproductive health emerge, illuminating the association of poverty and economic deterioration with the issues of SRH.

Zimbabwe's society and economy have steadily deteriorated over the past decades since independence. This has manifested as high levels of social exclusion especially in the rural areas where poverty rates are high. Social exclusion is described by Levitas et al. (2007, p. 25) as a complex and multi-dimensional process entailing the denial or deprivation of services, resources, and rights available to most of the population. In the opinion of Popay et al. (2008, p. 32), social exclusion is a state in which disadvantaged groups are structurally left-out or marginalized from social systems and relationships. Consequently, exclusionary processes have a profound effect on the standard of living or stability of a society as they contribute to unequal distribution and access to resources required for human growth. While material resources are the key drivers of exclusion, exclusionary factors such as language barriers, geographic distance from facilities or services, and non-supportive policies are also included (Bailey & Fahmy, 2017). For that reason, social exclusion is itself an immediate product of poverty, a phenomenon more prevalent in the rural wards and district councils than in urban wards. For instance, ZimStats (2015, p. 138) illustrates how Mangwe, a rural district in Matabeleland South with a total population of 67 005 has a poverty prevalence of 73.2 percent compared to an urban area like Bulawayo which has a population of 655 675 and 37.2 percent prevalence. By ward, Mangwe district has a higher prevalence at 82.8 percent and lowest at 69.5 percent whereas by ward Bulawayo's poverty

prevalence stands at 43.7 percent and the lowest at 23.4 percent (ZimStats, 2015, p. 14). So, since social exclusion is a result of poverty, communities with high poverty prevalence are most likely to be associated with exclusionary processes.

According to Popay et al. (2008) social exclusion limits individuals from partaking in social, economic, cultural, and political activities which has a detrimental effect on health and wellbeing. Lang et al. (2013), conclude that disadvantaged people face discrimination at the point of service delivery resulting in poor health access. Similarly, de Snyder et al. (2011), suggest that geographical areas of exclusion should not only be studied as mere disadvantaged dwellings, but as factors that lead to additional social and health risks. Thus, alluding to the fact that living in areas of exclusion increases risk of health inequalities. For example, poor health outcomes have been observed in densely populated Kenyan slum areas which are primarily related to socio-spatial exclusion. Compared to rural Kenyan mortality, infant mortality rates have been marginally higher due to insufficient hygienic practices, poor sanitation and ventilation which limit access to healthcare for the poor (de Snyder, et al., 2011, p. 1185). This shows how living standards or poverty are connected to social exclusion which in turn influences distribution and access to medical resources.

Studies reveal that countries with low socio-economic growth are often marked by violation of the rights of women to SRH (Adinma and Adinma, 2011; Milligan et al. 2002; Rugoho and Maphosa, 2017; Silver et al. 2003). Women are exposed to child and maternal mortality, unsafe motherhood, adolescent pregnancy, unsafe abortions, traditional harmful practises, period poverty and early marriages (Adinma & Adinma, 2011, p. 9). Such indicators of poor socio-economic development and poverty emerge within the case of Zimbabwe (Rugoho & Maphosa, 2017, p. 3). High rates of maternal mortality, child stunting and morbidity are related to the poor socio-

economic status of Zimbabwe which contributes to the challenges faced in service provision of SRH care. For instance, according to the Multiple Indicator Cluster Survey of 2019 (UNICEF, 2019), Zimbabwe has a maternal mortality ration of 462 deaths per 100,000 live births. While this is an improvement from the 614/100,000 live births of maternal deaths recorded in 2014, in 2017 458/100,000 per live deaths were recorded indicating the instability due to the socioeconomic situation Zimbabwe.

Owing to the inherited post-independence structures that prioritized the health sector among other industries, the health system was fairly sound during the late 1980s in Zimbabwe. In particular, priority was placed on interventions which targeted providing and delivering health services to women and children in poor areas through '*vanambuya hutano*' meaning women of health (Gordon, 1997). Trained health workers travelled household to household educating and providing SRH services like contraception, ante and post-natal care support for women in the rural areas (Gordon, 1997, p. 269). These interventions were effective in addressing challenges that rural and marginalised women faced in their traditional roles of reproduction. However, in the subsequent years reforms inspired by World Bank and International Monetary Fund (IMF) encouraged reducing social expenditure in order to stimulate economic growth. For instance, the health sector allocation for government per capita health spending was cut down from \$55.7 in 1980 to \$0.19 in 2007 (Makochekanwa, 2012, p. 3). Gordon (1997, p. 271) refers to a study that was conducted by the Zimbabwe Women's Resource Centre and Network (ZWRCN, 1995). The study (ZWRCN, 1995) indicates that the number of pregnant women who used the health facilities decreased significantly due to implementation of healthcare user fees, leaving more women vulnerable to complications of prenatal conditions. More so, due to the substantial inequalities in the provision of health services, the Zimbabwe Demographic and Health Survey (2015, p. 132) indicates that progress remains uneven between the poor and the rich households. For example, only 15.7

percent of poor people are likely to attend a post-natal check-up within 2 days of delivery, compared to 46.6 percent of the wealthy, demonstrating that the inequalities of access to healthcare and SRH services are largely based on socio-economic status. To support this, the study by Busumani and Mundagowa (2021) reveals how rural healthcare facilities in Zimbabwe fall short of providing the services they should, with 81.6 percent of women from rural areas being referred to central hospitals for pregnancy related issues. Thus, demonstrating the substantial inequalities in the provision of health services between rural women who are at a significantly higher risk of pregnancy related risks compared to their urban counterparts.

In a collapsed economy, basic social services are affected particularly health services because they are inelastic to demand and supply. The need for health services especially SRH is constant and cannot be forgone only because of socio-economic deprivation. This means that the most vulnerable population, women, and children, are affected and more uniquely rural women. SRH care is one service which is completely irreplaceable regardless of the economic status. For instance, when food prices go up, people can improvise and reduce the number of meals per day but cannot opt to reduce the need to use pads or obstetric equipment because of a poor economy. Therefore, the study sought to understand how Zimbabwe's economic crisis shapes rural women's access to and use of SRH services. It has to be noted that the situation in Zimbabwe is not a mono-crisis but a series of crises arising from diverse cases of the country's political and socio-economic challenges in different times (Besada & Moyo, 2008). The links between socio-economic status, social exclusion and access to health services indicate that SRH is not merely a women's issue but is linked to other economic indicators. For this study, I sought to understand the means through which rural women of Tshitshi in Mangwe rural district located in Matabeleland South province of Zimbabwe, navigate the challenges created by a need for SRH services amid ongoing socio-economic deprivation.

1.1.1 Background: Understanding the Economic Crisis and Healthcare

Political conflict in Zimbabwe led to different crises linked to scarcity of resources such as money, water, doctors, energy, and food (Chiumbu & Musemwa, 2012). Some scholars (Chiumbu and Musemwa, 2012; Raftopoulos, 2009) argue that the crises cannot be understood independent of the colonial and post-colonial developments. Zimbabwe inherited pre-independence structures that negatively influenced its economic and socio-political ideologies causing inevitable damage to the policies implemented in the post-colonial era (Chiumbu & Musemwa, 2012). In the 1960s, Rhodesia declared a Unilateral Declaration of Independence (UDI) which resulted in economic sanctions on the country from the international community. This crippled the country's ability to develop in consecutive decades under the new government post-independence as it inherited enormous debt (Makina, 2010, p. 101). So, upon independence, instead of reforms and fulfilment of the promises of equality made to the citizens, Zimbabwe perpetuated colonial practices that were undemocratic. The government reneged on promises to afford the nation basic needs such as improved living standards, freedom and led to a further decline (Besada & Moyo, 2008, p. 1). Therefore, post-independence development in Zimbabwe was hindered by the policies and practices that had been established by the colonial power and the government of Rhodesia.

Furthermore, external factors also influenced the rapid deterioration of the economy through introduction of neo-liberal policies that were meant to address socio-economic challenges. Unfortunately, implementation of Economic Structural Adjustment Programs (ESAP) was not backed up by a stable economy, which rendered it impossible to retain subsidised services for the citizens. Makina (2010, p. 102) states that implementation of the ESAPs intensified poor economic performance such that by 1996 the government had abandoned the policies. The government then reverted to unsustainable and disorderly economic policies which largely contributed to the

economic meltdown in the 2000s. In the subsequent years, the Reserve Bank of Zimbabwe (RBZ) started printing more money in order to manage depleted foreign reserves causing hyperinflation (Raftopoulos, 2009, pp. 220-222).

Further, Barry et al. (2009, p. 5) refer to the period between year 2000 and 2005 as the time when “the economy spiralled downwards under the weight of expropriation and mismanagement of farms, erosion of tax revenues and declining public services” which facilitated socio-economic repression. Besada and Moyo’s (2008, p. 12) views substantiate the aforementioned by attributing the 2000s economic meltdown to political, economic, and environmental factors that informed the formulation of ill-fated policies for the country. Poor governance, economic mismanagement and continuous human rights violations made Zimbabwe lose favour from the Western community. For instance, Besada and Moyo (2008, p. 2) highlight how the government held onto power by paying lump sums to the war veterans. These reparations to war veterans were effectively used as bribes in return for their loyalty and political support towards elections. During that period, the once-off payments of 3000 USD approximately 3% of gross domestic product (GDP) and a monthly pension of 125 US dollars (Buigut, 2015, p. 691). Such actions accompanied by the rife corruption contributed to the demise of the nation. Immediate inflation followed as the pay outs contributed to the budget deficit that was not substantially accounted for. Essentially, poor governance and poor land- and resource management led to a shortage of basic commodities and services.

These events further toppled the precarious economy, dropping it to levels that discredited the Zimbabwean currency as a means of trade. Dollarization was assumed in January 2009 (Makina, 2010, p. 116). This era was characterized by the use of the US dollar to manage and stabilise prices of goods that were constantly rising. According to Buigut (2015, p. 692), dollarizing normally

entails the use of one beneficial currency to reduce trade costs and to provide a reliable exchange rate for transactions. However, Zimbabwe's case was unique in that it adopted a multi-currency system where the US dollar was used concurrently with other currencies, namely the Pula, the Rand, the Pound, and the Euro (Buigut, 2015, p. 692). This meant that RBZ could no longer govern the monetary policy as it had no control over the printing of the currencies that were being used. Makina (2010, p. 117) confirms that the government's loss of seigniorage exposed the nation to dependence on foreign capital inflows, donor funds, and remittances for the supply of the currency. With the economy divided into five unequal currencies for market transactions, black-market activities escalated. Transaction rates differed from one city to another and in some cases, from shop to shop. This exposed the populace to the whim of black-market rates and left the people at the mercy of a government that had no control over the flow or supply of cash. Access to goods and services was dependent on meeting black market pricing, and many people were thus disenfranchised. In spite of the aforementioned, Matanda et al. (2018, p. 253) note the upside of dollarization was that there was gradual change in the economy from 2009 – 2012. People were eventually able to access basic commodities, and the country was able to engage in regional trade which stabilised the deficits and the standards of living.

In May 2016 Zimbabwe introduced the use of a substitute currency, 'bond notes,' which were aimed at addressing the severe cash shortage that was gradually consuming the economy (Matanda, et al., 2018). Bond notes were to be traded at par with the US dollar but were never fully embraced by the population and therefore came with their own challenges. International trade markets never acknowledged the currency, and this discouraged imports and investments while encouraging inflation and reignited the growth of the black-market economy (Matanda, et al., 2018, p. 255). The economy suffered because trade with regional partners like South Africa was impossible due to foreign currency shortages and the new, unidentified currency adopted by

Zimbabwe. Matanda et al. (2018, p. 258) state that “bond notes did not qualify as a store of value as they were founded on a non-existent notion of value, a liability backed by another liability.” This led the country into further economic turmoil.

Continuous upheaval has seen the formal economy subside and informality has become the most significant economic practise for households to survive. In 2019, Zimbabwe’s economic status was largely characterised by increased rates of unemployment, eighteen-plus hours of power cuts every twenty-four hours, shortages of water, cash, fuel, and food. When I wrote this chapter in 2020, annual inflation had risen to more than 600% and the population was dealing with shortages of basic services as a standard daily challenge (Mutsaka, 2020). As a result of these economic challenges, individuals adopted diverse livelihood practices as an overall strategy for necessity and survival, locally referred to as ‘*kukiya-kiya*’ (Jones, 2010). *Kukiya-kiya* refers to several ways of making do, where the requirements of survival and needs are balanced by temporary changes in economic activities (Jones, 2010). According to Ellis (1998) livelihood diversification refers to a phase by which individuals participate in several activities and social support capabilities to survive and enhance their living standards. It therefore encompasses income and social institutions essential for food security, poverty reduction and wellbeing. Jones (2010, p. 290) identified popular ways in which people survive through economic crises: bulk accumulation of goods for resell, gold panning, robbery, money changing and sex working, the latter being most common amongst women. In addition, Mushongah and Scoones (2012) note how rural people’s livelihood activities in Zimbabwe shifted from reliance on subsistence farming to vulnerable activities such as illegal border jumping into South Africa for temporary jobs. In a country with a collapsed economy, livelihood diversification not only encompasses economic attributes but also the social relationships and institutions that facilitate people’s access to various survival needs and services.

Zimbabwe's economic situation not only affected the stability of individuals and households but also the ability of the state to provide services such as medical care, as hospitals also experience electricity and water poverty (Mukerezi, 2019). Lack of access to clean water sources has led to outbreaks of cholera as people resorted to using water from polluted rivers (Burke, 2018). As a result, water-borne diseases have been a constant in Zimbabwe because of the unceasing water issues related to poor governance. The healthcare system is in tatters, with the cost of healthcare continuously increasing and standards remaining far below acceptable in those few places where such government services are available.

Most healthcare facilities are inaccessible due to lack of services, high prices and ongoing demonstrations by doctors against unsafe working conditions and low salaries. Public hospitals do not have medical basics like gloves and bandages, whereas private hospitals remain inaccessible for many due to high rates of informal employment and the cost which is always quoted in foreign currency (Chingono, 2019). Public medical centres have been severely incapacitated for at least a decade now, failing to provide basics such as water and electricity, and operating under extreme staff shortages due to brain drain (Burke, 2018).

“There is no urgency, there is no priority... We certify dead bodies.”

Head of Paediatrics at Parirenyatwa Hospital (Dr Mashumba, 2019)

This resonates with the Zimbabwean experience as many health facilities are white elephants that are under-resourced and under-staffed. Every Zimbabwean citizen is affected by the collapse of the health system, but the most vulnerable are the poor who cannot opt for private care and are exposed to bog standards and corruption. For example, to access obstetric services women have to negotiate bribes for the midwives or run the risk of being denied a bed and delivering without medical assistance (Chingono, 2020). Medical practitioners treat women who pay bribes in

foreign currency with urgency and neglect those who cannot afford to participate in this system. As an alternative, pregnant women are forced to resort to back-yard deliveries offered by unqualified ‘midwives,’ with all the attendant risks of complications which may be magnified by underlying conditions (Mutsaka, 2019). If state referral hospitals such as Parirenyatwa do not have basic health services, rural district hospitals that serve the rural poor are in worse off conditions. For example, the Jeke community in the Mberengwa rural district uses an ox drawn cart as an ambulance which does not have medical equipment (ZimEye, 2021). The situation with Zimbabwe’s public health is critical, given the country’s status as a weak political economy. This state of affairs has significant repercussions for the vulnerable poor, especially women and girls

1.2 Problem Statement

In a volatile and deteriorating economy, basic social services are affected and in Zimbabwe it is the poor who suffer most. In a country such as Zimbabwe where the economic crises is ongoing, access to basic services is compromised. However, services such as SRH for women cannot be replaced or forfeited making this one of the biggest challenges facing a deteriorating economy. Since SRH cannot be replaced women have to find other downstream strategies which are not government verified to satisfy the health needs. These strategies are impacted not only by social support practices but also by economic elements which shape women’s access to and use of SRH services. This study seeks to understand how women in Tshitshi, Zimbabwe navigate the challenges created by the Zimbabwean government’s failure to provide safe, affordable, and reliable medical care, with a particular emphasis on SRH services, based on the understanding that SRH service provision is not merely a women’s issue but also reflection and consequence of economic indices in a country.

1.3 Objectives and Questions

In order to learn from lived experiences, I set out to explore and navigate the actual practices of access and use of SRH by women in rural Zimbabwe. Through qualitative research methods, I investigated the following key question:

- *How does the economic crisis in Zimbabwe influence Tshitshi women's access to and use of sexual and reproductive health services?*

Research sub-questions to guide my investigation were as follows:

- How has the economic crisis influenced Tshitshi's local health facilities service provision?
- How does access to sexual and reproductive health shape Tshitshi women's livelihood diversification?
- What determines Tshitshi women's decision to use biomedical health services?
- What alternatives/ substitutions are considered in the absence of the government verified healthcare providers?

The research objectives were as follows:

- To map how women access and use sexual and reproductive health care in rural areas of Zimbabwe.
- To explore the linkages between healthcare providers and service delivery platforms.
- To investigate access and use of alternative local knowledge of sexual and reproductive health.

1.4 Significance of the Study

The absence of pragmatic approaches to the resource-poor country's ongoing problems impacts the country's success at micro and macro level. My study is a contribution to the continuous discourses on human rights as an obligation that all states should respect, with special emphasis on the SRH health rights of women in marginalised areas. The primary significance of the study is to influence investigation of the nature of women's health issues, as women navigate the

country's economic impasse. The focus on women in rural areas provides a different scope for academic discourse on accessibility and utilisation of SRH services in Zimbabwe, with the possibility of inspiring new thinking towards how the crisis has shaped their experiences. The study also brings to light the crucial role of transnational medical care in the absence of adequate local services, thus contributing to academic debates that focus on understanding medical care in times of crises. Furthermore, the study drives interest towards the importance of providing comprehensive SRH education in rural societies by bringing to life the voices of women living through the crisis. As Ngugi wa Thiongo (2006) put it, 'women bear the brunt of poverty.' I argue that only by including women's lived experiences in academic debate can we appreciate and understand the influence of the economic crisis on their SRH. Finally, the significance of my study is that it does not view SRH as merely a women's issue separate from other economic indicators, but as an interconnected element crucial to understanding economic crises.

