‘WE HAVE NO CHOICE’

FACILITY-BASED CHILDBIRTH:

The Perceptions and Experiences of Tanzanian Women, Health Workers, and Traditional Birth Attendants

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LIST OF ABBREVIATIONS

ANC	Antenatal care
EmOC	Emergency obstetric care
FGD	Focus group discussion
MCH	Maternal and child health
MOHSW	Ministry of Health and Social Welfare [Tanzania]
MMR	Maternal mortality ratio
TBA	Traditional birth attendant
TDHS	Tanzania Demographic and Health Survey
Tsh	Tanzanian shillings[1]
WD	Women's Dignity

[1] At the time of data collection (November 2005), USD1 = Tsh 1,170

EXECUTIVE SUMMARY

Maternal mortality in Tanzania remains exceptionally high. The maternal mortality ratio (MMR) from the Tanzania Demographic and Health Survey (TDHS) 2004-05 indicates over 8,000 maternal deaths annually (National Bureau of Statistics [Tanzania] (NBS) & ORC Macro, 2005). International estimates put this figure as high as 21,000 maternal deaths annually, placing Tanzania in a group of thirteen nations that accounts for two-thirds of global maternal mortality (AbouZahr, 2003). Skilled attendance at delivery and the availability of emergency obstetric care (EmOC) are extremely low; only 47% of births in Tanzania occur in health facilities (46% with a skilled attendant), only 5.5% of health centers can provide basic EmOC, and only 64% of hospitals can provide comprehensive EmOC (NBS et al., 2005; Ministry of Health and Social Welfare [Tanzania] (MOHSW), 2008). A detailed analysis of data from the TDHS also found that health services are inequitably distributed across the country, and that disadvantaged women – the poor, less well-educated and rural residents – consume less healthcare and access worse quality care. For example, the poorest women are almost 3 times less likely to receive skilled assistance at delivery, and over 7 times more likely to give birth at home than women from richer households (Smithson, 2006).

Tanzanian President, Jakaya Kikwete, acknowledging the extremely low coverage of skilled care during childbirth and the challenges of providing quality maternal health services free of charge launched the *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania* (also known as the 'One Plan') in April 2008. Under the 'One Plan', the government has committed to reducing the MMR by two-thirds from 578 to 193 deaths per 100,000 live births by 2015, which is in line with national commitment to the Millennium Development Goals (MDGs). Key operational targets for maternal health services under the strategy include increasing coverage of skill attendance at childbirth to 80%, as well as expanding coverage of comprehensive EmOC to all hospitals and basic EmOC to 70% of health centers and dispensaries (MOHSW, 2008).[2] To meet these targets, functioning health facilities are needed; staffed by trained health workers, equipped with essential medical supplies, and able to provide rapid referrals for women with obstetric complications. Services must also be delivered in a respectful and non-discriminatory manner, so that women and their families have confidence in facility-based care.

[2] District councils are responsible for facilities at three levels in the Tanzanian health system: dispensary, health center, and district hospital. A dispensary is the first formal unit of primary health facilities. A dispensary is expected to serve approximately 10,000 people, and supervises all village health posts. A standard dispensary should consist of an outpatient department, maternal and child health services, toilets, and a minimum of two staff quarters. Health centers form the second tier of facilities. Each center is expected to cover 50,000 people, which is approximately the population of one administrative division (ward). A standard health center should consist of an outpatient department, maternal and child health services, 24-bed medical ward for men and women, obstetrics theatre, diagnostic services, mortuary, surf-burner (improvised incinerator), kitchen, store, and a minimum of 10 staff quarters. According to the Primary Services Health Development Programme (or MMAM to use its Swahili acronym), the public health facilities currently available are 4,679 dispensaries, 481 health centers, and 95 district hospitals. However, the current infrastructure and services at most of these facilities fall far below standard (MOHSW, 2007).

To inform maternal health policy, services, and advocacy at this critical juncture, CARE International in Tanzania (CARE) and Women's Dignity, together with local research partners, conducted a qualitative analysis of women's access to facility-based delivery in three rural districts of Tanzania: Mpwapwa in the central part of the country, Tunduru in the south, and Kwimba in the northwest. The study was designed to give voice to women's choices and decisions about where they give birth, and to capture health providers' views of their capacity to provide quality delivery care. In particular, the research sought to understand why 94% of Tanzanian women use antenatal services, yet only 47% deliver at a facility. The study provides evidence of the key barriers that women confront in accessing facility-based childbirth, and that health providers face in delivering quality care.

In total, 24 focus group discussions were conducted with women in 12 villages (4 villages per district), and 19 women participated in in-depth interviews. In addition, 26 health workers from local facilities and 23 traditional birth attendants were interviewed.

Key Findings and Recommendations

Where do Women Want to Deliver?

Women wanted to deliver at a health facility but faced insurmountable obstacles to facility-based childbirth. Study data clearly show that women want to deliver at a health facility. The women interviewed were knowledgeable about the potential complications of childbirth and recognized that the appropriate medical care to prevent or manage complications is only available at health facilities. However, despite this clear and informed preference, poor women and those in remote rural areas often cannot reach or afford safe delivery at a facility. The testimony of participants revealed that women often encounter insurmountable barriers in accessing and using facility-based delivery services, and health workers face severe constraints in providing quality delivery care. Key findings on the barriers identified by the study together with recommendations for reducing these obstacles and improving maternal healthcare are presented below.

Barriers to Accessing Health Facilities

Women commonly faced barriers in accessing facility-based birth. These included the costs of preparing for delivery, the distance to the closest facility, the lack of affordable transport at the time of labor, and the formal and informal charges incurred for delivery at a facility. As a consequence of these barriers, women often had little or no option but to deliver at home.

Data clearly show that the Government policy of providing free maternal health services is not consistently or effectively implemented. Women were still routinely instructed by health workers to bring essential medical supplies for delivery as these were frequently not available at facilities. Supplies that women were typically requested to purchase and bring to the facility included a rubber mat for delivery, rubber gloves for the birth attendants, razor blades, thread for stitching,

as well as new clothes. Participants also related that they commonly had to collect and/or bring water, and carry lamps and kerosene for light. In addition, some women described formal service costs as well as unexplained 'informal' charges demanded by providers before they would provide care or services.

Recommendations

• Disseminate, implement, and enforce nationally the Government policy exempting women from paying for maternity care.

Women and their families need to know their right to free pregnancy and delivery services, and health workers and local authorities need to know and effectively implement the policy, so that maternal health services are provided without charge (both official and unofficial fees) and no pregnant woman is denied care.

• Expand coverage of comprehensive EmOC (which includes caesarean section) to all district hospitals and to 50% of health centers by 2015, with priority to the most underserved areas. Equip all dispensaries and the remaining health centers to provide basic EmOC.

Expansion of EmOC coverage will necessarily require the deployment of skilled health workers to facilities. In addition, government-funded ambulances should be made available at health centers to facilitate rapid referral of women with complications. Public education campaigns should also target community leaders and families on the importance of birth preparation and emergency transport plans for pregnant women.

Barriers in Using Delivery Services

Women's perceptions and experiences of staff and services at health facilities were mixed – sometimes positive, but predominantly negative. Women presented a consistent theme of abusive behavior by health workers, which discouraged women from utilizing services.
Study data also show that health facilities had no functioning complaints mechanisms for clients or for health workers to channel recommendations for service improvements to authorities, or to report unprofessional behavior by health workers. Indeed, some women expressed fear that complaints would bring retaliation from providers.

Encouragingly, health workers generally reported positive views about their working relationships with colleagues and supervisors, felt qualified to do their job, and would welcome further training. However, when asked how services could be improved, workers only related what the women needed to do, rather than what they could accomplish as providers. These findings reveal both the strong need and opportunity to institutionalize quality improvement systems.

Recommendations

• Establish a clear and effective complaints procedure, which incorporates the views of

health consumers and providers to inform and improve maternity care and health services, and which encompasses ethical and regulatory checks-and-balances to hold health staff accountable for misconduct or malpractice.