1.5 Chapter Organisation

My dissertation has been broken down into five chapters (including this one) in which I introduce and discuss the aim and questions of my study. I have provided an overview of the Zimbabwean economic crisis and identified the instability of the political economy in Zimbabwe as a reason for the poor performance of various sectors, focusing on the healthcare system and provision of reproductive health services. Further discussions on reproductive health issues will be addressed in Chapter Two of the dissertation, which justifies the study. In Chapter Two, I provide a literature review to understand how economic status influences access to and use of SRH services. The chapter also includes literature which showcases transnational medical care in times of crises while relating it to the Zimbabwean context. In Chapter Three, I focus on outlining the methodological design and techniques used for the study. A detailed explanation of how the data was collected, generated and the analysis tools used is provided, as well as the reflections on the

limitations of the study. Chapter Four presents a synopsis of the findings and analysis thereof. Through analysis of the findings, I identified transnational medical resources and care as the predominant theme emerging. This led to discussion of three categories and subcategories which show how women's access and use is mostly influenced by transnational resources and care due to the economic situation. Finally, Chapter Five gives the summary discussion of my investigation and concluding remarks.

Chapter 2 Literature review

2.1 Introduction

This chapter engages with literature on SRH services for women in Africa and how access and use is affected by economic circumstances. Access to SRH services is explored as a multifaceted process. The chapter is divided into four segments. The first section offers an overview of what has been observed with respect to African countries with low socio-economic status and the consequences for accessibility to public health. The second part introduces the concept of SRH and places it within the context of Africa. I explore how women's access to and use of SRH within society is affected by socio-economic circumstances, drawing a comparison with the experiences of Zimbabwean women. The third section looks at transnational medical services as an improvisation to accessing healthcare. I also discuss the advantages and challenges women face when escaping home in times of crises. The last section reviews the theoretical framework in an attempt to show the implications of the crisis on access to health services in developing countries. Ultimately, this review aims to investigate how access to and use of SRH is affected by economic factors specifically with reference to women in Zimbabwe.

2.2 Link Between Socio-Economic Status and Access to Health: An Overview

There is substantial evidence that there is a relationship between the socio-economic status of a nation and access to health (Adinma and Adinma,2011; Ayuk-Nkem, 2016; Burger and Christian, 2018). A strong understanding of this marriage is essential to the realization of the fundamental human right of access to adequate healthcare. However, with economies that are undermined by high rates of corruption, poverty, hyperinflation, nationalist authoritarianism, inequality, and a lack of basic needs, accessing health seems far-fetched particularly for the disadvantaged. Harris, et al. (2011) are of the opinion that in order to achieve adequate universal healthcare, the necessary services should be accessible to the entire population without any individual barriers to

affordability. This is demonstrated by the South African study (Harris, et al., 2011) which reinforced Julian Tudor Hart's (1971) 'inverse-care law' principle. The principle is that 'the availability of good medical healthcare varies inversely with need for it in the population such that it is distributed based market forces. In this scenario, the wealthy would most likely receive proper care compared with the poor, who in many cases are also the sick (Harris, et al., 2011). Despite the universal right to access to good healthcare, Harris et al. (2011) argue that access to healthcare in South Africa remains largely influenced by the socio-economic status, gender and residence of households which shows that individual status influences the ability to access healthcare. Further, unequal distribution of resources to different people promotes unequal access to healthcare (Whitehead et al, 2001; Harris et al, 2011). This could be the reason why access to healthcare in low and middle-income countries is ensnared in equity issues, where urban health facilities tend to be better resourced compared to rural health facilities and the ability to access it is based on affordability. (Whitehead, et al., 2001)

Similarly, Kiwanuka et al. (2008) provide evidence of Uganda's conditions impacting access to and use of healthcare where the most vulnerable are chiefly the disadvantaged and have less access. This was due to impediments arising from insufficient distribution and resource constraints such as distance to health facilities, expense, lack of drugs and lack of skilled public health workers. Despite implementation of the 'Uganda National Minimum Health Care Package' in the year 2000, the country's varying distribution of the care package was associated with resource constraints. This resulted in unequal rationing of the service across the population such that the higher-level health centres benefited more, and the situation worsened for the poor (Kiwanuka, et al., 2008). Peters, et al., (2008, p. 165) argue that in developing countries common healthcare problems of absentee health workers and lack of drugs at public hospitals are well documented but the different effects it has on poor people is not. They (Peters, et al., 2008) give reference to

how due to poor availability of health services, poor people in Sri Lanka readily use informally trained health providers and shopkeepers or bypass nearby clinics in favour of farther clinics. The poor are subjected to long distance or compromising on the quality of healthcare. This further reiterates the point that poverty influences access to healthcare.

Likewise, Kyei-Nimakoh et al. (2017, p. 2) argue that the key goal for any health facility is to provide appropriate services that satisfy patient needs while remaining accessible and affordable especially for patients with specific needs. In particular, Kyei-Nimakoh et al. (2017) suggest that in low-and middle-income countries there are strong discrepancies in access to maternal care based on residence, socio-economic status which are inequity markers. Kyei-Nimakoh et al. (2017, p. 8) somewhat agree with scholars such as Harris et al. (2011) that low socio-economic status influences access to health in interrelated affordability and accessibility problems. To back this viewpoint, Peters, et al., (2008, p. 165) note that poor people in Sri Lanka use shopkeepers as they are more likely to sell an incomplete dose of drugs which may be appreciated when cash is not available to buy a full treatment course.

However, Kyei-Nimakoh et al. (2017, p. 8) suggest that access to healthcare could also be influenced by socio-cultural obstacles. Countries such as Ghana, South Africa, Kenya, Uganda, and Zimbabwe in sub-Saharan Africa have abolished maternity user fees but household income still hinders access and use of health services through indirect costs like transportation (Kyei-Nimakoh, et al., 2017). Related to this view is Burger and Christian (2018, p. 13) who point out that health inequity remains a problem in South Africa because of the Apartheid legacy which created structures that fostered remoteness and exclusion of underdeveloped areas.

In relation to the views of the above-mentioned scholars, Houweling and Kunst (2010) suggest that various dimensions of social stratification such as ethnic group, migration status, education, cultural expectations, and occupation can also affect healthcare access. For example, levels of education can affect access to and use of maternal health and negatively impact infant mortality. This could be the reason why scholars such as Peters et al. (2008) put forward that the association between low socio-economic status and healthcare access can be viewed as part of a wider cycle in which poverty contributes to poor health and poor health preserves poverty.

McKay (2018, pp. 41-43) provides another interesting view that the provision of healthcare services in rural areas in Mozambique is also determined by the degree of vulnerability or the form of illness. For example, McKay (2018, p. 42) discusses how conditions such as HIV/AIDS take precedence over others, showing how healthcare is not accessed as a right or need, but rather according to medical categories used to filter service distribution to the population. In this case, medical resources are distributed on the basis that fits the perceived imagine of a real patient. Kyei-Nimakoh et al. (2017) conclude that the healthcare of sub-Saharan African countries operates mainly under poor conditions with insufficient resources and conditions which promote unequal access to healthcare and foster socio-economic inequities. Therefore, just as social status and geographical location always overlap, low socio-economic status and rural areas have a relationship which negatively influences access to and use of SRH services

I acknowledge that the socio-economic status of any country shapes access to healthcare services in various ways, including the ability to buy necessary resources, gain access to social determinants such as education, and break away from cultural expectations. Having presented an overview of the relationship between health and socio-economic status in some African countries,

I move on to introduce the concept of women's SRH care and explore its meaning and implications in an African context.

2.3 Women's Sexual and Reproductive Health

The right to control a woman's body was introduced to literature during Thomas Robert Malthus population debates in the 1800s, but his writing never addressed the health and well-being of women as in the current discussions. The importance of women's health, particularly their sexual wellbeing, is relatively new to the discourse around women's bodies. This became a concern after several international conferences including the Fourth World Conference of Women (1995) in China. This conference emphasized the need for all countries to reform their health policies in order to amend any initiatives that are against women who freely exercise sexual independence. Historically, men have made most of the decisions about fertility and contraception (Chrisler, 2013). More recently, other factors such as social, economic, and cultural developments have been considered to have an impact on the access to and use of SRH services (Chandra-Mouli, et al., 2015). The Sustainable Development Goals also suggest that health is essential for each country's development as illustrated in goals 3, 4, and 5. To achieve these three goals it is imperative for each country to implement health strategies supporting women and girls' needs. For example, inclusive education is important for the elimination of gender inequality as both girls and boys are equitably trained to eliminate any discriminatory attitudes towards women who openly embrace their sexuality.

Adinma & Adinma (2011, p. 11) suggest that reproductive health plays a crucial role in development because efforts to improve the economy with little emphasis on health provides little progress towards positive reform. This may be the reason why Davies (2013, p. 390) argues that as long as states lack political and economic commitment to reproductive health, women's access

to adequate healthcare will also lack value in society. For this purpose, states should invest in advancing sexual reproductive health needs at local and international levels to ensure that women do not suffer from health disparities.

Having explained the importance of women's SRH, it is equally important to understand what this entails. It is a nebulous term, difficult to define in detail, but attempts have been made to describe what it entails. Edward and Coleman (2004, p. 191) suggest that it means being able to make safe, disease-free SRH choices. To reinforce this, Ilsa Lottes cited in Edward and Coleman (2004, p. 190) notes that it refers "to the ability of individuals to appreciate and express their sexual being free from danger of diseases, unwanted pregnancy, coercion, violence and discrimination." The aforementioned definitions all emphasize that SRH, includes accurate informed education, and respectful, healthy, and consensual sexual relations. Meanwhile, Robinson et al. (2002, p. 45) describe SRH as an attitude to sexuality founded in correct understanding, personal experience, and self-acceptance, in which one's habits, beliefs and emotions are congruent and incorporated into a person's larger framework of personality structure and self-definition.

In Sylvia Tamale's book *African Sexualities* (2011, pp. 11-20) an understanding of SRH is derived from Africans' historical developments, including sexual awareness, attitudes, beliefs, values, and behaviours in various regions. In contrast to Western narratives, her argument focuses on the need to understand how Africans understand what SRH comprises, considering race, ethnicity, socio-economic status, age, or religion. Furthermore, the fact that the topic is often considered taboo or personal in African cultures is a mark of repressed or unknown knowledge that should not be generalized in order to define the experiences of SRH in a uniform manner (Tamale, 2011, p. 19). In addition, Klepp et al. (2008, pp. 7-11) found that the sense of SRH can also vary between older adults and younger women. This is because they may have different SRH needs which often

change from society to society. Certainly, the perception of SRH should consider personal, social, environmental, and structural aspects outside the general reach of medical description. It should recognize how awareness, beliefs, cultural differences, and behaviours vary and are important for understanding women's definition of SRH.

The above descriptions reinforce the importance of understanding women's access to and use of SRH services and the need to reasonably map what drives access to and use of SRH by women, particularly during an economic crisis. Also, an informed definition of SRH provides the correct setting through which to understand the sexual reproductive experiences of women, since socio-economic characteristics correlate with the perception of SRH which in turn may either encourage or hinder access to services.

2.3.1 Access to and use of Sexual and Reproductive Health

Access to and use of sexual reproductive health services continues to be a problem for women in many nations, and even more in crisis countries. According to Davies (2013, p. 393) access to healthcare refers to the freedom to openly pursue self-care without hindrance or pressure and also encompasses the right to provide the best possible care. Thiede et al. (2007) agree that it entails freedom but further stipulate that three interlinked elements namely availability, affordability and acceptability are essential to understanding the broader social context in order to map access to health. Availability refers to the relationship between physical access to medical services and the patient, where medical treatment is available, adequate, reachable, and suitable for the patient when necessary. Affordability requires an individual to have financial access to medical services. Thus, affordability refers to the relationship between the cost of medical services, the ability/willingness to pay for the services, and the patients' value for money (Nasiripour, et al., 2011). The ability and willingness to finance direct or indirect medical services may influence the desirability of SRH services. The third element, acceptability, refers to socio-cultural factors

wherein there is consideration of the quality and type of the medical service rendered in relation to how it is received by an individual (Nasiripour, et al., 2011). Therefore, patients' attitude toward healthcare provision may influence the health services' acceptability such that if the patient does not see the value of the service they will not access and use it. This also works in reverse: the attitudes of healthcare providers about who and what they consider appropriate for the patient can affect acceptability, especially if the providers find the patient unsuitable for some medical services. Hence, access and use of SRH services is conditional on these dimensions and should be understood within the social and cultural context of a society.

Thus far, literature has demonstrated that the socio-economic status of women affects access to and use of SRH, however it is unclear how these factors affect each other (Ayuk-Nkem, 2016; Burger and Christian, 2018; Kyei-Nimakoh et al., 2017). Wamoyi et al. (2014, p. 2) note that socio-economic factors such as social norms and poverty either increase or decrease women's access and use of SRH services. They (Wamoyi, et al., 2014) argue that most women in sub-Saharan Africa are at double risk of suffering since they are already in a poor region and are among the vulnerable population as women. Studies in Tanzania show how women forfeit SRH for economic benefit where the need for economic freedom prevails over the need to access and use the services. For example, women in rural Tanzania are essentially deprived of their power to negotiate the use of condoms for any sexual activity due to their economic needs (Wamoyi, et al., 2010). The power structure relies on both patriarchal norms and the economic disadvantage that causes women to rely on men for their needs.

Likewise, research conducted in South Africa, KwaZulu Natal by Hunter (2009, p. 693) shows how it is common for poor women to forfeit negotiating the use of contraceptives with multiple partners as a survival strategy. So, women make choices based on economic necessity. This is

particularly relevant because, initiatives that aim to provide access and use of SRH are often based on improving individual actions rather than understanding access within the framework of socio-economic conditions. For example, interventions available to promote SRH services concentrate on a “risk factor” where women’s access to and use of SRH is focused on the implications of not using the services rather than recognizing the risk-causing social environment (Wamoyi, et al., 2014). In this case, it is not possible to solve the problems of unintended pregnancies and sexually transmitted diseases by educating and providing contraceptives alone without addressing the economic issues that expose women to unprotected transactional sex. Due to poor socio-economic status women lack the agency to make choices about contraception.

SRH services may be available and affordable but limited acceptability of the services due to poverty results in poor access and use. An example of common difficulties found by Webber et al. (2012) is that women in Cambodia will prefer to assign money to essential things like food, shelter, and family needs over their own health needs. So, acceptability of healthcare in this case is compromised by the extent to which an individual values healthcare in relation to their socio-economic needs. Kyei-Nimakoh et al. (2017, p. 9) concur with this in their description of acceptability, that it includes the extent to which the patient trusts the healthcare services to meet their immediate socio-economic needs. This reinforces the fact that women’s access to and use of SRH is influenced by their economic status. Social sense of basic needs is dependent on household income, which then determines their willingness to pay informal costs for access to healthcare. More so, there is evidence that women are often the first to stop eating in order to ensure the supply of food to their family, despite the consequences for their own health, including risk of poor pregnancy outcome and maternal death (Phillips, 2009). Studies from India show that women, as caretakers of the family, are expected to eat only the remaining or leftover food, which can result in malnutrition for the mother (Nandal, 2011). Therefore, related gender norms around

the behaviour of women as requiring self-sacrifice also reduce the health-seeking behaviour of women, meaning they will often forgo essential medicines and put their own lives at risk during times of economic hardship. Peters, et al., (2008, p. 166) refer to studies in Bangladesh, Burkina Faso, and Afghanistan, which demonstrate that patients' acceptability can be more important determinants of utilization than prices or other dimensions of access. For instance, in Afghanistan, gender inequities in health services are common particularly for poor women and manifest as health services that are not acceptable to women.

Kyei-Nimakoh et al. (2017) confirms that low- and middle-income countries identify problems in maternal care, such as poorly resourced health facilities, lack of drugs/ equipment, insufficient medical transport and lack of water and electricity. This is true in Zimbabwe, where persistent shortages of medical equipment/drugs and deterioration of medical facilities are common (Busumani and Mundagowa, 2021; Chikanda, 2010; Mangundu, et al., 2020). The level of accessibility to women's services has declined most notably in rural areas, which is evidenced by the increase in the number of unplanned births as indicated in the National Family Planning Strategy (GoZ, 2016-2020). In his article, Mutsaka (2019) notes that the health sector has no basic medical supplies such that patients have to bring their own when they need medical attention. The shortage of items like syringes, bandages, required drugs and water, and strikes by medical staff worsen the medical negligence situation. Poverty robs many poor women of their right to access appropriate SRH care services. Silal et al. (2014, p. 6) argue that distribution of services poses a specific challenge for the poorest women in South Africa's under-resourced communities. Based on the study carried out in Bushbuckridge, Mpumalanga and Hlabisa, Kwa-Zulu Natal, to examine the perceptions of obstetric care access for the poorest women, findings indicated that clinics were without obstetric ambulances and were too under-resourced to handle even normal vaginal deliveries (Silal, et al., 2014). Related to this, Chingono (2020) reports that to receive obstetric

care in Zimbabwe, women in labour have to pay bribes to the midwives to get assistance. Due to the socio-economic situation, the state fails to fund public hospitals and provide adequate remuneration for the medical practitioners. Such ill management fosters the injustices which are crucial determinants of women's access to and utilization of SRH services.

Cultural perceptions, traditions, beliefs, norms, and values are significant determinants of reproductive health experiences and decision-making in societies. For instance, in Zimbabwe, the provision of termination of pregnancy services is criminalized to such a degree that women cannot access these services without being judged by society. Chiweshe et al. (2017, p. 219) illustrate the implications of criminalising access to SRH services and detail how the absence of such services creates dysfunctional social structures in which women are unfairly judged and do not have autonomy over their own bodies. Makinde and Adebayo (2020, p. 2) concur and state that Nigerian women also do not have autonomy over their bodies because of unfair gender roles that do not allow women the agency to control or make informed choices about their own bodies, particularly when married. Likewise, in Bangladesh, the social and cultural context plays an important role of the access to and use of health services for women. Social and cultural factors influence the role of gender and participation of women in decision making, as such, women are less likely to access and use health services due to gender bias that reflects that it is not appropriate for women to be seen by a male doctor (Mannan, 2013).

Contrary to women in Zimbabwe, South African women who do have legal access to termination of pregnancy services still make decisions based on social control and expectations, in which marriage is the acceptable institution for reproduction (Chiweshe, et al., 2017, p. 212). This shows how in addition to economic factors, societal beliefs, expectations, and regulations control women's access to and use of SRH services. Kyei-Nimakoh et al. (2017, p. 11) conclude that

governments are better positioned to build conducive environments for women's socio-economic well-being, suggesting that state policies should support women's access to and use of SRH services by investing in adequate healthcare for all. That could explain why Davies (2013, p. 390) said "as long as women's poor healthcare has no political or economic consequences for a state, women's health will be neglected." Only when there are distinct political and economic consequence can governments acknowledge the relationship between the economic status of a nation and the health system.

Policies and laws are essential to ensuring that women have access to SRH services. The goal of these policies is to achieve and ensure respect for the rights of women to SRH. Some of these policies include the Zimbabwe National Policy for Family Planning (ZNFPS), Reproductive Health Policy, Sexual and Reproductive Health Strategic Plan and most recently the Zimbabwe School Health Policy (ZSHP). These demonstrate that Zimbabwe recognizes the need for women's health, but the state fails to enforce these policies due to prevailing socio-economic circumstances. Interpretation of law seems to be left to the patients and service providers. Langhaug, et al. (2003) illustrates how nurses can deliberately discourage women who are sexually active from obtaining contraceptive care, regardless of legislation specifying that the provision of contraceptives should be made available for sexually active women. Also, delays in implementation of laws and policies often act as an obstacle to women's access to health services. For example, in 2013 twenty ministers of education and health from African countries signed a Ministerial Agreement on Comprehensive Sexuality Education (CSE) and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern Africa, which defined clear problems to address for school based CSE by 2020 (Ministries of Education & Health, 2013). Zimbabwe only implemented the initiative late towards the target year (2020) to evaluate the school based CSE. Only in 2018 did Zimbabwe launch the initiative leaving many young women exposed to the difficulties of accessing and use of SRH services (GoZ, 2018). As a result of launching the

initiative late, many young women become sexually active without understanding how to practice safe sex, sexually interacting with older partners due to economic pressure and failing to negotiate safe sex (Chiweshe, et al., 2017).

Another factor in women's access to SRH is the attitudes they receive from public healthcare providers. Studies conducted by Müller et al. (2018, p. 8) confirm that guaranteed confidentiality and, youth friendliness are significant determinants for young people accessing reproductive health information and services in Zimbabwe. Young people will choose to use private providers or NGOs irrespective of cost factors because they consider them more approachable and confidential. Public health providers often view young women as moral violators for being sexually active before marriage (Müller, et al., 2018, p. 8). According to Langhaug, et al. (2003, p. 155) cultural values in rural Zimbabwe prevent young women's free access to and use of SRH services because of attitudinal and non-structural components of the provision of services. Similarly, Feldman and Maposhere (2003) describe how availability of SRH services in Zimbabwe is limited by religious beliefs, giving the example of the Catholic hospitals that do not support the use of certain contraceptive methods that are perceived to promote immorality. Specifically, Feldman and Maposhere's (2003) findings revealed how staff members at the Catholic hospitals advise women to use the safe period, the rhythm method as birth control, and do not provide termination of pregnancy services which indirectly encourages use of alternative and likely unsafe procedures elsewhere.

According to the law in Zimbabwe, abortion is legal if pregnancy will affect the health of a woman or if it is the result of unlawful intercourse (Chiweshe, et al., 2017). A court has to determine this as advised by doctors. This illustrates, to some degree, how the barrier to access services is not just the provider but the system itself. Batisai (2014) states that women in Zimbabwe who are

within their legal right to access abortion face hindrances and delays due to the long legal processes which act as a barrier to many women in Zimbabwe and even worse for rural women who are disadvantaged by the lack of easy access to court rooms. Thus, rural women are more likely to use illegal and unsafe methods. This is not only unique to countries that criminalize abortion, Cambodia has one of the most progressive abortion laws in Southern Asia but the Cambodians including the health care providers consider that abortion is illegal (Hegde, et al., 2012). Due to moral parameters abortion is considered a sin in Buddhism and as a result, service providers are sparse and disproportionately available to women eliciting that women induce their own terminations or seek unsafe abortion services from unauthorised practitioners that result in complication.

Awareness is crucial to accessing and utilizing SRH services. Having access to information about the type of services available, where to get the services, and recognizing the value of SRH care allows women to make informed decisions about their own health. Women from low socio-economic background often lack awareness of the necessity of obstetric care. Based on the findings in Zimbabwe's Marondera district, Mugweni et al. (2008) noted that one of the factors leading to the inadequate access and use of obstetric services was lack of knowledge about the signs of danger in pregnancy, such that some women would only seek antenatal care when experiencing vaginal bleeding or early and prolonged labour pains, the assumption being that in the absence of any physical ailment there is no need for obstetric care. It must be noted that education towards SRH is an important means of addressing access and use of services. Panchaud et al. (2019, p. 289) argue that girls need to be provided with information and guidance on SRH issues while still in school, yet the opposite is true for many. This means that women are disadvantaged from an early age by lack of reliable knowledge about sex, relationships, and their health rights (Woog, et al., 2015).

Panchaud et al. (2019, p. 285) suggest that governments show interest in CSE due to the high fertility rates which affect the girl child mostly, however they fail to implement highly successful initiatives to address access to SRH care in communities. For instance, Langhaug et al, (2003, p. 150) in the study conducted in Zimbabwe note that while post-coital contraception is a recommended and legal drug, nurse practitioners refuse to dispense it as it is considered to be an abortion method and encouragement of sexual activity for young people. Any young woman who needs access to this drug is stigmatised and often humiliated, which often discourages others from accessing SRH services from professional healthcare providers who could also inform them about safe and healthy sexual decision-making. Also, in such cases, ‘young women’ does not only refer to women who have not reached the age of majority, but any woman that the community feels should not be participating in sexual activity (Langhaug, et al., 2003). This presents one of the many challenges to providing and receiving SRH services in Zimbabwe where implementation of initiatives is therefore poor.

In essence, economic deprivation does influence poor and vulnerable women’s access to and use of SRH care. The exploration of the socio-economic status is necessary to understand how Tshitshi women navigate challenges created by the economic crisis in Zimbabwe in accessing SRH services. The next section provides an analysis of how access to healthcare thrives in times of crises focusing on transnational medical services and how these have influenced access.

2.4 Transnational Medical Care in Times of Crisis

A declining socio-economic status leads to the unprecedented migration of many, who have to relocate to countries providing the ability to maintain a better standard of living. Chiumbu and Musemwa (2012, p. 123) emphasize how collapsing economies and weak governance leads to informal cross-border survival practices in unimaginable times for the vulnerable most affected

by downturn in the state economy. In times of crisis, living conditions are that of violating life rights, in which people reshape their survival skills by relocating and establishing transient social spaces to pursue better livelihoods. This may be the reason why Black et al. (2006, pp. 2-5) indicate that the movement of people is a critical livelihood strategy for poor households in search of different sources of sustenance and survival, however not only limited to the poor but the better off, particularly in many African countries. Through these fluid social spaces, transnationals send remittances to support their families back home and some people migrate in search of better medical attention from different countries. Dilger et al. (2012, p. 6) are of the opinion that health and medicine cannot be interpreted independently from transnationalism in a global world because of the multidimensional movement of ideas, practices, and objects in and beyond Africa. The concept of transnationalism is described by Basch et al. (1994, p. 6) as "...the mechanism by which immigrants create and maintain multi-stranded social relations that connect their origin and settlement societies together." Further, changes in African health sectors leading to cross-border quest for health alternatives are typically triggered by migration, weak socio-economic structures, civil wars, privatization of healthcare, lack of drugs/ equipment/ medical staff, especially in states with low public funding for hospitals and clinics (Dilger, et al., 2012, p. 4). Many of these contribute to specific distress and impacts most specifically the vulnerable when there is a lack of skilled and trained people in an economy affecting their way of life through health and educational outcomes. For example, Crush and Tevera (2010, p. 134) show how the health sector in Zimbabwe immediately faced a deterioration in the level of care with physicians and nurses leaving the country. The remaining health workers, mostly junior and less experienced were forced to bear the workload of doctors, nurses, and pharmacists, often with one person filling several posts. In this circumstance, medical improvisation becomes an effective and common means of survival in countries in crisis.

Ormond and Lunt (2019, p. 2) refer to transnational medical travel and describe it as “the temporary movement of patients across national boundaries in order to address medical concerns abroad that are (considered to be) unable to be sufficiently met within their countries of residence... both migrants and non-migrants.” The primary reason for transnational medical travel is discontent with home health systems and seeking solace in other countries’ health systems through fluid social spaces generated by migration. This is echoed by Dilger, et al. (2012) who conclude that multidimensional mobility has an effect on access to healthcare. This is so because it is not only limited to people’s travel, but also there is mobility of health-related resources between the host and home country such as ideas, money, and medical equipment.

Dewachi, et al. (2018) refer to the example of Iraq, when the citizens turned to Lebanon as a survival mechanism to access healthcare as war and sanctions had caused the state healthcare to crumble. A few Iraqis were selected to receive treatment at the expense of the state in Lebanon but proved to be an extra burden for patients as they faced poor services due to discontinued state funds (Dewachi, et al., 2018, p. 292). This resulted in poor relations between the provision of healthcare services in Iraq and Lebanon which shows a lot about the complications of nations in crises. Firstly, alternative medical treatment lacks long-lasting solutions. Secondly, patient mobility is influenced by circumstantial access to healthcare rather than personal choice, and lastly how investing in immediate interventions has public funds directed away from revamping local health facilities. Thus, creating a continuous cycle of dependence on healthcare alternatives. Related to this, McKay (2018) expresses criticism of the work done by the non-governmental organisations (NGOs) in that there is no longevity in the services they provide because of the life span of the program execution.

Dilger et al. (2012, pp. 120-122) present a case study between Senegal and France where medical expert movements are facilitated by 'Fouta Santé' which is an institution created by Senegalese transnationals living in France. This displays the dynamics of mobility between the two countries and how it has permitted multiple cash flows, doctors/healers, drugs, and patients between the two countries as needed. The Senegalese transnationals committed to refurbishing the healthcare system by sending medicine, money and medical supplies which provides medical improvisations that come as a result of transnational care. Kane (2012, pp. 192-200) suggests that the early generation of Haalpulaar men who migrated from rural Senegal had a major influence on the use of medicinal plants in France, preferring to use traditional healers because they had little faith in the biomedicine offered in France. This highlights another aspect that facilitates mobility of medical care, where not only does it require countries to be in crisis but encompasses acceptability of the available healthcare. Thereby reaffirming that access to and use of medicinal products does not solely rely on affordability and availability but is also influenced by the user's acceptance of treatment.

Chi et al. (2015) in their analysis of some African countries, state how due to armed conflicts in Burundi and Northern Uganda women faced challenges in accessing reproductive health services. The consequences of armed conflict included scarcity of medical supplies, theft, destruction or closure of health facilities, brain drain, and restricted movement of people (Chi, et al., 2015). This means that women could not access and use SRH services freely - restrictions to movement and fear of loss of life influenced access to health services. Like every other nation in times of crisis, women from Burundi and Northern Uganda depended on NGOs to access reproductive health services. In some cases, women had to be moved to government-recognised settlements or temporary basic healthcare camps to access health services that were funded by international institutions (Chi, et al., 2015, p. 12). Thus, necessitating access to and use of SRH services through

transnational medical care. Sadly, this also exposed women to the detrimental repercussions of being separated from family/kin in times of crisis in order to access SRH services. Such are the consequences that women in crisis countries must bear.

Unfortunately, women's dependency on transnational medical care i.e. NGOs is not a guarantee of long-term access to healthcare. This is illustrated by Chi et al. (2015) where women's access to and use of SRH services was disrupted when they had to return to their homes after the war. Women had to return to homes with little to no healthcare facilities, which resulted in an unexpected new health crisis in the midst of war recovery (Chi, et al., 2015). This relates to McKay's (2018) sentiments on how international organisations offer temporary medicine which does more damage than good for future healthcare provision.

Further, movement of people is a critical livelihood strategy in crisis countries, they move in search of different sources of sustenance and survival. Medical care accessibility is one of the essential benefits experienced when people migrate from a poorly resourced country to one that offers better services. However, in accessing medical care as transnationals, women also suffer from what Batisai and Manjowo (2020, p. 12) call medical xenophobia. This refers to a situation where transnational women suffer from ill treatment in a foreign country (Batisai & Manjowo, 2020). Findings from the study (Batisai & Manjowo, 2020) indicate that most Zimbabwean migrant women in South Africa do not have medical insurance and are left at the mercy of public hospitals where they experience medical xenophobia. Also, migrant women's medical conditions may be exacerbated by the pressures of family obligation back home and because of inaccessibility of proper medical care women's health deteriorates (Batisai & Manjowo, 2020). This in turn affects their work performance leading to loss of employment to support families back home. This illustrates the complexities of transnational medical care, for the poor who cannot rely on medical options from both the host and home country.

Global health also presents multiplicities of healthcare practises. McKay (2018) in her writing explores Mozambique's medical space in hospitals, clinics, and community-based programs to show how they are interconnected in transnational healthcare. She (McKay, 2018, p. 10) introduces a somewhat different dimension to transnational medicine, whereby the conceptualisation of seeking and providing medical services is inseparable from care, referring it to 'medical multiplicity' because of how single medical treatment translates into diverse medical care provision. NGOs implement transnational care through food aid for medical programmes, social links are created not just as medical resource providers but more. The food program in Maputo and Morrumbala, for example, aimed at improving the biological well-being of individuals but instead also established bonds between communities and institutions.

The above literature demonstrates how socio-economic crisis can influence access to and use of SRH services. Accordingly, understanding access to medical care in times of crisis, reveals multiple aspects of provision and care that is enmeshed in transnational resources and forms of multiplicity. I now switch to the last part of the literature that addresses the applicable theoretical context for this analysis.

2.5 Theoretical Framework: Transnational Care

For analysis, I adopted transnational care as an empirical method to understand the dynamics of interconnections of care in modern Zimbabwe. Tronto (1993, p. 103) describes the idea of care as a type of dedication that includes taking action to support the needs and concerns of others. However, not limited to a single action but also the processes within the act of caring about, caring for, caregiving and care-receiving. Baldassar (2007, p. 280) explores mobility of care and concludes that there are non-economic reasons that largely influence migration within families. For example, she (Baldassar, 2007, p. 280) refers to literature (Ackers & Dwyer, 2002) on

retirement migration where family relationships are explored as important determinants of migration, thus deciding where to move to, when to move and even choosing not to move. Also, Batisai and Manjowo's (2020) study supports this, their findings reveal that mobility of Zimbabwean women is influenced by sociocultural reasons such as avoiding patriarchal and societal stigma, or the obligation of caregiving. In their study, (Batisai & Manjowo, 2020) mobility was influenced by need to care, where in non-adult homes the oldest child is responsible for supporting the younger siblings.

Williams, (2018, p. 550) describes how transnational care is the product of unemployment, civil wars, difficult living conditions making it difficult to support themselves and their families, and therefore have recourse to migration. Baldassar (2007, p. 280) adds that economic needs may not be the primary incentive for mobility, but access to resources that influence the capacity and capability to care from a distance are highly influential. So not only is transnational care a product of financial need, but also culturally constructed principles of kinship commitments and responsibilities that play a fundamental role in shaping mobility of care. Transnational care is embedded within the 'economies of kinship' and sharing resources with family (Baldassar, 2007).

Zhou, (2015) theorizes transnational care as a framework to show the inequalities from interconnections and disparities between 'global time' and peripheral temporalities. Zhou (2015, p. 163) believes that transnationalism has mostly been conceptualised as 'spatiality-based' in geographical aspects, where theorization is limited to border-to-border relationships. Instead, she (Zhou, 2015, p. 168) suggests paying more attention to the transnational families' temporal-spatial intersections and their caregiving practices on a day-to-day basis for both home and destination countries. That way it also enables examination of the differences between processes of care and human experiences embedded in transnational relationships for both the left behind and migrants. For instance, Batisai and Manjowo (2020, pp. 7-8) identify how forms of interaction, are

fundamental factors, such that mobility of people is not only influenced by economic reason but also the availability of social networks. Social networks play a pivotal role for women migrating from Zimbabwe to South Africa, because they determine access to job opportunities which will enable them the care support for the family back home.

Baldassar (2007, p. 276) states that transnational care encompasses various types of care which are distinguished by levels and forms of interactions. These include monetary, practical, personal, emotional, and moral support. Transnationalism, in reality, has facilitated greater range and scale of informal care and support such that proximity is not a hinderance to provision of support and care across borders (Wilding & Baldassar, 2018, p. 229). For instance, informal care and support is demonstrated by sending remittances to families back home to support household expenses or interacting through video calls. Wilding and Baldassar (2018, p. 232), suggest that with transnationalism, support networks are enmeshed and depend on mobility and long-distance communication so much that there is a need to acknowledge the crucial role of access to media. Thus, the idea is that caregivers are only able to continue providing care and informal support across national borders when digital literacy is at the centre of it all because information, care, support, and services are increasingly being delivered online.

I conceptualize care within the realms of access to and use of SRH services and explore how care at the societal level is interpreted and experienced by rural women. I investigated what caregiving means from the perspectives of the care-receivers which revealed that women in Tshitshi receive transnational care. Through transnational care I was able to navigate the relationship between the transnationals and need for SRH services. This is so because to theorise transnational care, better understanding of the expectations of the non-migrants can show the motivation for mobility by the caregivers (Baldassar, 2007). Understanding the motivation of mobility helped to dissect

participants' views on economies of kinship which show how the migrants' obligations are shaped.

Further, transnational care exposes issues of dependency and interdependency which helped to understand how they feature in relations of care. In this study, interdependency entails some form of reciprocity in that one who accepts the duty of caring for another is and can also be the receiver of care (Walmsley, 1993, p. 136). Essentially interdependence is experienced in intertwined social systems that facilitate overlying networks of dependency (Fine & Glendinning, 2005, p. 612). Dependency is "characterised by a need for assistance, which may be met through the provision of care" (Fine & Glendinning, 2005, p. 608) Therefore, dependency relates to the action of relying on someone for help or support in the form of care receiving, while interdependency relates to reciprocity within the relations of caregiving. So, through transnational care, issues of interdependency and dependency were analysed understanding the connections, intimacy, and the affection within the fluid social spaces created. Such that, the framework exposed caregiving or care receiving patterns and how these patterns were formed or sustained between Tshitshi women and the migrants.