• Institute a robust health governance system to ensure accountability for the delivery of quality health services.

The existing – but weakly implemented – health governance system should be strengthened as a matter of urgency, starting with the clear assignment and communication of responsibilities to all key actors – MOHSW, Council Health Management Teams, Health Boards, Health Facility Committees, citizens' groups, community health funds, and elected leaders and representatives. The system's main objectives should be to encourage public engagement in assessing and monitoring services, and to promote quality improvement through partnerships with health workers and health authorities. To be effective, all institutions and actors must be clearly allocated responsibilities in managing and implementing quality services.

• Disseminate the existing Clients' Service Charter nationally so that health consumers know their rights and how to register concerns and complaints. Implement a regular, public process to review and update the Charter.

Barriers to Provision of Quality Delivery Care

Data indicate that health facilities were understaffed, and not all workers were adequately trained to provide delivery care. In addition, health workers felt that current financial and professional development incentives were inadequate.

Women and health workers also commonly cited a lack of basic infrastructure and ancillary services – particularly water and power supply, sanitation, waste disposal facilities, and space in delivery rooms and wards – as well as routine shortages in essential equipment, supplies and drugs, which severely constrained the capacity of health workers to provide adequate delivery care.

Recommendations

• Recruit and deploy trained health personnel to expand coverage of skilled birth attendance in underserved areas.

The shortage of trained staff, particularly at lower-level facilities, undermines delivery care. Providing adequate salary and particularly incentive packages will be critical in attracting and retaining qualified health staff in these locations. Further exploration of financial incentives for documented good performance would be valuable. Other key components are professional development and training opportunities, effective supervision, and training that emphasizes team-based, rights-oriented, service delivery.

- **Ensure water, sanitation, waste disposal services, and a reliable power supply are available in all health facilities.**

Improvements in infrastructure, equipment, and supply chains at health facilities are essential for enabling delivery of quality delivery care. Improvements can also positively impact the morale and performance of health workers, as well as the confidence of women in utilizing facilities. Lack of space and privacy in labor wards also need to be addressed.

- **Secure supply chains for essential medical supplies. Stock-outs can no longer be accepted as normal operational context at health facilities, and officials and staff responsible for supplies must be held directly accountable for their actions.**

[3] The current World Health Organization definition of a skilled attendant is: 'a health professional – such as midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns' (WHO, ICM, & FIGO, 2004).

INTRODUCTION

The maternal mortality rate in Tanzania remains exceptionally high with no decrease over the last decade. The latest TDHS estimates the MMR at 578 deaths per 100,000 live births (NBS et al., 2005). To address this alarming situation, robust policies and targeted, evidence-based interventions are urgently needed to improve maternal health outcomes.

Skilled attendance at delivery[3] and the availability of emergency obstetric care are internationally agreed indicators of progress towards reducing maternal mortality (Campbell & Graham, 2006; Stanton, Croft, & Choi, 2007). They also represent valuable benchmarks for assessing equity in the provision of healthcare services. However, only 47% of births in Tanzania occur in health facilities (46% with a skilled attendant), only 5.5% of health centers can provide basic EmOC, and only 64% of hospitals can provide comprehensive EmOC (NBS et al., 2005; MOHSW, 2008). In addition, a detailed analysis of data in the THDS found that the poorest women are almost 3 times less likely to receive skilled assistance at delivery, and over 7 times more likely to give birth at home that women from richer households (Smithson, 2006).

Acknowledging this critical lack of services, the Tanzanian government launched the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (also known as the 'One Plan') in April 2008, in conjunction with the national advocacy campaign, Deliver Now for Women and Children in Tanzania. The goal was to coordinate the various maternal health initiatives in the country, and to mobilize communities to improve maternal and child outcomes. The 'One Plan' has set the goal of a two-thirds reduction in the MMR to 193 deaths per 100,000 live births by 2015. Key operational targets for maternal health services under the plan include increasing coverage of skill attendance at childbirth to 80%, expanding coverage of comprehensive EmOC to all hospitals, and expanding coverage of basic EmOC to 70% of health centers and dispensaries (MOHSW, 2008).

Meeting these targets will require immediate and sustained investments in the primary healthcare system in Tanzania. Functioning health facilities are needed; staffed by trained health workers and equipped with essential medical supplies, with rapid referral systems for obstetric complications. Services must also be delivered in a respectful and non-discriminatory manner so women and their families have confidence in facility-based care.

To inform maternal health policy and advocacy, CARE International in Tanzania and Women's Dignity, together with local research partners, conducted a qualitative analysis of women's access to facility-based delivery in three rural districts of Tanzania. The study was designed to give voice to women's choices and decisions about where they give birth, and to capture health providers' views of their capacity to provide quality delivery care. The research aimed to understand why 94% of Tanzanian women use antenatal services, but only 47% deliver at a facility, and in particular to identify the key barriers they face in accessing facility-based childbirth.

METHODOLOGY

Study Locations

The research was conducted in three rural districts of Tanzania: Mpwapwa in the central part of the country, Tunduru in the south, and Kwimba in the northwest. In total, 12 villages were involved in the study. Participants were drawn from two wards per district, and from two villages within each ward. The wards were chosen based on their distance from the district (government) hospital. One ward was in close proximity to the hospital; the other was far from the facility. A mission hospital was also located in each district.

Research Partners

Members of two organizations – Grassroots Female Communicators Association (GRAFCA) and the Tanzania Midwives Association (TAMA) – were engaged as researchers. Development of the research protocol and study tools, as well as training of the researchers, was done by Dr Charles Mayombana of the Ifakara Health and Development Research Center with support from staff of CARE and Women's Dignity. The Ministry of Health and Social Welfare in Tanzania facilitated implementation of the study by providing a letter of introduction and support to authorities in participating districts.

Study Participants and Survey Tools

Women, local health workers, and traditional birth attendants (TBAs) participated in the study, and all participants agreed to take part. Methods included focus group discussions (FGDs), semi-structured interviews, and case studies. All tools were developed in English by staff of CARE and Women's Dignity, translated into Swahili, and field-tested and revised by the research team in Mwanza.

Women

Two focus group discussions were held in each village; the first with women aged 24 years or under, and the second with women aged between 25 to 45 years. Six to eight women participated in each of 24 focus groups. In the original study design, only women who had given birth in the prior 6 to 12 months were eligible for the survey. However, it was not possible to identify enough women who met this criterion in every village; therefore, some participants were recruited who had given birth more than one year ago. In addition, nineteen women were interviewed individually using the case study approach to explore in greater depth the experiences of women who had delivered at home and women who had delivered at a health facility.

Health workers

Twenty-six health workers from local health facilities were interviewed individually; eleven using a semi-structured interview tool, and fifteen using a case study approach. Participants included

15 hospital staff, 7 health center staff, and 4 dispensary staff. The health workers selected for interview were either staff who attended deliveries at dispensary or health center level, or hospital staff for whom delivery attendance comprised a major part of their duties.

Traditional birth attendants

Twenty-three TBAs were interviewed individually. Village leaders were responsible for identifying and selecting the TBAs interviewed.

Data Collection and Analysis

Data collection took place in November 2005, with teams of four researchers in each district. Researchers worked in pairs – one pair for each ward – and were equipped with tape recorders. One person led the interviews or discussions, while the other operated the tape recorder and took hand-written notes. In several instances, the interviewers were unable to record the interviews due to technical problems, and submitted their hand-written notes or summaries instead. The tape-recorded data were transcribed and then translated into English. Translations were quality checked by Women's Dignity and CARE staff. The data were then analyzed against key themes and sub-themes, reviewed for accuracy and completeness, and amended accordingly. The current report is based on the themes and sub-themes identified.

Prior to going into the field, the researchers received training on the research objectives and data collection methods, and the teams received additional field support to assure the quality of data.