In this study, transnational care was conceptualised within the context of the economic crisis in Zimbabwe, to understand how unemployment, need for resources, family obligation shapes the mobility and care giving practises. Not only does transnational care influence the level and forms of care practises, but transnational care also facilitates economic growth through remittances. Basically, a country that facilitates the export of labour in turn has the remittances which provide foreign currency sources that are useful for infrastructural development or improving standards of living for the non-migrants (Williams, 2018). To reinforce this, Schaab and Wagner (2020, p. 193) state that transnational care for the country-of-origin influences provision of services that facilitate

access to healthcare, education opportunities, and improved financial status. Therefore, transnational care facilitates socio-economic growth through the provision of required resources and services especially for the rural population. The framework assisted in revealing the crucial role played by transnational care but also demonstrated how the need for efficient provision of services by the government is the ideal solution.

Overall, the framework helped to examine the economic growth perspective and show the systemic effect of transnational care on social, political, and cultural development. Firstly, through dissecting how resources are shared with members of the family, the forms of help provided in response to their needs and how the types or forms of interactions sustain the affectionate connection. Further, the description of how resources are shared not only revealed patterns of interdependence/ dependence but also the context of why interdependence/ dependence is necessary together with what forms these practices. In doing so, I drew parallels to show how the economic crisis influences medical resource distribution, access to information, transnationals responsibility, cultural ethos, and reliance on transnational care. Then I also linked this to how it builds family power dynamics, where the transnationals have the power to influence and shape the type of SRH services available and the time when Tshitshi women access and use SRH services.

In view of the research objectives, I used a qualitative approach which revealed the participant's lived experiences to unpack access to and use of SRH in various factors. These included religion, culture, emotional and financial support, the role of the state, the role of and importance of digital literacy in Zimbabwe. All things considered, transnational care framework allowed for the identification of circumstances showing differential accessibility and use of SRH services in Tshitshi. Williams, (2018, p. 558) alludes to the fact that transnational care in its representation

as a global issue illustrates how inequalities emerge through care. Therefore, it facilitated that I problematize and broaden the socio-economic status of the rural poor so as to expose the discrepancies of how a nation functions during an economic crisis. Due to the economic crisis, insufficient resources lead to limited access to and use of SRH services, by those in marginalised regions. Thus, transnational care is applicable to the study because of how poorly resourced Zimbabwe is, leading to different dynamics of transnational care for women in the country to access and use SRH services.

2.6 Conclusion

In this chapter, I explored how SRH can be understood in the context of Africa. I found that poor socio-economic status is related to less access to and use of SRH in African countries. I discussed how transnational medical care is an adopted survival strategy in poorly resourced countries showing numerous facets of provision and access most notably, through remittances and international agencies. This led to the last section of the chapter outlining the theoretical framework as essential for understanding the study, particularly how transnational care influences access to and use of SRH by women in Tshitshi. Thus, demonstrating overall how this research constitutes a valuable contribution to academic discourses on how socio-economic status shapes access to and use of SRH services for women in resource poor countries.

Chapter 3 Methodology

3.1 Introduction

The following chapter discusses the methodological framework that I used, and the importance and relevance of the methods used for the study. I set out the methods used to collect and gather data, describe the approach to data analysis and the instruments used. I outline the design of the research, the sampling strategy and show how data analysis techniques were implemented to analyse the data generated from focus group discussions and in-depth interviews. I also present the strengths and limitations of the study and finally share the ethical considerations taken into account during data collection.

3.2 Study Site and Population

The study employed qualitative research which Mason (2002, p. 1) views as an enticing approach because it allows researchers to engage with things that matter in ways that matter. The objective of the research was to map how women in rural areas access and use SRH services, given that the prevailing economic situation influences their ability to obtain services. This meant investigating how perceptions and lived experiences of the women shape their attitudes and behaviours towards SRH services. Therefore, I collected data with the aim of understanding and finding meaning, which qualitative research allows. Shank (2002) defines qualitative research as ‘a form of systematic empirical enquiry into meaning’ meanwhile Mason (2002, p. 3) is of the view that because of the great strength that qualitative research has it cannot be neatly defined within a set of principles. Instead, it can be loosely understood as a ‘broadly interpretivist’ methodology which is concerned with interpreting, understanding experiences, and finding meaning of how the social world is produced (Mason, 2002, p. 3). Qualitative research allows for an explorative study in different scopes of the social world in order to understand and generate meaning in context. This method allowed me to study the actions, perceptions, attitudes, beliefs, and feelings of the women at the study site through engagement with their lived experiences. Such data would have been

unattainable by counting or measuring. Since I aimed to explore the perceptions and personal experiences of particular women towards SRH, this method proved to be highly sensitive to the context of the participants. Additionally, it provided an opportunity for greater understanding and in-depth interrogation of individual experiences around accessing and utilising reproductive health services. Through use of qualitative research, the study revealed unexpected issues, similar to Mishler's (1991) observation that qualitative research is advantageous because it facilitates openness and in-depth understanding that unveils new, unforeseen matters of the subject under study.

Following the interpretivist methodology, the social world is understood in a discursive way which requires understanding that discussions or interviews do not only play the role of describing the participants' world. Also, it provides one with an insight of how individuals come to know their world. Foucault (1981), cited by Hall (2001, p. 72) posits that discourse "is a group of statements which provide a language for talking about – a way of representing the knowledge about a particular topic at a particular historical moment." Therefore, discourse not only represents what is said but also produces what is known. Accordingly, through in-depth discussions on women's practices more meaning was provided on how knowledge of access to and use of SRH services has been reshaped based on their understanding of economic system. For instance, due to the poor economy, most women's responses on access were anchored on affordability, thus discussion of social practices was shaped by how women thought of money would give them access to service, completely overlooking the issue of availability of services to purchase and access. The qualitative method facilitated the deeper exploration and detailed description of experiences needed to understand the social context in which women access and utilize SRH services in rural Zimbabwe. Through the descriptions and narratives, I was able to discern what they knew about their world and expose deeper unspoken meaning beyond the directly stated.

The study was conducted in Tshitshi, Mangwe rural district which is located in the Matabeleland South province of Zimbabwe. Its main town is Plumtree which is about 100km away from the second largest city, Bulawayo, and is close to the Botswana border (ZimStat, 2012). The population in this district comprises of two ethno-linguistic groups: more than half the population are IsiKalanga speakers and the rest are IsiNdebele speakers. All the selected participants spoke and understood IsiNdebele which I also speak, and as a result IsiNdebele was the main language used. Mangwe District is inhabited by approximately 35,059 females who outnumber the males making up a total of 52.9 percent¹ (ZimStat, 2012). I identified the study site based on my knowledge of the demographic profile within the district which allowed for relatively easy selection of a range of women that the study focused on. Tshitshi presented a reasonable site because of the knowledge obtained from my previous work networks to the effect that some of the community members had previously received some form of education on what SRH entails. This allowed me to focus on in-depth understanding of the issues than on introducing a new concept to the community members and educating them.

While my already existing networks facilitated access to the study site, it was reasonable to expect that my beliefs, political stance, cultural background, gender, socioeconomic status are important variables that would affect the research process. Throughout my preparation to conduct the study, from the formulation of the initial research questions, data collection to the analysis, my positionality as a Ndebele woman studying issues of SRH remained at the forefront of my mind. My study, in the context of my positionality can be described as reflexivity, which involved self-scrutiny as a researcher and being aware of the relationship between the participants and myself. I had to be careful that I do not attempt to speak for the participants, but rather be an advocate through the study to reflect their voices. My positionality as a Ndebele woman, born in Zimbabwe, aided me in connecting well with the participants based on the logic that people tend to gravitate

¹ The study gives reference to the dated statistics because current and official studies are few and far between.

towards those with whom they share some level of commonality. The participants were much more open to discussing their experiences on SRH with another woman as this was considered a sensitive subject. As became apparent during interviews, my positionality served to create spaces in which women have a voice and space in which they are not silenced but engaged in a discourse of inclusion. I deliberately selected a rural setting because of the study objectives. A rural setting provided fewer complications relating to social differences than an urban setting would have done.

3.3 Study Design

The way in which women access and use SRH services is related to the social context that they live in. This fact means that the study required a method that would show the nuances of the social factors influencing their choices around SRH. I borrowed the principles of a peer ethnographic method from anthropological work. This approach prioritizes creating a relationship of trust and understanding with the community as a requirement of working in social life (Price & Hawkins, 2002, p. 1329). This approach guided me in navigating social views without change due to the level of trust built between participants and I. Price and Hawkins (2002) note that peer ethnography considers the timeline of the study and allows working with a member within the society who is familiar to the community, a ‘peer researcher’. I instead used a ‘peer informant’ who is a well-known member in the community with background knowledge on SRH. As a result, I needed less time for rapport building. For the purposes of this paper, a ‘peer’ is viewed (by the community) as a somewhat noteworthy individual who volunteers within the community and speaks IsiKalanga. Using principles of peer ethnography allowed me to quickly familiarize myself with the social life of the study site within the limited time available.

To gain meaning and understanding I used in-depth interviews to capture and generate substantial data through face-to-face interaction. Mason (2002) identifies in-depth interviews as semi-structured or loosely structured forms of interviews. Specifically, focus group discussions and

individual interviews formed the base for data collection because these subscribe to a constructivist approach which facilitates creation of knowledge through active participation of the respondents. Babbie and Mouton (2001) note that qualitative interviews allow for explorative conversations where the interviewer guides the direction of the discussion by probing into subjects that come up from the responses. I used open-ended questions that were pre-drawn before meeting to identify topics of discussion as per research questions and objectives. The questions were in English but translated to IsiNdebele during discussions for ease of communication. Questions were designed to be easy to comprehend while at the same time capturing the study objectives.

3.4 Sampling Strategy

The study was focused on women's health, so I primarily used purposive sampling. Purposive sampling is a non-random method that deliberately selects respondents based on their knowledge of the topic, features that can be explored and voluntary participation in the research (Ritchie, et al., 2013). For purposive sampling, I used population characteristics as the main identifiers to select participants. To access respondents, I used my existing networks in Plumtree that led me to an informant who lives and works within the community. Ten respondents were the initial target but through the existing social networks I interviewed eighteen respondents (see Table 1) based on availability, willingness to participate, and familiarity with the topic of discussion. Selection was based on characteristics that included age; all the women were of childbearing age ranging from 15-42 years. In identifying sampling criteria, I was aware that the age of consent in Zimbabwe is 18 years however, because of evidence showing high rates of adolescent pregnancies in rural areas (GoZ, 2016-2020) the study also included younger girls who are 15 years of age.

Prior to data collection I familiarized myself with the Department of Health Guidelines with regard to research that involves minors. I recognized that minors need not bear the unnecessary troubles of research, but on the other hand they are entitled to better quality healthcare and their experiences

and appropriate participation in research can contribute to that. As per the requirements of Section 10 of the Children's Act 38 of 2005, South Africa, a parent/guardian must give consent and permission for a minor to participate in such activities. I used the South African Children's Act 38 of 2008 for guidance because the study is being done under the auspices of an institution in South Africa. I was aware that I was being guided by the South African legislation when conducting research in Zimbabwe. This is so because the closest Zimbabwe legislation to informed consent for minors are not specific to research approaches, but rather acts that are for clinical trials or organ donation (Bwakura-Dangarembizi, et al., 2012).

Seeking permission from the parent/guardian was an acknowledgment that the minor cannot independently decide to engage in the research without permission from guardian or parents. I explained to each guardian that the research is purely for academic purposes and had minimal risk to the participants. According to UCT Standard Operating Procedure (2019, p. 165) minimal risk refers to research that has low magnitude of harm to the participant relative to the discomforts or harms of everyday life. My research was 'Non-therapeutic' meaning that the activities did not have direct health benefit for the minors but would produce valuable outcomes.

Further, the research considered women who are sexually active in relationships but unmarried, single mothers who are in sexual relationships and women who are married (both legal and informal union was considered as married). Based on the age and relationship status of the participants, two groups were formed for focus group discussions. Each comprising of 8 women between the ages of 15 to 23 years for group 1, and 24 to 42 years for group 2. The two groups were separated based on age in order to maintain confidentiality between women who were viewed as 'young' and 'older' by the society. The 15-to-23-year group included 3 in-school young women, 4 unemployed women and 1 who was employed. The 24 to 42 group had 2 women

engaged in voluntary community work, 2 unemployed but house-sitting relative homes and 4 women who were self-employed selling curios and engaging in cross-border trading. Nine individual interviews were conducted. Seven women were recruited from the focus groups based on availability, experience, familiarity with the topic, and information I obtained during the focus group discussions. The other two were identified through the snowball sampling which came as a result of recommendations from the women interviewed who thought that the others would be relevant for the study.

Table 1: Summary of the participants with pseudo names assigned

Participant	Age	Occupation	No. of pregnancies	Level of education
Buhle	15	Student	0	Form 2
Qhu	19	Unemployed	0	Grade 7
Toye	17	Student	0	Form 4
Sphe	22	Employed	1	Form 4
Tamia	17	Student	0	Form 4
Khethiwe	21	Unemployed	0	Form 6
Nicole	20	Unemployed	1	Form 4
Prisca	18	Unemployed	0	Form 3
Precious	15	Unemployed	1	Grade 7

Sindi	25	Unemployed	1	Form 4
Girl	24	Unemployed	0	Form 6
Buhle	31	Unemployed	2	Form 4
Olwethu	32	Self employed	4	Grade 7
Phindi	28	Self employed	1	Form 4
Asanda	28	Self employed	1	Grade 7
Spice	30	Self employed	6	Form 4
Lucy	35	Unemployed	3	Form 4
Village health Worker	42	Voluntary work	4	Form 4

3.5 Data Collection

Prior to the interviews, I visited the peer informant to discuss, identify and meet the participants relevant for the study. The aim was to explain the purpose of the study and how the interviews will be conducted. Dates were set according to the participants availability in order to get maximum participation. I had to commute a distance of approximately 75km from Plumtree to Tshitshi to conduct interviews. Data collection was conducted in two phases with the initial interviews done in focus groups and the follow-up interviews were one-on-one for in-depth discussion. Both data collection methods allowed for probing to get more details from the participants. Primarily, time spent at the research site was influenced by how much rich data is

collected. I collected my data over a period of 3 weeks in November 2019 and interviews were guided by a set of semi-structured open-ended questions alongside a list of important topics from the main research questions. These were used to ascertain that fundamental issues are discussed in each interview while allowing for flexible participation and adaptability to uncover new important topics of discussion. Moreover, this allowed for observation of non-verbal communication. While my positionality facilitated access to the study site, I was aware of the biases that might arise from that. Therefore, to minimise acquiescence bias, I continuously reviewed and adjusted any questions which might have elicited a favourable answer and rephrased the same question to get a different view of it.

Firstly, I facilitated focus group interviews with the assistance of the peer informant. Interviews were conducted in third person so as to protect the participants' narratives while at the same time conceptualising their experiences. The discussions were held over 2 days with one group each day, but both guided by the similar interview topics. Also, before the start of the discussion I indicated to the participants that the information shared will be treated as confidential but noted that I could not guarantee confidentiality as I could not prevent participants from taking focus group discussions outside of the group. I asked that they not do this and requested that pseudonyms were used at all times during my time with the groups.

The second phase involved semi-structured open-ended individual interviews where I was able to probe more and uncover underlying details with meaning. For this study, open-ended interviews were advantageous in dealing with a sensitive topic like SRH which is often very personal such that closed-ended questioning may not have yielded the desired results, these being the generally held views of the interviewees (Reja, et al., 2003, p. 161). I conducted the interviews in various places such as under a tree, by the shops, their place of residence and at the clinic hall when available for use, depending on participants' availability. In the case of an interview with a minor, I conducted the interview at their home, after the parent or guardian had given permission. The

parent/ guardian remained nearby but allowed a private conversation, offering distant but present supervision. The interview process was conducted in the local language, IsiNdebele. I provided the participants with details of the study before starting every interview and asked for consent to record the interview. Also, I made the participants aware that if at any point they were no longer willing to participate they were welcomed to excuse themselves. None of the participants excused themselves from interviews. To capture the interviews, two USB voice recorders were used and I later translated and transcribed. As I was transcribing the interviews, I had the opportunity to revisit the data and noticed patterns that were useful for when I began sorting.

3.6 Data Analysis

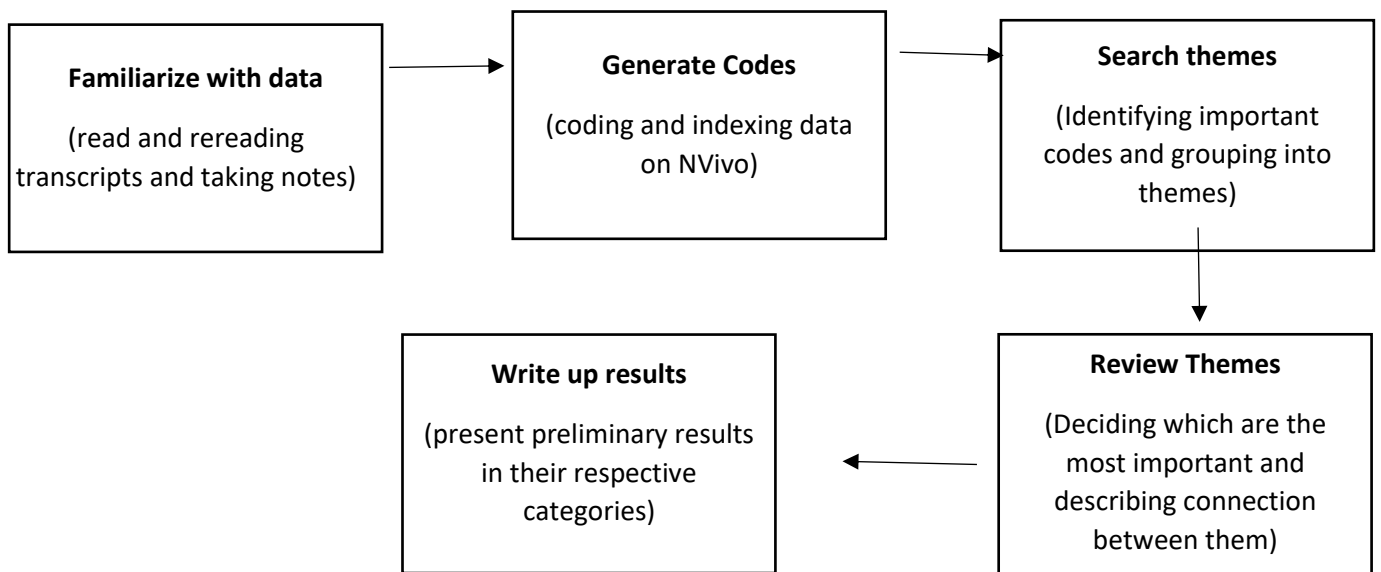
Upon completion of fieldwork, all interviews were translated to English and transcribed while noting common themes appearing within the data. Then I read the transcripts closely to identify outstanding patterns. The use of in-depth interviews ensures generation and collection of detailed accounts of the experiences of women in SRH access thereby facilitating extraction of rich data and meaning. I then employed thematic analysis with the help of NVivo version 12, a computer software for qualitative data analysis. Spencer et al, (2013) state that thematic analysis entails identifying themes and coding data, which means interpreting, reporting patterns, and discovering meaning within the data in a systematic way. I used this approach to offer cross sectional analysis from the respondent's comments, narratives of their lived experiences, opinions on social life and SRH systems. For the study, I sought to understand rural women's access to and use of SRH care in the current Zimbabwe's economic situation. Therefore, thematic analysis provided better understanding of the scope, diversity, and range of experiences that women have across different age groups. According to Braun and Clarke (2006) thematic analysis is advantageous in that it enables study of perceptions of different people and highlights any noteworthy differences and similarities while unveiling unforeseen insights.

There are two major ways to identify themes within data namely, inductive, and deductive manner (Braun & Clarke, 2006). I applied the inductive method because the themes and theory identified were largely informed by findings observations. According to Babbie (2016, p. 23) inductive reasoning entails moving from interpreting and analysis of observations to the discovery of a pattern. Therefore, with inductive the aim is not to test or validate a theory like the deductive approach, but to generate explanations and prepositions of phenomena. Tracy (2012, p. 118) states that the strength of inductive approach is its in-depth exploration of attitudes, perceptions, and people. Unlike the inductive approach, deductive reasoning can hinder in-depth analysis and interpretation because it focuses analysis on existing theory. I used inductive reasoning because the nature of my research required in-depth understanding of Tshitshi women's experiences in order to map how the economic crisis influences access to and use of SRH services. However, the inductive approach has its shortfalls. It cannot guarantee solid conclusions as interpretations are drawn only from observations and interviews that have been accessed (Tracy, 2012).

I started the analysis process by reading and rereading the interviews in which important themes and categories were identified, followed by sorting, or coding the data. Sorting or coding data is an interpretive technique of organising the data so that it can be interpreted in line with the study objectives (Saladana, 2012). Therefore, I had to demarcate the data and label it with a code which is a short phrase showing how the selected data in that code is relevant to the study objectives. Coding was supported by the use of NVivo which only replaced the hand coding and not any form of interpretive nature of analysis. According to Saladana (2012), qualitative data analysis software does not replace interpretive work in analysis but only enhances efficiency towards data storage and the coding process itself. I generated data from the interviews and placed it into different thematic categories and interpreted it within the perceptions provided in relation to the study topic.

Throughout analysis I reread the data to reorganise it into finer categories, taking notes grounded by the interviews. In addition, interpreting the data sets led to preliminary analysis which involved reporting the findings of the study guided by the research question. Preliminary analysis of the generated data was guided by existing literature of the identified themes to relate it to the research question. The stages of analysis that I applied are shown below in figure 1.

Figure 1.



Source: Author's own

3.7 Strengths and Limitations

The study adopted a qualitative research method which is mostly based on interpretive and contextual data thereby making the results easy to scrutinize and revealing any limitations. The contextual data is based on the interviewed individual's experiences and cannot be extrapolated to the rest of the population. The use of purposive sampling technique does not explicitly reflect the experiences of the population at large or of any other rural area in the country. Instead, it can only be used for similar study sites. Moreover, the sampling approach did not cater for any woman who might have had different experiences to those related by the Tshitshi participants.

Nevertheless, the sample size was a strength for the study. I collected the data on a face-to-face basis which helped me to read each interviewee's body language closely. As such, I was able to make more interpretations that might not have been clearly observed with a larger sample size. Therefore, the sample provided an opportunity to generate more detailed accounts of women's perceptions on the topic, which allowed for in-depth understanding. On the other hand, the research design also involved conducting focus group discussions.

3.8 Ethical Considerations

Prior to going to the field for data collection I received approval from the University of Cape Town Ethics Committee² and for the engagement with the minors I followed the regulations as per Section 10 of the Children's Act 38 of 2005, South Africa. This required that the parent/guardian give consent and permission for a minor to participate. During the time of this study, the research topic appeared to be a sensitive one. A sensitive topic is identified as one that may render problematic for data collection because of the judgemental connotation that may be attached to it (Ritchie, et al., 2013). Conversations about SRH were still mostly limited to private discussions with trusted people. The study setting also acted as a limiting factor in that it is located in a rural area where adulthood is defined not by the legal age but by community views. This influenced the sampling strategy such that those who are legally minors and have children were considered adults, but in following the legal age and focus group classification would be considered minors. As a result, formulation of the focus groups had to be flexible and mix both the legal minors with the legal age women to accommodate the societal views on adulthood as there were women who are sexually active and with children.

My priority before carrying out the interviews was to ensure privacy for the respondents during discussion by not requiring names. Confidentiality and anonymity were observed, participants

² Refer to appendix 4

were informed that their participation was voluntary and that they could ask questions if there was need for clarity on the expectations. I would always seek verbal consent to record and encourage participants to use pseudo names throughout the interviews. More especially during group discussions, I requested that the participants uphold the morals of confidentiality, by respecting and not discussing matter discussed outside of the group. I further, communicated with the rest of the group that I could not guarantee confidentiality in that some members could disclose the information with other people.

Before going to the field, I requested and received permission to conduct the study in Tshitshi from the Rural District Council offices for Bulilima Mangwe District. I also met with the ward councillor for Tshitshi to seek permission and get advice/ guidance in navigating the community. At all times I ensured that participation of the women in the research did not interrupt their daily activities. Interview recordings and transcripts were managed with strict confidentiality during data collection and analysis. I managed to do this by storing the recordings in a protected device and not sharing these with anyone. Throughout the data collection period I did not experience any circumstance that placed me in a position to forgo ethical considerations. Thus, I managed to consistently observe ethical codes and maintain professional conduct to avoid any implications of wrong-doing while conducting my research.

3.9 Conclusion

In this chapter, I discussed the reasons for using the qualitative research method, which included use of purposive sampling, focus group discussions and semi-structured in-depth interviews. I also explained how thematic analysis was applied to this study. This study focused on women in rural areas, so I then justified my selection of one residential area. In addition, I highlighted the required ethical clearances for me to undertake this study. Overall, this chapter presented an outline of the

research methodology that was followed throughout data collection, generation, and analysis all within the ethical conduct expected.

Chapter 4 Findings and Discussions

4.1 Introduction

The results provided in this chapter illustrate the lived experiences and responses to the questions posed during the focus group discussions and individual interviews. I present and discuss ‘transnational medical resources and care’ as the predominant narrative that emerged from research findings on women's access to and use of SRH services. I was guided by available literature (Batisai and Manjowo, 2020; Crush and Tevera, 2010) that examines migratory patterns and alternatives for access to resources and healthcare in Zimbabwe. I identified the broad theme through deductive reasoning informed by the findings of the research. Initially, I had expected to use a reproductive justice framework for analysis but after data collection I noticed the salience of the transnational care theme and how it connects well with my main argument. Thus, the results of the participants’ responses highlighted a common narrative that revolved around reliance on transnational resources and care for most women’s SRH services within the Tshitshi community. I then engaged with and analysed the contribution literature brings into understanding how cross-border resources influence the experience of Tshitshi women in accessing and using SRH care.

Following discussion of the broad theme I discuss and analyse three key categories and subcategories extracted from the data. The first category is ‘Access to and use of SRH.’ I explore the role of socio-economic circumstances and how it complicates women’s access to information, geographical location of facilities, service provision/delivery, and financial capacity to access SRH care. I then discuss the implications of mothering from a distance due to migration in the second category ‘Distance mothering.’ In this category, transnational care is primarily examined within the context of the young women who are being cared for from a distance, to consider how they acquire SRH services and the decisions they make in the absence of adult supervision. Lastly, ‘Role of religion and tradition,’ here I delve into women’s use of non-biomedical services as an

alternative. These categories overlap and cannot be viewed in isolation as data shows a pattern in which most participants rely more on alternative services than on public services. The data presents potential barriers and facilitators of access to and use of SRH services for women in Tshitshi. Therefore, I argue that while Zimbabwe's economic crisis affects all citizens, the most affected are the rural poor who are unable to sustain their livelihoods and are forced to resort to transnational care for survival. Women in Tshitshi have limited access to public health facilities leaving them in precarious positions where they have to seek alternatives, improvise for their health and well-being, and live with the minimal bare resources at their disposal.

4.2 Profile of Tshitshi Women and Resources

The first interviews were divided into two focus group discussions, with the first focus group discussion was with group 2, women between the ages of 24 to 42 and all spoke IsiNdebele. While most identified as unemployed, their livelihoods included being caretakers of the emigrant relatives' homes, selling vegetables, airtime, mopani worms, piecework such as brick moulding and cross-border trading in Botswana and South Africa. Botswana is the trading country of choice due to its proximity to the village which is 6km from the border. The second group consisted of individuals between the ages of 15 to 23, 3 out of 8 were still in secondary school and all either living with grandparents or on their own because of migration. An important fact to note is that their means of acquiring essentials for everyday living are the same, such that even the young women who are out of school see no options beyond cross-border trading for income generation. The currency used in Tshitshi is mainly the Pula and the Rand and not the national currency due to the main economic activity being cross-border trading. In essence, Tshitshi has a trade currency that is spatially separated from the national currency given that foreign currency was banned as legal tender during this study (Reserve Bank of Zimbabwe, 2019). This means that the women eke out a living independent of the national economy. Tshitshi has one clinic which has at most four nurses serving seven villages, five of them in the Tshitshi ward namely Mzila, Makuzeze,

Bambanani, Guqukani, and Sikwali, and two villages under Ngwanyana namely Dilankobe and Madlaziduli because there is no clinic in Ngwanyana. There are three primary schools and one high school in Tshitshi.

4.3 Access to and use of Sexual and Reproductive Health

In this section, I discuss the potential facilitators or barriers to access and use of women's SRH services in Tshitshi that are sub-categorized into four main determinants.

4.3.1 Access to SRH Information

This sub-category explores information access during transition between first sexual intercourse experience and when they can use SRH services. This is to determine how lack of SRH education before the age of fifteen has influenced women's access to and use of SRH services in Tshitshi. Also, in this sub-category I examine what motivates women to access SRH information, and under what conditions/ determinants they access information so as to assess how access to and use of SRH services is navigated by Tshitshi women.

In an individual interview with *Precious*, a 15-year-old pregnant girl, she states that she did not know anything about SRH and had never used any contraception. Fifteen women indicated that they had never heard the term SRH before, and the three who had heard it could not define it but were able to provide examples of contraceptives such as pills. This indicates that most participants remain unsure of what SRH encompasses. Although I had anticipated before the field work that most participants would know what SRH is, the participants failed to describe it. It was only after I had explained what it entails that they managed to provide examples of what may be considered SRH. As examples, the participants' responses below:

“Mina ngicabangela ukuthi kumayelana ngendaba zokuba labantwana... izinto ezinjeng’ amaphilisi, antibiotics nxa usizwa ubuhlungu” (Spice 30 years, focus group discussion 2),

“It was the first time, but after explaining what it is now, I know, I have an idea. Where would I have learnt about this really, at school they never taught us about this. Can you imagine at primary being taught such things” (Qhu 19 years, Individual Interview)

This poses a challenge in that women must have sufficient health information in order to actively seek medical care, and for successful access to and use of SRH care particularly for those who are sexually active. Meanwhile, statistics (ZIMSTAT, 2016) indicate that women’s age of sexual debut occurs at a young age, suggesting that they are less likely to use SRH services as they lack knowledge and are unaware of the services. The median age of sexual debut for women in rural Matabeleland South is 18.1, compared to 20.0 in urban Harare meaning that 40 percent of women had sexual intercourse before age 18 (ZIMSTAT, 2016, p. 63). This points to the disparity between rural and urban women. Rural women are more likely to participate in sexual activities with insufficient knowledge, education, or guidance to make informed decisions about their health and well-being relative to their urban counterparts. Initiating sex at an early age most likely leads women to not using SRH services because of lack of knowledge. Historically, and particularly in rural areas, paternal aunts or other elders were responsible for introducing reproductive health care discussions. However, such traditional activities have steadily declined over time due to migration facilitated by the poor economy in Zimbabwe. The lack of knowledge about SRH services in rural areas can thus be attributed to the lack of support. Several studies (Moyo and Zvoushe, 2012; Remez et al., 2014; Grossman et al., 2018; UNFPA, 2003) support the aforementioned finding, suggesting that traditional education systems are compromised due to the on-going socio-economic decline that Zimbabwe has faced for decades that has led to an exodus of people. Moyo and Zvoushe (2012, p. 27) noted in particular that parents view the dissemination of sexual education as the position of grandparents and aunts, but with family separation it has become a challenge to educate young people on such matters. In essence, the absence of traditional education in Tshitshi is a consequence of the country's poverty that has seen many families

relocate, affecting young women's ability to access and use reproductive health services. Moreover, the compromised traditional system has not only deprived women of early reproductive knowledge, but also potentially shaped future family relationships to potentially decline due to fractured extended family structures.

Excerpts from the interviews also indicate that insufficient knowledge of SRH is due to low educational levels. Four out of eighteen women interviewed had only primary level certificates but the rest who had made it to secondary level had learned enough to offer examples of contraceptives. Nevertheless, as critical as formal education is in the distribution of knowledge, it has its limitations in a poverty-stricken country like Zimbabwe where there are disparities that leave the poor exposed to educational opportunities that are below-par. Seven women revealed that they had to drop out of school before completing secondary level due to lack of finances. Three who were still in school revealed that topics of reproductive health are limited only to lessons in biology that are far removed from sex and sexuality education. Moreover, not all pupils take Biology as a subject which means only those who make it to the biology class get exposure to such topics. Ngwenya (2016) agrees with the view that teachers follow a stipulated curriculum which does not address SRH and can hardly spare time for CSE. Teachers themselves may also lack the necessary information and training to address these issues even after the launch of the new curriculum (GoZ, 2018) that addresses SRH issues.

Findings also indicate that due to the lack of funding for educational opportunities, accessing SRH information, is often through merit and performance as seen from 21-year-old *Khethiwe*'s answer below:

"I was fortunate enough to learn about healthy living when I was still in primary. Because I was always top of my class, I would always be selected to attend girl's empowerment workshops from grade 5. Up

until grade 7 I would always attend several workshops and at some point, would represent the school at district level when there were other major workshops. I would learn about children's rights, and sometimes get free pads, and things like that. By the time I got to high school I had foundation knowledge that guided me through things of sexuality like life skills, HIV/AIDS, anger management and peer pressure.” (Khethiwe aged 21, individual interview).

This situation exemplifies the embedded essence of educational systems such that individuals who excel in school are more likely to be exposed to opportunities and initiatives promoting SRH information. Whereas those who do not do exceptionally well at school or are unable to continue with their schooling due to lack of funds, are prone to victimization through systematic exclusion to information, leaving many women unfit to make suitable decisions for their well-being. For instance, Zimbabwe National Family Planning Strategy (ZNFPS) (GoZ, 2016-2020) recognizes that challenges such as lack of funding impede effective delivery of services in the country. The economic situation in Zimbabwe affects availability of adequate health services and initiatives, which in turn forces use of a specific criterion in which women qualify to access SRH services. In addition, not only does it affect the volume of available resources but the acceptability of health services because it reduces women's ability to recognize the value of SRH care and promotes misconceptions that discourage use. If you are not informed about it, then you will not access and use it.

My study further revealed that in some cases unmarried women are discouraged from obtaining adequate information about SRH due to adults who believe that SRH education encourages sexual activity. An interview with the *village health worker* (42 years) indicates that parents' fear of providing sexual education is consistent with cultural norms that generally vilify sexual activity among young women and encourage abstinence as an SRH strategy:

“Some cases are hard really because some parents don't even want me to come talk to them (young women) so it's a matter of good timing when to get them to have conversations. Or we say there are

workshops, and you also say there will be food, especially when you say there is food they will let the young women come...There should be something that they gain or benefit, be it you lie and say there will be seeds or food to be distributed.” (Village health worker 42 years, individual interview),

Women's health is embedded in cultural, political, and socio-economic environments which influence and facilitate access to knowledge on SRH. As such, there is a disconnect between existing policy and a culture that considers sexuality as a taboo subject reserved for married people. To support this, during an individual interview with *Qhu* (19 years), expresses how it is unheard of to be taught issues related to SRH in Primary school. This illustrates the politics of living as a young woman in Zimbabwe where strategies that aim to provide SRH as a basic human right are debased by local sociocultural values. Remez et al. (2014) argue that being unmarried is not a pass to presume people would not participate in sexual activities. Instead, the reality of the situation is that they engage early and are vulnerable to risky sexual behaviours because of such stigma. This may be the reason why Ngwenya, (2016, p. 459) says that the Zimbabwean government and the elderly perpetuate poor access to and use of SRH services because they prioritize the principle of abstinence when in reality young people are already engaging in sexual activities. In a society that does not believe in the need to educate young women about SRH, it becomes a challenge to enforce policies that rely on conducive socio-cultural factors. This is echoed by Remez et al. (2014) who argue that SRH service providers and parents need to be informed on the guidelines for family planning to overcome the prejudices of society. In particular, misconceptions that prevent women from accessing information based on age, when it does not constitute the criterion for accessing SRH information. This could be the reason why Batisai (2014, p. 181), discusses the disconnect between policy and reality. She (Batisai, 2014) highlights the inefficiency in the role of the state as it fails to address the discriminatory aspects to SRH access by providing policies applicable to the Zimbabwean society.