Study Limitations

The researchers had limited experience in using qualitative study methods and, consequently, some tools were not consistently applied. In particular, data collected in the case studies tended to reflect the lines of enquiry of individual interviewers rather than conform to the data collection instruments. Data collected in FGDs more consistently reflect participants' most recent childbirth experiences.

In addition, the study collected more data from women and TBAs and less data from health workers than originally planned, due to the relatively higher numbers of women and TBAs participating in focus groups and interviews.

FINDINGS

1. At Home or at a Health Facility? Where Do Women Want to Deliver?

Study data clearly show that women want to deliver at health facilities. The women interviewed were knowledgeable about the dangers of pregnancy and childbirth, and were aware that the only appropriate medical care to prevent or treat these dangers is available at health facilities. They do not want to deliver with TBAs or at home. There was no evidence that women preferred traditional birth practices, such that they decided against using health facilities.

Women spoke about a range of birth complications, including failure of the placenta to come out, risk of infection in home delivery or with a TBA, and perineal tears being repaired, if necessary, at the health facility. Participants were also aware of the higher potential risks for a woman during her first delivery or during higher order deliveries, and that these births should take place in a hospital.

Indeed, many women had experienced a complicated delivery that required emergency or remedial action during or soon after birth, or knew someone who had experienced an obstetric emergency, suffered a disability, or died during childbirth.

> *"...We carried her on a bed all the way to the mission hospital and, once we got there, she was admitted, checked, and later they said, 'We can't do it. She needs to go to Mpwapwa hospital'. So we took her to Mpwapwa. When we got to Mpwapwa they examined her and told her that the baby had died in the womb and she must be operated. So when they did (the operation) they found the baby had died. The mother survived....but she was hospitalised for 21 days."*

Women described some of the key components of appropriate technical care during delivery, for example, assessment of the baby's heartbeat, assistance to push, and tying of the umbilical cord. Moreover, respondents described health concerns that necessitate delivery at a health facility, for example, if a woman is anemic, dehydrated, needs medication to speed up delivery, has a narrow birth canal, experiences prolonged labor, suffers excessive bleeding, or if the baby is in the breech position. As one woman described:

> *"To deliver at hospital has a lot of advantages. You can have a pregnancy and the baby can be in a wrong position or you can have anemia, so you go to deliver at hospital. The nurses have the knowledge to pull the baby out by a machine or they can use other techniques of delivery."*

Some women did relate that greater freedoms associated with giving birth at home – for example, being able to walk around during labor – are appreciated. However, no data suggest that this sentiment influenced women's decisions to deliver at home or with a TBA. On the contrary:

> *"We don't like [to deliver with a TBA]. For me, it is because I have no money; if I had money, I would go to hospital."*

Participants were also clear that it is not just access to a health facility that matters; the type of facility, the medical staff on hand, and the location of the facility are all important. Women knew whether or not the local facility was equipped with staff or equipment for supporting childbirth, and they indicated that they would bypass lower-capacity facilities. Some respondents also discussed what type of health workers they wanted to assist them, and referred to the different colours of uniforms assigned to each cadre of health staff, such as aides who wear orange uniforms:

> *"[Our health center] should also have experts like the hospital, where we are attended by people wearing white or blue uniforms, but at [our health center] they wear orange."*

2. Barriers to Facility-Based Delivery

Women, health workers, and TBAs consistently cited multiple barriers that pregnant women face in achieving safe delivery at an appropriate health facility. Their testimonies revealed three major categories of barriers:

- Barriers to accessing health facilities, including the financial and physical barriers in preparing for facility-based birth, reaching facilities, and paying for delivery services.
- Barriers in using health services, particularly the abusive treatment by staff.
- Barriers to the provision of quality delivery care, especially the shortage of qualified medical personnel, and the lack of essential infrastructure, ancillary services, equipment, and supplies at facilities.

Each category of barrier is discussed in detail in the following sections. For many women, even one barrier may prove impossible to overcome. If women encounter more than one barrier, it can mean they have no chance of receiving appropriate care during labor and delivery.

a. Barriers to Accessing Health Facilities: Financial and Physical Barriers to Facility-Based Birth

Costs of Preparing for Delivery in a Facility

The Deputy Minister of Health in Tanzania stated in July 2006 in Parliament that women are not required to bring a 'delivery kit' with them for childbirth (Mkinga, 2006). However, the study data show women are still required to purchase and bring essential medical supplies and related materials, as well as new clothes, for delivery at facilities. Health workers related that they routinely instruct women to bring supplies, because health facilities frequently do not have sufficient stocks to serve all of the women who utilize their services. Box 1 lists supplies that women were commonly told to bring for delivery.

Box 1: Medical Supplies and Other Items that Women Were Commonly Directed to Purchase and Bring to the Facility for Delivery

- Rubber gloves (3 to 4 pairs) for use by the birth attendants
- Rubber mat
- Thread
- New khanga (2 to 6 pairs) for wrapping the new baby, as well as for woman herself. In some cases, khanga may also be required as gifts for relatives or friends who accompany the woman to the facility.
- Razor blades
- Basin
- Catheter

Not all of these supplies were required by all facilities. Data indicate that hospitals are more likely to provide basic supplies than lower-level health facilities. Differences were also noted between districts.

Women interviewed by the study were aware of the requirement to bring supplies with them to the facility:

> *"Women are advised during ANC visits to prepare (supplies and materials). When we are pregnant they ask us to prepare ourselves. You save… and by the time you are nine months pregnant you would have enough. This is the advice they give us, to save some money for our needs."*

However, for many women, the challenge of 'being prepared' presented a major barrier to accessing delivery at a health facility.

> *"When we go to hospital we face a lot of troubles… When the pregnancy is six or seven months, they advise you to buy new clothes – five pairs [of khanga] – then you have to carry thread and razor blade and catheter and then you go to hospital. When you reach the reception of the hospital they examine you and they ask you to go and buy other things."carry thread and razor blade and catheter and then you go to hospital. When you reach the reception of the hospital they examine you and they ask you to go and buy other things."*

Participants had a strong perception that women will be refused admission if they arrive without the required supplies.

> *"If you go without the items they don't assist you. They send you back."*

"We encounter many problems during delivery. For example, I gave birth but I had a tear, and my father said they should stitch me up. They answered, 'Yes, but we do not have a needle or thread. You must give us money so we can go and buy them at the pharmacy.' He gave them the money and that is when they stitched me up. Similarly, I did not have the rubber mat for delivery and they asked me for money. I gave them money and shortly after, the rubber mat arrived. I wondered, did they really buy that from the pharmacy?"

Women described making trade-offs between buying one item or another as they could not afford to purchase all of the required supplies.

"In terms of preparations, you need to have adequate clothes and supplies, including baby soap, powder, and lotion. But perhaps you may find you had overspent purchasing the gloves to the extent that you can't afford soap. So you end up smelling because you have no soap for you or the baby."

For others, the trade-offs are even more drastic: between using the family's limited financial resources to buy enough food to eat in the household or to use for delivery in a health facility.

Cost and Availability of Transport, and Distance to the Nearest Facility

Another major barrier to women accessing a health facility for delivery is the lack of affordable transport at the right time. This is significantly compounded by the nature and/or timing of the onset of labor, as well as the distance to the nearest facility that is adequately equipped to provide delivery services.

"Many of us would like to be attended at the health centers. The transport problem is the one that forces us to deliver at home."

"I have four children; my youngest was born in February 2005. I had him at home. I had forgotten to keep track of my pregnancy period and I thought I was eight months gone. But suddenly at 7 o'clock in the evening my contractions started. There are many lions around so I had to give birth at home. It had to be that way because of transport problems and because health care is so far away. The road is bad, so transport is a problem and my husband doesn't have money. I would have liked to give birth in hospital but going to hospital creates the problem of carrying food, and I don't have anyone to leave my family with."

For women in rural areas, the usual means of transport to a health facility involves some combination of a two- to five-hour walk, and a bus ride. Transport in an emergency is frequently on the back of a bicycle or a make-shift stretcher. Locating and paying for a private vehicle are extremely difficult, reaching a cost of 100,000 Tanzanian shillings (Tsh) and above.