In addition, women presented as having learned of the post-coital contraceptive from people who have travelled outside the country and not local health facilities. Four participants received this knowledge from their voluntary engagements with NGOs, twelve from local people who have travelled outside Zimbabwe, and the other two had never heard of post-coital contraceptives. Despite the ‘morning-after pill’ being approved as a treatment in Zimbabwe’s Essential Drug list (MOHCC, 2001) *Prisca*, who is 18 years old, confirmed that she had heard of a morning after pill which is only available in neighbouring countries while the *village health worker* (42 years old) also said that she had never heard of it being available at the clinic:

“there are also pills called morning after pills that if you drink them you don’t get pregnant, but they are not popular here only found in Botswana or South Africa” (Prisca aged 18, focus group discussion 1),

“...hatshi ngokwazi kwami, angikaze ngizwe ngawo kodwa ngingakubuzela eclinic ngoba ngiyandise ukusebenzisana labo kakhulu...” (village health worker aged 42, individual interview).

This shows that participants’ sources of knowledge are not the healthcare centre or school, but peers and others in the community whose information is not comprehensive and may be inaccurate. It is not as surprising to learn that Tshitshi women do not know about such services because of the social disparities generated by the socio-economic and political situation in Zimbabwe. This has left many public health facilities in rural areas unfit to service their people. Ndhlovu, with similar sentiments, (2019) argues that Matabeleland’s socio-economic reality is especially dire due to ‘development marginalisation’ in governance resulting in biased provision of basic services hence the argument that the political economy of Zimbabwe disadvantages women’s access to health services in Tshitshi. Moreover, the fact that women in Tshitshi learn about post-coital contraception from sources outside the country reflects how information is shared across transnational fluid spaces which are a direct consequence of the forged social relationships that bind people in various societies. For example, findings show the role of non-governmental organisations in facilitating access to services in the absence of public facilities.

This substantiates the aforementioned argument that acknowledges the dependence on transnational medical services. Dilger, et al. (2012) supports this view by stating that the absence of public medical services attracts greater dependence on transnational medical agencies, especially for rural residents in resource-poor countries. This is possibly why transnational medical care obtrudes in Tshitshi where, in the absence of reliable public providers, women rely on NGOs to access information and services from the SRH.

Again, based on *Khethiwe's* and the *village health worker's* responses, people attend SRH educational workshops with the hope to potentially receive tangible items such as T-shirts and free food snacks:

“vele uyazi ohealth worker labo abayenzi umsebenzi wabo, labo babuya nxa sekulama organizations abazoyenza amacampaign, kodwa akula bantu vele abangathi bayabhenefitha ngoba siyabesilande izinto zamahara” (Khethiwe aged 21, individual interview).

And;

“... especially when you say there is food, they will let the young women come...There should be something that they gain or benefit...” (Village health worker 42, individual interview),

The finding reveals that in the absence of incentives, young women are not motivated to attend the educational SRH workshops or campaigns. Interestingly, even the parents/guardians only welcome sex education for their children when there are tangible benefits. This expresses the conditions under which SRH education is acceptable in the society and confirms the statement that acceptability of health services is readily apparent when there is belief that the services will benefit an individuals' immediate socio-economic needs (Kyei-Nimakoh, et al., 2017, p. 9). Women prioritise tangible benefits that alleviate poverty showing how access to and use of SRH is influenced by their economic status and the degree to which it satisfies or meets their needs. In addition, due to poor socio-economic conditions in Tshitshi, the provision of health services by

international organisations is being turned into a food service. Using ethnographic content in Mozambique, McKay (2018, p. 113) echoes how poverty and medical assistance constitute relational circumstances under which care, and resources are simultaneously drawn together under the principle of ‘therapeutic food.’ For my study site as with McKay’s (2018), the social and food relationships accentuate how transnational medical provision envelops multifaceted forms of care, especially in complex economic situations.

4.3.2 Geographic Access to SRH Services

In this section I look at the socio-economic condition and its links with geographical accessibility of healthcare services as a fundamental factor for women’s access to SRH. Geographic access examines the location and distance to accessing health services, factoring the travel time, availability, and costs of how it influences experiences of SRH care.

The participants reported that the longest time spent travelling to the nearest local clinic is up to two hours. Of note, the local clinic serves five villages plus two more from a different ward, possibly suggesting that there are women who spend even more time travelling to access health services. During a focus group discussion, *Asanda* a 28-year-old woman, expressed how she has to plan for the long-distance walk-in order to get to the clinic regardless of her health condition:

“I walk about 2 hours, and I have to prepare myself that tomorrow I will only be going to the clinic, walking fast.” (Asanda aged 28, focus group discussion 2),

Buhle who is a 31-year-old married woman, agreed with *Asanda* as she has to walk for an hour and without certainty that her medical needs will be addressed:

“like me it takes about an hour, you can’t just wake up and say I’m going to the clinic you plan for the clinic. Also, what is helpful is when I am told when to come back for my injections so I plan my travel

along that time but that never means you will get what you need. It is frustrating” (Buhle aged 31, focus group discussion 2),

Irrespective of the need for the services, such experiences are likely to discourage women from accessing and using SRH care, forcing them to live without the service or to visit the clinic less frequently than required. Significantly, McKay’s (2018) work provides detailed accounts of inequalities resulting from situations that systematically exclude individuals from accessing health on the basis of geographical differences. One example is Francisco from Morrumbala (McKay, 2018, p. 113), who despite living with HIV was discouraged in his attempts to seek medical care by how far health facilities were from him. Similarly, women in Tshitshi suffer the consequences of having one under-resourced clinic which leaves them at the mercy of inequalities in access to healthcare due to their geographical location. This reaffirms how people living in deprived settings are less likely to receive adequate healthcare due to their geographical location. In addition, geographical accessibility perpetuates inequalities in the sense that not all women have to travel long distances. Instead, based on geographical location, some women have easy access to the clinic over others, thus creating unequal opportunities to access SRH services.

For Tshitshi women, Botswana and South Africa are metaphorically closer than local health facilities that lack funding and medical personnel and are far. *Buhle* states how it is better to travel to Botswana to buy what she needs than to rely on the local suppliers:

“you will find that if you cross over with that money then you can buy more pads in bulk, and it’s cheaper. That is how we have been surviving ever since, if anything we rarely use the bond notes we see these bond notes from taxi drivers otherwise to survive people save their little money to buy from Botswana” (Buhle aged 31, focus group discussion 2)

In Zimbabwe, the economic crisis has left the health sector crippled by lack of medical kits, shortage of personnel, and this is especially worse in rural areas. Rural areas not only suffer from lack of medical drugs and workers, but also have to contend with the minimal available medical services and facilities. Zimbabwe's health situation bears the same characteristics as that of war-crisis countries in terms of the failure of government to provide for its citizens. Dewachi et al. (2018) demonstrate how countries pursue alternative medical sources and various methods within networks of 'therapeutic geography' during times of crisis. Smyth, (2005) describes therapeutic geography as a field of social relations where health is enacted in less formalized care networks. So as a health and survival strategy due to infrastructure failure, Tshitshi women follow geographic therapeutic spaces through regional networks. Similarly, Peters et al. (2008, p. 165) argue that transport networks, distance, and use of medical services cannot be interpreted in isolation when considering factors influencing access to health. This can be seen in Tshitshi where women who are affected by the rarity of good roads use non-government regulated transport options which are often unreliable and costly.

Apart from the distance travelled to access obstetric care, pregnant women are required to travel a month before their due dates and stay in rooms called '*Emaziko*'³ which are 500 metres from the hospital, and to walk that distance when in labour. At *Emaziko* the rooms are specifically designed to house pregnant women in waiting from both Bulilima and Mangwe rural districts. Women cater for themselves when they move in with month worth of daily supplies such as firewood, blankets, food, delivery preparation meanwhile sharing rooms at a number uncontrolled by the hospital.

Not only does geographical location impede women's access to SRH care but it also reveals a violation of the women's rights as patients. According to the Patient's Charter of Zimbabwe, every

³ Introduction of these waiting rooms in Zimbabwe's health care system was aimed at reducing maternal mortality rate in rural communities, in the event of complications in the absence of an ambulance to take the women to the nearest healthcare centre.

patient is entitled to the right to confidentiality, privacy, and respect (Mpofu & Shumba, 2017). However, Tshitshi women's experiences show violation of their right to privacy when they are at *Emaziko* because they share living space with 10-15 people or more. *Sindi* (25), has experienced giving birth at Plumtree Hospital and narrates her experience:

“when I was there you would have 10-15 people in one room. There were 2 beds in that room and if you are lucky you get the bed but if you are late you sleep on the floor. I got there when it was full, the rooms were full to the point that some people would sleep under the bed, there was space because the bed was high you know those high beds” (Sindi aged 25, individual interview);

Consequently, women pursue alternative SRH services provided by the local people because of the difficulties of geographic access to public facilities. For instance, *Buhle* (32 years) and *Olwethu* (32 years) indicated a preference for the traditional *ukumiswa* option over going to the clinic for contraceptives. *Ukumiswa* is the practise of using traditional herbal medicines prepared by locals as a form of contraception. This is preferred because the clinic will inevitably refer women to Plumtree to purchase pills, forcing them to incur additional costs. Andersen (1995) said that attitudes and beliefs determine human behaviour when seeking health services based on complications that may be involved, and the Tshitshi women's preference for traditional medicine demonstrates this. Peters et al. (2008, p. 166) reinforce this view, arguing that pluralistic medical networks operate in most poor settings, encouraging people to consider medical services that are financially and locally convenient. Likewise, Batisai, (2016, p. 118) states how in Zimbabwe, it is common for people living with HIV/AIDS to seek and choose non-biomedical care especially in instances where both medical systems are considered efficient for healing. Thus, it is normal for a community to have different but equally acceptable medical systems to address their medical needs. In the case of Tshitshi, non-biomedical resources represent convenience in terms of access to available, cheap, and efficient medicine which is cemented by the long-lasting social relationships and not undermined by staffing challenges.

However, Olsen and Sargent (2017, p. 118) argue that medical pluralism presumes people have a choice when in fact acceptable biomedicine is not available to many rural people and therefore is not a viable option. To put it in perspective, women in Tshitshi may be using non-biomedical services not out of choice but because of the socio-economic setup that does not afford them the opportunity to make a different choice. Biomedical health services are not merely barred to them by distance and the unavailability of reliable and affordable transport; such services are simply not available.

4.3.3 Service Provision and Delivery

In this section I analyse service provision/delivery as one of the crucial factors affecting accessibility and utilization of SRH services. This requires an understanding of the circumstances under which SRH care is provided, taking into account how the economic setting influences the duty-bearer/ provider in the delivery of the services.

The study results indicated that in Tshitshi the clinic provides services for ‘free’ however the drugs required for SRH care are often unavailable. *Asanda* a 28-year-old married woman, reveals how although she is willing to use the clinic services, the clinic does not always provide the medical attention needed:

“... I always use the clinic because I get services for free, it’s just unfortunate that I will not always get what I need there and end up having to buy, but if the clinic has medicine, I will just use it” (Asanda aged 28, focus group discussion 2)

‘Free’ service provision is thus revealed to be problematic and raises the question of whether the state as the duty bearer is providing services when technically they are unavailable. Free healthcare provision is commendable but because of the irregularities within the health sector, it does not work well. In view of this, the responsibility to provide care is transferred to the hands of those seeking the treatment, forcing them to procure their own medicine. The ‘free’ service in

Tshitshi then amounts to ‘free’ medical advice/consultation. Essentially, because of the state’s lack of medical resources, the provision of medical care is reduced to treatment through information provision. A case in point is the response from Phindi who is 28 years old and married:

“when you have a big health issue, they just tell you to go buy it at the chemist, they will not have anything totally. The only thing they can do is tell you what to buy, but in terms of getting medicine from the clinic rarely, you see, as mentioned earlier we can get contraceptives maybe after 6-7 months. If you are lucky maybe they could just give you antibiotics, or painkillers but not so much. So, I think really the clinic is just there to tell us to go buy it at the chemist.” (Phindi aged 28, focus group discussion 2),

Tronto (1993) notes that ‘caring about’ is the awareness and recognition of the fact that care is needed, while ‘caregiving’ requires directly addressing an individual’s needs. In this case, the state as the duty-bearer of medical care provision ‘cares about’ the women of Tshitshi and as such, stations medical facilities but fails to act as ‘caregiver’ which would require provision of care beyond the provision of information. There is a shift in roles as women are left to self-provide for their medical needs because of a weak economy that does not finance the health sector.

Young women are further prevented from accessing and using SRH services by local and moral constructions of an acceptable contraceptive user and valid recipient of SRH knowledge. For example, women from focus group 1, who ranged in age from 15-23 years, all expressed discomfort at the prospect of getting condoms despite knowing where to get them for free, due to fear of censure by other community members. The *village health worker* also reported that the clinic does not offer contraception to women who do not have children because they are not classified as adults:

“engikwaziyo eqinisweni eclinic ngeke baphe umntwana wesikolo amaphilisi...” (village health worker aged 42, individual interview)

And,

“Shy from seeing people who know you, and they will know that you are now having sex, and they can tell the whole village that I am not a virgin anymore, and sometimes they exaggerate and make it seem like I am sleeping with a lot of people.” (Toye aged 17, focus group discussion 1).

The above narratives show that their society’s judgmental attitudes towards sexually active young women causes them to avoid accessing SRH services regardless of their rights to such services, representing issues of conflict and care in the medical space. Pillay et al. (2020) confirm that in South Africa, moral beliefs and judgemental attitudes of the medical providers often hinders and clouds their medical duty to provide care to young women requiring SRH services. Nurses attend to young women’s SRH needs with preconceived ideas of what is best for them, ignoring the young women’s rights and agency to make decisions about their bodies. McGinn et al. (2011, p. 20) note that the involvement of guardians and parents in SRH education is necessary since they often discourage their children from being involved due to their own misconceptions. This echoes what was identified in the study as one of the barriers to accessing care: parents believe that information encourages them to be sexually active. Similarly, Mkhwanazi (2012) shows that nurses often treat young women as immature, ignorant, and reckless concerning issues of sex and sexuality and take it upon themselves to manage young women’s ‘irresponsibility’ by making choices for them, not realising that this deprives the young women of vital information about proper access to and use of SRH services. According to Webber et al. (2012, p. 14) refusing access to services that help young women avoid unplanned pregnancies and make informed decisions about their SRH is a detrimental practice in public health. Parents and local medical providers need to be educated about the value of SRH education as a way of dealing with the societal stigma that vilifies young women who access SRH services.

Notably, depriving young women of their agency in matters of reproductive health is not only detrimental to a community’s well-being and that of the young women, but also represents a disconnection between the laws/policies that guide access to reproductive services and observed

reality, where it is assumed that young women should not and therefore do not engage in sexual activity. In order to achieve acceptable and successful public health management policies provision of healthcare must clearly state what is required, without prejudice or negligence. In application, Zimbabwe's health sector can be viewed as a social factor of SRH because the outcomes are directly linked to education and income, which are all influenced by the economic status of a country.

In an interview with the village health worker, she states that the community has many young women who have assumed roles of adults because of migration to bordering countries such as Botswana, South Africa. Concurring with this trend are Crush and Tevera (2010) who assert that Zimbabwe has lost a lot of parents/adults to countries such as South Africa, Botswana, Mozambique, and Britain due to the economic status. This lack of supervision and guidance often means that young women do not access health services despite being sexually active and living alone.

Moreover, the requirement of legal parental consent before SRH services can be offered violates the confidentiality needed for access to contraception and SRH information. Young women in Zimbabwe are prohibited by law to access health services without a parent or adult's consent. The Public Health Act [Chapter 15:17] defines a child as a person under the age of 18 as per the 2013 Zimbabwe constitution. However, this overlooks the young women who assume positions of adults in the absence of their parents due to migration. Shaw (2009, p. 132) notes that the context of the people affected by the laws being implemented is often neglected in such a way as to have serious implications on access to reproductive care. It is also important to note that the law prohibits young women below the consent age from accessing health services but does not prohibit consensual sexual activity among the minors, by comparison highlighting the law to be defective.

Another study finding was how women reported experiencing attitudes and behaviours that discourage them from accessing SRH from health workers while they were seeking medical attention. *Olwethu* a woman of 32 years of age, describes experiences including verbal abuse and neglect when she went to the clinic for maternal care:

“...already in a taxi to go to Plumtree because my stomach was now painful, but I could see that I won't be able to get there, so instead diverted to the clinic. When I got there, I found a nurse outside who was doing her washing, told her that my stomach is now painful, and she just said she will not deliver the baby here because I am supposed to go to Plumtree. Despite trying to explain to her what happened she ignored me, so I went into one of the rooms that had a bed, got up there and pushed the child out alone.”

(*Olwethu* aged 32, individual interview).

The details of her experience relate to obstetric or reproductive violence which Castro and Savage (2019) refer to as different forms of maltreatment of women when they give birth in healthcare facilities. Scholars such as Castro and Savage (2019), Jardim and Modena (2018) believe that obstetric violence is primarily committed against vulnerable women in public medical facilities that have over-worked personnel operating in poor working environments. Such explanations for obstetric violence may be true for medical facilities in Zimbabwe due to the drastic economic demise since year 2000. The attitudes of the health staff therefore relate to their service arrangements, which in turn impact the decision-making of women seeking SRH care. On the other hand, Jardim and Modena (2018) present an interesting dynamic in which what is referred to as obstetric violence is not likely to be recognised as violation of women. Chadwick (2017, p. 493) describes a type of obstetric violence; objective violence as ‘invincible violence’ because maltreatment of women during birth is subtle. Maltreatment of women during birth is interlaced into everyday routines, indirect and concealed so the women do not recognise it as violation as proposed by Jardim and Modena (2018). Based on her study (Chadwick, 2017, p. 498) obstetric violence acts as a disciplinary measure for women when in labour as they are forced to be docile,

passive, and compliant under the care of the nurses. Although this is related to areas of conflict and care, it cannot be disputed that this violence is largely attributed to inadequate reinforcement of reproductive governance and lack of awareness on SRH rights.