"Bicycles are used. They put you in a big bamboo basket...and tie the bamboo basket on a bicycle and push the bicycle…You lay on your back…You go to the hospital. When you arrive there, they untie you and carry you inside…When we arrive they laugh at us… You don't get first aid immediately, you are put to task first. You are asked, 'Why do you

delay until you got into this situation? Why don't you come in advance?' You explain that you don't have money. That is why you decided to stay at home. [The nurse] starts to boycott assisting you and your carer…She doesn't accept your card. If she takes it, she will throw it away and they start insulting you."

For some participants, access to their nearest facility was seasonal, and heavy rains made travel difficult or impossible. The onset of labor at night can also prevent travel due to dangers on the road or lack of transport. For women who do not know their due date, any plans to deliver at a health facility can be completely undermined by the inability to access affordable transport quickly. Numerous references were made in the focus group discussions and interviews to women delivering on the way to a facility.

Some women dealt with the barriers of transport and distance by staying with a relative close to a hospital in advance of the due date, or setting aside sufficient funds for transport in an emergency. However, these choices may not available to all women.

"My afterbirth wouldn't come out so I had to be taken by stretcher to Tunduru where I was given assistance and also had a blood transfusion. So I don't think it is good to give birth at home. It is just poverty that makes us live far from hospital."

Formal and Informal Charges at Facilities

The official government policy for maternal healthcare provides for free services for women during pregnancy and childbirth. However, the reality for Tanzanian women is starkly different. The current study provides extensive evidence that women routinely face significant formal and informal charges for antenatal care (ANC) and for delivery at health facilities. The women interviewed indicated that some costs were anticipated, but other charges were arbitrary and unexpected. These expenses present a significant barrier to women being able to plan for, access, and afford facility-based birth.

"The costs involved in one day of giving birth are different from those involved in nine months of attending clinic. The cost of that one day is like 12 months or more! You could go to give birth and you are told to pay 15,000 and you don't have that money in your pocket."

Formal service costs cited by women included payments for registration cards during antenatal care visits, charges for some ANC services such as blood tests (which are not provided if the woman cannot pay), and the purchase of basic medical supplies, drugs, and materials required during delivery and in-patient care at a health facility. Participants also related the prohibitively high costs of emergency procedures, for example, caesarean section which can cost as much as Tsh 80,000.

Some participants expressed their suspicions about why they were asked to pay for certain items.

They questioned what the policy on free services for pregnant women and children actually meant, and suggested that some health workers were involved in corrupt practices.

> *"Medical supplies might come there and they are all taken away to the pharmacies. When you go to hospital the only thing you get is a written prescription and are told to buy the medicine from the pharmacies."*

Health workers said that the purchase of medical supplies and drugs by patients is the predictable reality of the situation. Indeed, some health workers said that the practical need for them to ask people to come with, or to purchase supplies and drugs once at the health facility, lays health workers open to suspicion of corruption.

Women also described unexplained payments that providers demanded before they would provide care or services. These included, for example, Tsh 3,000 – 4,000 demanded at reception for admission (with no receipt provided), and Tsh 3,000 – 4,500 required by nurses following delivery. However, these informal charges appear to be random and individualized; women in the various focus groups described a range of experiences. For example, if a woman was known at the health facility because a friend or relative worked there, she would be treated better than patients who were not known to the staff. Not surprisingly, no health workers related asking for informal payments.

In addition, women incurred costs at health facilities, both for themselves and for any carers who accompanied them. Participants routinely had to collect and bring water, carry lamps and kerosene for light, and buy and/or cook their own food at the health facility. All of these implied costs for the woman and her family.

Finally, it is critical to note that women are assessing their options and making careful decisions about where to deliver based on the potential costs and quality of care at home or at different facilities. In locations where women had access to both a government district hospital and a mission hospital, the evidence indicates that women made informed choices about their place of delivery. For example, some mission hospitals charge a single fixed fee for delivery services in comparison with government hospitals where, as noted above, unexpected service costs may creep in. The fixed fee at mission hospitals was preferred and appreciated by a number of the women interviewed.

For example in the case of one mission hospital, the delivery fee is Tsh 3,000 and covers provision of gloves, rubber mat and thread. Women are required to bring their registration card and basin for washing clothes. Like government facilities, the mission hospitals insist on new clothes or materials for wrapping the baby – not just that these should be clean – and do specify the number. As one participant described:

> *"Three thousand shillings only – the examination is free, you don't pay for syringe, medicine or water. You are treated for free. Your cost is only three thousand shillings, no more. Then you can return home."*

b. Barriers in Using Delivery Services: Women's Perceptions and Experiences of Health Facilities and Care

Client-Provider Interaction: Abusive Behavior by Health Workers

Data show that some health facilities had a reputation for providing good care and others for poor care, and women usually judged the facilities based upon staff behavior. A number of women reported a good experience, felt supported, and were grateful for the medical care and interventions they received; or were appreciative of the efforts of an individual health worker.

> *"Frankly, those who serve us here try hard. Their service is good."*

> *"They took my card and showed me my bed. I fell asleep immediately. When my time was up they came and caught the baby and fixed it up…I said to a nurse, 'Come and see', and she came and looked and the baby was emerging. I did not call out, she just came. She did not abuse nor hit me. I had a comfortable delivery."*

However, the evidence strongly indicates that negative perceptions about health workers' behavior prevail. Indeed, negative experiences during childbirth at facilities were cited by a several respondents as a reason for deciding against using facilities for subsequent deliveries.

"Some nurses are good and they give you a good reception when you enter the labor room. But I can't describe the attitudes of some other nurses. You could go in there and relieve yourself and they tell you that you are not ready, just lay there. You struggle and eventually give birth by yourself and then she comes all apologetic. So I think it is best to give birth at home with a traditional birth attendant. She loves us, she is collected, and she tells, 'You don't do that, do this and this'. There are many good things in hospital, but there are many that are bad because of people's attitudes."

Women appeared to tolerate a variety of abuses because they recognized that facilities provided technically appropriate assistance in the event of complications, but their experiences during deliveries were often negative. One woman described calling out for assistance but being left to deliver alone.

"When I was expecting, I went to…hospital and registered with my card. Suddenly I was hit by labor pains. The person accompanying me went to the nurse and told her of my condition. She told her to bring me in. My card was thrown at me and the nurse wandered off to talk to her colleagues for some time. And then she comes and asks me what the problem is. It is written on my card that I am pregnant and she knows my time is up. She says, 'Take her over there so that she cools down'. You go into the labor room and she leaves. You call her saying you are ready, but she says they've already examined you and you are not ready. So you stay there and the child comes and you deliver by yourself. When she comes she just deals with the waste. So we face problems. We are not happy."

Other individuals related being refused service if they did not come with the required items, and that health workers provided no assistance unless they were given money.

"There are bad things. First of all the hospital attendants are very disparaging. You have a caesarean and then while your wound is open they tell you they do not have supplies. 'Go and buy some.' You go and buy and return and you are told 'We have no time for dressing wounds. We do that in the morning.' That is very irritating."

"I had my third child at the health center. I didn't really get good care until I paid the demanded 2,000 shillings for gloves and for an injection to stop bleeding. It was then that I received care. It means that had I not given money, I would not have received good care."

One respondent described the dismissive and abusive manner in which health workers responded to their practical needs.

"For example, currently they don't allow people to get into the ward, including parents, so it's left to you to get rid of your mess and come back, and you hear them say, 'You can do it [urinate] on the bed… it's your urine.'"

Other participants reported being told they were dirty or that their clothes were too old, that they were slapped or otherwise abused by a health worker during childbirth.

"If you go with old khanga, they [the health facility staff] throw them and insult us so much. If the khanga are not too old – like you have washed them two or three times – they can accept them."

"To be honest, for now, hospitals are not good. For example, when requesting assistance from nurses, they ask you, 'What kind of help do you want? At the time you had sex, you felt pleasured. Now why are you complaining?'"

The data strongly indicate that women frequently feel marginalized and disempowered. Many participants lived in rural areas far from the nearest health facility they. Some spoke of living in remote villages disregarded by politicians and development organizations, and where they do not have access to basic services such as water, roads, education, and healthcare.

"We need piped water. Fetching water is an all-day thing…And when we are pregnant with huge stomachs we can't walk to fetch water or even to bathe. We just sit! Water is 12 miles away; you are eight, nine months pregnant. Can we manage that?"

Others expressed that they are not treated with dignity and are looked down upon when they arrive at a health facility on the back of a bicycle.

"She was not examined and had to give birth by herself. She tried calling out but couldn't. After giving birth they came and said the clothes for wrapping the baby were dirty. They had to be new clothes. The result is that my daughter has now given up going to hospital. Now she gives birth with traditional birth attendants."

Health workers participating in the study related that women's difficulties in preparing for delivery and women's perceptions that health staff will treat them harshly are both barriers to women attending facilities for childbirth.

"On the few occasions I have gone to the villages, what they complained most about is the unfriendly language used by nurses. They said the nurses are too harsh and they also complained about things they are required to prepare for delivery. When a mother can't afford to get all the needed supplies, including clothes, she feels uncomfortable and is reluctant to deliver at the health center, and therefore delivers at home. So this is another deterrent. Nurses should be humble and kind. Most of them act to the contrary, are not well trained, and such nurses, if women ask too many questions, they get angry."

However some health workers expressed their concern and frustration in being blamed by patients.

"The problem we have here is that there are a lot of blames. You will find people complaining that their patient is not well treated. You can find that they brought her very late and in such a way she can come out without a baby. Due to their ignorance they find it difficult to understand what happened to the baby, so they throw all the blame to us…But for anyone who understands or is in the medical field he can understand the cause of the problem. So there are a lot of blames in this maternal unit."

Complaints Mechanisms

Study data indicate that there is no functioning complaints system to articulate and address service delivery problems. Women do not have relevant or effective ways to make complaints about their care or treatment, and health workers do not have direct knowledge or experience of a complaints process for registering their own concerns.

Asked about their knowledge of complaints procedures or whether they had ever complained or questioned the quality of service, women stated that they do not see any realistic way to make complaints. Some participants feared that complaining would lead to even worse treatment; that the health facility staff would know which village a letter came from, and any criticism would result in bad treatment in the future.

Evidence was mixed on whether health workers are aware of the existence of complaints mechanisms for clients, and on whether they see the relevance of receiving and acting on complaints. None of the health workers indicated participating in a system of quality improvement, and certainly not a client-centered process.

> *"I have never heard them complain…If we have complaints we accept them…that is why we have this suggestion box. People write letters if they see anything bad …We are not the ones who open the box…District officials open it…We have never received any feedback (from district officials). Maybe there are no complaints from the clients."*

When asked about how health services could be improved, health workers talked about what women need to do – such as attend ANC earlier or come prepared with supplies for delivery – rather than what they could do as service providers.

c. Barriers to Provision of Quality Delivery Care: Facility-Based Constraints in Providing Delivery Assistance

Asked about hours of operation at facilities, women responded that they would be attended during childbirth by a health worker even when a health facility is closed. However, even those women who managed to reach a health facility on time and with all of the basic medical supplies encountered further barriers in receiving quality delivery care, especially due to the shortage of trained health workers and the lack of basic infrastructure, ancillary services, equipment, and supplies at facilities.

Shortage of Trained Health Workers

According to the information provided by participating health workers, the staff at hospital level appeared to meet the basic criterion for a skilled attendant. Each staff member reported having four years of Nurse and Midwifery training. However, data collected at dispensaries and health centers indicate that Nurse Assistants or Maternal and Child Health (MCH) Aides are the principal cadres providing services to women during childbirth. Most of these staff reported having completed one year of training, but it was not clear to what extent this training included

midwifery skills, or whether these health workers felt adequately trained to provide skilled delivery assistance.

Evidence strongly indicates that the shortage of skilled staff in health facilities – particularly in lower-level facilities – undermined the capacity of services to provide quality care. Health workers described understaffing as a fact and that they regularly work double shifts.

> *"Due to staffing shortages we have to work every day and we also have few trained experts in reproductive health. Indeed, it is hard work and you are forced to run from here to there. It is too much work and you don't even have time to rest…I am the only trained nurse [at this health center]."*

To manage their workload – and recognizing that some women struggle to come to health facilities – a few health workers accepted referrals from TBAs whom they knew to be competent. These health workers accepted TBA-supported deliveries, and also requested that TBAs bring clients to the facility the next day for follow up.

> *"Before being sensitized and given education on how to handle delivery services, there were a lot of problems (as a result of TBA deliveries). There were many problems such as deaths of a mother, a child or both, because they did it blindly. However, with education, the services provided have been improved. We normally tell these traditional birth attendants to bring the expectant mothers to the center because it is easier to work together collaboratively in case there are some complications. In this way it is also a good opportunity to share our experiences and exchange knowledge with them."*

Another way health staff managed understaffing was to involve the relatives or neighbors who came to the health facility with a woman. One health worker said:

> *"They help us a lot. For instance, because of the shortage of staff here, they stay with those patients who have an operation until they regain their consciousness. When the patient has gone back to normal, we will tell the person escorting the woman to leave."*

Interestingly, while relationships with clients were often described as challenging, health workers related that they liked their jobs and talked about strong positive working relationships with colleagues, including their supervisors.

> *"I love my job. I like it more when the mother has a safe delivery and both the newborn baby and mother are doing well…Sometimes we get patients from the villages in a bad state, and if you take care of them and they get better, I feel very happy."*

However, health workers also felt strongly that financial and professional development incentives were inadequate. This sentiment was expressed by mission hospital staff as well as government health workers.

> *"I like my job because I am trained and gained knowledge and professional skills. After completion [of my training] I got employed as a qualified professional…In my opinion, I*

need more training in order to improve my performance because there are too many new changes and developments. With more education and training, I can improve the quality of service I provide."

Lack of Basic Infrastructure and Ancillary Services at Health Facilities

Lack of basic infrastructure and ancillary services – including water and electricity, space in the delivery room, beds in the maternity ward, sanitation and waste disposal facilities, and transport in the event of emergency referral – diminished the capacity of health workers to provide women with safe delivery. Health workers related that the operating space was too small to cope with family members during delivery, and frequently referred to the lack of a reliable water supply, chlorine, functioning latrines, and electricity.

"Sometimes we don't have enough supplies when we need them. Water is also a problem and we spend a lot of time fetching water. And if you have an emergency delivery case, it's a headache because then you have to look for transport to take a woman to the referral hospital. It is a pity. If a patient dies accidentally, it is hard and demoralizing for us."

The lack of ancillary services at facilities is also a major barrier to women and their families in using facilities and receiving quality care. Discussions highlighted how patients are largely unsupported once at the health facility. They are required to bring or find their own water, wash themselves and their clothes, prepare meals, and handle their other needs.

"I don't understand why the government does not address the question of food. Some of us don't go to the hospital, especially if you know you have no food even though you may have soap. You say to yourself, 'Why bother to go to the hospital? I can just deliver at home'...Water, especially at night, is a major problem. If you deliver at night you are forced to stay the way you are, you can't even clean the delivery room. Also electricity – we need it. If you decide to go to the hospital, it means you must carry a makeshift lamp with you. If you don't have a lamp, you deliver in the dark."

"A long time ago they used to provide some assistance to pregnant mothers, but not these days. You have to do it yourself."

"There was a woman who delivered by operation and she didn't have any relatives. She needed food. Luckily they brought me food from home so I shared my food with her, because I did not eat much. I shared mine for five days when she was hospitalized. Then I left, but she was still there. They said, 'Now that you are leaving, your friend will have a hard time. Where will she get food?' Meanwhile the nurses were selling food inside…In the old days, food was available at the hospital. Everything was available."