Further, I found that women relied heavily on transnational support. In this study, fourteen out of eighteen women confirmed directly accessing some form of SRH services through remittances or travel to neighbouring countries. The rest of the women confirmed that it is through international organization' outreach programs. As hypothesized, in the absence of medical provision from local facilities women resort to transnational medical resources facilitated through remittances and international organisations. McKay's (2018) work shows that medical space within transnational services is interconnected with politics of multiplicity in the social, political, and economic contexts. In other words, transnational medicine is not only about health provision, but it also allows for caregiving beyond biomedical scope to include social relations, thus 'medical multiplicity'. For instance, women in this study experience multiplicity in the form of programmes aimed at providing SRH services that also provide food packages to incentivize attendance.

Transnational medical care brings into question the position of NGOs and the longevity of the care services they provide thus highlighting the temporality of care rendered in times of crisis. According to McKay (2018) 'medicine in the meantime' eliminates the sustainability of medical accessibility. In this study, two of the participants *Khethiwe* (aged 21) and *Precious* (aged 15) related the challenges that came with the absence of a well-known NGO '*Sister to Sister*' which provided sanitary wear. When '*Sister to Sister*' shut its doors, they resorted to using scraps of cloth as the NGO was no longer there to provide pads, illustrating the temporality of provision by NGOs in crisis countries.

In addition to its temporary nature, NGO service provision tends to focus on the implications of an individual not using the services rather than recognizing the risk-causing social environment.

Thus, SRH is considered (by NGOs) as a problem of individual decision-making and familial negotiations when the challenges of access to and use of SRH service are more structural and systemic. Women in Tshitshi attend educational workshops for the incentives which are more valuable to the women because of their economic status.

Furthermore, the findings reveal the availability of services which are illegal. *Nicole*, a 20-year-old woman with one child, points out that women in the community often seek termination of pregnancy services even though this is illegal in Zimbabwe. Women needing this service will resort to 'back street' practitioners or travel to South Africa. Batisai (2014, p. 183) confirms that the need for abortion services in Zimbabwe is not ahistorical but a sought-after service to date, despite it being illegal. On another note, she (Batisai, 2014) brings in an interesting analysis of how abortion practises are an illumination of the levels of acceptability of nonbiomedical medication. Essentially, if a woman wants to have an abortion, they cannot access it the legal way except if it is within the parameters of the Termination of Pregnancy ACT of 1977. This forces women to turn to illegal traditional remedies as an alternative. The state as the duty bearer of service provision is disregarded as the women have to find alternatives within their means. Ormond and Lunt (2019, pp. 1-3) note that a country with a poor political economy is subject to the mobility of medical resources and people as there is transnational temporary movement of patients across national borders to resolve medical issues that cannot be adequately handled within their countries of residence (Ormond & Lunt, 2019). This applies to Tshitshi, with women who travel to South Africa for services such as abortion when needed but not provided in the country. Medical travel in this case represents not just the gaps in medical provision in Zimbabwe but also the need for social change in ideas and standards.

4.3.4 Financial Consideration

In this section, I draw links between financial capacity to access SRH care services and socio-economic freedoms. I analyse, the relationship between cost of SRH services, the willingness to pay for indirect and direct costs of services available in relation to the value women place on services.

The results from the study indicate that financial flexibility is a key obstacle to using SRH services for many. The political economy of the state is critical because its ability to fund the health sector provides sufficient medical practitioners and medicine which affects citizens' access to health. At the Tshitshi clinic, availability of services when needed is questionable despite services being free. Women resort to buying medication from private pharmacies despite exorbitant costs. Cost is not only understood in the sense of affordability but also accepting the value of the service in times of crisis in an economy that does not provide the cash required to access services. Understanding 'cost' within a crisis is problematic where notions of acceptability, availability and accessibility are redefined because of the economic environment's separation from people's realities. For instance, women face a situation where they have to forgo SRH services due to lack of money, which in turn influences their accessibility and acceptability of the services. That is, if women do not trust the service to meet their immediate socio-economic needs, healthcare drops lower on the priority list. Narotzky and Besnier (2014) reiterate that in times of crisis economic structures often become inefficient such that people end up reshaping formal institutions as a survival strategy. As seen through Zimbabwe's post-2000 'Kukiya-kiya' economy where proper economic operations were suspended and people adopted temporary survival solutions and informal businesses such as necessity-driven money-trading (Jones, 2010). Economic decline not only affects access to SRH services by measures of affordability but also impacts how it is

conceptualized within an economy where essential needs are readjusted to prioritize basic survival.

The study results also show that because of the ‘*Kukiya-kiya*’ economy Tshitshi women engage in transactional sex as a means of sustaining themselves. The *village health worker* reported that young women participate in sexual relationships in order to receive material support from partners, thereby exposing themselves to situations in which their sexual decision-making is compromised:

“I realise that girls at 15 have not matured at all and are forced to mature fast by these boys that they meet, they get a packet of jiggies and the next thing they feel like they have to let go of their body to please the boys. It is because of the hardships they face, they will do that and get pregnant, but the boy will be nowhere to be found and girl left pregnant. Usually most of these young ones who are pregnant if you realise, they will not know what would have happened for them to get pregnant, these boys trick them just because they need money. In some cases, there are children where the parents are in SA or Botswana working, and the adults probably only come once a year. So, throughout the year that child has no one who is helping her or guiding them around these things. Or even in times when these parents do not send anything, they decide to do that just to get supported by a boy financially” (village health worker aged 42, individual interview).

From the above narrative it is clear that poverty comes with pressure to survive and forces women to engage in sexual relations as a way of navigating their unfavourable economic circumstances. Kyegombe et al. (2020, p. 3) note that transactional sex includes interpersonal as well as structural ways under which people have sex due to coercive economic circumstances. Batisai (2014, p. 186) links transactional sex to abortion because due to the women’s lack of SRH knowledge and inability to negotiate safe sex they have unplanned pregnancies and resort to illegal termination. Those who are in school are often forced to drop out should they fail to terminate, worsening their situations even more as the future is then also compromised by lack of education.

In some cases, sources of income influence access to and use of services. This response from *Olwethu* illustrates the inconvenience of transnational resources and how it contributes to cost as a barrier to access:

“during that time, the clinic was not doing deliveries, only recently and only if it is less than 5 years from the previous pregnancy. So, with the 3rd one I was definitely supposed to go to Plumtree after 7 years, but I didn’t because the money for me to travel to Plumtree came late, the money was coming on the 5th and I was supposed to go to plumtree on the 1st ... my uncle in SA, I was staying at my uncle’s house just taking care of his house.” (Olwethu aged 32, individual interview).

Reliance on transnational care means that women access services based on what is convenient for the transnational carer, meaning that the recipient has no control over whether and when they access SRH services. Consequently, in the absence of reliable financial support, access to appropriate health services is jeopardized and health outcomes compromised.

4.4 Distance Mothering

Here I address the relationship between distant mothering and the experiences of remote caregiving for young women. I discuss this within the context of how access to and use of SRH resources is shaped by mothering from a distance.

In this study, I discovered that eight out of the fourteen women who confirmed direct access to resources through remittances or travelling to neighbouring countries were the primary caregivers in their homes with distant support from the transnationals. The *village health worker* states how in Tshitshi, most homes are taken care of by young women whose parents are out of the country:

“... most of these girls you see around here they are the one taking care of their parent homes. Sometimes it’s not that they are totally alone but, in this area, relatives build close to each other such that aunts, uncles are close by, but they wouldn’t manage to control the child who has the homestead to herself the whole night.” (Village health worker aged 42, individual interview)

This is a direct consequence of Zimbabwe's economic crisis. Many adults have migrated for work. Most able-bodied adults have migrated from Tshitshi because of its close proximity to the South African and Botswana borders. As a result, young women are either left in the care of extended families, with grandmothers, or pseudo child-headed families where they automatically assume adult roles. Cantwell (2012) notes that child-headed families occur when a child's responsibility is shifted in the absence of an adult and the child takes charge and makes household decisions. Weda and Siziba (2016) describe a scenario where parents leave children in charge without adult supervision such that a child assumes the primary caregiver's duties. Often, in a child-headed household, the majority of the household members are below the age of 18 although Phillips (2011) states that it is not unusual for the household to include an incapacitated adult. Young women in these circumstances often rely on the transnational relations for access to SRH services through remittances, or SRH services sent home. Mothers then maintain relationships through phone calls and occasional visits. This is a phenomenon common with distance parenting as seen in this interview excerpt:

“Ngakhutha ukungena esikhathini for 2 months ngase ngithumela umama imessage ngeWhatsApp ngimbuza ngakho, yikho lapho athi ngiye eclinic ukuyokwenza amatest... ngasengisibakwazi ukuthi sengimithi lapho.” (Nicole aged 20, individual interview).

This shows the complexities that come with transnational care giving, where the forms of care are only available to young women in times of need and only limited to 'caring about' and 'care giving.' From the migrant's perspective, emotional and moral support is enacted through 'caring about' which involves maintaining relationships with non-migrants through regular communication over WhatsApp and phone calls, and 'care giving' through sending remittances and resources which constitute practical and physical provision. Parenting is thereby minimized to a monetized care lacking in intimacy and that does not provide for the physical care needs of the young women. Concurring with this is Boccagni (2012) who notes that monetization between

the transnational and children ends up being care based on economic terms in a bid to compensate for physical absence. Thus, in this study, young women who are without adult guidance are left to learn about SRH care on their own from unsupervised sources of information as a result of migration thereby creating gaps in access to and use of SRH services by young women. In addition, because support is limited to monetized care, lack of adequate money for upkeep leaves the young women in vulnerable situations. A study conducted by Weda and Siziba (2016) in Gwanda, Zimbabwe illustrates how child-headed households are mostly characterized by misuse of money which eventually leads to unsafe transactional sex to makes ends meet.

The reality is that young women are exposed to notable unmet information needs and services because of the disconnection between policies guiding access to SRH services and the reality of the effects of parental migration. Without an adult to consent to provision of health services, young women have poor access to and use of SRH services. Thus, the lack of direct adult supervision exposes young women to notable unmet information needs and results in them making ill-informed choices such as transactional sex in a quest for survival.

4.5 Role of Religion and Tradition

In this section I present findings about the use of non-biomedical alternatives and their role in bridging the gap in women's access to and use of SRH services in Tshitshi. Then I examine the role of religion and cultural traditions on uptake of SRH services. I also discuss the influence of social norms in relation to the role of men in access to and use of SRH services by women and, lastly, the societal consequences of SRH myths.

Most participants reported having either used religious or traditional SRH care options, but also agreed that these options are increasingly becoming uncommon. However, due to lack of continuity and other challenges with biomedical care such as shortage of drugs and service

inconsistency, women revert to use of non-biomedical alternatives. *Olwethu* (aged 32) reported problems with use of biomedical care such as continuous bleeding. This led to her discontinuing use and switching to non-biomedical options:

“... bengisebenzisa ‘isintu’ (traditional things) njenga mambodlela le ntambo. iChurch engihamba kuyo bayasenzela intambo ukuthi sifake ekhalweni ... Then 2012 I met someone and went to church to have the thread be removed for me to get pregnant. And I did, then I had my 3rd born.” (*Olwethu* aged 32, individual interview)

African Traditional Medicine in the Tshitshi area makes use of herbal concoctions, plant roots, and other natural substances such as *‘inyeluka’* (a type of fish skin) for menstrual and conception difficulties. In religious circles, the use of specially prepared and consecrated string is tied around the waist to prevent conception. Findings suggest that in Tshitshi, religious and traditional forms of SRH care function effectively alongside biomedical services. Options that women choose is based on convenience, availability, and personal belief system. *Khethiwe* (aged 21) narrates the use of traditional remedies for menstrual challenges:

“I had a cousin of mine who used to have terrible period cramps, failed to have a child after being married until my grandmother helped her... she fixed something for her, took the tree roots of mshashanyama that’s the popular one that they use to heal period cramps. Or you use isinyayi (kitchen smoke soot) which you put in water and drink then one can get healed.” (*Khethiwe* aged 21, individual interview)

For Tshitshi women, traditional and religious remedies are easily available and cost less which makes them a more rational choice under the prevailing economic circumstances. Although Gabrysch and Campbell (2009) suggest that the role of religion and tradition poses challenges to reproductive health, the analysis of the study findings shows that the alternative methods that are provided by either traditional or religious service providers are effective for the women in most cases. Concurring with this, Batisai (2016, p. 119), in the discourses of an integrated approach to

medicine, suggests that non-biomedical and biomedical systems should be considered to coexist in meeting the medical needs of African people.

On a related note, women indicated that males oppose the use of some forms of contraception that they claim alter their experience of sexual intercourse. The interview excerpts below, for example, indicate that men will often end a relationship if a woman uses contraceptives because they consider it disrespectful:

“even the boyfriends, they don’t want the girlfriends to use contraceptives... because they say it doesn’t go well with them, that when we have sexual intercourse, they don’t feel it well if there is some sort of contraceptive because it changes the feel of sex.” (Sindi aged 25, individual interview),

And;

“...men do not accept using them, they won't even think about that... he would rather leave you than to use a condom because he says you are my woman, I cannot be using a condom with my woman, that’s for people who are still playing games” (Spice aged 30, focus group discussion 2).

Both *Sindi* (aged 25) and *Spice* (aged 30) confirm how women’s access to and use of SRH services might be determined by their male partners. Batisai (2014, p. 179) explains that patriarchal structures still exist today and give men power over women’s bodies. Study findings indicate that women in Tshitshi grant men power over their bodies as a means of maintaining control over their economic realities. If a partner who is providing financial support exerts control over a woman’s body, her choices are reduced to allowing such control or losing a form of financial support. Landa and Fushai (2018, p. 8) argue that there is a clear connection between women living in poverty and risks of losing control over their reproductive health due to patriarchal constructions. Given this, in the Tshitshi community, social constructions of appropriate women’s actions and economic freedom are continually being modified around patriarchal ideas. Therefore, adding to the fact that poverty as a phenomenon not only deprives women of their human right to health,

but in a way perpetuates patriarchal constructions in rural Zimbabwe affecting their ability to have control over their own bodies.

There are significant misconceptions that women in Tshitshi are subjected to that potentially have an effect on their use of SRH. Seemingly influenced by socio-economic status, the misconceptions are shared by males who have travelled outside the country. The participants report that there are male contraceptive pills available only in South Africa and Botswana, and that men who have been to these countries and purchased these pills do not allow women to use any contraception as it is unnecessary. The women in Tshitshi are not sufficiently informed to counter such fallacies, which further demonstrates the importance of education in debunking misconceptions around SRH care, particularly in poor and marginalised rural economies. Buller et al. (2020) hold that incorporating SRH issues, religious, modern, and traditional aspects is necessary in order to minimize women's exposure to misconceptions. Particularly because poor women appear to be gullible and have minimal awareness due to their level of education and exposure to transnational settings.

4.6 Discussions

In this section, I present a summary review of the findings. I argue that there is a need for recognition of life conditions such as education, healthcare, livelihoods, geographic location, religion, transnational care and how they influence women's freedom of making informed decisions about their bodies. I provided data showing significant observations for understanding how SRH access and use are affected in the country's current economic status. However, generalizations should not be made based on the information presented, since the sample was only that of Tshitshi. The merit is that the study reflects women's experiences in Tshitshi and that could contribute to literature and further examination of Zimbabwe's 'untapped' knowledge.

In a functional economy, rural-urban relationship involves the distribution of resources where the rural produce for urban markets and the urban markets flows manufactured goods into the rural areas (Ayuk-Nkem, 2016, p. 167). In such cases, macroeconomic policies that aim to reform will have an effect on rural-urban relationships. However, for Zimbabwe the study noted the effects of the multi-faceted economic woes such as economic mismanagement, political instability, and corruption on rural-urban relationships. Rising commodity prices forced Tshitshi's rural economy to be disconnected from the national economy and operate independently, uninfluenced by state-level reforms. This is due to the distant relationship between the rural and urban economies, where Tshitshi's supply of necessities from the urban area is limited. Tshitshi is largely supported by neighbouring countries. Confirming this, Crush and Tevera (2010, p. 352) noted that Zimbabwe's rural southern parts rely on remittances as sources of capital to start traditional rural businesses which are informal, microscale and seasonal, but contribute to job creation. Therefore, Zimbabwe's government's fiscal policies have continuously led to hyperinflation and rural areas have been the hardest hit with inadequate access to basic essentials. As a result, Tshitshi residents adopted and rely on neighbouring countries' currencies, as evidenced by their use of the rand and pula irrespective of forex use being prohibited in Zimbabwe (Reserve Bank of Zimbabwe, 2019). In this way, financial, institutional, social, and political factors take part in the reshaping of the rural economy. Also, the fact that Tshitshi's supply of necessities is largely supported by neighbouring countries shows the patterns of mobility. People from Tshitshi mostly travel to either Botswana or South Africa, because of their close proximity, which through theorisation by transnational care can be interpreted to show how the economic crisis has shaped the mobility of people. From the patterns, it seems Tshitshi's mobility is largely determined by close proximity to home implying that mobility is influenced by the need to maintain close ties with home while still accessing needed resources and services.

The findings indicate that women from Tshitshi have limited knowledge of how to access SRH information. Most of the women interviewed did not advance far in education and rely on non-formal education that may be distorted. Specifically, this means that women are deprived of comprehensive sex and sexuality knowledge, and this deprivation largely has structural and systemic roots. Results from a study conducted in Uganda, DRC, and Sudan indicate that the use of contraceptives by women of reproductive age is poor in contexts with low school attendance rates (McGinn, et al., 2011, p. 5). This was due to insufficient knowledge of contraception especially in countries experiencing poverty and war. Thus, related to Zimbabwe, the economic situation has eroded the government's ability to provide basic health services for women in rural areas. This not only affects accessibility but also the quality, availability, and acceptability of SRH services to the women. Poor contraceptive awareness shapes how women recognize or understand the value of SRH care and promotes misconceptions resulting from non-formal education.