Women highlighted the problem of not being able to have their partners, carers, or family members stay with them during birth or visit them on the ward. Participants commonly related having to manage all of their practical needs by themselves.

"The good thing with hospital is that you receive all important services. But they have one problem: they don't allow relatives to visit patients. Sometimes when relatives bring food

"they are not allowed to see us, even though we are not healthy enough to walk outside. You use a lot of energy walking to the door. This is not good at all."

Women also described the difficulties of managing basic hygiene while in hospital. For example, the wash basins they brought with them had to be used for all needs.

"Because I was there for five days, I saw what my fellow women went through. They had to defecate in there, throw up in there, and urinate there. And, after delivery, all their clothes were dumped in the same basin."

Some women also expressed concern about the lack of privacy at facilities, especially where labor and delivery rooms are next to the outpatients' area.

Women felt that much could be done to improve the way that care is delivered. Box 2 lists some of the major areas in facilities cited by women that need to be upgraded or expanded.

Box 2: Lack of Basic Infrastructure, Ancillary Services and Supplies at Facilities Cited by the Women Interviewed

- Beds: Wards are overcrowded with two women sharing a bed in many cases. Mosquito nets are also not provided for beds at government hospitals.
- Electricity: Women need to bring a lamp and/or kerosene to health facilities, or deliver in the dark.
- Food: Women are responsible for bringing and cooking their own food when staying in facilities.
- Water and Washing Facilities: Women must collect or provide their own water, wash their own sheets and clothes. Patients often have to go to another ward or travel some distance to access water.
- Poor sanitation and waste disposal facilities, especially lack of toilet facilities.
- Drugs and medical supplies: Lack of anesthesia during stitching and drugs in general; lack of gloves, rubber mats.
- Transport in emergencies is not provided.

Lack of Medical Equipment and Supplies

Health workers routinely faced shortages of medical equipment and supplies to enable safe delivery, including key drugs and supplies necessary for managing complications, for example, lack of blood for transfusion. One health worker described:

"Now, you might find that there are no drips, not even at the entire hospital, so you have to instruct the relatives of the patient to go to town and buy some. If it happens that they

brought no money then that is when things become even more difficult. You want to help the ailing woman, but you have no means of helping her. During such a time, if no immediate action is taken, she might end up losing her life…"

Another staff member related:

"Sometimes we have enough supplies and sometimes we don't…For example, gloves … and chlorine and suction tubes…At times the suction machines themselves break down and this can be problematic when you are trying to resuscitate a baby…if these things are in short supply, we often resort to traditional methods such as mouth-to-mouth to resuscitate a baby, or we borrow one from the theatre in order to save the life of the baby."

Such severe constraints mean that health workers – even those fully trained as delivery attendants – cannot provide adequate delivery care.

"There are such instances as some mothers need to have some glucose, and we might not have it here; or we have to enlarge the way the baby will go through and we don't have stitches; or after delivery a mother will need some medicine to help stop the bleeding, but sometimes there is no such medicine…"

As discussed previously, a common mechanism used by health workers to overcome shortfalls is to inform women to purchase and bring basic supplies with them to the health facility. Some participants recognized the challenges faced by poor women in preparing for delivery in a facility,

and they described alternative ways to work around the supply problem, including holding back on certain items so that they are available for the poorest patients, or using the supplies brought by other women for a patient with urgent needs, while the patient's relatives are sent to buy replacements. One health worker related a series of strategies for managing the lack of supplies:

> *"For example, here you can find that there are no threads to use to fix up after expanding the birth canal. So I receive the patient, and after receiving her, I will check her as usual: all the necessary measurements. And if her time has not come yet, I will write a list of things that I want to have and give it to her mother or any other relative who brought her here, and tell them to go to town and buy all the things I have listed and bring them to me… If that woman shall deliver before those things have been brought I can go to the ward and take another patient's things, such as threads and use them for this delivering mother. And then when those I had ordered come, I will replace them to the person concerned… However, before sending her to buy them I have to assess if she can buy them… If she has no money during the delivery process, I have to use all the tactics I have been taught to make sure that I help her… I will refrain from expanding her birth canal. I will have her lie on one side until I see the baby's head coming out. In this way I can help her deliver safely. She can get bruises, but we do it because she cannot buy the necessary things needed in delivery process... We will have to go to MCH if they have threads or you will have to go to the theater to request for some, or go to the pharmacy if they have some…"*

In these ways, health workers attempt to serve the women who come to their facilities. However, none spoke of their own role in ensuring more reliable flow of supplies, or of what they would do if higher numbers of women accessed delivery services.

3. 'We Have No Choice': Reflections of Women, Health Workers, and TBAs on Their Expectations, Limitations, and Frustrations Related to Delivery Care

All participants expected women to go to a health facility for delivery and expected health workers to provide appropriate delivery services. However, as detailed above, data revealed severe limitations in accessing, using, and providing quality care. As a result, many women had little or no real choice about where and how they delivered, and health workers often had limited choice and capacity in providing delivery services. Furthermore, many TBAs did not want to, but at times had no choice but to, support women through childbirth outside health facilities.

a. Women's Perspectives: Is the Government or the Individual Responsible for Delivery Care?

Women interviewed by the study who delivered in facilities largely attribute the failure of other women to access services due to cost and transport barriers. However, a few respondents felt it was due to the failure of women to get organized for childbirth, and indicated support for implementation of village by-laws that require women to deliver at health facilities, with fines for those who do not.

On the other hand, the women who never or occasionally deliver at a health facility thought that nurses should be more accepting of people's situations, and appreciate mitigating circumstances rather than be abusive. For example, a woman might have been ill and unable to prepare her money and supplies, or might have delivered at home due to a short labor and this should be understood when she goes to the facility with the newborn baby.

In general, women felt that the role of health workers was to provide good quality care, meaning care that is professional and offered with humanity. While many women appreciated that health workers may have a heavy workload, there was an implicit expectation in women's testimonies that the services provided and standard of care at health facilities could be better with improved professional norms. Women felt that the way they are treated at health facilities is not dignified and respectful.

> *"I would like to be treated properly when I go for delivery at the hospital. When we go into labor, we should feel free to run to the hospital. I am saying this because when we get there, we don't get the assistance we need. So all we want is for you to help us and ensure we get proper treatment and quality care at the hospital."*

Women also felt that it was the government's responsibility to ensure that adequate delivery services are provided.

> *"We (women) ask to be given gloves… They should bring us kerosene and they should bring us those items like razor blades. We should find those things there. If we are to carry anything from home it should only be our clothes that we will wear. I can prepare my clothes and those of the baby, but the government should do the other things."*

Lastly, in some discussions, male involvement in maternal healthcare was raised, and health workers did mention trying to involve men in birth preparedness. However, in discussions with women, lack of male involvement did not emerge as a barrier to accessing services.

b.Health Workers' Perspectives: Room for Change?

Most health workers focused on the responsibility of women to be prepared for childbirth. Their own role was largely to inform women and their partners on what they needed to bring to effectively utilize the health facilities. Some staff acknowledged the barriers that many women face – particularly the distance to facilities and difficulties of getting transport – but health workers were not generally sympathetic to the challenges women face in coming prepared for delivery. Health workers largely attributed women's failure to adequately prepare for delivery to women's lack of focus on the issue.

> *"I don't think people take this matter very seriously. A person carries her pregnancy for nine months. She reaches nine months and she is to give birth. When she comes here she will come with just two pairs of old khanga. Now it is difficult. What is she going to use to cover herself with? What shall she use for her baby? It is a big problem, if you*

ask them they will tell you that they were still preparing. Nine months and still one is preparing?"

In addition, some health workers referred to the negative behavior of clients, and the difficulties this created in providing services.

"Whatever you tell a patient, she will tell you, 'That is your job'. For example they can drop water in the ward or leftovers or any other type of dirt. If you tell her not to do that, she will reply, 'Clean the place; that is your job.'"

"Some patients don't want to follow instructions. These are really stubborn."