It is worth noting that although education is one of the key factors impacting access to and use of SRH services, issues such as distant mothering and household poverty force women to engage in unsafe transactional sex. Thus, rendering it difficult to address unintended pregnancies and STI transmission by providing contraceptives, prophylactics, and education alone.

Economic deprivation issues which affect whether and how women access and use SRH services need to be identified. For example, because of financial constraints, women might prefer to access more local affordable services that will not incur any indirect costs with only minimal concern for efficacy. Obstacles that impede access have to be addressed within the socio-economic context in Tshitshi because trying to provide information or supply of SRH services will not guarantee acceptability.

Socio-cultural factors such as societal views on access and use of SRH, patriarchal practices, religion, and the guiding policies, shape the quality, type, and delivery of services which in turn determines how women receive SRH services.

Additionally, poor relationships between the patient and the healthcare provider have been recognised as a factor that dissuades women globally from accessing and utilizing reproductive health services. However, particularly countries in economic crises, it is more horrifying because they do not have substantial medical facilities and resources available. So, the volume, type, and way of delivery of services does influence the value of access to and use of services.

Additionally, in a state in crisis, availability of services to enhance access and delivery of proper SRH care should be prioritized. McGinn et al. (2011, p. 11) state that in conflict zone areas the staff should be trained, have access to support, and have adequate supplies of medications. Emergency contraception, female condoms should be available as a family planning service in areas where access to regular contraception is limited (McGinn, et al., 2011). This is because unplanned pregnancies in conflict zones can be disastrous and lead to unsafe abortions, particularly in countries where abortion is illegal. The study findings indicated that women who desire to terminate a pregnancy will do so even if it is illegal and unsafe. This means that a safe, affordable, and legal way to access this service is needed.

In this study, transnational medical care and non-biomedical alternatives play an important role in bridging the gap of SRH service provision that the government is unable to fulfil. Thus, the duty-bearer roles are shifted in times of crisis introducing medical pluralism. Women access SRH services either through transnational medical care, or non-biomedical services, both of which have their strengths. Transnational medical care is accessible through remittances, international organisations, and transnational medical travel. Additionally, women use traditional medicine,

which is relatively cheaper, available, accessible, and acceptable. This could be the reason why Batisai (2016) suggests a healthcare system that accommodates biomedical and non-biomedical systems, especially in a country like Zimbabwe that is not consistent in provision of healthcare and whose healthcare costs are beyond the reach of the majority of the citizens.

Transnational care played a key role in a complexly interconnected set-up, where women can take solace in other countries resources for survival. Through transnational care resources Tshitshi women receive care through remittances, maintain kinship ties, get moral and emotional support over phone calls or social media. For those who temporarily travel outside the country, they are able to care for their families at the same time and provide physical and practical support. This shows the multi-faceted viewpoint of transnational care on women's socio-economic experiences affecting their livelihoods, health, knowledge in the context of access to and use of SRH. In theorizing transnational care to the study findings, it is evident that without any sort of transnational care Tshitshi women are not able to access the biomedical services required to exercise their rights to healthcare.

Moreover, transnational care revealed patterns of dependency/interdependency and how they are formed within the society. One thing for certain is the patterns are formed through need for care and survival for both the migrants and the non-migrants. Dependency is seen through the constant reliance on transnational care resources and services. For instance, women in Tshitshi rely on relatives outside the country to send them remittances and resources which vary in purpose from facilitating access to SRH care, education, or day to day necessities. On the other hand, interdependency is revealed through the non-migrants taking care of the transnational property or children back home. So, while women in Zimbabwe depend on them for financial support, the transnationals also depend on them to look after their property. Interestingly, while transnational

care plays a crucial role in providing the necessities, patterns of distribution highlight that one aspect of care cannot solve societal needs. For example, transnational agencies that share information or provide SRH services alone do not address deficiency in other areas, such as costs leading to acceptability of healthcare. Even so, the life span of transnational medical care does not guarantee continued use of SRH services if economic issues that influence availability and acceptability are not addressed.

Overall, transnational care not only showed how access to and use of SRH services is enabled but also complimented the forms of care available during an economic crisis through social connections explored. Also, SRH care challenges for women were identified and linked back to social, cultural, religious, political, and economic realities in Zimbabwe. In this study, I used transnational care framework to facilitate in identifying cases that demonstrate differential access to and use of SRH services embedded in the consequences of economic crisis . This helps ensure an evidenced-based approach to SRH challenges for women. Equally significant, it facilitates the management of SRH challenges from a socio-economic level rather than addressing them as a women's issue, that is to say, SRH challenges should be part of the broader socio-economic policy framework that addresses the myriad factors that expose poor rural women to almost insurmountable SRH challenges.

The study also informs short-term policy interventions that attend to symptomatic fundamentals, but the overall idea is to create a self-sustaining long-term solution.

4.7 Conclusion

For this chapter I presented, examined, and discussed the research findings. Significant insight for the participants was that their socio-economic status influences access to and use of SRH services

based on availability, affordability, and acceptability aspects. As a result, women adapt their lifestyle to practices that promote survival through transnational medical care. Throughout the chapter, I linked barriers and facilitators of access to healthcare to the experiences of women in the current salient environment. The next final chapter has my overall research conclusions and recommendations.

Chapter 5 Conclusion and recommendations

5.1 Conclusion

In this thesis, I used semi-structured interviews to interview eighteen women from Tshitshi. The aim was to explore their perceptions and experiences pertaining to accessing and using SRH care in the current Zimbabwean economic situation. I set out to investigate and map how women navigate health access and the aspects that occur as a result of the economic situation. I interviewed women between 15 to 42 years of age in order to acquire diverse experiences from various age groups. Initially, the plan was to use the reproductive justice framework as a theoretical tool however, after data collection I noticed the prevalence of transnational care that I then adopted for analysis because it was well-connected to my argument. I contend that Tshitshi women's access and use of SRH is affected by the economic situation in Zimbabwe. As a result, women then adapt certain ways of living in order to meet the demands within the existing socio-economic status, in this case transnational medical care.

Firstly, availability, access to and use of SRH service for women in Tshitshi, is a challenge and limited. Availability of SRH services includes having access to medical resources that are adequate, reachable, and suitable for the patient. However, in Tshitshi, women noted disparities in the availability of services such as the fact that local medical facilities never have the medical resources required, let alone those suitable to address women's needs. Also, SRH services are not always within reach. For instance, in order to purchase contraceptive pills or access obstetric care women have to travel over 70km and also move into shared hostels for obstetric care. Secondly, affordability is a challenge. Participants pointed out the exorbitant cost of accessing biomedical care. However, cost is not the only issue affecting affordability. The value of the service must be considered in light of possible improvement in socio-economic status. Last is acceptability, which includes consideration of sociocultural factors in how SRH services are rendered and received.

Factors considered include adequate knowledge of SRH, societal attitudes towards SRH, and trusting that resources to address their medical conditions are available. Tshitshi women have limited SRH knowledge and societal attitudes hinder young women's access to and use of SRH services, all of which influences access to and use of SRH services by women in Tshitshi.

Through the use of thematic analysis I closely examined the findings and came up with three key categories for analysis namely, 'Access to and use of SRH', 'Distant mothering' and 'Role of religion and tradition.' The first category; Access to and use of SRH, revealed how Tshitshi women have limited access to information attributed to, lack of formal and traditional education, and the disconnection between health policies and societal reality. I also addressed the geographic position of SRH services and showed how women adopt therapeutic geographic networks which are metaphorically closer for them to access healthcare. Additionally, I described how inadequate service provision/delivery influenced women's access to and use of SRH care by forcing them to be self-providers or rely on transnational agencies. I further examined women's financial ability to access and use the SRH services. This revealed how exorbitant medical costs are borne by women and because of the economic crisis, cost is redefined to recognise aspects of acceptability when accessing services. One of the characteristics of the economic crisis was shortages of cash, which complicated access by reducing value and acceptability of SRH services by women as they prioritised other needs. Some women depend on remittances and therefore access SRH services depending on the availability of transnational resources.

The second category, distant mothering, examined how young women's access to SRH is affected by transnational care. In the absence of adult supervision young women are exposed to notable unmet needs of SRH information resulting in unsafe sexual activities. I discussed how most homes in Tshitshi are headed by children due to migration and how young women are subjected to caregiving which is minimized to monetized care. I also examined the roles of religion and

tradition and how they shape access and use of SRH services, discussing how women use alternative forms of SRH care based on availability and convenience. Interestingly, the findings indicated how biomedical and non-biomedical care can function together without any complications, irrespective of the literature (Gabrysch & Campbell, 2009) which suggests otherwise.

Overall, I argue that Zimbabwe's economic crisis leaves no one immune to its difficulties, and disproportionately affects the rural poor. Mainstream issues such as lack of public funding, deteriorating health facilities, and rising costs have resulted in women relying on transnational medical care to access and use SRH services. This echoes the presented theoretical framework, that demonstrates how in times of crisis access to healthcare is entangled in transnational forms of multiplicity and care.

5.2 Recommendations

Based on the findings of the study, I believe that there is a clear need for an economic improvement in Zimbabwe that will allow the state to restore the public health system. I am fully aware that this will require an overhaul of the country's governance system. In the meantime and as an immediate measure, the state should aim for an equal distribution of medical resources and care with transnational agencies. If the state cannot provide the women of Tshitshi with adequate healthcare resources, then outsourcing of medical suppliers might be an acceptable measure, particularly because the state as the main duty-bearer of medical provision should have knowledge of the services that are offered to women and be able to procure these services affordably and reliably. This would ensure consistency and longevity in service provision, in a way that is not harmful to women. State involvement would help transnational agencies serve neglected and vulnerable regions provided the state can be trusted to commit to meeting the needs of the people in positive, sustainable ways. Other suggestions include the use of vouchers to mitigate costs for women

needing medical care, and a servicing of the Tshitshi-Plumtree route with reliable, state-subsidised public transport.

The study indicated a need for CSE which should not be left up to schools alone, but require the involvement of parents, guardians, and community leaders, to successfully influence and positively impact local attitudes and beliefs towards SRH education for all. Workshops run by the state are ideal as intervention to help close the gap between SRH policies and reality.

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Appendix 2: Interview guide questions

1. What do you understand by SRH?
2. Where do you usually get information about SRH/ who do you learn from about SRH?
3. What are the most common SRH services you use and why?
4. Do you understand why you need to use SRH services?
5. Where do you usually get SRH services?
6. What do you consider or think about when it comes to accessing and using SRH services?
7. Do you ever find yourself reluctant to try access and use SRH services and why?
8. Any major challenges that inhibit access to SRH services?
9. Describe your current economic/ livelihood status?
10. How has these economic challenges influenced the delivery and provision of SRH services at the local clinic/ district hospital?
11. Describe the how you access SRH providers i.e. public, private, traditional?
12. What determines your decision to use a private/public/traditional service provider?
13. Do you have any alternative/substitutes to the government verified SRH services?
14. What determines your decision to use alternative services?
15. If you are currently sexually active, what age did you start engaging in sexual activities?
16. Describe what your ideal world would be like for you to access SRH. What would you change about the current SRH accessibility and use?

Appendix 3: Excerpts from an interview transcript

A single mother 4 children, 32 years of age and grade 7 for level of education.

Participant: So, when I started my period my schoolteacher took me to my aunt, my father's sister, because I didn't have a mother close by. Also, there was a time I once broke my leg so I stopped going to school for a while that how I ended up doing grade 1 a lot. She understood and then told me about what that meant and because she knew how things were done, she cooked for me things that were used for periods, mostly roots of certain trees that I did not know, traditional stuff. So, you know when you start your period you can have it for 2 weeks, so those cooked trees were meant to cut the number of days I spend on my period, and it was only for 3 days. I finished grade 7 at 17years and I already had a boyfriend when I finished primary. So, we were together for a while, and one day you know period was still something new unfamiliar with to know my cycle, It started when I was with him at his home.

Interviewer: so, you had already started having sex then? What preventative measures where you using?

Participant: yes, no we were not using anything, we trusted each other, not getting pregnant *she laughs* was not a problem, I never got pregnant. You know its not easy to get pregnant.

Interviewer: where you guys using the withdrawal method?

Participant: not even, he would ejaculate inside me and like I'm saying it's not easy to get pregnant, as long as your blood has not connected you do not get pregnant your blood has to be connected in order for you to get pregnant.

Interviewer: when you got pregnant, what medication or care where you getting from the clinic, this was 2001?

Participant: so, they only test you check for any diseases and gave me tablets to increase the blood. And I went to the clinic until it was time to give birth. Then I gave birth in plumtree because that was my first child, so if it is your first pregnancy you do not give birth at the clinic maybe if it is your second child without any complications. And also, they don't deliver if your first child is now 5 years, they consider that to be as good as starting again. So, I went to plumtree and waited '*emaziko*' (which is were pregnant women from rural areas are placed meanwhile waiting for their delivery dates at plumtree hospital). I didn't stay there for long; I spent a week and I was out I was lucky.

Interviewer: please explain what '*emaziko*' is what happens there what obstetric care do you get?

Participant: a place where those from the villages stay while waiting to deliver. So, we are put in rooms where you can share maybe in 6s, 10s or more depending on the size of the room. This place is close to the big hospital, so all pregnant women gather there from different villages both in Bulilima and Mangwe. You cook for yourself, you leave your home with your own grocery, blankets, firewood,

anything that you would need during your stay because it is not provided. Then there is like one kitchen that would be used each person with their own fire. You just have to have maybe a bucket or plastic bag to put your labour things in there because you will not carry the whole suitcase when in labour. So, the other women who are not yet in labour can walk you to the doorstep of the hospital from there the nurses will direct you were to go. Then 2003 I had another child. This was because of the prevention pill I was using that are given to mothers who breastfeed and it did not work for me, it rejected me I tried to use depo also rejected me, I'd have my period from the 1st to the 31st non-stop.

Interviewer: oh, I see, how were you handling having your period everyday like this, what sanitary wear were you using during this time.

Participant: I did go to the clinic, but they would just always say that it will end eventually. But it was a tough time so I would use pads when I have money but mostly ended up using cloths because buying pads everyday was an expense. So, I ended up resorting to not using prevention and the bleeding stopped but got pregnant.

Interviewer: so, you were not using any prevention?

Participant: I didn't use any prevention from the clinic, but I was using '*isintu*' traditional things like bottles and threads. The church that I go to they do threads for us to use put around your waist. It's a mix of things that you get from the people who do it and you drink it only everyday once at night until you stop when you want to get pregnant. Then 2012 I met someone and went to church to have the thread be removed for me to get pregnant. And I did, then I had my 3rd born.

Interviewer: so, where did you give birth with the 3rd one?

Participant: at the clinic, although I was supposed to go to plumtree hospital, I didn't go. It was because of the circumstances, money. So, because I was giving birth after more than 5 year I was supposed to go to plumtree. But when I had my 2nd child that time the clinic was not doing deliveries, only recently they started saying if it is less than 5 years from the previous pregnancy. So with the 3rd one I was definitely supposed to go to Plumtree but I didn't because the money for me to travel to plumtree came late, the money was coming on the 5th and I was supposed to go to plumtree on the 1st.

Interviewer: where the money coming from?

Participant: no, but my uncle in SA, I was then staying at my uncle's house just taking care of his house. The father was in Botswana, but he would sometimes send stuff too problem is his transporter only came once a month on the 15th. And I delivered at the clinic, never had any complications only that little harassment you know that they had told me to go to Plumtree, but I didn't. I did tell them why I ended up not going to Plumtree, it was early morning on the 4th, already in a taxi to go to Plumtree because my stomach was now painful I could see now that I wont be able to get there, so instead diverted

the driver to the clinic. When I got there, I found a nurse outside who was doing her washing, told her that my stomach is now painful, and she just said she will not deliver the baby here because I am supposed to go to Plumtree. Despite trying to explain to her what happened she ignored me, so I went into one of the rooms that had a bed, got up there and pushed the child out alone. Good thing about me is I don't stay in labour for long but in 2 hours I'm done, and I walk.

Interviewer: where did you get the courage to do that? How did you do it?

Participant: I was ready to do it on my own, I was ready. So, I got onto the bed and pushed out the child on my own, the nurse only came when she heard the child cry. She got there the only thing I asked her was to just cut the code because I was already done. Labour is never painful for me. So when the nurse came she just asked why I would do that alone, but you know I was the one feeling the pain because I had told her but she just continued washing so I had to do what I could to relieve myself of what I was feeling. You know if I knew how to cut, I would have cut on my own but because I don't know I had to wait for her.

Interviewer: but that took really a lot of courage, to even do that on your own, were you not worried about the baby or anything going wrong?

Participant: you know what at that point I had made up my mind already, because my stomach had started bothering me at night around 2am, I was alone, with kids only who could not help, so the courage came from that and at that point I will give birth alone. I was ready to cut the code alone, I asked for god's mercy but I was ready for it, you know what they say about cutting the umbilical code you measure with the length of the child's knee so I was going to do it then. So, I gathered my birth stuff, water, razor and the baby's clothes and I went to sleep at the kitchen and kept praying. But when God has not willed it doesn't happen, however the whole night I spent I was unsettled having cramps...

Appendix 4: Ethical clearance



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31 October 2019

Confirmation of Research Ethics Approval Samantha Moyo [SOC2019/21]

This is to confirm that Samantha's research proposal, Health Provision in Istutsh, Zimbabwe: A focus on Sexual and reproductive health, under the supervision of Prof A. Pande, has been reviewed by the Sociology Department. Ms Moyo presented her proposal to the Department on 23 October 2019.

The Department is satisfied that the research carries no significant risk of harm to human subjects. We are further satisfied that appropriate informed consent and confidentiality/anonymity/data protection mechanisms are in place.

It is a condition for the acceptance of Ms Moyo's proposal that she complies consistently with strict ethical standards. This will entail proceeding only on the basis of the consistently informed consent of interviewees and will require regular monitoring of ethical issues which may emerge as the project develops.

Please contact the Department should you have any questions or concerns.

Kind regards,

Gerritne Valentine

Signature Removed

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excelling for life and addressing the challenges facing our society.