Health workers also considered it was their responsibility to provide clinically appropriate care. In general, they seemed to take it for granted that they were providing technically appropriate services, albeit within the severe constraints of the health system. Participants discussed some aspects of their role as providers of care, but this was overshadowed by their concerns about workload and working environment. A few expressed frustrations at the contradiction between stated government policy that women should receive free services during pregnancy and childbirth, and the reality of routine supply shortages at facilities. One participant proposed that the government has a specific responsibility to assist women who are in difficult circumstances:

"If it is possible, I would suggest that there should be some equipment and requirements ready for emergencies, and maybe there should also be some money set aside to help those women who have no money at all. This should be like a loan to that woman. She will then come and pay when she recovers. The money should be there for this task only…"

Some health workers indicated they had developed a pragmatic response to a shortfall in supplies and equipment or their working environment, such as retaining scarce supplies only for those who looked least able to purchase them. It was rare, however, that a health worker critiqued the situation. Respondents seemed to view obstacles and limitations as the normal operating context rather than as problems to overcome. For example, the data does not tell us why gloves are often not available, and whether this is a question of 'policy' or poor logistics. Health workers did not discuss – or were unaware of – the reasons why breakdowns in the supply chain occur, or who is responsible for fixing them. This raises a number of issues. Do health workers have expectations that things can be improved? Do they recognize potential for change and see what things could change? Do they perceive themselves as having a role to play in improving health service provision?

c. Traditional Birth Attendants' Perspectives: Referral or Delivery Services?

TBAs want women to deliver at health facilities, but some related that they had no choice but to assist the women who came to them without the resources or time to get to a health facility for childbirth. No evidence indicated that TBAs influenced women to deliver at home. Indeed, most TBAs interviewed did not have any prior interaction with the pregnant women they

referred to facilities or supported through delivery. TBAs recognized that only health facilities can provide the technical interventions to prevent or treat complications during childbirth, and they acknowledged that they do not have the basic supplies for safe and hygienic delivery. TBAs were also aware that under the government's policy, they are not allowed to perform deliveries.

However, as de facto service providers sought out by women and often recognized by local health workers, TBAs expressed frustration at the lack of recognition for their role by government authorities and the women they assist. In practice, the TBAs referred and accompanied some women to facilities, and delivered others. The findings indicate that TBAs do not necessarily ask for payment but there is a working assumption that a woman will give a small sum in return for assistance. Women in the study referred to TBAs charging as much as Tsh 6,000 – 7,000, but the TBAs interviewed frequently complained that the women they helped did not pay them at all. To enable them to continue providing support to women in their villages, TBAs seek better clarity and recognition of their role, greater interaction with health facilities and staff, adequate training and materials to enable safe delivery where necessary, and reasonable payment for their services. However, a number of TBAs strongly expressed that they preferred not to be called upon at all. Of note, according to the TDHS, only 14% of rural women in Tanzania deliver

with a TBA or Village Health Worker, compared with almost 40% who deliver alone or with a relative, indicating that rural women are not typically delivering with a TBA as often assumed (NBS, et al., 2005).

Box 3 provides details of the characteristics of the TBAs involved in the current study.

Box 3: The Characteristics of TBAs Interviewed

The TBAs in the study were overwhelmingly older women; the youngest was forty-two years old. In some interviews, the ages of the TBAs were not recorded, but the interviewers refer to the women as 'grandmother'.

Most participants had limited formal education; many were unable to read and write. A number referred to being 'taught' their skills by other women, often their own grandmother. Lessons included, for example, to not use their hands to check the progress of labor, or to just be with the woman during childbirth, to let her sit, hold a stick, or otherwise support her. Some participants had been initiated in female genital cutting prior to becoming TBAs.

Most of the TBAs had participated in some formal training provided by health workers and had obtained a certificate. Several TBAs cited that they had been required to pay for their certificates after completing their training. The TBAs interviewed showed awareness of HIV transmission and the need to use gloves and a new razor blade during delivery, as well as the overall need for cleanliness and hygiene. They understood that women can suffer complications and that these women need to be referred to a facility. The TBAs also demonstrated knowledge that they are not supposed to deliver women, and that they should certainly not deliver young girls and older women, which reflects the government policy that first pregnancies and higher order deliveries (para 6 and higher) should take place in a hospital.

The number of women assisted by the TBAs varied widely. One participant cited supporting only one birth in the past year; another referred to assisting ten deliveries per month. Almost none of the TBAs cited having problems with the women they assisted or their babies. However, two TBAs talked about a baby dying.

RECOMMENDATIONS

Tanzanian women want to deliver in health care facilities. Study data show they were knowledgeable about the potential complications of childbirth, and recognized that the appropriate medical care to prevent or manage complications is only available at health facilities. But their testimonies also reflect that, despite this clear and informed preference, poor women and those in remote rural areas often cannot reach or afford safe delivery at a facility.

The recommendations of this report, therefore, focus on strategies to overcome the key barriers women face in accessing and using delivery services, and the barriers health workers face in providing quality delivery care. Removing these barriers is vital for enabling all Tanzanian women to translate their clear preference for facility-based birth into reality, and to ensure that all mothers are able to realize their basic right to be safe in pregnancy and childbirth. The key research findings for each of the three categories of barriers identified by the study are summarized below with accompanying recommendations to strengthen maternal health services.

1. Barriers to Accessing Health Facilities

The major barriers cited by women in accessing facility-based delivery included the distance to the closest facility, the lack of affordable transport at the time of labor, and the formal and informal charges incurred for delivery at a facility. These findings are consistent with findings from the TDHS 2004/05. In that study, the 'big problems' perceived by women in accessing health services were: 'distance to health facility' (38%); 'having to take transport' (37%); and 'getting money for treatment' (40%) (NBS, et al., 2005).

However, the current research also found that the costs of preparing for facility-based birth represented a further significant financial obstacle to women and their families. Due to routine stock-outs at health facilities, women were instructed by health workers to bring essential medical supplies – such as rubber gloves for the birth attendant, razor blades, a rubber mat for delivery, and thread for stitching – as well as new clothes. Participants also related that they commonly had to buy and cook their own food at the health facility, collect and/or bring water, and carry lamps and kerosene for light. In addition, women described paying formal service costs, as well as unexplained 'informal' charges that were demanded by health workers before they would provide care or services. Accumulated together, these out-of-pocket expenses were often prohibitively high, such that many women had little or no choice but to deliver at home.

Recommendations

- **Disseminate, implement, and enforce nationally the Government policy exempting women from paying for maternity care.**

Comprehensive and clear information on the exemption policy for pregnant women must be

disseminated nationally. Women and their families need to know their right to free pregnancy and delivery services, and health workers and local authorities need to know and effectively implement the policy, so that health services are provided without charge (i.e., free of both official and unofficial fees), and no pregnant woman is denied care. Importantly, the policy needs to cover all fees for pregnancy, delivery, and post-delivery care. Essential medical supplies for delivery must be provided to women free of charge, consistent with the Government's statement that no pregnant woman should have to provide a 'delivery kit' for childbirth.

A national monitoring system will be needed to ensure that the exemption policy is effectively implemented, and that adequate supplies for delivery are available at facilities. To achieve this outcome, health budgets must be openly available and subject to public scrutiny, and facility- and district-level priorities for health services, including maternal health, must be announced and discussed with existing health management structures (such as district and facility health committees) and local government authorities (village, ward, and district councils). A public reporting mechanism on the effectiveness and failures of the exemption policy should be instituted as part of on-going health governance reforms, including processes of Health Boards and Health Facility Committees.

• Expand coverage of comprehensive EmOC (including caesarean section) to all district hospitals and to 50% of health centers by 2015, with priority to the most underserved areas. Equip all dispensaries and the remaining health centers to provide basic EmOC.

Public health facilities with the capacity to provide emergency obstetric care (inclusive of caesarean section) must be within reach of poor women and women in rural areas. As an initial strategy to expand access, this study recommends that all district hospitals and 50% of health centers be fully equipped for comprehensive EmOC by 2015, with priority to the most underserved areas. In addition, all dispensaries and the remaining health centers should be able to provide basic EmOC. This will require deployment of skilled health workers to these facilities.

This recommendation is further informed by the THDS 2004/05 and the Tanzania Service Provision Assessment Survey 2006, which show that the majority of rural women use dispensaries and health centers, where they encounter lower quality services due to lower-level cadres of staff and greater gaps in drugs and supplies. Therefore, the upgrade of health centers in rural areas – where barriers to access to hospitals are most significant – should be prioritized.

In addition, government-funded ambulances should be made available at health centers to facilitate referral of women with complications. Clear, publicly announced and monitored, guidelines on the use and management of these vehicles should be instituted. Public education campaigns should also target community leaders and families on the importance of birth preparation and emergency transport plans for pregnant women.

2. Barriers in Using Delivery Services

A number of women in the current study reported having a good experience during delivery at a health facility, and others were appreciative of the medical care and support they received from staff. However, references to unprofessional, inappropriate, and unethical attitudes and actions by health workers were commonplace. For example, women described calling out for assistance but being left alone to deliver, being refused service if they did not come with the right medical supplies, being told they were dirty or their clothes were old, or being slapped during childbirth. The evidence indicates that women also frequently feel marginalized or disempowered to access and demand quality care. As a consequence of abusive treatment and disempowerment, some women were discouraged from using facilities and now prefer to give birth at home.

Moreover, the research revealed that there were no functioning complaint mechanisms at participating health facilities. Women perceived no realistic way to lodge a complaint; indeed, some participants feared that any criticism would result in retaliation from health workers. On the facility side, none of the health workers interviewed indicated participating in a system of quality improvement based on health users' feedback. When asked about how services could be improved, staff talked about what women need to do, rather than what they could do as providers.

Recommendations

• Establish a clear and effective complaints procedure, which incorporates the views of health consumers and providers in order to inform and improve maternity care and health services, and which encompasses ethical and regulatory checks-and-balances to hold professionals accountable for misconduct or malpractice.

Health workers and their supervisors need to be informed of their responsibilities in providing quality health services to all users, while clients need to be informed about the services they can expect and the complaints mechanisms they can use when a health worker or service fails to provide proper care.

Consumers should also be able to challenge corrupt practices, including instances when they are made to pay for services that are free according to government policy. In addition, clients need to be made aware of the rights of health workers to be treated with respect. A system of monitoring should also be established to assess the effectiveness of the complaints procedure for clients, health workers, and managers as a tool for positive change, and to ensure 'whistle blowers' do not face retaliation.

• Institute, as a part of health and local government reforms, a robust health governance system that ensures accountability for the delivery of quality health services.

The existing – but weakly implemented – health governance system should be strengthened as

a matter of urgency starting with the clear assignment and communication of responsibilities to all key actors, including MOHSW, Council Health Management Teams, Health Boards, Health Facility Committees, citizens' groups, community health funds, and elected leaders and representatives. The system's main objectives should be to encourage public engagement in assessing and monitoring services and to promote continuous quality improvement working in partnership with health workers and health authorities. To be effective, all institutions and actors must be clearly allocated responsibilities in managing and implementing quality services.

• Disseminate the existing Clients' Service Charter nationally so health consumers know their health rights, and how to register concerns and complaints.

A regular process to review and update the Charter should be implemented, that involves key actors in the health governance system as well as strong public input.

3. Barriers to Provision of Quality Delivery Care

The capacity, commitment, and morale of health staff to provide high quality care needs to be actively supported through improvements in infrastructure, equipment, and supply chains at health facilities. While some women in the study requested a health facility that was closer to them, it was clear that they were not simply referring to the health facility as a building. Respondents understood that facilities need to be adequately staffed and equipped to deliver quality health services. If not, women with sufficient resources will bypass lower-level facilities, and those without the means to reach hospitals will continue to be left without appropriate care.

The testimony of health workers indicates that the shortage of trained staff, particularly at lower-level facilities, undermines the provision of quality delivery care. From the data collected, health workers at hospitals appeared to meet the basic criterion for being a skilled attendant, but it was not clear whether most staff at dispensaries and health centers were trained in midwifery or had adequate practical skills to assist delivery.

Recommendations

• Recruit and deploy trained health personnel to expand coverage of skilled birth attendance in underserved areas.

Quality services are dependent on skilled professionals to deliver them. Therefore, substantial and sustainable improvements in maternal health services can only be achieved by addressing the shortage of trained health personnel in Tanzania. Only an estimated 32% of funded health posts are staffed, so quality of care is severely compromised. More trained staff need to be deployed with a focus on expanding coverage in remote and underserved areas. Providing adequate salary and incentive packages will be critical to attract and retain qualified health staff in these locations. Further exploration of financial incentives for documented good performance would

also be useful. Other key components would include professional development and training opportunities, effective supervision, and training that emphasizes team-based, rights-oriented, service delivery.

As an initial measure, the allocation of mid-level providers (i.e., assistant medical officers) to health centers, and training providers at dispensary level in basic life-saving skills, would augment coverage. This will help to encourage women to deliver at facilities, rather than at home because they fear that no skilled workers are available at facilities.

Importantly, health workers surveyed in the current research were positive about their working relationships with colleagues and supervisors. On balance they felt qualified to do their job, but would welcome further training and continuing professional development. These findings present as a strong opportunity to promote and institutionalize team-based, rights-oriented, quality improvement systems.

• Secure supply chains for essential medical supplies. Stock-outs can no longer be accepted as normal operational context at health facilities, and officials and staff responsible for supplies must be held directly accountable for their actions.

Key medical supplies must be on hand at all times so that women are confident to seek facility-based delivery. National and district council budget allocations and procurements must explicitly and transparently reflect provision for adequate equipment, drugs, and supplies for labor and delivery services. Stock-outs can no longer be accepted, and responsible officials and staff at the Medical Stores Department (MSD), MOHSW, council representatives, and health facility managers must be held directly accountable for planning, budgeting, ordering, distribution, and monitoring of supplies. Securing supply chains will also act to improve working conditions for health workers and protect them from allegations of corruption for failing to provide essential drugs or supplies to clients.

• Ensure water, sanitation, waste disposal services, and a reliable power supply are available in all health facilities.

Women and health workers commonly cited a lack of basic infrastructure and ancillary services – water and power supply, sanitation, waste disposal facilities, space in delivery rooms and wards – as well as the routine shortages in essential equipment, supplies, and drugs to manage complications. Such severe constraints mean that health workers cannot provide adequate delivery care. Adequate water, sanitation, and waste disposal services, as well as a reliable power supply must be made available in all health facilities and in the labor and delivery wards of hospitals. Lack of space for service provision as well as privacy in labor wards also need to be addressed. To fund improvements, existing allocations for construction, upgrading, and rehabilitation of health facilities under the Primary Health Services Development Program 2007-2017 (MMAM) could be utilized.

CONCLUSION

Evidence-based planning and investment in health services as well as clear accountability for healthcare funding, expenditure, and delivery are essential to realize the basic right of all Tanzanian women to health and well-being and to achieve the objectives of 'One Plan'. For these goals to be reached, strategic action is required now, informed by the testimonies and experiences of women and health workers, and by Tanzanian best practices in healthcare.

The barriers to quality care identified by women and health workers in this study are not restricted to maternal health services but reflect systemic challenges in delivering primary healthcare. Interventions to improve women's health, therefore, must focus on strengthening basic health systems with priority given to the most under-served areas. Comprehensive strategies are urgently needed to recruit, equitably deploy and retain skilled health workers, secure supply chains of essential medical equipment and supplies, expand access to emergency obstetric care including an efficient referral system, reduce logistical and financial obstacles to maternal health services, and institute an effective governance system that holds all actors accountable for delivering quality maternity care to all Tanzanian women. With strong political will and strategic decision-making at all levels, maternal death and disability in Tanzania can be dramatically reduced.

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